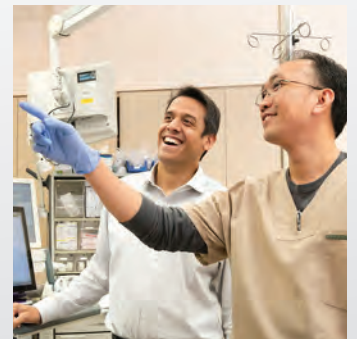


To every patient...



BETTER HEALTH



BETTER CARE



LEAST WASTE



MORE JOY

MALCOLM BALDRIGE NATIONAL QUALITY AWARD  
2020 APPLICATION



*"To every patient, every time, we will provide the care that we would want for our own loved ones."*

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## Glossary of Terms and Abbreviations

<b>Item</b>	<b>Definition</b>
<b>AAR</b>	After Action Review
<b>AC</b>	Audit Committee
<b>ACLS</b>	Advanced Cardiac Life Support
<b>Active Shooter Drill</b>	Exercise to prepare for unpredictable active shooter (gun) incident
<b>AD</b>	Associates Degree
<b>Advisory Board</b>	The Advisory Board company; 5000 member healthcare research group
<b>AHA</b>	American Hospital Association
<b>AHRQ</b>	Agency for Healthcare Research and Quality (US Government)
<b>ANCC</b>	American Nurses Credentialing Center
<b>AOS</b>	Available on Site
<b>API</b>	Associates in Process Improvement
<b>ASHRM</b>	American Society of Healthcare Risk Managers
<b>BC</b>	Better Care (the second of the Four Aims)
<b>BH</b>	Better Health (the first of the Four Aims)
<b>BLS</b>	Basic Life Support
<b>BOD</b>	Board of Directors
<b>BQC</b>	Board Quality Committee
<b>BSN</b>	Bachelor of Science in Nursing
<b>CAHPS</b>	Consumer Assessment of Health Care Providers and Systems
<b>CAUTI</b>	Catheter Associated Urinary Tract Infection
<b>CC</b>	Our Core Competency: Redesigning Care
<b>CCO</b>	Corporate Compliance Officer
<b>CDC</b>	Centers for Disease Control
<b>CEO</b>	Chief Executive Officer
<b>CEU</b>	Continuing Education Unit
<b>CFO</b>	Chief Financial Officer
<b>CGCAHPS</b>	Clinician and Groups Consumer Assessment of Health Care Providers and Systems
<b>CHAP</b>	The Community Health Accreditation Partner
<b>Chief of Staff</b>	President of the Medical Staff; an elected position by the medical staff
<b>CHNA</b>	Community Health Needs Assessment
<b>CHRO</b>	Chief Human Resources Officer
<b>CLABSI</b>	Central Line-Associated Bloodstream Infection
<b>CLRS</b>	Customer Listening and Response System (Figure 3.0-1)
<b>CME</b>	Continuing Medical Education (credit)
<b>CMO</b>	Chief Medical Officer
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CNO</b>	Chief Nursing Officer
<b>COMP</b>	Comprehensive Obesity Management Program
<b>CompC</b>	Compensation Committee
<b>COO</b>	Chief Operating Officer
<b>COPIS</b>	Customer, Outputs, Process, Inputs, Suppliers; a technique to design processes
<b>COVID-19</b>	Coronavirus Disease 2019 (COVID-19) (Pandemic)
<b>CRM</b>	Customer Relationship Model (Figure 3.2-1)
<b>CSS</b>	Community Support System (Figure 1.2-3)
<b>DART</b>	Days Away Restricted and Transferred
<b>DNP</b>	Doctor of Nursing Practice
<b>DV</b>	Domestic Violence
<b>DVT/PE</b>	Deep Vein Thrombosis & Pulmonary Embolism
<b>EA</b>	Environmental Analysis (Figure 2.1-2)
<b>EBP</b>	Evidence Based Practice
<b>ED</b>	Emergency Department
<b>EDCAHPS</b>	Emergency Department Consumer Assessment of Health Care Providers and Systems
<b>EDI</b>	Electronic Data Interchange
<b>EHR</b>	Electronic Health Record
<b>EKG</b>	Electronic Cardiogram
<b>EOC</b>	Environment of Care
<b>EOP</b>	Emergency Operating Plan

<b>EOS</b>	Excellence Operating System (Figure P.1-2)
<b>Epic</b>	Vendor for Electronic Health Record
<b>ERAS</b>	Enhanced Recovery After Surgery
<b>ESM</b>	Enterprise Systems Model (Figure 6.0-1)
<b>EVS</b>	Environmental Services (Housekeeping)
<b>FA</b>	Four Aims: 1) Better Health; 2) Better Care; 3) Least Waste; 4) More Joy
<b>FAR</b>	Four Aims Recognition
<b>FC</b>	Finance Committee
<b>FY</b>	Fiscal Year
<b>GBMC</b>	GBMC Healthcare System (parent company)
<b>GBMC Hospital</b>	Greater Baltimore Medical Center (hospital)
<b>GBMC-HP</b>	GBMC Health Partners (physician group practice)
<b>GBMC-U</b>	GBMC “University” (Leadership Development program)
<b>GHX</b>	Global Healthcare Exchange
<b>Gilchrist</b>	Providing post-acute care, geriatric care, palliative care, hospice care
<b>GPO</b>	Group Purchasing Organization
<b>GWGL</b>	“Get With the Guidelines” from the National Stroke Accrediation Agency
<b>HAI</b>	Hospital-Acquired Infections
<b>HCAHPS</b>	Hospital Consumer Assessment of Health Care Providers and Systems
<b>HIMSS</b>	Health Information and Management Systems Society
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HITECH</b>	Health Information Technology for Economic and Clinical Health
<b>HospiceCAHPS</b>	Hospice Consumer Assessment of Health Care Providers and Systems
<b>HR</b>	Human Resources
<b>HSCRC</b>	Health Services Cost Review Commission; sets the rates in Maryland
<b>IDS</b>	Innovation Determination System (Figure 2.1-5)
<b>IHI</b>	The Institute for Healthcare Improvement
<b>IMP</b>	Innovation Management Process (Figure 6.1-3)
<b>InfoWeb</b>	GBMC’s Intranet
<b>iROUND</b>	Electronic data gathering tool
<b>IT</b>	Information Technology
<b>Ivantage</b>	Benchmarking Data Source
<b>JHHS</b>	Johns Hopkins Health System
<b>JIB</b>	Job Instruction Breakdown
<b>KMS</b>	Knowledge Management System (Figure 4.2-3)
<b>KPI</b>	Key Performance Indicator
<b>LDM</b>	Lean Daily Management
<b>LDS</b>	Learning & Development System (Figure 5.2-2)
<b>LED</b>	Light Emitting Diode
<b>LMS</b>	Lean Management System
<b>LOC</b>	Language of Caring
<b>LOS</b>	Length of Stay
<b>LS</b>	Leadership System (Figure 1.1-1)
<b>LW</b>	Least Waste (the third of the Four Aims)
<b>MBSAQIP</b>	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Project
<b>MGMA</b>	Medical Group Management Association
<b>MJ</b>	More Joy (the fourth of the Four Aims)
<b>Moody’s</b>	Integrated Risk Assessment firm providing research and credit ratings
<b>MRSA</b>	Multiple Resistant Staphylococcus Aureus
<b>MSN</b>	Masters of Science in Nursing
<b>MVV</b>	Mission, Vision, Values
<b>MyChart</b>	Electronic Health Record Patient Portal via Epic
<b>NCCN</b>	National Comprehensive Cancer Network
<b>NDNQI</b>	National Database for Nursing Quality Indicators
<b>NHSN</b>	National Healthcare Safety Network of the Centers for Disease Control and Prevention
<b>NICU</b>	Neonatal Intensive Care Unit
<b>NIMS</b>	National Incident Management System Training through the FEMA
<b>NSQIP</b>	National Surgical Quality Improvement Project
<b>O/E</b>	Observed to Expected Result; based on risk-adjusted medical claims data
<b>OAS</b>	Outpatient Ambulatory Surgery

<b>OASCAHPS</b>	Outpatient Ambulatory Surgery Consumer Assessment of Health Care Providers and Systems
<b>OP</b>	Outpatient
<b>OSHA</b>	Occupational Safety and Health Administration
<b>PCMH</b>	Patient Centered Medical Home
<b>PCP</b>	Primary Care Physician(s)
<b>PDMP</b>	Process Design & Management Process (Figure 6.1-2)
<b>PDSA</b>	Plan, Do, Study, Act; Model for Improvement (Figure P.2-2)
<b>PFAC</b>	Patient Family Advisory Council
<b>PI</b>	Performance Improvement
<b>Pop. Health</b>	Population Health
<b>PMS</b>	Performance Management System (Figure 5.0-1)
<b>PMSS</b>	Performance Measurement Selection System (Figure 4.1-1)
<b>POU</b>	Point of Use
<b>PPE</b>	Personal Protective Equipment
<b>Press Ganey</b>	Vendor of CAHPS survey data
<b>PRP</b>	Performance Review Process (Figure 4.1-3)
<b>PT</b>	Prothombin; laboratory test for clotting factor
<b>QBR</b>	Quarterly Business Review
<b>QPS</b>	Quality and Patient Safety
<b>RCA</b>	Root Cause Analysis
<b>RN</b>	Registered Nurse
<b>SA</b>	Strategic Advantage
<b>SAFE</b>	Sexual Assault Forensic Examiner
<b>SAR</b>	Semi Annual Report
<b>SBAR</b>	Communication Model: Situation - Background - Assessment - Recommendation
<b>SBIRT</b>	Screening, Brief Intervention, and Referral to Treatment
<b>SC</b>	Strategic Challenge
<b>SDP</b>	Strategic Deployment Process (Figure 2.2-1)
<b>SDP Dashboard</b>	Strategy Deployment Dashboard that includes Targets to Improve (TTI)
<b>SEIU</b>	Service Employees International Union
<b>Service Line Leaders</b>	The administrator and physician dyad who lead a service line
<b>SIPOC</b>	Supplier, Input, Process, Output, Customer - a technique to manage processes
<b>SIR</b>	Standard Infection Ratio; actual vs. predicted number of infections.
<b>SL</b>	Senior Leader(s)
<b>SM</b>	Social Media
<b>SO</b>	Strategic Objective(s)
<b>SOPP</b>	Strategic Opportunity
<b>SPC</b>	Strategic Planning Committee
<b>SPP</b>	Strategic Planning Process (Figure 2.1-1)
<b>SSI</b>	Surgical Site Infection
<b>SVL</b>	Service Line Leaders
<b>SWOT</b>	Strengths, Weaknesses, Opportunities, Threats
<b>TAT</b>	Turnaround time
<b>TB</b>	Tuberculosis
<b>TCOC</b>	Total Cost of Care
<b>THA</b>	Total Hip Arthroplasty (hip replacement)
<b>TJC</b>	The Joint Commission
<b>TKA</b>	Total Knee Arthroplasty (knee replacement)
<b>Troponin</b>	Cardiac Enzyme laboratory test
<b>TTI</b>	Target to Improve
<b>VAE</b>	Ventilator Associated (Adverse) Events
<b>VOC</b>	Voice of Customer
<b>VOWF</b>	Voice of the Workforce
<b>VP</b>	Vice President
<b>VTE</b>	Venous Thromboembolism
<b>WBC</b>	White Blood Count
<b>WES</b>	Workforce Environment System
<b>WF</b>	Workforce
<b>Why Not the Best</b>	National Comparison of Publicly Reported Data and Performance Measures

## P: Organizational Profile

Imagine a couple with two young children wanting to make a lifetime of memories to savor...but instead life is painful—it's complicated with morbid obesity, hypertension, diabetes, chronic back and joint pain. Amusement parks are out of the question—you can't fit in most of the rides—even small local trips are complicated. This is the life of John and Kelly, patients in one of our medical homes. They had almost given up hope of a normal family life and being the parents they felt their children deserved.

While others may treat conditions, we take a holistic approach towards the patient and their family. We focus on what matters to them. And for John and Kelly it was the ability to live an active lifestyle, creating a lifetime of memories for themselves and their children.

When their GBMC primary care provider referred them to our Comprehensive Obesity Management Program (COMP), they were unsure if they would be successful. But when they watched the Facebook Live educational sessions in the comfort of their own home, they felt immediately connected and had hope for the first time. They engaged with our care team who connected them with other patients where they received inspiration and motivation to start the journey to achieve their dreams. Both John and Kelly made the decision to pursue bariatric surgery—a decision not made lightly. John said joining COMP was like “joining a family that wraps their arms around you” every step of the way. That is who we are and every employee responds from their heart to our vision phrase: “To every patient, every time, we will provide the care that we would want for our own loved ones.”

John and Kelly each lost over 100 pounds. Life is no longer complicated with hypertension, diabetes, and chronic pain. Their children are so inspired that they are making better diet/exercise choices. Friends and family, watching their success, have joined John and Kelly advocating for GBMC at many events and through social media. Recently, John and Kelly ran the GBMC NICU 5K along with friends and family, something that was previously impossible. John recently said on Facebook “I have a lump in my throat just thinking about it. Our children now have the parents they deserve, we are healthy and full of life.” He goes on to say, “For those just starting your journey at GBMC, you are in the right place for a second chance at life. Thanks to COMP and GBMC: Bucket list: Ride a horse at Gettysburg National Battlefield .

The family is now making the memories they always wanted—and truly living days that can be savored. Through this and the many other programs GBMC is always there to serve our community.

### P.1 Organizational Description

Nearly a decade ago our leaders committed to finding a better way of providing healthcare. We focused on redesigning health care that mirrors what we would want for our own family. In hindsight this was visionary, since the industry has since adopted the Triple Aim, population health, care redesign, and other initiatives with a similar direction, but a smaller scope. This vision has given us a 10-year head start on many others. Our core competency, **Redesigning Care**, is not one executive-level episodic event or program, but it permeates the organization every day at every level and in every strategic objective.

Throughout this application we will refer to **Redesigning Care**, recognizing that it ties to the entire fabric of everything we do for our stakeholders. For example, early on this began with establishing accredited medical homes for our primary care patients, assuring centralized coordinated care. We are now expanding this to include a fuller range of services, providing in-network specialty care, creating a medical neighborhood.

In the United States the Centers for Medicare and Medicaid Services (CMS) are the largest payor for health care services. Healthcare systems are paid through the prospective payment system in the other 49 states. **Maryland is the sole exception.**

For over 40 years, the federal government has “waived” federal Medicare rules to allow Maryland to set hospital payments at the State level. The “waiver” requires that all payers pay the same rate for the same hospital service at the same hospital. For example, Aetna and CareFirst pay the same rate for any procedure at GBMC hospital. The Health Services Cost Review Commission (HSCRC) is Maryland's hospital rate-setting authority.

At the beginning of each fiscal year, HSCRC sets the annual total revenue that they will provide for each hospital based on inflation, market changes, and quality-based outcomes (similar to CMS's Value Base Purchasing program). GBMC does not receive additional revenue for an increase in volume during the year. This means there is short-term disincentive (more work with no more money) for increased service to the community. For example, in FY2018, our volume increased, but revenue remained the same.

The "waiver" in Maryland has progressively transformed to meet the needs of the patients and give hospitals more flexibility in the management of their care. In the newest model of the waiver, adopted in January 2019, hospitals in the state of Maryland are responsible for the Total Cost of Care (TCOC) for its patients. Key elements of the TCOC Model include: 1) care coordination across both the hospital and non-hospital settings, including mental health and long-term care; 2) patient-centered care teams and primary care enhancements; 3) population health goals addressing opioid use and deaths, diabetes, and other chronic conditions; 4) quality and care improvement goals; and 5) maintaining the Medicare spending/capital in Maryland lower than the national growth rate.

The TCOC Model gives Maryland hospitals the flexibility to tailor health care initiatives, and encourage providers to drive health care innovation. Some Maryland hospitals responded by trying to control volumes to reduce cost and maximize margins.

**That is not the culture of GBMC**—we are here to serve our community, and leverage our core competency (**Redesigning Care**) to allow us to improve, set us apart, and serve those who need our help. GBMC has accepted and effectively responded to the challenges and opportunities the "waiver" presents as illustrated in the summarized Figure P.1-0.

### P.1a Organizational Environment

**P.1a(1) Health Care Service Offerings** GBMC is comprised of three key work systems: 1) GBMC Health Partners (our physician group); 2) GBMC Hospital; and 3) Gilchrist (our advanced illness, elder care, and end of life care company).

Under each of these work systems are three key work

Challenges the "Waiver" Presents		GBMC Healthcare Response
Effectively managing growth with framework of global budget revenue for GBMC Hospital	➔	Reduce inappropriate or unnecessary utilization
Population Health infrastructure cost with lagging reimbursement	➔	Maximize value-based financial incentives from payors
Opportunities the "Waiver" Presents		GBMC Healthcare Response
Transition to Value for our patients	➔	Maximize the appropriate access to care across GBMC Healthcare
Addressing unmet community need	➔	Strengthened behavioral health, diabetic, & chronic disease care

Figure P.1-0 Medicare "Waiver" Challenges & Opportunities

processes: 1) Care Access; 2) Care Delivery; 3) Care Transition.

Our clinical service lines are: Medicine; Surgery; Women and Children; Oncology; Gilchrist; Primary Care.

Figure P.1-1 shows our patient continuum from top (healthy

Innovation Culture			
Patient Continuum	Examples of Redesigning Care (Core Competency)	Impact of the Redesign	GBMC Key Work Systems
Healthy Individuals/ Individuals with Asymptomatic Conditions ~60-80% of Patients	Established Primary Care Medical Home ("PCMH")	Team approach to care delivery includes providers, nurse care managers & care coordinators	GBMC Hospital
	Increased Access	Primary care delivery staffed w/extended hours, 365 across 11 locations	
Chronic Illness ~15-30% of Patients	Addition of Episode of Care Improvement Program	Mgmt of scheduled & traumatic joint replacements post surgery	GBMC Health Partners GBMC Hospital
	Chose to Participate in Maryland Primary Care Program	Mgmt of population health metrics—i.e., diabetes, hypertension, substance abuse, & reduction of unnecessary utilization through IP & OP centralized care teams of providers & care mgmt	
	Implemented Social Determinants of Health in EMR	Social determinants w/potential to adversely effect access, delivery & transitions in care	
	Added Behavioral Health in PCMH	Addition of behavioral specialists, psychiatrists, & addiction specialists w/in all primary care locations	
	Implemented Advanced Care Mgmt in the Hospital	Increased adherence to the staff for Palliative Care utilization	
5% of Patients	Process Redesign for Throughput of Medicine Patients	Increased efficiency, effectiveness & reduce overall duration of stay	GBMC Hospital
	Reduced Unnecessary ER & Hospital Visits	Provision of appropriate clinical care through PCMH,	
	Conducted Care Planning High & Rising Risk Patients	Opened the Complex Care Clinic	
	Implemented Elder Medical Home, Home Support, Skilled Nursing Facilities, Assisted Living Facilities	Improvement of efficiency & effectiveness of clinical interventions, Care Mgmt, Counseling & Education	
Dying	Addition of Integrative & Palliative Care Team across GBMC	Hospice & Integrative & Palliative Care, Counseling & Education, Bereavement	Gilchrist

Figure P.1-1 Care Integration System

individuals) to the lower portion (end of life), and shows where our work systems and service lines are integrated to meet care requirements.

**P.1a(2) Mission, Vision, Values, and Culture** Our culture can be felt when you enter our organization or meet our people. It starts with 1) our foundational beliefs (Figure P.1-2) and is supported by our Mission and Values; it is accomplished through 2) hardwiring alignment and integration as we work in a collaborative team environment (Figure P.1-3); and is structured through 3) a disciplined focus in **Redesigning Care** around the Four Aims (FA) (**Better Health** [outcomes], **Better Care** [experience], **Least Waste** [efficiency], **More Joy** [meaningful work]); and comes to life through 4) Lean Daily Management (LDM).

**What is LDM?** LDM Rounding starts every morning (365) at 9 am: 1) Senior Leaders (SL) gather for a 5 minute report out of key organizational performance measures (i.e., incidents

of patient and employee harm) during the last 24 hours. Measures cascade and align from the strategic objectives through the FA; 2) organizational-level learning and problem-solving opportunities are identified; 3) SL divide into teams and go to the work areas. 4) In the work area front-line leaders and staff report out at their LDM board on daily measures, learnings and problem-solving (PDSA, Figure P.2-2) that occurred during the previous 24 hours. 5) SL share organizational learnings and then ask "do you have everything you need to meet your goals" and "do you have any safety concerns." If so, SL supports the staff in their improvement and help them to remove barriers. SL also inquire if there are recognition opportunities for thank you notes that are sent to staff homes. 6) After the rounds, at approximately 9:50 a.m., SL conducts a second 5-minute gathering to discuss what was seen/heard on the LDM rounds and address any barriers that may have been reported. At the action level it is a key part of our "DNA"—it connects the "front office" with the "front line." Leaders must be both approachable and accessible. Our servant leaders achieve this every morning. LDM is helping to create an organization of problem-solvers.

After several PDSA cycles of improvement, and when an LDM measure reaches a level of reliability, the metric is "graduated" to standard work. Learning is shared throughout the organization as appropriate through the Knowledge Management System (Figure 4.2-3). This process

	Cultural Component	Approach to Hardwire the Culture	Purpose/Impact
WHY	<b>Mission:</b> To provide medical care & service of the highest quality to each patient & to educate the next generation of clinicians, leading to health, healing & hope	Simplified "vision phrase" & Mission as "Health, Healing & Hope". Begins at orientation; on every employee badge; posted widely for the workforce & customers. Incorporated into key communications.	Sets the beliefs for GBMC. Guides decision-making.
	<b>Vision (phrase):</b> To every patient, every time, we will provide the care we would want for our own loved ones		
HOW	<b>Core Competency: Redesigning Care</b>	Individual performance reviews match values & corresponding behaviors & are expected that every leader role model & is an expectation of workforce. Must agree to values prior to applying to GBMC. LS used by leaders for every aspect of daily work.	Translates beliefs into values that fully align & integrate with behaviors.
	<b>Values:</b> Respect, Excellence, Accountability, Teamwork, Ethical Behavior, Results. Each value has corresponding behaviors (AOS)		
	<b>Code of Conduct:</b> Ethical & Compliance Standards & Expectations (signed annually)		
	<b>Leadership System (Figure 1.1-1):</b> How every leader leads—what they must achieve & what they cannot delegate		
WHAT	<b>GBMC Plans &amp; Goal Deployment</b> (how we measure if we are getting closer to our Vision): <b>Four Aims (FA)</b> <b>Better Health:</b> Best health outcomes for patients <b>Better Care:</b> Best care experience for patients <b>Least Waste:</b> Least amount of waste <b>More Joy:</b> The most amount of Joy for those providing care	Everything we do is integrated with the FA. SPP (Figure 2.1-1) One-year goals SPD Staff recognition - FA Award, etc.	Develops goals & plans. Deploys them across & down the system. Displays at LDM board & fully aligns & integrates plans & actions on a daily basis through LDM.
		Bi-monthly SDP Action Plan Review Service Line Review System Goals Dashboard Review	Review progress & makes adjustments to validate plans are aligned, integrated & ultimately achieved
		Lean Management using The Model for Improvement: PDSA (Figure P.2-2)	Continuously improve to achieve our vision as measured through our FA
	Improvement		

Figure P.1-2 Excellence Operating System

promotes integrated improvement and makes the Vision and FA transparent and real. Because of our work with LDM, we received the National Patient Safety and Innovation Award from the American Society of Healthcare Risk Managers (ASHRM). In addition, we frequently host other organizations from across the country who are interested in learning this best practice, including leaders from the CMS Innovation Center and the Institute for Healthcare Improvement. In 2019, based on our 7-year legacy of the LDM process and our strategic priorities we determined the need to mature our approach to a full scale Lean Management System (LMS) in targeted units. This enhanced approach seeks to optimize the "value stream" (processes by which service is delivered to the customer). LMS uses a variety of lean tools and real-time visual management of standard work to promote transparency, accountability and problem-solving that leads to value. By design, LDM and LMS are deployed differently within each work system.

The Mission, Vision, and Values (MVV, Figure P.1-2) are reviewed annually during the Strategic Planning Process (SPP, Figure 2.1-1). In 2019, through systematic evaluation, the Mission statement was revised to reflect our commitment

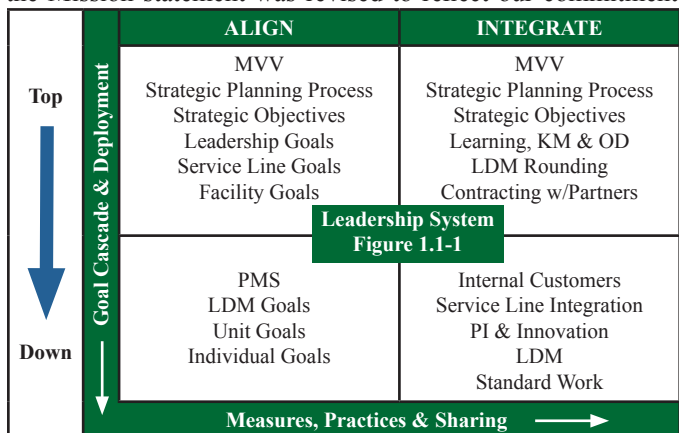


Figure P.1-3 Hardwiring Alignment & Integration

to future clinicians. We measure our progress towards achievement of the MVV through the FA. The strategic plan, strategic objectives and all measures align with the FA.

Our culture is hardwired at all levels of the organization from top-to-bottom (alignment) and across (integration), as shown in Figure P.1-3.

**Redesigning Care**, has been integral in our ability to remain independent and provide value. Value to our community not only comes in our delivery of healthcare services, but also in our commitment to our community beyond healthcare delivery. Some of our programs include provision of healthcare for underserved communities, programs with religious affiliations, the honoring of military service at the end of life, our sexual assault and domestic violence program, and our child protective services program. In addition, GBMC has a state-of-the-art Simulation Lab and is the only hospital in Maryland to use the American Heart Association's Resuscitation Quality Improvement program ensuring confidence and capability when delivering life-saving intervention (Figure 7.1-28).

**P.1a(3) Workforce Profile** Our workforce profile in Figure P.1-4 describes our physicians, nurses, other administrative and support staff, and volunteers with their key drivers for engagement. Nurses are a major component of our WF and a strategic objective has been to recruit an engaged workforce. The recent national nursing shortage, has led to a redesign of nursing career paths and expanded engagement programs AOS.

We have one bargaining unit, the Service Employees International Union (SEIU), which represents more than 500 hospital support staff (i.e., housekeeping). Key workforce health, safety, security and accessibility requirements and measures are referred to in Area 6.2c(1) and listed in Figures 7.3-7 through 7.3-10.

**P.1a(4) Assets** Our facilities include a 72-acre campus in Towson, Maryland housing the 5-story hospital inpatient tower



Customer Segment	Requirements	Category 7 Figure Reference			
		7.1a Results	7.2a(1) Results		7.2a(2) Results
		Response to Customer Requirements	Customer Satisfaction	Customer Dissatisfaction	Engagement
<b>Patients &amp; Families - See the approaches in Item 3.2</b>					
Inpatient	High quality, safe care	7.1-1-21	7.2-1	7.2-4	7.2-11
	Communication	7.1-22; 7.1-26	7.2-2-3		
	Responsiveness	7.1-27-29			
Emergency	Timeliness	7.1-30-32	7.2-5	7.2-6	7.2-14
	High quality, safe care				
Ambulatory (OP, including surgery), diagnostics, primary & specialty care	Communication	7.1-22; 7.1-26	7.2-7-9	AOS	7.2-12-13
	Access	7.1-33-34			
	High quality, safe care				
Home/Facility	Comfortable	7.1-35-36	7.2-10	AOS	7.2-15
	Respect/participatory	7.1-37			
	Access	7.1-38			
<b>Workforce - See the approaches in Item 5.2. Educational requirements included below.</b>					
Physicians	High quality, safe care	Post-graduate	7.3-22		7.3-20-21; 7.3-26; 7.4-2
	A good place to practice		7.3-6		
Nursing (RN)	Meaningful work	RN (AD, BSN, MSN, DNP)	7.3-11-12		7.3-16-18; 7.4-7
	Safe work environment				
	A good place to work				
All others (Admin/Support)	Meaningful work	Up to post-graduate	7.3-11-12		7.3-16-18
	A good place to work				
Volunteers	High quality, safe care	N/A	7.3-5		7.3-23
<b>Other Stakeholders</b>					
Community	High quality, safe care Value		Figures 7.1-1-20; 7.1-30-32; 7.1-39-40; 7.1-42-44; 7.1-49; 7.1-58		
Kaiser Permanente					
Other Payors					

**Figure P.1-4 Stakeholder Requirements**

and three medical office buildings. An additional medical office building is located in Owings Mills, Maryland. Multiple physician offices are leased throughout northern Baltimore County and Baltimore City. Gilchrist has three locations for inpatient services in Towson, Baltimore City, and Howard County.

**P.1a(5) Regulatory Environment** Health care is highly-regulated. We comply or surpass all state, and federal regulatory requirements. Other bodies include CMS, OSHA, The Joint Commission (TJC), and Community Health Accreditation Program (CHAP). We also undergo voluntary accreditation and review by a number of other professional programs (AOS).

**P.1b Organizational Relationships**

**P.1b(1) Organizational Structure** We have 23 Board (BOD) members who have fiduciary responsibility for the system. The Nominating Committee selects a diverse cross-section of the community. The ex-officio members are: the CEO, the Chief of Staff (President of the Medical Staff), the Vice Chief of the Medical Staff, and the Chair of the Gilchrist BOD. Gilchrist is the one subsidiary that has a BOD. The GBMC BOD has oversight for the Medical Staff.

The President/CEO reports to the BOD and SLs report to the CEO. The Chief of Staff reports directly to the BOD and is a SL member.

**P.1b(2) Patients, Other Customers, and Stakeholders** Patients are the key customer group. Other key stakeholders include payors, Kaiser Permanente and the community. Kaiser Permanente (a leading \$80 billion health care provider) selected us to provide care for its patient population in the Baltimore area based on our ability to provide high-quality, safe value-based care. Figure P.1-4 provides key customer and stakeholder groups, key requirements, and performance expectations.

**P . 1 b ( 3 ) Suppliers, Partners, and Collaborators** Systematic communication approaches help ensure achievement of KPIs that are linked to the FA and promote agility in a rapidly changing healthcare environment.

Transparent understanding of our needs has resulted in innovation and improved results. Figure P.1-5 outlines our partners and their role in key supply chain requirements.

**P.2 Organizational Situation**

**P.2a Competitive Environment**

**P.2a(1) Competitive Position** Our primary service area encompasses a population of over 1.2 million people within portions of Baltimore, MD, and segments of the surrounding Baltimore, Harford, Carroll, and Howard Counties. While the population of the service area has remained relatively constant, the demographics have changed with an increase in the elderly and a decrease in women of childbearing age.

GBMC Health Partners primary care offers our patients a patient-centered medical home (PCMH) in 11 locations. Each of the locations provides care management, behavioral health services, and rotating multi-specialty practices on site. None of our competitors offer this complement of services in a PCMH setting. GBMC Health Partners includes the largest employed group of primary care physicians in our primary service area. Our investment in the PCMH is now a strategic advantage as measured by growth in primary care patients (Figure 7.5-10).

Gilchrist is the market leader in advanced illness and end of life care serving over 1,000 patients daily, compared to its primary competitor (Figure 7.5-9).

(See Figure 6.0-1)	Suppliers Collaborators Partners	Role in Services	Enhance Competitiveness	Role in Contributing/Implementing Innovation	Key Supply Chain Requirements
Systems that Guide	Premier	Supply Chain GPO Value analysis	Competitive pricing; Waste reduction	Actionable data, clinical best practices & efficiency improvement strategies	Value, quality/cost
Systems that Work	Sodexo	Hotel services (i.e., EVS, transport, food)	Expertise	Bring best practices—nutrition, cleaning, infection control, transport	Improve CAHPS, reduce infections
	JHHS Partnerships	Specialty services	Access & integration of care	Access to new technologies & techniques	Quality metrics (i.e., readmissions)
Systems that Support	Continuing Care Partners	Services that augment care for our patients	Access & integration of care	Transition guides for complex high risk patients	Quality metrics (i.e., readmissions)
	Epic	Integrated electronic health record	Aggregation & data sharing	Clinical workflows & best practices	One patient, one seamless, integrated care record

Figure P.1-5 Key Partner Relationships

**P.2a(2) Competitiveness Changes** These key competitive changes have affected our competitive situation.

**Key Change:** Competitor is now part of a large hospital company. **Redesigning Care:** Strengthened population health approach across the care continuum. **Key Change:** Ongoing market shift by the HSCRC. **Redesigning Care:** Strengthened focus on appropriate care, at the appropriate place, at the appropriate time. **Key Change:** Increased competition for clinical staff. **Redesigning Care:** Developed an ANCC accredited practice transition residency program. **Key Change:** Tuesday, a key competitor closed its pediatric ED, inpatient unit and child protective services. **Redesigning Care:** Friday, a plan was in place to accommodate increased volume.

**P.2a(3) Comparative Data** Key sources of comparative and competitive data include comparisons in Maryland as well as national benchmarks such as CMS, AHRQ, Press Ganey (PG) and Epic. When national or local benchmarks are not available, we rely on Baldrige healthcare organizations. Limiting factors to comparisons include: 1) some comparisons are not publicly available or do not exist; 2) some comparisons (especially from CMS) only give us the mean; 3) some comparisons lag by up to 18 months; 4) for Gilchrist and GBMC HP, comparisons are limited, and 5) many organizations measure very similar items differently, so comparisons are not valid. Where these situations exist, we use the best comparison available. Direct competitor performance data is not typically reported. In some areas where

we are a leader and there are no comparisons, we track against historical performance, i.e., leading edge sim lab.

**P.2b Strategic Context**

During the SPP, strategic challenges and strategic advantages are identified, aligned with health care services, operations, societal responsibilities, and workforce (Figure P.2-1).

**P.2c Performance Improvement System**

Our Performance Improvement (PI) System is The Model for Improvement—Plan, Do, Study, Act (PDSA, Figure P.2-2). The Model for Improvement was developed by Associates in Process Improvement (API), used by the Institute for Healthcare Improvement (IHI). The Enterprise Systems Model (ESM, Figure 6.0-1) shows everything we do as a process. The model for improvement is used to improve all processes. Once a process is mature and stable, it creates Standard Work. Process owners are expected to improve their processes. If process owners do not achieve improvement, it is quickly seen through the reviews in Figure 4.1-3, and the discussions during LDM.


Model for Improvement	1. What are we trying to accomplish? 2. How will I know if the change is an improvement? 3. What change will we make that will be an improvement?
Improvement Approach	PDSA 

Figure P.2-2 Performance Improvement System

Four Aims	External Strategic Challenges	Success Factors for Any Healthcare Organization	Strategic Advantages	Strategic Opportunities	Continued in Figure 2.1-3	Strategic Objectives
Better Health	<ul style="list-style-type: none"> <li>TCOC model</li> <li>Competition</li> <li>Behavioral Health</li> <li>Financial risk with quality outcomes</li> <li>ED Utilization</li> </ul>	<ul style="list-style-type: none"> <li>Evidence-based outcomes</li> <li>Leader in <b>Redesigning Care</b></li> <li>Performance Improvement &amp; Innovation system</li> </ul>	<ul style="list-style-type: none"> <li>Mature deployed advanced primary care model</li> <li>Signature services</li> <li>Gilchrist</li> </ul>	<ul style="list-style-type: none"> <li><b>Redesigning Care</b> rewards</li> <li>Strategic partnerships</li> <li>Behavioral Health</li> <li>Increase marketing</li> </ul>	<ul style="list-style-type: none"> <li>1. Redesign care to provide value to our patients/community</li> <li>2. Lead in addressing key elements of the Behavioral Health needs of our community</li> <li>3. Improve health equity</li> <li>4. CAHPS by health service entity</li> <li>5. Expand, modify, or create new GBMC Healthcare offerings</li> <li>6. Improve critical systems</li> <li>7. Improve operational efficiency &amp; effectiveness</li> <li>8. Workforce engagement</li> <li>9. Safe work environment</li> </ul>	
Better Care	<ul style="list-style-type: none"> <li>Stakeholder expectations</li> <li>Age &amp; functionality of health system facilities</li> <li>Innovative/creative culture</li> </ul>	<ul style="list-style-type: none"> <li>Innovative/creative culture</li> <li>Meet stakeholder needs</li> <li>Patient loyalty</li> </ul>	<ul style="list-style-type: none"> <li>Key partners</li> <li>Brand &amp; Reputation</li> </ul>	<ul style="list-style-type: none"> <li>Tele-health &amp; other innovative deliveries of care</li> </ul>		
Least Waste	<ul style="list-style-type: none"> <li>Global Budget System</li> <li>Reduce unit cost of services</li> <li>Funding LT capital needs over</li> </ul>	<ul style="list-style-type: none"> <li>Improvement</li> <li>Sustained profitability</li> <li>High quality/Low cost</li> <li>Patient experience</li> </ul>	<ul style="list-style-type: none"> <li>Philanthropy &amp; community support</li> <li>Incentives to manage total cost of care</li> </ul>	<ul style="list-style-type: none"> <li>Growth in strategic partnerships</li> <li>Data analytics</li> <li>Rate of improvement</li> </ul>		
More Joy	<ul style="list-style-type: none"> <li>Supply/demand for providers</li> <li>New workforce competencies</li> <li>Identify needs &amp; recruit effect.</li> <li>Limited workforce/quality resources</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment &amp; retention</li> <li>Effective visionary leadership</li> <li>Multi-specialty physician org.</li> </ul>	<ul style="list-style-type: none"> <li>Culture &amp; GBMC Brand</li> <li>Agility</li> </ul>	<ul style="list-style-type: none"> <li>Workforce diversity</li> <li>Agility</li> <li>Succession planning &amp; retention</li> </ul>		

Figure P.2-1 Strategic Context

# 1: Leadership

## 1.1 Senior Leadership

Leaders at all levels lead the organization using the integrated Leadership System (LS) (Figure 1.1-1). Over a decade ago, Senior Leaders (SL) developed this with transparency and input from leaders throughout the organization. At that time, it was tested, refined, and implemented and is integral to the deployment of the mission, vision and values (MVV) and the achievement of strategic objectives (SO) and goals. Our CEO John Chessare personally led the development and deployment of this system which is reviewed at each leadership meeting and updated annually as part of the Strategic Planning Process (SPP, Figure 2.1-1, Steps ①–③).

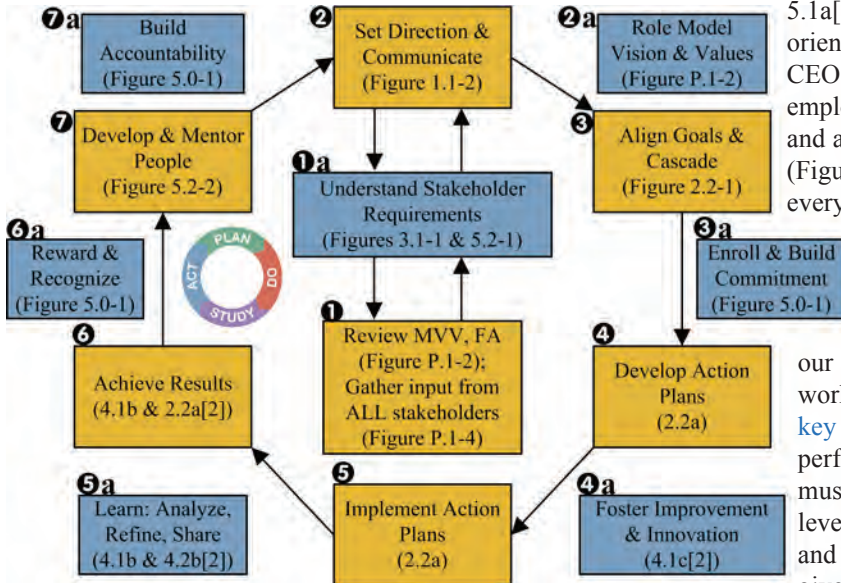


Figure 1.1-1 Leadership System

In the LS (Figure 1.1-1), the yellow boxes (①–⑦) are activities leaders must ensure are performed effectively. Multiple cycles of learning have strengthened our ability to systematically teach leaders the skills needed to lead, and to analyze and evaluate their performance against those skills (Figure 5.0-1). The blue boxes (①a–⑦a) are responsibilities no leader can delegate and must role model. Every leader is responsible for reviewing the *MVV, Four Aims (FA), and Stakeholder Input* ①. With an *Understanding of The Stakeholder Requirements* ①a they must *Set Direction and Communicate* that direction ②. All leaders must *Role Model the Vision and Values* ②a as they *Align Goals and Cascade* them ③. In cascading goals leaders must ensure the workforce understands them and are *Committed* to their achievement ③a. To achieve the goals, *Action Plans are Developed* ④ which are designed to *Foster Improvement and Innovation* ④a. When the *Action Plans Are Implemented* ⑤ leaders must *Analyze* the results, *Refine* the approach and *Share* knowledge of what works ⑤a. Leaders are expected to *Achieve Results* ⑥ (their goals) and *Reward and Recognize* ⑥a those people who contributed to the success. This includes their responsibility to *Develop and Mentor People* ⑦ to *Build Accountability* ⑦a. Throughout the LS process, PDSA (Figure P.2-2) is used to continuously improve by studying data and making changes to achieve goals by **Redesigning Care**.

## 1.1a Vision and Values

**1.1a(1) Setting Vision and Values** Our [mission statement](#) was set over 50 years ago and still guides us today. In 2010 SL and the Board of Directors (BOD) conducted a vision retreat and developed the current [vision](#) and [values](#) to lead the organization through a transformation to the delivery of preventative care and population health. The MVV are reviewed during the annual SPP by all key stakeholders and most recently the mission statement was revised to more fully reflect our commitment to future clinicians. Feedback is elicited on relevance and potential improvements. The MVV are fully deployed to the [workforce](#) (WF) starting with the hiring and onboarding process (Area 5.1a[2]). The first agenda item of every new employee orientation includes a session given personally by the CEO about the MVV and their importance to the WF. All employees sign a MVV commitment statement upon hire, and are evaluated on their values and behaviors annually (Figure 5.0-1). All [leaders](#) continue to [deploy the MVV](#) every day using the LS (Figure 1.1-1 ①) and through Lean Daily Management (LDM, Area P.1a[3]) where the entire SL team are active participants.

During the systematic contract negotiation process with key suppliers, we discuss the MVV, our core competency (CC), and the importance of their work in achieving our goals. They are deployed to [key suppliers and partners](#) in contracts, and are part of performance reviews. Clinical suppliers and partners must have 2 quality metrics to validate their performance levels. The results of these reviews are shared with SL and BOD. [Other stakeholders](#), including patients, are given the opportunity to continually give us feedback where we have opportunities for improvement (Figure 3.1-1).

SL's [personal actions reflect a commitment to the values through](#): 1) their performance evaluation vs. the values; 2) their responsibility to evaluate each employee vs. the values; 3) all leadership processes starting with the MVV (Figure 1.1-1 ①); and 4) their personal responsibility to be a Role Model for Vision and Values (Figure 1.1-1 ②a).

**1.1a(2) Promoting Legal and Ethical Behavior** Ethical Behavior is one of the Values and is role-modeled by SL through the 4 steps above. In addition, SL's use an 8-step approach (Figure 1.2-2) to [demonstrate their commitment](#) to and promote an organizational environment that requires legal and ethical behavior. Leaders are evaluated by their [personal actions](#) to support the values through the performance management system (Area 5.2c[1]).

SL [promote an organizational environment that requires legal and ethical behavior](#) by setting the standard for zero tolerance for non-compliance. The Chief Compliance Officer (CCO) has responsibility for oversight and reports up to the BOD Audit Committee. Ethical behavior is promoted throughout the organization in the *Great Save Wednesday Story*.

## 1.1b Communication

SLs communicate and engage with the entire [WF, patients and other key customers](#) through the deployment of LS (Figure 1.1-1 ②) and through the Communication Process (CP, Figure

1.1-2). In Steps ①–④, communication goals and tactics are identified and the strategy determined. The details of the tactics (AOS) shows 37 tactics under the categories of: *Meetings* (Internal and External); *Electronic*; *Direct Mail*; *Social Media*; *Recognition*; and *Direct Employee*. This grid also defines the *Purpose*, *Key Customers* (for the communication), and *Frequency*. Under the *Purpose* communication category, 19 tactics are used to communicate **Key Decisions and Organizational Change** (Area 5.1a[3]). Twenty two techniques are **frank two-way communication**, each of which are validated and measured individually for effectiveness. Effectiveness of communication is monitored (Step ⑥) and if not effective or timely (Step ⑦) the strategy is modified or replaced using PDSA. An example was Facebook live events. When surveyed, 27% reported making a change in their healthcare as result, moving them through the Customer Relationship System (CRS, Figure 3.2-1).

The CEO’s Blog, published weekly and open for comment, communicates both Key Decisions, and Organizational Change. This also is a **direct means of motivating the WF toward high performance and a patient, business and customer focus**.

LDM and the Leadership Cascade reinforces a focus on high performance. SO are visually aligned to each LDM metric. The Leadership Cascade focuses on one metric and how each person can impact. It also includes the Vision Dashboard and related values. In a cycle of improvement, the CEO shares a video with the WF highlighting the dashboard, connecting their work to the vision, and providing key information about organizational change.

As we write this application amid the **COVID-19 pandemic**, our processes for two-way communication have been effective. We used technology to find new ways to virtually communicate, internally and externally, to update key decisions in the rapidly changing environment. For example, the CEO video has been aired on social media and local television stations to address public safety and provide assurance for the WF and community.

**1.1c Mission and Organizational Performance**

**1.1c(1) Creating an Environment for Success** SLs take action to **create an environment for the achievement of our mission** and ensure that it is **successful now and will be in the future** through the LS setting direction (Figure 1.1-1 ②), and through the SPP (Figure 2.1-1). Additionally, we use a systematic Sustainability Process (AOS), led by the CFO and a team comprised of SLs. During the SPP and quarterly, the Sustainability Team reviews 13-factors to ensure we remain sustainable in these areas: **Operational Factors** (now = short-term): 1) safety; 2) people (including **fostering a culture of customer and WF engagement and culture of patient safety**); 3) critical skills (including **individual learning**) 4) facilities and equipment; 5) money; 6) data; 7) distribution channels; and 8) supply chain. **Strategic Factors** (in the future = longer-term): 9) an **environment of achieving our mission**; 10) **patient and customer engagement**; 11) an environment for **accountability, organizational culture of agility, organizational and individual learning, innovation and intelligent risk taking**; 12) focus on strategy achievement; and 13) **succession planning** (Area 5.2c[4]) and leadership skills (the **development of future leaders**). These 13 factors are included in a Sustainability dashboard (AOS).

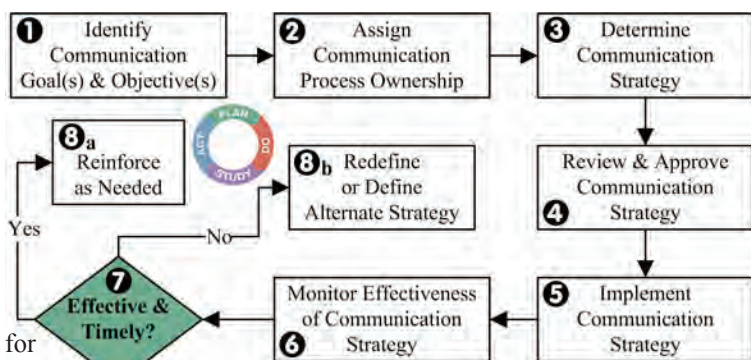


Figure 1.1-2 Communication Process

**Sustainability Process:** Each factor in the process is owned by a SL, who is accountable for managing a systematic approach to ensure the factor is sustainable (both short- and long-term) and assessed for its impact across *Economic*, *Social*, and *Environmental* factors (Area 1.2c[1]). They are also responsible for assessing and planning for the factor’s impact on disaster preparedness (**prevention**), ongoing operations (**continuity**), disaster **recovery** (Area 6.2c[2]). The SPP integration ensures organizational sustainability. *Sustainability Deployment* is achieved through action plans (Area 2.2a[1]). Learning occurs through day-to-day feedback, analysis, and a formal annual assessment as well as in quarterly meetings to address changes. Improvements are integrated into our SPP. This process promotes organizational learning through annual evaluation and ongoing monitoring by the SL to identify unexpected changes and needed modification of action plans. For example, in a cycle of improvement through analysis of employee engagement results, SL identified the need to engage more fully with employees working nights and weekend shifts in the hospital. As a result, key leaders are assigned to round regularly on all shifts.

**Sustainability Validation:** Sustainability is ensured through regular business reviews, business continuity reviews, and disaster preparedness reviews (Area 6.2c[2]) providing **agility, accountability, learning, innovation, and intelligent risk taking**.

**Innovation Integration:** Innovation is integrated through triggers from the following processes: 1) SPP (Figure 2.1-1); Strategic Deployment Process (SDP, Figure 2.2-1); Innovation Determination System (IDS, Figure 2.1-5); LDM (Area P.1a[2]); and the Performance Review Process (PRP, Figure 4.1-3). These triggers feed into the Innovation Management Process (IMP, Figure 6.1-3 ①).

**1.1c(2) Creating a Focus on Action** SL **create a focus on action to achieve the organization’s mission** through the LS (Figure 1.1-1) and the SPP (Figure 2.1-1). During the SPP, SL determine the Vision Dashboard Goals, and then identify the needed actions which are directly linked to achieve those goals and **improve the organization’s performance**. These are cascaded down the organization using the SDP (Figure 2.2-1). Alignment of the goals with the FA creates and **balances value for patients, other customers, and other stakeholders**. **SL demonstrate personal accountability for the organization’s actions** by owning and **setting expectations** (LS, Figure 1.1-1 ②–⑥) for the achievement of SO and goals for which they are responsible (Area 2.2a[1]). Throughout the year, progress is monitored through the PRP (Figure 4.1-3).

**1.2 Governance and Societal Contributions**

**1.2a Organizational Governance**

**1.2a(1) Governance System** We have a defined and systematic **Governance System** (AOS) that fully addresses the criteria and has been in place and improved since the organization started over 50 years ago. It’s fully deployed and has been improved throughout the years to meet the changes and complexity of a growing healthcare organization. In addition to the high-level discussion of our governance system in Area P.1b the BOD has 7 committees that provide oversight. This system integrates with the SPP and ensures checks and balances for the **protection of all stakeholder interests** as described in Figure 1.2-1. We survey best practices to stay current in **responsible governance**.

**1.2a(2) Performance Evaluation** The CEO is evaluated using the framework of the PMS (Figure 5.0-1) by the Compensation Committee (CompC) of the BOD. The CompC monitors the **CEO’s performance** quarterly based on: 1) achieving annual goals set during the SPP and on 2) the CEO’s specific goals. Annually, a formal assessment of the CEO is completed by all Board members using the Sullivan Cotter survey (a nationally recognized firm). The CompC combines the survey data and performance on individual and annual goals to assess the overall performance and support a formal feedback meeting with the CEO, the Board Chair, and the CompC Chair. The **CEO evaluates the performance of the SLs**

based on: 1) individual KPIs; 2) annual goals; 3) organizational culture; and 4) the deployment of the LS (Figure 1.1-1). KPIs for SL are reviewed quarterly by each SL’s direct supervisor. These conversations are used to **advance development and improve the effectiveness of leaders** as well as to **evaluate the effectiveness of the LS**. The CompC **determines compensation for the CEO and SL based on achievement of goals**. To ensure that compensation is competitive in the local market and nationally, the CompC commissions an annual compensation survey through an independent third party.

The **BOD conducts regular performance evaluations** through a standard self-evaluation process that allows for systematic evaluation and improvement of key governance approaches and educational needs. Annually, the Board Chair and CEO review the evaluation for the BOD **to determine the effectiveness** of the Board: 1) Board member selection; 2) decision making process; 3) meeting responsibilities as a board; and 4) meeting responsibilities individually. The BOD and BOD committees use the results of survey evaluations to **improve their governance and leadership effectiveness**. This fact-based, systematic evaluation led to two changes in governance approaches: 1) the BOD now includes the CEO in executive sessions, resulting in more transparent dialogue and timely follow-up; and 2) the BOD added focused operational reports to their regular agendas to increase transparency in operations.

Key Aspects	BOD Committee (Cmte)	Processes to Ensure the Key Aspects are Achieved	Figure or Area to Address	Results
Accountability for senior leaders’ actions	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Compensation Cmte</li> <li>• Audit Cmte</li> <li>• Finance Cmte</li> </ul>	Performance review process Legal/ethical requirements; audits internal/external Annual performance goals & review of CEO & SL Standing reports of Board Cmtes & review of goals	4.1-3 1.2-2 5.0-1	7.4-14 7.5-11
Accountability for strategic plans	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Strategic Planning Cmte</li> </ul>	BOD participates & approves in SPP Considers environmental changes Performance review process Reviews dashboard by the BOD at each meeting	2.1-1 – 2.1-3 2.2-1 4.1-3	7.5-11
Fiscal Accountability	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Audit Cmte</li> <li>• Finance Cmte</li> </ul>	Annual external independent financial audit CFO-led monthly financial reviews Holds SL accountable to achieve financial goals	2.1-1 1.2-2 4.1-3	7.5-1– 7.5-6
Accountability for Patient Safety & Healthcare Quality	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Board Quality Cmte (BQC)</li> </ul>	BQC includes members of BOD, staff, physicians & patients/families Recommends quality goals (Better Health) Reviews dashboard at each BQC meeting Approves Quality & Performance Improvement Plan (QAPI)	2.1-1; 2.1-2 2.1-4 2.2-1 4.1-3	7.5-11 BH, BC
Transparency in operations	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Governance &amp; Board Development Cmte</li> <li>• BQC, Audit &amp; Finance Committees</li> </ul>	Communication mechanisms (Figure 1.1-2) Quality & safety data published monthly on website Internal audits & publicly reported metrics 23 Board members representing diverse cross-section of the community	P.1a(2) – LDM 1.1-1; 1.1-2 1.2-2; 1.2-3 2.1-1 4.1-3	AOS
Selection of board members & disclosure policies	<ul style="list-style-type: none"> <li>• Full BOD; Audit Cmte</li> <li>• Governance &amp; Board Development Cmte</li> </ul>	BOD recommends new members COI disclosure for BOD & SL BOD reviews disclosure statements	1.2-2	7.4-12
Independence & effectiveness of audits	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• BQC, Audit, Comp &amp; Finance Cmtes</li> </ul>	BOD Audit Cmte reviews internal & external audits Internal Auditor/Chief Compliance Officer reports to the BOD	1.2-2 4.1-3	7.4-14
Protection of stakeholder interest	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• BQC, Audit, Finance &amp; Philanthropy Cmte</li> </ul>	Compliance hotline; Internal audits Medical staff credentialing Quality & safety program	1.2-2 4.1-3	7.4-12 7.4-15
Succession planning for senior leaders	<ul style="list-style-type: none"> <li>• Full BOD</li> <li>• Compensation Cmte</li> </ul>	Succession plan developed by CEO & CHRO that includes anticipated retirement year of each SL (presented to BOD Compensation Cmte)	1.1c[1], 5.2c(4)	7.4-10 7.4-12

**Figure 1.2-1 Key Aspects of Organizational Governance**

**1.2b Legal and Ethical Behavior**

**1.2b(1) Legal, Regulatory, and Accreditation Compliance** We **proactively prepare for legal, regulatory, and community concerns** with our healthcare services and operations as part of the SPP (Figure 2.1-1 in the Plan Preparation Phase, Steps **1 2 3**). During Steps **1 2** concerns are identified and analyzed. Once identified, these are **addressed and the impact of the concern anticipated** through the Legal and Ethical Behavior System (Figure 1.2-2). In Step **1** (Figure 1.2-2), SL listen and learn through: 1) calls to the compliance hotline; 2) other inputs from

patients and staff; 3) listening and learning mechanisms in the VOC processes (Figure 3.1-1) including any adverse societal impacts of our healthcare services and operations; and 4) through audits and environmental scanning of regulatory changes and industry trends. In Step 2 SL develops policies and procedures to describe standard work to uphold laws and regulations. The Code of Conduct and Appropriate Use Agreement are reviewed annually and signed by every member of the WF. In Step 3 all potential members of the WF are screened through background checks, behavioral interviewing, drug screening and profile testing. Upon hire, training begins at orientation, described in Area 5.1a(2). In Step 4, leaders using the LS (Figure 1.1-1 (Steps 2 and 7a) to set the expectation and hold staff accountable to use and follow policies. In Step 5, both internal and external audits are conducted to ensure compliance with policies and procedures. If concerns are identified they are investigated by the appropriate leader (either the CCO, general counsel or another SL) in Step 6. Corrective action plans are developed in Step 7 and monitored by compliance or quality and safety. Reports are provided on a regular basis to the BOD and other appropriate committees or leaders in Step 8.

Key compliance processes, measures, and goals are found in Figures 7.4-15 and 7.4-16 and demonstrate that we meet and surpass regulatory, legal, and accreditation requirements as appropriate to the business needs. We ensure regulatory compliance through the Quality and Patient Safety Plan and the Annual Compliance Plan (AOS). A comprehensive risk assessment process includes an annual internal audit with input from WF, leaders, and stakeholders as well as a review of the annual report from the Office of the Inspector General. Potential vulnerabilities or gaps are identified, prioritized and a work plan is developed which is monitored by the AC. Figure 7.4-16 lists our key processes, measures, and goals for addressing risks associated with our health care services and operations.

We regularly conduct reviews of accreditation standards to evaluate compliance with any changes. Monthly scheduled audits (tracers) were improved with a follow-up meeting with key leaders to review findings and facilitate effective action plans. We view the current standards as the threshold performance and seek to surpass that through our commitment to Excellence.

**1.2b(2) Ethical Behavior** We systematically promote and ensure ethical behavior in all interactions through the Excellence Operating System (EOS, Figure P.1-2) as measured by Figure 7.4-16. Every employee commits to the MVV and Code of Conduct on hire and annually commits to the Code of Conduct and the Appropriate Use Agreement (Step 2, Figure 1.2-2). Steps 3–7 of Figure 1.2-2 ensure ethical behavior in all interactions. We monitor and respond to breaches of ethical behavior through: 1) Establishing multiple listening and reporting mechanisms. 2) Encouragement of reporting of ethical issues through an Ethics Hotline and through the Safety Event Reporting System by anyone observing potential unethical behavior, including WF, patients, customers, partners, suppliers and other stakeholders. Reports are reviewed by appropriate leader (CCO, general counsel, HR, QPS) and analysis and

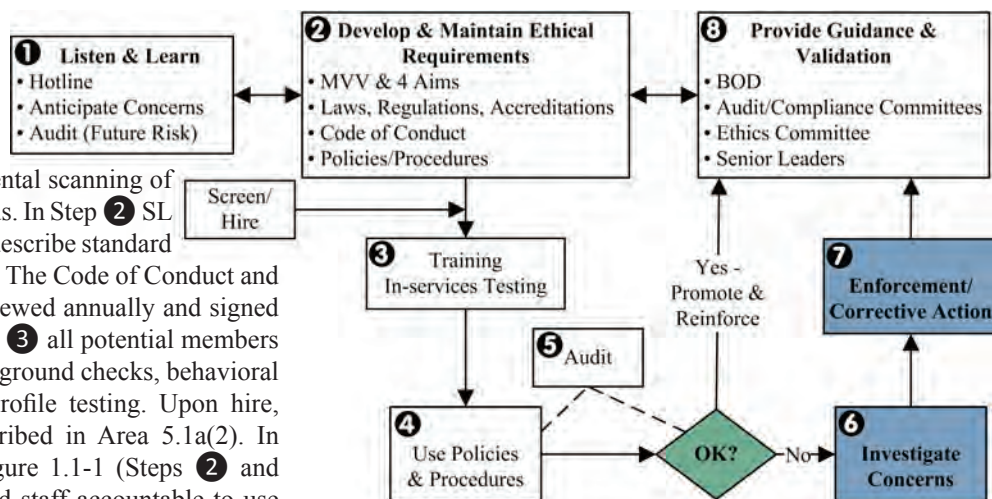


Figure 1.2-2 Legal & Ethical Behavior

investigation is completed; 3) Internal audits and external audits; 4) When an issue requires action, we use PDSA. System-wide trends or certain key issues are provided to SLs and the BOD in Step 8 of the Legal and Ethical Behavior system. In a cycle of improvement, the Chief of Staff implemented the Vanderbilt Professional Behavior Model (AOS) to address violations of ethical and professional behavior by the members of the medical staff. Figure 7.4-16 lists our key processes, measures, and indicators for promoting and ensuring ethical behavior in our governance structure.

The Ethics Committee is available anytime to assist with ethical patient or family matters. Any employee, patient or family can request a meeting.

**1.2c Societal Contributions**

**1.2c(1) Societal Well-Being** We consider societal well-being and benefit as part of our strategy and daily operations through the Community Support System (CSS, Figure 1.2-3) which is integrated into the SPP (Figure 2.1-1 1 2). We contribute to societal well-being through our environmental, social, and economic systems by integrating the community and overall society into the EOS (Figure P.1-2) as exemplified by our MVV, FA, and through our CC of Redesigning Care as part of our Care Integration System (Figure P.1-1) where we focus on meeting the health and wellness of our society. Societal considerations include the Community Health Needs Assessment (CHNA) and community request for contributions. Economic inputs are identified from the finance department, the BOD Finance Committee and other external indicators that are used to develop the SPP (Figure 2.1-1, Step 1).

Long-term, our 5-year sustainability plan focuses on a measurable and lasting green impact and energy savings, waste reduction, food and nutrition sustainability, environmental services (ensuring cleaning products and practices are environmentally friendly). Daily Operations includes sustainability through the efforts of our facilities team, and a focus on environmental protection, social responsibility and waste reduction. Learning included changing to LED lighting (\$250,000 a year in energy savings, better lighting, no toxic elements (mercury) entering the waste stream, and reduced maintenance calls for light changes). An example of contributions to the social and economic systems include our responses to the opioid crisis through programs such as Screening, Brief

Intervention, and Referral to Treatment (SBIRT) (Area 1.2c[2]) and Enhanced Recovery after Surgery (ERAS).

**1.2c(2) Community Support** We actively support and strengthen our key communities through the CSS (Figure 1.2-3). It starts with our MVV and Culture (Figure P.1-2) which defines our cultural expectations for our patients and communities (Step 1). In Step 2 CHNA is conducted every two years. These are inputs into the SPP (Figure 2.1-1, Step 1). In Step 3, we identify key communities. These are basically the communities where our employees live, and our patients work and live. Our Primary Service Area (PSA) are our key communities. It includes Baltimore city, and Baltimore, Harford, Carroll, and Howard counties. Outputs from the SPP include many SO and action plans that meet the identified community needs (Figure 2.1-3).

In Step 5, we determine the areas for organizational and/or leader involvement through the Community Benefit Steering committee which refines priorities. In Step 6 SL, in concert with the WF, identify and engage with community partners such as elder services, the American Heart Association, schools and universities, etc. to collaborate in action planning to meet the needs. They also review all requests for community financial support in Step 6a. Requests are considered in Step 6b, based on their alignment with priorities. Priority areas are focused on

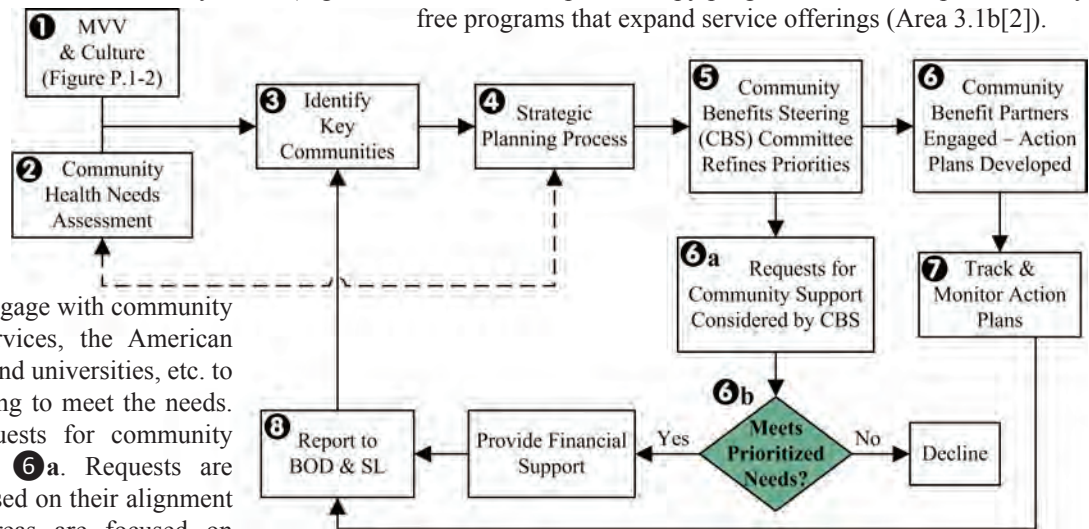


Figure 1.2-3 Community Support System

## 2: Strategy

### 2.1 Strategy Development

We develop strategy using a closed loop Strategic Planning (SPP, Figure 2.1-1) cycle that ensures that our Strategic Objectives (SO) are aligned with our Four Aims (FA) and address our strategic challenges (SC), success factors, strategic advantages (SA), and strategic opportunities (SOPP) (Figure P.2-1). Our 3-year long-term and annual short-term action plans, have goals, performance measures, targets and benchmarks. Performance is monitored, analyzed, and improved through the Performance Review Process (PRP, Figure 4.1-3).

#### 2.1a Strategy Development Process

**2.1a(1) Strategic Planning Process** We conduct our SPP using a 4-phase (Plan Preparation, Plan Development, Plan Deployment, and Review and Learn), 9-step integrated strategic planning and deployment process (Figure 2.1-1) that is aligned with our FA. The key participants are shown 10. The SPP results in a 3-year long-term plan (SO), and annual action plans (short-term goals) and, within these action plans, Targets to Improve (TTIs), and individual Key Performance Indicators (KPIs) (Steps 4–8). The SPP (Figure 2.1-1) and PRP (Figure 4.1-3) enable us to continuously review progress, identify opportunities for course correction, and innovation that support organizational agility. The 3-year planning cycle allows a longer time to change a product, service or infrastructure.

obesity, care access and mental health services based on the CHNA. SL and WF are actively engaged in community events that support these objectives. Examples of responses include our partnership with a food co-op to provide weekly fresh produce to our at-risk community; addressing mental health issues by providing behavioral health first-aid for our community; and, conducting SBIRT/opioid additional program in our emergency department.

Actions taken are monitored in Step 7 and reported to the BOD and SL in Step 8. SL's are members of the Community Benefit Steering Committee, and twice annually we conduct a Community Partners Meeting to: 1) review the CHNA; 2) evaluate the progress toward our original plan; 3) refine our actions; and 4) strengthen our integration among the Community Partners. Our philanthropy program allows us to provide many free programs that expand service offerings (Area 3.1b[2]).

SL analyze inputs for PI and innovation (transformational change) 3. Prioritization of change initiatives occurs in Step 3 (Area 2.1a[2]) to gain results better than previous performance. Organizational agility is also supported and integrated through LDM and through inputs in the Innovation Management Process (IMP, Figure 6.1-3 1) and PRP (Figure 4.1-3). As with all our systems, the SPP is deployed and improved 9. For example, during a cycle of improvement, we broadened our stakeholder analysis to include feedback from the Voice of the Customer (VOC, Area 3.1a[1]) Steering committee, which represents the interests of customers across our three work systems, Patient Family Advisory Councils and volunteers across all three work systems, and the results of our Community Health Needs Assessment (CHNA).

**2.1a(2) Innovation** The SPP is one of four inputs to innovation as shown in the IMP (Figure 6.1-3 1). During the SPP review of inputs (Figure 2.1-1 1 internal and external factors and 2 robust stakeholder surveys) leaders analyze 3, using multiple tools, including brainstorming and multi-voting, to determine and evaluate SC, SA and SOPP at a working retreat. This alignment, and the analysis in Figure 6.1-3 2, helps us to identify and prioritize strategic opportunities and intelligent risks to pursue. If the priority of the innovation is not high enough, it is held in the innovation pipeline for future

action. In cycle of improvement we added a second strategic planning retreat in Plan Development phase of the SPP (Figure 2.1-1). In the second retreat, we validate the outputs of the first retreat and to stimulate and incorporate innovation, stakeholders brainstorm innovative ideas aligned with each SO. Each of these ideas are evaluated through the Innovation Determination Process (IDP, Figure 2.1-5).

2.1a(3) Strategy Considerations Relevant data are



collected and analyzed to develop information for use in the SPP, as shown in Figure 2.1-2, Environmental Analysis (EA). This shows potential changes in regulatory and external business environment, potential blind spots in the SPP, key elements of risk, and our ability to execute the Strategic Plan. The alignment of the Strategic Challenges and Strategic Advantages to the SPP and SO is shown in the linkages within and between Figures P.2-1 and 2.1-3. Within the FA, these tables show alignment from the external factors (Strategic Challenges) all the way down to the lowest level of internal factors (Action Plans).

2.1a(4) Work Systems and Core Competencies Our Work Systems, key processes and core competencies are reviewed annually through the SPP (Figure 2.1-1) to determine which will be accomplished by WF and which will be accomplished externally. Decisions consider: our SO; CC, internal capacity and capability, and the CCs of potential suppliers, partners and collaborators.

After completing an internal assessment of capacity and capability, we conduct a “make/buy” analysis (Area 6.1c) to determine what we can achieve on our own or what should be sourced externally.

Every year through the SPP (Figure 2.1-1 1-3) we listen to inputs and validate or revise our CC using a Systematic Core Competency Determination Process (AOS). 1) We determine if there are any future work systems we may need, and 2) we identify future organizational CCs based on a review of changes to our SC, SOPP, and SA, which are key inputs to the process. As a cycle of learning, using this process, we determined our CC of Redesigning Care.

2.1b Strategic Objectives

2.1b(1) Key Strategic Objectives Our Key SO and timetable for achieving them are shown in Figure 2.1-3 (all

Planning Phase	PLAN PREPARATION	PLAN DEVELOPMENT	PLAN DEPLOYMENT	USE, REVIEW & LEARN
	<b>Redesigning Care</b>			
Timing	November–January	February–May	May–June	July–June
Key Participants	Leadership (SL/SVL)	SL/SVL	SL/SVL	SL/SVL
	Physician Chairs	Physician Chairs	Physician Chairs	Physician Chairs
	Ancillary Service Leadership	Ancillary Service Leadership	Ancillary Service Leadership	Ancillary Service Leadership
	Board of Directors (BOD)	BOD	BOD	BOD
	Key Stakeholders/Customers		Front Line Managers/WF	Front Line Managers/WF
Key Inputs & Actionable Data	See Environmental Inputs to SPP (Figure 2.1-2)	SWOT Results	Communication Strategy	Annual Action Plan Goals & TTIs
		Strategic Challenges	Innovation Opportunities	KPIs - Leadership
		Strategic Advantages	CC/SO	KPIs - Staff
		Success Factors	Annual Action Plan Goals	Financial Reports
		Strategic Opportunities	Operating/Capital Budget	Environmental Inputs
			Workforce Plan	
Outputs	SWOT Results	Innovation Opportunities	Annual Action Plan Goals & TTIs	Countermeasures
	Strategic Challenges	CC/SO	KPIs - Leadership	Financial Variance to Budget
	Strategic Advantages	Annual Action Plan Goals & TTIs	KPIs - Staff	Workforce Plan
	Success Factors	Operating/Capital Budget		Performance Reviews
	Strategic Opportunities	Workforce Plan		

Figure 2.1-1 Strategic Planning Process

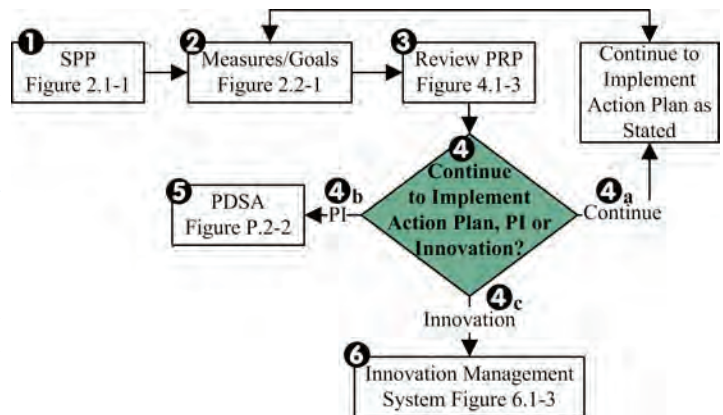


Key Elements of Risk	Collect Data	Analyze Data	Responsibility to Develop Information
<b>Strategic Challenges &amp; Strategic Advantages</b>			
SWOT	Financial Reports, EA, Gap & <b>Blind Spot</b> Review	Figure 2.1-1, Steps 1-3; Figure 6.1-3, Step 2; & Figure P.2-1, <b>Blind Spots</b>	SL, SLC, Nursing Leadership, Physician Leaders, BOD, Key Stakeholders, Key Customers
<b>Potential Changes in Regulatory &amp; External Business Environment</b>			
Regulatory Environment	Current & Future National, State, & Local Regulatory, Legal & Ethical Requirements	Review Survey Results, Gap Analysis, Audits, Mock Surveys, Concurrent Reviews, Gaps in Key Support Processes, <b>Blind Spots</b>	SL, SLC, Finance, QPS, Compliance, Legal, Suppliers, Partners
External Business Environment	All External Stakeholders (i.e., Figure 3.1-1)	Review Data Collection: Analysis through PRP (Figure 4.1-3); Innovation Management Process (Figure 6.1-3, Step 2) & <b>Blind Spots</b>	SL, SLC, Finance, QPS, Compliance, Legal, Suppliers, Partners
<b>Ability to Execute the Strategic Plan</b>			
Ability to Execute	Leadership System, Governance System, CC, Annual Goals, Targets to Improve (TTI's), Figure 2.1-3	Review of process performance for these systems & processes, Annual CC, SC, SA review, Annual review of Health Care Service Work Process Requirements, Review of Support Process Performance, Review of Key Support Process Performance & Gaps, <b>Blind Spots</b>	SL
<b>Blind Spots - See the Blue Words Highlighted Above</b>			

**Figure 2.1-2 Environmental Analysis**

detailed goals AOS). The **most important goals** are the nine SO, aligned with the FA and are identified in the longer-term planning horizon, reflected as 3-year **goals**. The external challenges are translated all the way down to actions, as shown in Figure P.2-1 and Figure 2.1-3. For example, **key planned changes** reflected in actions are identified in our SPP include: a change to Medline for our supply chain (**partners, suppliers**), expansion of behavioral health services within our primary care offices, (**healthcare services**), provision of at-home outpatient rehabilitative services in addition to our services at our skilled nursing facility on campus (**customers**), partnership in the provision of behavioral health services in our emergency department (**operations**), addition of a patient centered medical home through a new office in our core market (**markets**).

**2.1b(2) Strategic Objective Considerations SO** are balanced among the varying and potentially competing organizational needs. Balancing key stakeholder needs means we: 1) understand the stakeholder needs (Figure 2.1-1 Steps ① & ②); 2) perform analysis (Step ③); and 3) determine what balance the leaders wish to achieve (and the impact, Step ④); 4) deploy (Steps ⑤–⑧); and 5) have the ability to achieve the balance we intended. To do this our SO address



**Figure 2.1-5 Innovation Determination Process**

our **SC, SA, SOPP**, and our **CC** (the linkage is shown in Area P.2b, Figure P.2-1, Key SO Figure 2.1-3). We validate the appropriate **balance** between our key SO and **short- and longer-term planning horizons** for achieving them using a cross-needs assessment. This is a closed-loop process where the **key stakeholders** meet to validate the balance between their needs, between time horizons, and the integrated linkage (starting with the **SC** [Figure P.2-1]).

**2.2 Strategy Implementation**

**2.2a Action Plan Development and Deployment**

**2.2a(1) Action Plans** The key **action plans** are shown in Figure 2.1-3. Each **SO**, developed during the SPP has **short- and longer-term action plans** aligned with the FA (Figure 2.1-3). During Step ⑤ of the SPP (Figure 2.1-1), individual action plans are assigned to a member of SL. Through the LS (Figure 1.1-1) the action plan owner assembles the participants involved in the 1-year action plan, uses PDSA (Figure P.2-2) to **develop action plans** (Figure 2.2-1, Step ④) to achieve the desired result. This hardwires top-to-bottom alignment. Our Value of *Teamwork* ensures effective integration. Using the measures identified in PDSA, TTIs are used to evaluate progress during the SDP ④ and in Steps ⑤ and

Level/ Impact	Culture Driver	Innovation Forcing Function	Measures	Decision Making Group
<b>ORGANIZATION</b> Senior Leaders	MVV	Macro Healthcare Changes	SPP/SDP Goals	BOD & SL
	Sustainability	Maryland Healthcare Changes		
	FA & LS	Core Competency		
	SPP/SDP	Reimbursement	Overall Quality	
	PI Culture/LDM	Benchmarking		
<b>CROSS DEPT.</b>	Leadership System	SPP/SDP	Mortality	Quality Cmte, Service Line, Nursing Leadership, PI Govern. Cmte
	PI Culture & LDM	SPP/SDP	PI Measure Sustainability	
	Just Culture	PI System	<b>Redesigning Care</b>	
<b>DEPT. WF</b>	Values	PMS	CAPHS	Department Managers, Collaborative Practices
	PI Culture & LDM	SPP/SDP		
	FA & Values	KMS, Just Culture		

**Figure 2.1-4 Innovation Culture**

Continued from Figure P.2-1

Aim	1 Strategic Objective (3 Yr Goals)	Changes	2 Action Plans (Most Important Annual Goals—all goals AOS)	3 Performance Measures/TTIs	FY18	4 FY19
Better Health	1. Redesign care to provide value to our patients/community	HCS, O	Redesign the key work processes for medical patients admitted to the hospital	Reduce the ED Admit Decision to Departure time	144	109
			Readmission reduction within 30 days	Readmission rate	10.42%	10.8%
	2. Lead in addressing key elements of the Behavioral Health needs of our community	HCS, O, SP	Increase political awareness & advocacy for Behavioral Health needs at state & county levels	LOS in ED for Crisis Patients	23 hrs 6 min	24 hrs 28 min
Continuously improve out implementation of outpatient Behavioral Health Services*			Primary Care Preventative Care & Screening for Clinical Depression & Follow Up	80%	80%	
	3. Improve health equality	HCS, C, O	Design & deploy the Community Benefit System	Diabetics: Patients with A1C>9%	27%	23.0%
Better Care	4. CAHPS by health service entity	HCS, C, O	Achieve targeted customer service measures (CAHPS)	Recommend this provider office	92.0%	93.0%
			Hospital Overall	73.0%	71.0%	
		SP, C, O	Continuously adjust & align the Master Facility Plan with Strategic Objectives*	Grateful donors (\$)	Confidential	
	5. Expand, modify, or create new GBMC Healthcare offerings	HCS, SP, O	Expand the services of GBMC Health Partners*	Increase in covered lives	79,829	79,664
			Expand the services of Gilchrist	Hospice Average Daily Census	877	957
Least Waste	6. Improve critical systems	HCS, SP, O, C	Improve critical Baldrige systems	ADLI by system	50%	70%
			Operating budget	Days cash on hand	280	264
	7. Improve operational efficiency & effectiveness	HCS, SP, O	Supply Chain	GHX Overall Rank	118	58
HCS, SP			Liquidity	Cash to Total Debt	218%	277%
More Joy	8. Workforce engagement	SP, C, O	Improve Employee Engagement	Meaningful Work	4.5	4.53
			Physician Satisfaction Scores	Satisfied Working	4.29	4.32
	9. Safe work environment	O	Reduce workplace injuries	OSHA Injury Case rate	3.0	1.6

HCS: Health Care Services, C: Customers & Markets, SP: Suppliers & Partners, O: Operations; \* = Intelligent Risk

Figure 2.1-3 Key Strategic Objectives

F. SL cascades the action plan steps to the individual level to achieve the annual goal. All of the action plans are monitored and the monthly TTIs populate the annual SDP dashboard. Action plans and TTIs are reviewed monthly during PRP (Figure 4.1-3). SL expects ~80% of TTIs to be on target each month as a level of stretch is built into the determination of the end goals for the year.

**2.2a(2) Action Plan Implementation** To ensure we achieve our key SO, we use the Strategic Deployment Process (SDP, Figure 2.2-1) to deploy action plans to the WF and are deployed to key suppliers, partners and collaborators as appropriate (Area P.1b[3]) during contract negotiation, performance reviews, ongoing two-way communications, and as changes are made during the PRP (Figure 4.1-3). If the target is not met, or the action step is not completed by the expected date, the accountable SL develops a plan with their direct reports to “course correct” the action plan and TTI. These plans are monitored to get the TTI back on track to ensure that we achieve key SO. SL follows a standard process through monthly reviews that ensure accountability and progress towards TTIs that will achieve and sustain the key outcomes of the action plans. The achievement of the action plans is incorporated into the SL performance evaluation as described in (Area 1.2a[2]).

**2.2a(3) Resource Allocation** To ensure that financial and other resources are available to support the achievement of our action plans while we meet current obligations, we have a carefully managed process that incorporates the annual budget, capital budget, WF plan, and information systems.

The budget planning cycle is aligned with the SPP, thus the budgetary resources can be allocated to support action plans as they are built, and long-term budget needs are identified and incorporated into the operating and capital resource allocation processes (Figure 2.1-1 5).

Financial and other risks associated with our plans to ensure financial viability are proactively managed through ongoing environmental scanning and the PRP (Figure 4.1-3). This provides a comprehensive understanding of our current risk state and allows us to prioritize risks with the greatest impact.

**2.2a(4) Workforce Plans** Key WF plans are shown in Figure 2.1-3 under the More Joy aim. They center on the recruitment and retention of an engaged WF to support our short-and longer-term SO and action plans. To address potential impacts on our WF members, we establish key WF plans as a part of the plan development and deployment phases of the SPP (Figure 2.1-1 5-8). Each action plan owner identifies any changes in WF capability or capacity created by the SO and action plans. These WF plans are integrated with the budgeting process to address specific staffing and training needs. In our systematic process to identify and recognize potential changes in WF capability and capacity needs (Area 5.1a[1]), HR reviews WF capability and capacity with action plan owners frequently. Additionally, during the PRP (Figure 4.1-3), other key WF indicators (turnover, productivity, staffing levels, etc.) are reviewed. SL and HR determine what, if any, changes need to be made to accomplish SO.

**2.2a(5) Performance Measures** Our key performance

4 FY20 YTD	3 Year Projections	Reference Results	5 Comparison
AOS	5% improvement	7.1-39	Maryland HSCRC
AOS	Top decile in Maryland	7.1-3	Maryland HSCRC
22 hrs 36 min	22 hrs	NA	National standard def. of <24 hrs
AOS	Top decile	NA	CMS
AOS	Top Decile CMS 2019 MIPS Benchmark	7.1-19	CMS 2019 MIPS Benchm 80th %ile
94.0%	Top Decile	7.2-12	National
73.4%	Top Quartile	7.2-1	Maryland HSCRC
AOS	5%	7.4-20	Local Competitor
81,738	10% growth	7.5-10	N/A
AOS	8% growth	7.1-38	Local Competitor
AOS	Baldrige recipient	NA	Baldrige Recipients
268	Moody's A2 rating	7.5-1	Moody's A2 rating
AOS	National Top Decile	7.1-59	National
312%	AOS	7.5-3	Moody's A2 rating
AOS	Top Decile	7.3-18	National
AOS	Top Decile	7.3-22	National
AOS	<1.6	7.3-7	National/State

Figure 2.1-3 Key Strategic Objectives Continued

measures and indicators are shown in Figure 2.1-3. As described in Area 4.1a(1), we have a systematic process of data selection, collection, alignment and integration. We ensure the action plan measurement system reinforces organizational alignment through SDP (Figure 2.2-1). Figure P.1-3 describes how alignment and integration is hard-wired.

**2.2a(6) Performance Projections** Figure 2.1-3 shows our performance projections for the short- and longer-term planning horizons. We continuously scan the marketplace for strategic initiatives or initiatives of competitors that affect future performance to understand their performance and rate of change. We review performance across the organization on several timeframes (PRP, Figure 4.1-3). Any gaps between us and the current or projected performance of our competitors or organizations offering similar healthcare services are addressed through PDSA, or IDP (Figure 2.1-5), or the process described in Area 2.2b.

### 3: Customers

We use a highly integrated 7-step process, the Customer Listening and Response System (CLRS, Figure 3.0-1) to ensure that we have a closed-loop ability to continuously engage, evaluate, and execute on desired and necessary services based on what we obtain from our patients and other customers. In Phase 1, Steps 1-3 we Listen, Analyze and Evaluate the Voice of Customer (VOC, Figure 3.1-1). In Phase 2, we determine if improvement is needed in Practices 4 or in Listening 5. If change is needed it may lead to a PDSA cycle or, if strategic, it would move to Step 6 as an input to the Strategic Planning

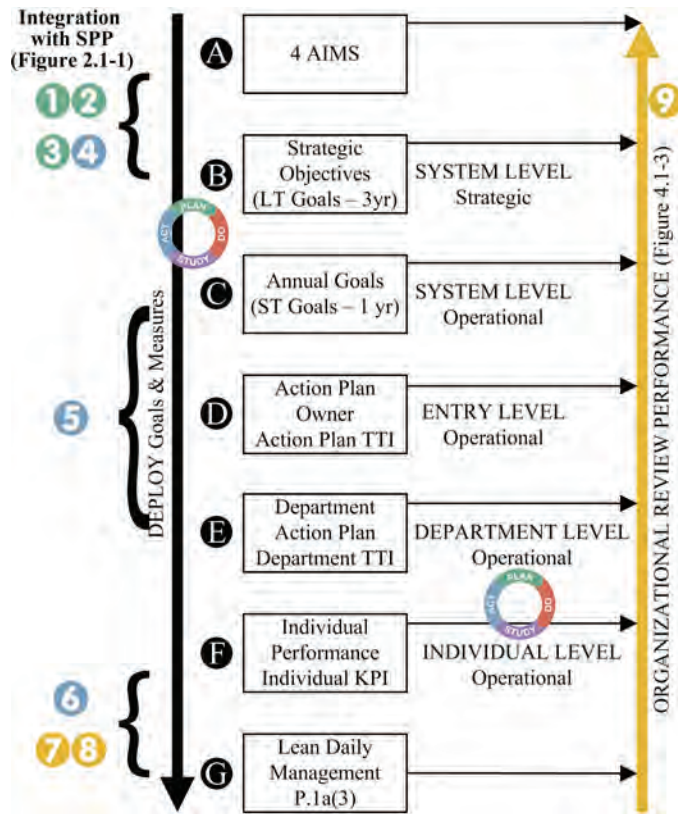


Figure 2.2-1 Strategic Deployment Process (SDP)

#### 2.2b Action Plan Modification

One of our strategic advantages is agility. We can make decisions to the executive and CEO level daily and to the board level in less than a month. Action plans are established during the annual SPP, but they can be modified at any time during the year. SO Owners are expected to proactively modify action plans, communicate with all impacted stakeholders, and course correct. Our LS (Figure 1.1-1 5, 5a, 6) requires all leaders to act when they recognize circumstances that require a shift in plans and rapid execution of new plans to achieve an associated performance measure. The PRP (Figure 4.1-3) shows when and what we review, and how we analyze and respond to improvement actions needed (PDSA or Innovation) and identify countermeasures (Figure 4.1-3, "Decisions Made" column) for plans that need modification. See example of Redesigning Care (Area P.2a[2]), Child Protective Program.

Process (SPP, Figure 2.1-1 1). If no change is needed, we continue Phase 1. The decision of whether to move to the SPP is based on the level of resources needed and length of time to address the change.

#### 3.1 Customer Expectations

##### 3.1a Listening to Patients and Other Customers

**3.1a(1) Current Patients and Other Customers** We listen to, interact with and observe patients and other customers to obtain actionable information through a wide range of

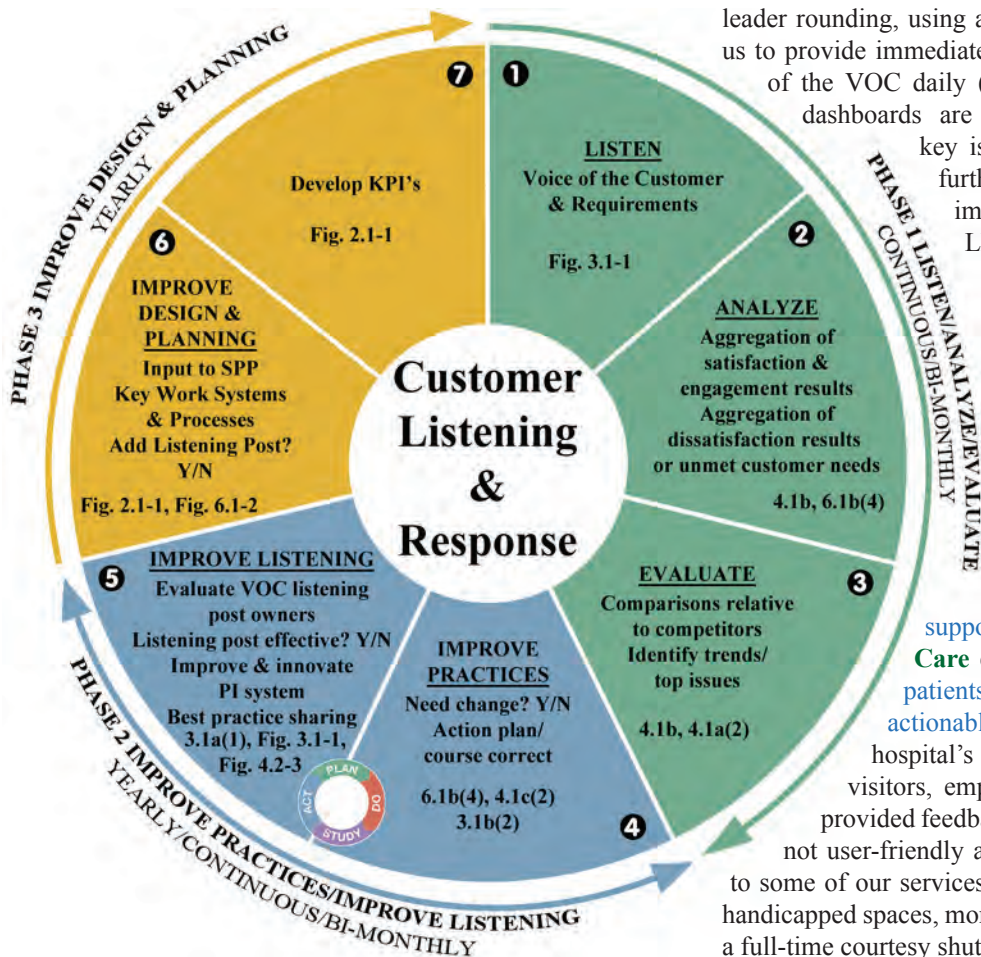


Figure 3.0-1 Customer Listening & Response System

formal and informal listening posts (VOC, Figure 3.1-1—the rows). The rows represent the various quantitative ① and qualitative ② methods and vary across all stages of patients and other customer relationships/lifecycle ⑥ (and Figure 3.2-1 Steps ①–④). Figure 3.1-1 shows how listening methods vary for different patient groups ③ other customer groups and market segments ④ (Figure 3.1-1—the columns). To ensure that we are seeking immediate and actionable feedback, each listening post (Figure 3.1-1—the rows) is assigned an owner responsible to validate the effectiveness of their listening post. This feedback includes the customer’s perception of the quality of health care services, patient and other customer support, or any aspect of their transactions with us. Area 3.2a(2) and Figure 3.1-1 ⑦ describe how customers seek information and support, obtain services, and provide feedback. Through our closed loop system all of the VOC tools are discussed at the VOC Steering committee meetings and systematically evaluated and improved as needed.

In a cycle of learning, we established objective criteria for each row owner to use in decision making relative to the actionability of their row. Using the criteria they determine if they should “Keep”, “Modify” or “Discard” their listening post (AOS). Each row is reviewed bi-monthly using the criteria at the VOC Steering Committee. This committee is chaired by the CNO, and is charged to ensure each listening post is effective, and that actionable data is identified for improvement, elevation to SPP (Figure 2.1-1), or for best practice sharing (Knowledge Management System KMS, Figure 4.2-3). Based on analysis of timeliness and effectiveness of data inputs, we implemented

leader rounding, using an electronic tool *iRound* that enables us to provide immediate service recovery and track measures of the VOC daily (Area 3.2a[1]). Weekly/monthly data/dashboards are sent to leaders to identify trends/key issues that tie to in-process measures, further enabling us to identify process improvements that can be made through LDM (Area P.1a[2]).

3.1a(2) Potential Patients and Other Customers VOC (Figure 3.1-1) also shows how we listen to potential patients, patients of competitors, and former patients ④ and other potential customers ⑤. The same process described in Area 3.1a(1) is used to obtain actionable information on our health care services, patient and other customer support, and all transactions. A Redesigning Care example of how listening to potential patients and other customers was used to gain actionable information, was the redesign of the hospital’s parking system. The PFAC, patients, visitors, employees, physicians and their patients provided feedback that the current parking system was not user-friendly and did not provide convenient access to some of our services. The new system now includes more handicapped spaces, more designated patient/visitor spaces and a full-time courtesy shuttle.

**3.1b Patient and Other Customer Segmentation and Service Offerings**

3.1b(1) Patient and Other Customer Segmentation Patient and other customer groups and market segments are systematically determined during the SPP based on customer requirements. Internal Data (Figure 4.1-3) and External Data (Figure 3.1-1) are integrated and analyzed and used as an input to the SPP (Figure 2.1-1, Step ① ②) Customer listening (VOC, Figure 3.1-1) is used to collect information on patients, other customers, markets, and health care service offerings and to anticipate future needs. Similar requirements are grouped into common customer segments and markets. If the requirements are different than our current segments, we evaluate whether we need a new segment.

Additional analysis is conducted using market share data and demographics to determine potential changes in market segmentation. For future requirements or where new requirements emerge, they are assessed to determine if they align within existing market segments and customer groups, or if a new segment is needed. We analyze competitors’ offerings, market share, image, preference and reputation positioning to determine if there are potential gaps in the marketplace that might represent a growth opportunity or a new segment. If the potential exists for a new customer group or market segment or offering, we utilize the CLRS (Figure 3.0-1 ②). Then, if appropriate, we would integrate it into the long-term and short-term business planning process of the SPP.

We determine which groups to emphasize and pursue (target) for business growth based on analysis of market demographics

Listening Posts	6 Lifecycle Fig. 3.2-1	3 Current Patients				4 Other Customers			5 Other Listening Posts			7 Customer's Use of Mechanism 3.2a(2)		
		Inpatient	Emergency	Ambulatory	Home/Facility	Potential Patients	Patients of Competitors	Former Patients	Ambulatory Service Line	Hospital Service Lines	Referral Services	Seek Info & Support	Obtain Services	Provide Feedback
1 Formal	Phone Line	1			X	X		X	X	X	X	X	X	X
	Interview	1-3			X	X	X	X	X	X	X	X	X	X
	Post Dischg Calls	2-3	X	X	X							X	X	X
	Diversity Council	2-4	X	X	X	X						X	X	X
	Patient Portal	2	X		X							X	X	X
	Unable to Serve	1-2			X	X	X	X	X	X	X			X
	PFAC; Community Board	2-4	X	X	X	X		X	X	X		X		X
	CAHPS	1-3	X	X	X	X	X	X	X	X	X	X	X	X
	Referral Source Survey	2-3			X				X	X	X			X
	Reputation Mgmt	1-4	X	X	X	X	X	X	X	X	X	X		X
	Complaint Process	2-3	X	X	X	X			X	X	X	X	X	X
	Community 1:1 Follow Up	1				X	X					X	X	X
	Pop. Health Outreach	2-3			X							X	X	X
	LDM	2-4	X	X	X	X			X	X		X	X	X
2 Informal	Interview	1-4			X	X	X	X	X	X	X	X	X	X
	Community Events	1-4	X	X	X	X	X	X	X	X	X	X	X	X
	Survey	1-4	X	X	X	X	X	X	X	X		X	X	X
	Leader Rounding	1	X	X	X	X						X	X	X
	Social Media/Web	1-4	X	X	X	X	X	X	X	X	X	X	X	X

Figure 3.1-1 Voice of the Customer

(Environmental Analysis, EA, Figure 2.1-2) and through an assessment of needs obtained through the Community Health Needs Assessment (CHNA) in the Community Support System (Figure 1.2-3 2).

**3.1b(2) Service Offerings** New products and services are identified, analyzed and developed using the CLRS (Figure 3.0-1, Steps 1-3), and during the EA (Figure 2.1-2). These systematically enable us to determine if patient and other customer requirements are being met or exceeded or if new healthcare service offerings are needed. For example, GBMC supports community needs through unique leading programs such as our Sexual Assault and Forensic Examination (SAFE) and Domestic Violence services. These critical services are not offered elsewhere in the community and are funded primarily through philanthropy. This is one of the programs offered at no cost to our community and is supported by 13 forensic nurses and 5 victim advocates who provide sexual assault forensic exams and support to individuals of all ages, from 6 months to 98 years. GBMC works collaboratively with state and local authorities, has trained more than 1,400 police officers statewide, and is recognized for its successful prosecution rate. Another program that responds to the root cause of other community issues (and is addressed in strategic challenges, Figure P.2-1) is our proactive approach to the opioid crisis. Our Screening, Brief Intervention, and Referral to Treatment (SBIRT) program has provided more

than 32,000 screenings and referred more than 3,600 patients for substance abuse treatment. This Redesign of Care has saved many lives.

Health care service offerings are identified and adapted through the CLRS (Figure 3.0-1) that systematically links with the SPP (Figure 2.1-1 6) to meet and exceed the expectations of our patients, other customer groups and market segments. If this analysis reveals gaps in service offerings (Figure 3.0-1) there is an improvement opportunity with the VOC Steering Committee to adapt services, or link to the PRP (Figure 4.1-3) to identify new service offerings and resource requirements. We determine the need for the change and if the change requires PI or innovation (Figure 2.1-5, Step 4). For example, we identified a cultural gap in hospice services for the Jewish population. Through a donation submitted in remembrance of a former patient, Gilchrist created

a private space for anyone who feels the need for quiet contemplation and prayer. Contained in the room is a replica of the Wailing Wall, made from Jerusalem stone, where patients and their family members/friends can place a small, folded paper containing prayers or wishes. A local Rabbi regularly collects the items which are flown to Jerusalem.

To ensure that we identify and adapt service offerings to enter new markets, attract new patients, other customers and to create opportunities to expand relationships with current patients and other customers, our VOC Steering Committee's information, evaluation, and environmental scans are taken into consideration at both the strategy and service line levels. When appropriate, business plans are developed to determine intelligent risk (Figure 6.1-3 and Figure 4.1-3). If intelligent risk is determined, the business plan is approved and resource requirements are allocated (Area 6.1d).

**3.2 Customer Engagement**

**3.2a Patient and Other Customer Relationships and Support**

**3.2a(1) Relationship Management** We build and manage relationships with patients and other customers through our four-stage Integrated Customer Relationship Model (CRM, Figure 3.2-1) which defines the life cycle of a relationship from "Never Tried" in Level 1 to creating customers who are "Loyal Advocates" in Level 4. Customers can enter into relationship in any one of our work systems. Our Care Integration System (Figure P.1-1) strengthens loyalty to the GBMC brand. We

Patient & Other Customer Relationship Stage	Tools to Move to Next Level	Examples of Measures/ Actual	Figure
① Never Tried	Outreach; Health Lecture Series; Support Groups; Health Fairs ; Social & Traditional Media ; Geomarketing; Physician referral	• Facebook Likes	7.4-9
② Tried	Leader/purposeful rounding ; Ambassadors Rounds; CRM software; Bring a friend to GBMC Events ; Referral to other work system; Post discharge phone calls	• CAHPS Results	7.2-1-3; 7.2-5; 7.2-8-10
③ Liked	Population health outreach; Support Groups ; Donor thank you contacts; Participate in fun philanthropic events (Legacy Chase, Walk-a-Mile)	• Covered Lives • Market Share	7.5-7-8; 7.5-10
④ Loyal Advocate	Advisory Councils/PFAC; Grateful Donor events & recognition; Branded Merchandise; Volunteer Program; Volunteer Opportunities for fun philanthropic events (Legacy Chase, Walk-a-Mile)	• Grateful Donations	7.4-20-22

Figure 3.2-1 Customer Relationship Model & Tools

market, build and manage relationships with patients and other customers through the tools identified in Figure 3.2-1. With a focus on acquiring new patients and other customers and building market share, we can manage and enhance our brand image by continually building and leveraging successful programs. For example, to move customers through to higher levels of our CRM we leverage our CC, **Redesigning Care**, by capitalizing on our health and wellness programs. Since health and wellness are drivers of why patients seek care, they are key focal points for acquiring patients and other customers to build market share. This approach has been successful as we are the only providers with increased market share (Figures 7.5-7-9).

As a cycle of improvement, leaders from PI/Innovation, Service Line, and Strategy were added to VOC steering committee. They systematically analyze VOC results, propose and implement tactics to ensure the VOC is considered in business development and innovation design. By doing this they further move customers along the CRM within each service line to build Loyal Advocates for GBMC.

An example of how we move customers through the model is our approach to support morbidly obese patients beyond their initial treatment. Patients, their families and friends attend a weekly-organized comprehensive training program to prepare for running in the NICU Father’s Day 5K Race. This builds relationships and helps support wellness. Annually, we sponsor a “Reveal” party in an “Oscar-like” fashion to celebrate the achievements of the hundreds of patients treated at GBMC. The most recent event was attended by more than 1200, and from that, over 100 guests moved from ① “Never Tried” to ④ “Loyal Advocates” by volunteering at and promoting other GBMC-sponsored events (see Figure 7.4-22).

We retain patients and other customers by understanding, meeting and exceeding their expectations through use of the CLRS (Figure 3.0-1). To ensure that our tools (including the survey) measure and capture actionable information to use in exceeding our customers’ expectations and securing engagement, survey responses are analyzed externally by the vendor and validated internally to identify key drivers of

satisfaction/dissatisfaction. These provide us actionable data to continuously validate the key customer requirements we use from the VOC (Figure 3.1-1 ① ②). Data are aligned with our work processes (Area 6.1a[1]) to drive continuous improvement and mitigate process issues before they lead to customer dissatisfaction. We exceed expectations and secure their engagement in each stage of their relationship through using the tools shown in CRM. For example, in a learning cycle we added weekly multidisciplinary meetings with nurse leaders to do a deeper dive of the real-time feedback obtained using the *iRound* tool. Data analysis and problem solving in these meetings allows us to respond in real time to the VOC. For example, when one of the hospital dishwashers malfunctioned, food was delivered on disposable plates and satisfactory temperature could not be maintained. Problem-solving during this difficult time included increased dietary leader rounding and service recovery such as provision of cafeteria vouchers, and in some areas a coffee and snack buffet.

**3.2a(2) Patient and Other Customer Access and Support**

We enable patients and other customers to seek access, information and support, through multiple mechanisms. We gather and analyze results and learnings through the CLRS (Figure 3.0-1). The specific mechanisms, and how they are used to seek support, access services, and provide feedback is achieved through our listening posts in column ⑦ (Figure 3.1-1). This column also shows our key means of patient and other customer support and communication methodologies and how each listening post varies for different patient and other customer groups or market segments. Information is reviewed and utilized continually (Figure 3.0-1 ②) and the PRP (Figure 4.1-3) and annually through the SPP (Figure 2.1-1 ③).

Deployment of requirements determined (Area 3.1b[1] and 3.2b[1]) to the WF begins at orientation where components of the Excellence Operating System (Figure P.1-3) are presented. This not only establishes the foundation of beliefs, but defines how we translate the Language of Caring (LOC) to the bedside. Each employee is coached in customer interactions focusing on how to listen and respond to the customer in order to identify and meet their requirements. These are deployed to processes involved in patient and other customer support through our Process Design and Management Process (Figure 6.1-2).

**COVID-19 Response:** To enhance safety for patients and employees, CDC recommendations led to no visitors. A process was implemented to manage special exceptions such as end of life or adoptions. We also implemented video visits via Skype and increased our communication between staff and family members. In all three work systems, we implemented provider telehealth visits leveraging our investment in Epic.

**3.2a(3) Complaint Management**

Our complaint management is accomplished through the systematic Complaint Management Process (Figure 3.2-2) which enables us to resolve complaints promptly and effectively. Potential issues that may result in patient dissatisfaction or a complaint begin with listening, and are proactively identified through the formal and informal listening methods in VOC (Figure 3.1-1). Many complaints identified while patients are in our care, can be resolved in real-time at the point of contact ②. Our

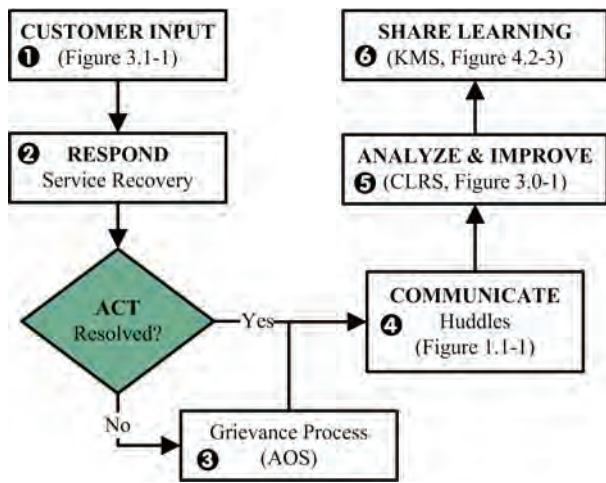


Figure 3.2-2 Complaint Management System

service recovery process includes blameless apology, included in LOC, and a service recovery tool kit 2 that enable us to recover our patients' and other customers' confidence, enhance their satisfaction and engagement. If the complaint cannot be resolved by the staff or leader at the time or it requires additional investigation or action, the complaint is escalated into a formal grievance 3 and is handled through the Grievance Process (AOS). We avoid similar complaints in the future through communicating 4 the complaints at learning huddles. In Step 5 complaints are logged into our event reporting system and are analyzed for system failures, and included as an input into the CLRS (Figure 3.0-1, Step 1). In Step 6, knowledge is shared informally at the VOC Steering Committee and through the KMS (Figure 4.2-3).

**3.2b Determination of Patient and Other Customer Satisfaction and Engagement**

**3.2b(1) Satisfaction, Dissatisfaction, and Engagement**  
Patient and other customer satisfaction, dissatisfaction and engagement are systematically determined and differentiated among our patient and other customer groups and market segments (Figure 3.2-3) using qualitative VOC inputs and the survey process. In a cycle of improvement, we created standard work for purposeful and leader rounding through developing Job Instruction Breakdown (JIB, AOS), a process that details major steps, key points, and reasons ("the why") for key points. These are two key processes that serve as inputs to the VOC. Standardizing these two processes enables us to

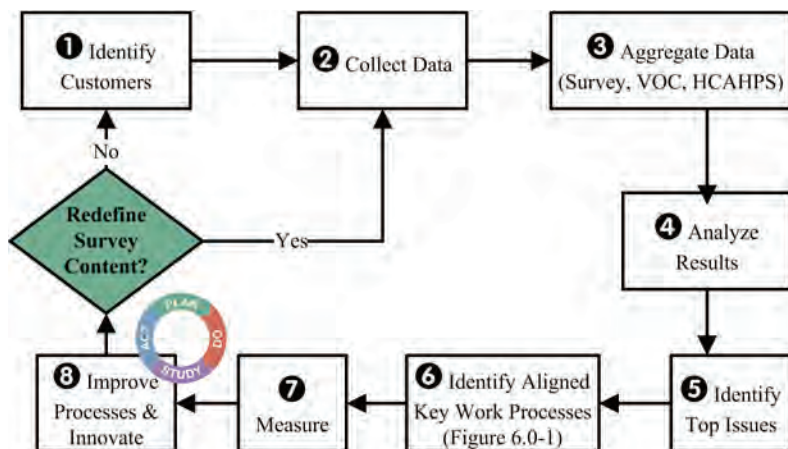


Figure 3.2-3 Customer Satisfaction/Dissatisfaction & Engagement Determination System (Survey Process)

proactively identify barriers to optimizing patient experience and provide real time service recovery (using iRound Area 3.1a[1]). This also allows us to identify practices and thank people that provided excellent care leading to patient satisfaction. We identify our key customer segments and their requirements (Figure P.1-4) through analysis and aggregation of the qualitative and quantitative data, to validate that we understand their requirements and determine if we are asking the appropriate questions to measure satisfaction with the requirements for each patient segment.

Each patient segment has customized survey instruments such as HCAHPS (the primary quantitative assessment for inpatients), ED surveys, and ambulatory surveys. CAHPS surveys include nationally standardized survey questions. Additional customizable questions assess our unique requirements. This enables us to compare our results both nationally and locally, as appropriate. The survey vendor provides analysis of comments, categorized as "positive," "neutral," and "negative." Negative comments are a measure of dissatisfaction (Figure 7.2-6). Our event reporting system enables us to track, trend, and analyze the number and types of complaints. Dissatisfaction data are aggregated in the dashboard as part of the bi-monthly VOC Steering Committee. Understanding the top issues that are key drivers for satisfaction/dissatisfaction and aligning these requirements within our key work processes enables us to capture actionable information in order to exceed their expectations and secure their engagement with us for the long-term.

**3.2b(2) Satisfaction Relative to Other Organizations**

Our various listening posts (VOC, Figure 3.1-1 1 2) are used to obtain information on patient and other customer satisfaction with our organization relative to other organizations that provide similar healthcare services or to healthcare industry benchmarks. Data are analyzed in Figure 3.0-1 2 3 and as described in Area 4.1(b). Our Comparative Data Selection Process (Figure 4.1-2) is used to guide benchmark comparisons, projections and goals. Surveys enable us to benchmark against our competitors and customers of other organizations, both regionally and nationally. Limitations on comparative data are shown in Area P.2a(3). We create a patient experience dashboard including this data and cascade the information to leaders and frontline staff. This information is used to drive change (Figure 3.0-1 4).

**3.2c Use of Voice-of-the-Customer and Market Data**

Our patient-focused culture begins at orientation (Areas 5.1a[2], 5.2b and Figure P.1-2 ) Our vision embodies everything we do and is reemphasized through the Language Of Caring. The success of the customer focused culture is measured and monitored through the VOC (Figure 3.1-1) and market data and information that are used as inputs to the SPP (Figure 2.1-1 1) and through PRP (Figure 4.1-3).

Our CLRS (Figure 3.0-1) is a systematic way to begin with the VOC inputs and support operational changes that may occur immediately or may be considered during the SPP. Additionally, voice of the patients and the community are monitored real-time by our marketing department through social media. To enhance our focus on designing processes to meet the needs,

wants and desires of our patients (Figure 6.1-2) we combine market data and information with the VOC (Figure 3.1-1). We use successes both in patient experience and in supporting wellness to design other programs that will benefit current and potential patients. A key focus are programs designed from the

customer's needs, rather than from the traditional provider, payor and facility focus. This has led to adaptation of services, and/or new services based on VOC which supports operational decision making. In a cycle of learning, we now include PFAC input as part of the EA (Figure 2.1-2). See also Area 3.1a(2).

## 4: Measurement, Analysis, and Knowledge Management

### 4.1 Measurement, Analysis, and Improvement of Organizational Performance

#### 4.1a Performance Measurement

**4.1a(1) Performance Measures** Our strategic objectives (SO) and detailed actions plans (SPP, Figure 2.1-1) are focused on daily operations and overall organization performance and are tracked using our Performance Review Process (PRP, Figure 4.1-3). We select data based on the criteria in the Performance Measurement Selection System (PMSS, Figure 4.1-1 ③-⑧) and collect them from the systems shown in ⑨. We have hard-wired alignment and integration in our culture (Figure P.1-3). This translates to the alignment and integration of data and information as shown in ⑩. We track progress on achieving SO and action plans at the leadership level, and cascade them

down to the action levels of the organization. Each action plan owner tracks achievement of those plans. Key organizational and performance measures, including key short- and longer-term financial measures are shown in Figure 2.1-3, and the frequencies of tracking these measures are shown in Figure 4.1-3. In a cycle of learning, as part of the SPP, SL have strengthened the process of identifying Targets to Improve (TTI's) and the corresponding cascading action plans and KPIs to further align and integrate actions needed to achieve annual SO and goals. This discussion is led by the COO during the SPP Plan Development and Plan Deployment phases and as part of the monthly review in the PRP.

#### 4.1a(2) Comparative Data

Comparative data and information are obtained by benchmarking, using a standard comparative selection guide, aligned and integrated across the organization (Figure 4.1-2). Recognizing some healthcare limitations (P.2a[3]), we use this guide to support us in fact-based decision making for selecting comparisons. Based on business needs and SO, preferred benchmarks may vary. For example, comparisons for social media are more meaningful when we compare to Maryland competitors ②. Hospital outcome measures may vary based on whether metrics are required by the Maryland HSCRC or for national accreditation ①. Some hotel-type services are best compared to other industries ⑤. Overall, this guide helps us balance preference and availability to select the strongest comparative data for each system that guides, does work or supports (ESM, Figure 6.0-1 ①-③). In a cycle of improvement as we have matured in our use of Epic (Figure 7.1-5), we now have the capability to segment comparisons based on both regional best ④, and national leaders ③, through sophisticated analytical Epic

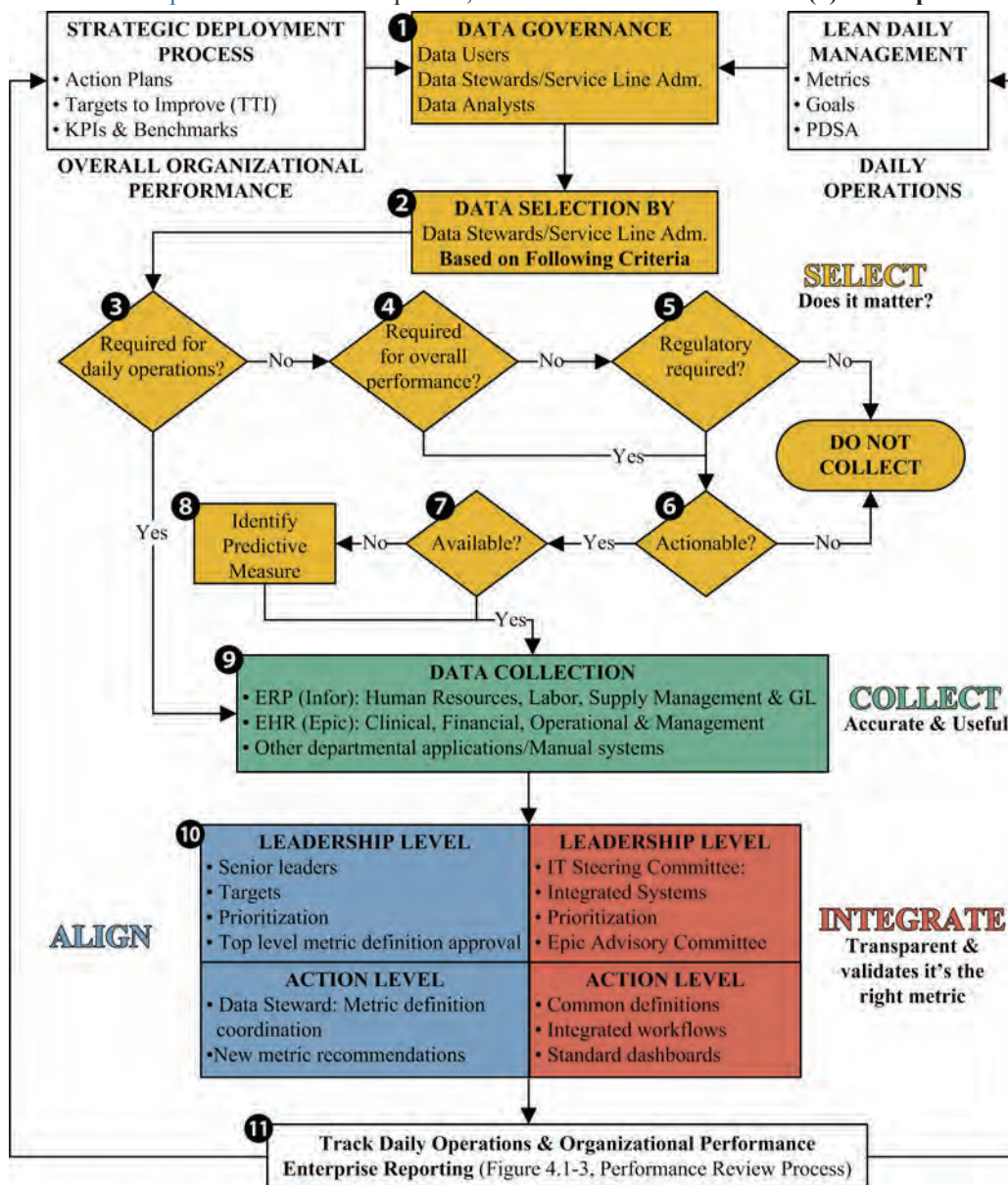


Figure 4.1-1 Performance Measurement Selection System (PMSS)



tools. For example, we have built dashboards for both clinical, operational and financial leaders to assist in **fact-based decision making**.

**4.1a(3) Measurement Agility** We ensure our performance measurement system can respond to rapid or unexpected organizational or external changes and provide timely data through our SPP (Figure 2.1-1); deployed through SDP (Figure 2.2-1); our ongoing PRP (Figure 4.1-3); and our assessment of performance gaps (Innovation Determination Process [IDP, Figure 2.1-5]). Any of these can trigger a change in the measurements used. Action plan owners review data including best practices to stay current with issues that may impact the SDP, and are responsible for action plan modifications and countermeasures when a gap is identified or there are unexpected organizational or external market changes.

**4.1(b) Performance Analysis and Review**  
The PRP (Figure 4.1-3) shows our systematic performance and capabilities review process, including our SDP (Figure 2.2-1), key organizational performance measures and goals which have embedded comparative data and customer data (clinical quality, patient satisfaction, and social media). It also includes the analyses

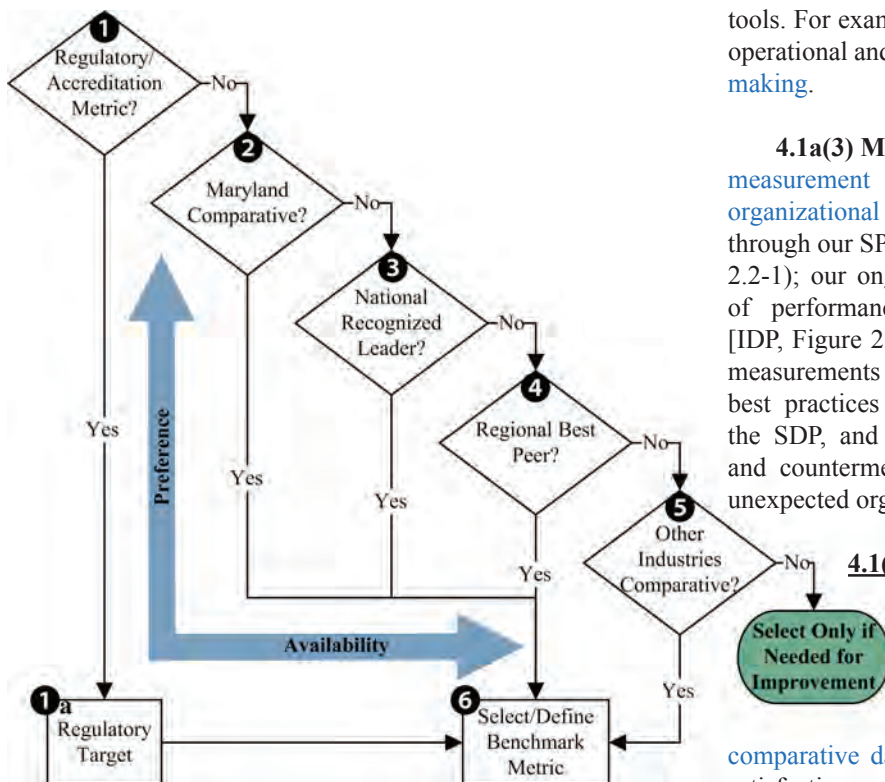


Figure 4.1-2 Comparative Data Selection Process

WHEN	WHO							ANALYSIS TO ENSURE VALID CONCLUSIONS	DECISIONS MADE	Info Flow
<b>DAILY</b>	SL	N/MS	SS	SL	P	BOD	<ul style="list-style-type: none"> <li>Variance (Daily vs. Budget)</li> <li>Trending/LDM</li> <li>Review of Safety Events</li> <li>Social Media monitored by Marketing &amp; issues communicated</li> <li>Patient compliments &amp; complaints</li> <li>Work process in process measures</li> <li>Support process requirements</li> </ul>	<ul style="list-style-type: none"> <li>Daily operational changes</li> <li>Service recovery</li> <li>Safety/Regulatory</li> <li>Resource Pool/Call-offs</li> <li>Physician notification</li> <li>Patient flow</li> <li>Performance Improvement</li> </ul>	FOCUS ON ACTION BASED ON SIZE OF VARIANCE, TREND, RISK	
Safety (Patient/WF)	x	x	x	x	x					
Census/Volume/Staffing	x	x	x		x					
Admissions/Referrals	x	x	x		x					
Productivity/LDM	x	x	x	x	x					
Satisfaction/Quality	x	x	x							
<b>WEEKLY</b>							<ul style="list-style-type: none"> <li>Trending/Variations</li> <li>Process change</li> <li>Root cause analysis</li> </ul>	<ul style="list-style-type: none"> <li>Safety/Regulatory/Service Recovery</li> <li>Staffing/Recruitment/Recognition</li> <li>Operational Changes/Action Plans</li> </ul>		
Productivity/Financials	x	x	x	x	x					
Patient Satisfaction	x	x	x	x	x					
Position Control	x	x	x	x	x					
<b>MONTHLY</b>							<ul style="list-style-type: none"> <li>Social media campaigns</li> <li>Budget Target vs. Actual</li> <li>Statistical comparison</li> <li>Action Plan evaluation/LDM</li> </ul>	<ul style="list-style-type: none"> <li>Modify social media campaigns</li> <li>Modify Action Plans for SDP/LDM</li> <li>Resource allocation/New teams</li> <li>Budget changes</li> <li>Business development</li> </ul>		
Clinical Outcomes	x	x	x	x	x					
SDP Dashboards	x	x	x	x	x					
Financial Performance	x	x	x	x	x					
<b>QUARTERLY</b>							<ul style="list-style-type: none"> <li>Budget Target vs. Actual</li> <li>Statistical comparison/action plans</li> <li>Work/support process in-process &amp; outcomes</li> <li>Aggregation of patient experience data</li> <li>Identification of gaps</li> </ul>	Address performance gaps: <ul style="list-style-type: none"> <li>Safety/Regulatory</li> <li>Resource allocation/changes</li> <li>Operational changes/action plans</li> <li>Opportunities for PI/Innovation</li> </ul>		
Patient Satisfaction	x	x	x	x	x	x				
Work Process	x	x	x	x	x					
SDP Dashboards	x	x	x	x	x	x				
<b>ANNUAL/BIANNUAL</b>							<ul style="list-style-type: none"> <li>Budget Target vs. Actual</li> <li>Year end results compared to annual projected performance compared to benchmarks</li> <li>Impact of year end results on SPP accomplishment</li> <li>Gap analysis: current performance vs actual</li> </ul>	<ul style="list-style-type: none"> <li>Safety/Regulatory</li> <li>Recognition</li> <li>Action Plan modification/New Plans</li> <li>Opportunities for PI/Innovation</li> <li>Organizational success vs competitors</li> <li>SPP &amp; Organizational Review Processes</li> </ul>		
WF Performance Reviews	x	x	x	x	x	x				
Employee Satisfaction	x	x	x	x	x	x				
Physician Satisfaction	x	x	x	x	x	x				
Patient Safety Culture	x	x	x	x	x	x				
Strategic Plan achievement	x			x	x	x				
<b>CONTINUOUS</b>							<ul style="list-style-type: none"> <li>Shifts in technology, market, services, competition, economy, regulator environment</li> </ul>	<ul style="list-style-type: none"> <li>Changes in SO, Annual Goals, Action Plans to adapt to shifts in market conditions/priorities</li> </ul>		
Environmental Analysis	x			x	x	x				

Legend: SL=Service Line; N/MS=Clinical Nursing & Medical Staff; SS=Ancillary Support Services; SL=Senior Leaders; P=Partners; BOD=Board of Directors

Figure 4.1-3 Performance Review Process (PRP)

performed at each level and the frequency of the reviews to ensure our conclusions are valid. Patient and WF safety are always most important. In addition, the PRP shows how the organization and our SL use these reviews to assess organizational success, competitive performance, financial health, and progress on our SDP goals (SO and action plans) through the analysis and decisions made. The frequency of our review process and our agility to provide and rapidly deploy action plans and countermeasures, as described in Item 2.2, allow us to rapidly respond to changing organizational needs and challenges in our operating environment. As shown in the PRP, our Strategic Planning Committee of the BOD reviews our performance and progress on our SO and action plans through a review of our SDP dashboard. Although not often required, we have the ability to make Board-Level decisions within one week. Since implementing Epic in 2016, GBMC has consistently leveraged its use of the system to improve quality, care coordination, data availability, and system performance (full list AOS). As a result, GBMC has improved each year in its “Gold Star” rating (Figure 7.1-5). In 2019, GBMC received the prestigious HIMSS *Davies Award of Excellence* where we demonstrated through case studies and results our ability to improve clinical care outcomes in alignment with our FA. We are the only health system in Maryland that has achieved this award and are only one of 11 worldwide in 2019.

**4.1c Performance Improvement**

**4.1c(1) Future Performance** We project future organizational performance during the SPP through a review of data from our Environmental Analysis (EA, Figure 2.1-2). This contains key comparative and competitive data, and the results of our performance reviews (Figure 4.1-3). Each review has analysis performed, and these findings are used to make future projections to guide decisions for future goals and SO. Each action plan owner projects whether they will hit their target and will make appropriate adjustments as needed.

**4.1c(2) Continuous Improvement and Innovation**

We use findings from our PRP (Figure 4.1-3) to develop priorities for continuous improvement and opportunities for innovation by using our IDP (Figure 2.1-5). Through a review of our measures and goals 2 3, we determine if an action plan should be continued as stated, or if PI or Innovation are necessary 4. If the action plan continues as stated, review of the PRP continues. If a new level of performance requiring PI (4b) or Innovation (4c) is needed, either PDSA (5) or the Innovation Management System (6) is deployed. We deploy performance improvement and innovation priorities and opportunities to work groups and functional-level operations throughout the organization through the goal cascade process (Figure 2.2-1) and through the need for action plan modification (Area 2.2b) if they arise after annual goals and action plans have been established for the year. We also deploy performance and innovation priorities

through LDM (Area P.1a[2]). To ensure alignment with our organization, performance improvement and innovation opportunities are deployed to our suppliers, partners, and collaborators as described in Areas 2.2a(2) and 6.1c. Our PI Governance Committee provides oversight and prioritization of our PI and innovation opportunities.

**4.2 Information and Knowledge Management**

**4.2a Data and Information**

**4.2a(1) Quality** We verify and ensure the quality of organizational data and information as described in Figure 4.2-1. This is accomplished via the tools described to ensure their accuracy, validity, integrity and reliability, and currency through their systematic application. Mechanisms exist to evaluate the effectiveness in-place for each criterion on a continual basis.

**4.2a(2) Availability** We ensure the availability of needed organizational data and information in a user-friendly format and timely manner throughout the system through the application of the processes and tools detailed in Figure 4.2-2. This begins with understanding the user’s data needs. The IT systems are reviewed on a continual basis to ensure they are providing needed data and are user-friendly for the WF, suppliers, partners, collaborators, patients and other customers. We measure IT system reliability via multiple approaches and measures with mechanisms to evaluate effectiveness (AOS). Our overall framework includes a continual cycle of learning applied to IT systems through frequent system builds and updates. An example of how we have leveraged our data availability in Redesigning Care was with inpatient diabetic management. Timely and relevant data on hyper- and hypoglycemic events was not easily available. We met with key stakeholders to create user-friendly daily reports that identified patients who experienced variation in glycemic control within the past 24 hours. This metric is reported daily at the Executive LDM board for real-time problem-solving (Figure 7.1-8)

**4.2b Organizational Knowledge**

**4.2b(1) Knowledge Management** We build and manage

	Data	Information
Accuracy	Co-signatures for high risk medications (B) Bedside barcoding/monitoring for misses (V) Standard data collection & fields (E) Processes maturing to standard work (E)	Adverse drug reaction Process (E) Denial Reconciliation (V) Daily EMR Reports (B) Compliance Audits (V)
Validity	Frequent internal audits (V) Validation via daily & on-demand reporting (V) Testing & validation (V)	Meaningful Use Attestation (V) IT support tickets/project requests (B) LDM/leader rounding (V)
Integrity	Database integrity & virus scans (B) Secured data center & workstations (E) Role based system access controls (E) Access audits/password controls (E)	Bedside barcoding (B) Paperless workflow (E) HIMSS Stage VII (V) Non-production environments for testing (V)
Reliability	Disaster Recovery Plan/testing database backups (B) Co-located datacenters/back-up datacenters (E) Downtime drills (V) Change control process (E)	Planned system maintenance & patching (E) Track daily system up-time (V) Hardware refresh (annual) (E) On site, remote & cloud accessibility (E)
Currency	High speed data connectivity (B) Near real time data mirroring (E) Real-time reporting & analytics (E) On-site, remote & cloud accessibility (E)	Epic response time monitoring (E) Network & server performance monitoring (E) Ease of access: smartphone, tablet access (E) Daily Epic reporting (V)
V= Verify; E = Ensure; B = Both Verify & Ensure		

**Figure 4.2-1 Data & Information Quality**

How are End User Needs & User-Friendliness Determined		Availability Platforms (How it's Available)	Data & Information Formats	Timeliness
<b>Workforce</b>	IT Support Ticket/Project requests WF & Enterprise Model Surveys; LDM/Leader Rounding Strategic Development Plan Regulatory Compliance Industry Best Practice & Assessments	Desktop Workstations & Laptops Smart Phones/email/cloud High Speed Secure Wifi High Speed Secure Internet/Intranet Remote Desktop	EMR/PACS Policies & procedures HR, Employee Health info. Reporting & analytics Financial documents Surgical posting/lab testing	EMR Real-Time Updates Daily & on-demand Reports Lean Daily Management Remote & Cloud Access Mobile Messaging/alerts Real-Time Status Boards
<b>Partners &amp; Suppliers &amp; Collaborators</b>	Data Sharing Agreements Contracts Performance review meetings VOC/LDM	Email Electronic Data Exchange Phone Contract documents	Purchase orders & invoicing Receiving Contracts EMR/PACS	Daily Reporting On-Demand Real-Time Reports Digital Supply Network
<b>Patients &amp; Families</b>	VOC—Figure 3.1-1 Social media Patient Portals & Messaging Patient Focus Groups Population Health Initiatives	High Speed Wifi Smart Phone/Epic Portals Digital Status Boards Mass Media Platforms Email/Printed Materials/signage	EMR Patient Portal Billing Patient Handbooks/wellness info Mobile Messaging Video Visits/education	Mobile Device Access Electronic Patient Portal Mobile Messaging/Alerts Tablet Based In-Patient Care info.

**Figure 4.2-2 Data & Information Access & Availability**

organizational knowledge through the systematic process listed in Figure 4.2-3. Knowledge is used by our WF, patients and families, other customers, suppliers, partners and collaborators and the community 1. For each of these groups we have methodologies to collect, blend, and correlate data to build new knowledge, assemble and transfer that knowledge to those that can use it 2–4, and that ensures the use and integration of the knowledge. Step 5 describes how the methodologies are used to ensure new knowledge becomes a part of our innovation (IMP, Figure 6.1-3) and SPP 6 (Figure 2.1-1).

**4.2b(2) Best Practices** We use specific tools, methods and committees and forums to share best practices within our organization (Figure 4.2-3 3). Through these methods and our PRP (Figure 4.1-3) we can identify internal and external organizational units or operations that are high performing. When a group is high performing we identify best practices

from that group during LDM (Area P.1a[2]) and other means (AOS). Standard work is created using a one-page visual diagram that describes the process, key points, and the reason the work is important to our FA and is placed on the intranet for any member of the WF to access and implement as appropriate. Other methods include 1) face-to-face meetings; 2) committees and councils; 3) education offerings; 4) simulation; 5) nurse residency graduation celebration and poster sharing; 6) physician residency safety rounds and 7) other methods, as described in the Transfer Mechanisms in Figure 4.2-3 5. As a cycle of learning we offer an annual PI/Innovation Summit where WF can share best practices discovered during LDM or as part of an evidence-based project.

**4.2b(3) Organizational Learning** We use our knowledge and resources to embed learning in the way we operate through our LS (Figure 1.1-1 5 a), our PI System (Figure P.2-2), EOS

1 Knowledge Usable By	2 How knowledge is collected	Manage			
		3 How knowledge is transferred & best practices shared	4 How we blend & correlate (build new knowledge)	5 Forcing Function for Sustainability (See Area 1.1c[1])	
				5 How we Assemble and transfer for use in Innovation	6 How we Assemble and transfer knowledge in Strategic Planning Processes
<b>Workforce</b>	<ul style="list-style-type: none"> <li>EA (Figure 2.1-2)</li> <li>VOWF Listening Posts - WF meetings; surveys - Staff meetings</li> <li>Evidence Based Practices – Literature Review</li> <li>PRP (Figure 4.1-3)</li> <li>LDM (Area P.1a[2])</li> </ul>	<ul style="list-style-type: none"> <li>LDS (Figure 5.2-2)</li> <li>Formal Committees</li> <li>Staff Huddles</li> <li>PI/Innovation Summit</li> <li>LS (Figure 1.1-1)</li> <li>CP (Figure 1.1-2)</li> <li>Great Save Wednesdays</li> <li>Newsletters; Infoweb</li> <li>LDM (Area P.1a[2])</li> </ul>	<ul style="list-style-type: none"> <li>Interdisciplinary councils - EBP; Nursing Practice</li> <li>Formal Committees</li> <li>PI System (Figure P.2-2)</li> <li>Improvement Events</li> <li>‘Coffee &amp; Collaborate’</li> <li>SDP (Figure 2.2-1)</li> <li>HR Advisory Council</li> </ul>	<ul style="list-style-type: none"> <li>Innovation Management Process (Figure 6.1-3 1)</li> <li>LDM process (Area P.1a[2])</li> <li>Leader rounds</li> <li>VOC Committee</li> </ul>	<ul style="list-style-type: none"> <li>EA (Figure 2.1-2)</li> <li>Learning &amp; Development</li> <li>VOWF</li> <li>Enterprise System Model (Fig. 6.0-1)</li> <li>Survey Assessment between systems (Area 6.1b[3])</li> </ul>
<b>Patients/ Families</b>	<ul style="list-style-type: none"> <li>VOC (Figure 3.1-1), e.g. - Leader rounding</li> <li>MyChart</li> <li>Rounding</li> <li>PFAC</li> <li>Social Media</li> </ul>	<ul style="list-style-type: none"> <li>Bedside handoff</li> <li>Purposeful rounding</li> <li>Welcome packet</li> <li>Interdisciplinary rounds</li> <li>PFAC</li> <li>Educational Lectures &amp; Facebook Live /YouTube</li> <li>CLRS (Figure 3.0-1)</li> </ul>	<ul style="list-style-type: none"> <li>Listening &amp; Response System (Figure 3.0-1)</li> <li>VOC Steering Committee</li> </ul>	<ul style="list-style-type: none"> <li>Innovation Management Process (Figure 6.1-3 1)</li> <li>Learning &amp; Development System (Figure 5.2-2 5)</li> </ul>	<ul style="list-style-type: none"> <li>EA (Figure 2.1-2)</li> <li>VOC listening posts</li> <li>CHNA</li> </ul>
<b>Suppliers/ Partners/ Collaborators/ Other Cstmrs</b>	<ul style="list-style-type: none"> <li>Quarterly Business Review meetings</li> <li>Evidence Based Practices</li> </ul>	<ul style="list-style-type: none"> <li>Value analysis</li> <li>Partner (Kaiser, JHH, Sodexo) meetings</li> <li>Payer meetings</li> </ul>	<ul style="list-style-type: none"> <li>Service line/ops meetings</li> <li>Epic/IT steering</li> <li>Value Analysis</li> <li>Contract evals</li> </ul>	<ul style="list-style-type: none"> <li>Value Analysis</li> <li>Emergency Preparedness – unexpected events</li> </ul>	<ul style="list-style-type: none"> <li>EA (Figure 2.1-2)</li> <li>Contract evaluation</li> <li>Cost analysis</li> </ul>

**Figure 4.2-3 Knowledge Management**

(Figure 6.0-1), IMP (Figure 6.1-3), LDM (Area P.1a[2]), and PRP (Figure 4.1-3). These approaches promote systematic learning, real time problem-solving and best-practice sharing. Processes that are improved or innovated become a part of our work systems and work processes (through policies, procedures, and documenting the new approach in standard work). For example, we identified a delay in reading of EKG's.

All appropriate departments tracked, improved and reported their results through LDM. This quickly resulted into a redesign of the process for performing and reading the EKGs timely and accurately. This new knowledge was shared with nursing leaders using the one-page standard work document (Area 4.2b) from the graduated metric.

## 5: Workforce

### 5.1 Workforce Environment

We build an effective and supportive workforce (WF) environment through recruitment, selection, development and retention of our WF through various systematic strategies and processes. New WF members are oriented to the cultural components of the organization listed in the Excellence Operating System (EOS, Figure P.1-2). Processes that support

our WF have been fully deployed, systematically improved, and integrated across the organization. Key to achieving this is the accountability fostered through the four-phased, closed-loop, Performance Management System (PMS, Figure 5.0-1), discussed in Area 5.2c(1). The PMS is designed to assess WF capability skills (Area 5.1a[1]) on a regular basis, to set and monitor performance goals and development plans to achieve SO.

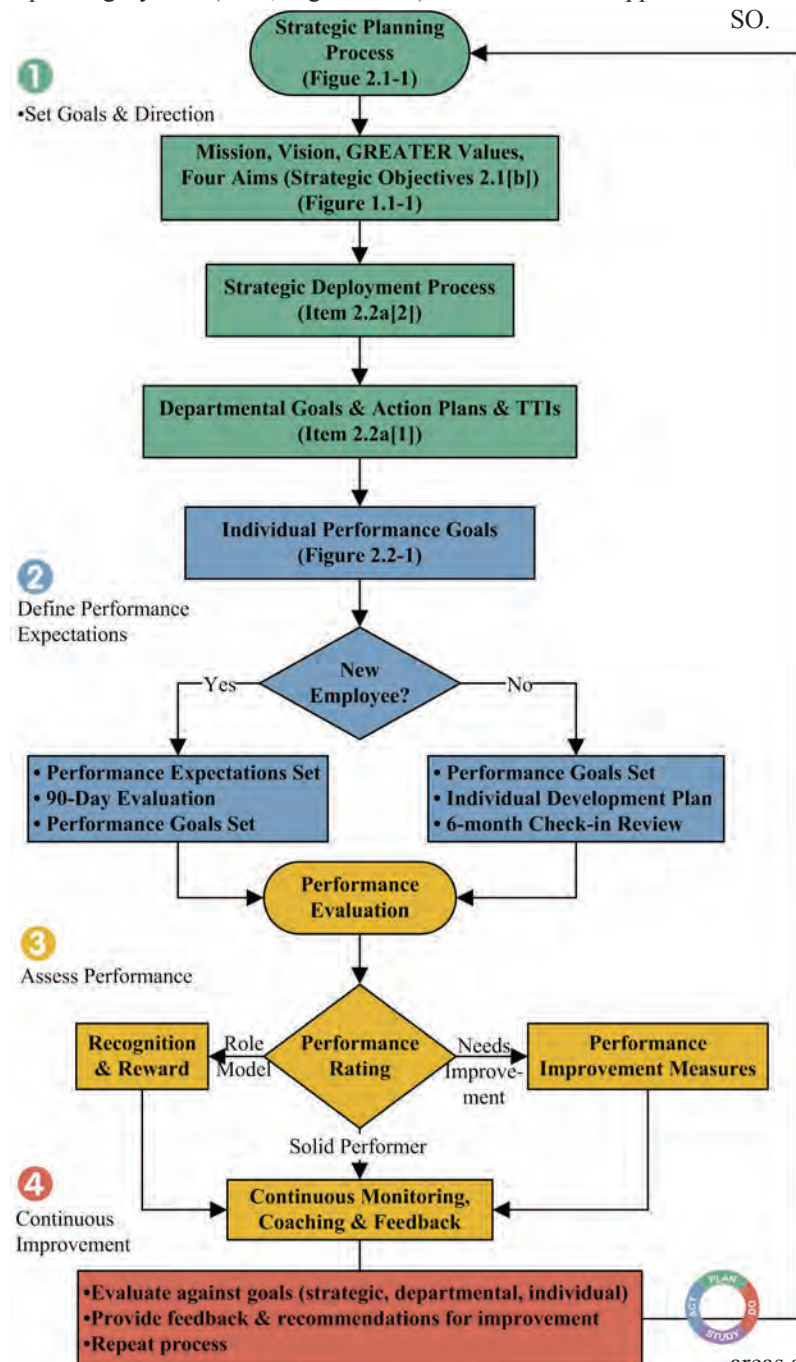


Figure 5.0-1 Performance Management System (PMS)

### 5.1a Workforce Capability and Capacity

**5.1a(1) Capability and Capacity Needs** WF (including physicians) capacity and staffing levels are assessed and projected systematically 1) annually during the SPP (Figure 2.1-1 ①-③); 2) ongoing through SDP (Figure 2.2-1) and the PRP (Figure 4.1-3); and, 3) on short-term intervals based on need e.g., daily using the nursing staffing model (AOS). WF capability and capacity are both an input (current state and needs) and an output (plans) of the SPP and are integrated as an input to the strategic WF plan. To assess WF capacity needs, during the SPP, new or existing services are evaluated, with forecasting tools that provide guidelines, for the number of WF, salary costs and staffing mix needed to ensure safe care and achieve our SO. The multi-year WF plan is an output of the SPP that incorporates costs, volume, training and hiring needs. Volunteer capacity is determined through an assessment of needs conducted by the Director of Volunteer Services with input from SL.

We identify capability needs through evaluation of our customer requirements and the strategic direction of the organization. This fully integrates all work systems and service lines. Skill requirements are outlined in job descriptions as required competencies and certifications, licenses, education and level of experience. Future capabilities are determined as an output of the SPP in the Plan Development phase (Figure 2.1-1). WF and Volunteer capability is assessed based on a match of their skills and competencies and our needs and requirements. An example of our agility with this process is discussed in Area P.2a(2). Ongoing WF capability assessments are done at the local level and organizationally. For example we use scenarios where staff demonstrate their competencies (Area 5.2c[3]). There will be coaching and feedback until a threshold is met and performance is audited. LDM boards provide ongoing assessment and implementation of cycles of learning to improve processes and improve WF knowledge, skills and understanding in key work areas across all work systems.

At the organizational level, we deploy a Learning Needs Assessment to identify the learning needs of WF segments. Our Learning & Development System (LDS, Figure 5.2-2) is used to implement organization learning offerings that are strategically aligned and include required and non-required courses.

Capability and capacity needs are reviewed monthly, weekly, daily and at each shift based on the annual WF plan, current needs/volumes and/or operational metrics. For instance, daily and weekly capacity may be adjusted based on key items such as census or volume and schedules. Business requirements, staffing needs, and skills are reviewed during the PRP (Figure 4.1-3). The review includes patient volumes, staff turnover, time-to-fill vacancies, and budget monitoring. On a weekly basis, staff productivity levels are assessed during a Position Control meeting of SL and hiring managers, to assess and discuss the [skills, competencies, and certifications](#) needed for staff vacancies or staffing increases, and to give us responsiveness and agility. An example of how we adjust capability and capacity to meet emerging needs is evidenced by the relocation of our growing NICU. Through [Redesigning Care](#), we now can accommodate intermediate level babies in the normal newborn nursery. We reassessed and adjusted the capabilities and capacities of those nurses to meet this change.

**5.1a(2) New Workforce Members** Our fully deployed 18-step systematic process (AOS) to [recruit, hire and onboard all new WF members](#). Steps ①–③ establish the staff needed. Steps ④–⑬ are the hiring process where candidates are introduced to our culture and acknowledge our MVV prior to an offer to ensure fit. Steps ⑭–⑱ are onboarding and orientation (Area 1.1a[1]). We continuously monitor key measures and trends through a Talent Acquisition dashboard (AOS) to evaluate the effectiveness of this 18-step process. Trends are inputs into the WF capability and capacity Environmental Analysis of the SPP (EA, Figure 2.1-2).

To ensure our WF [represents the diverse ideas, cultures, and thinking of our patients and communities](#), which are identified in our environmental analysis (Figure 2.1-2), our [hiring](#) process in Steps ④–⑨ includes posting and sourcing in various communities and the use of targeted search tools (Step ④). In a cycle of learning, we expanded our sources to include organizations such as ethnic professional associations and various socially diverse talent pools. Using our automated and upgraded applicant tracking system and analytics, the WF Planning Committee systematically evaluates the effectiveness of recruitment mediums and makes recommendations for improvement.

To ensure an [effective fit of new WF members with our organizational culture](#) we use varying approaches. All potential hires complete a screening Job Fit Indices tool (Step ⑪) that measures cultural fit, service excellence, and retention. This helps to ensure [fit](#) and strengthen onboarding success. In Gilchrist, there is specific focus on the various cultural needs and rituals surrounding death and dying. Interdisciplinary caregivers experience as many deaths as they do admissions in a month, and we provide specialized orientation to ensure [organizational](#) and [cultural fit](#). In an additional 4-day orientation, all WF members participate in interactive sensitivity training that helps them explore their own feelings and experiences to better understand the grief journey of both patients and their

families (Figure 7.1-37). In the hospital setting, nurses, our largest WF segment, participate in peer interviews and job shadowing, to allow mutual determination of fit between the candidate and unit. We also require all RNs entering their first nursing job to participate in the year-long residency program to assist in the transition. Evidence supports that brand-new nurses are hesitant to speak up about safety issues. One of the components of this program includes simulation training in evidence-based communication methods such as SBAR to support them speaking up and strengthening our safety culture (Figure 7.1-26) (also Area 5.2c[2]). As a cycle of learning, to ensure fit and support retention, we conduct a 45-day survey and a 90-day focus group, to provide feedback on new WF satisfaction with employment and intent to stay. This has had a favorable impact on WF retention (Figure 7.3-2 – Figure 7.3-4).

**5.1a(3) Workforce Change Management** We continually and systematically prepare the WF for [changing capability and capacity needs](#). The process starts with our EA (Figure 2.1-2). Our SO drive Service Line business plans, and as an output of SDP, an annual and multi-year WF plan (including capacity and capability) is developed (Figure 2.1-1, Steps 4-6 ②). Our ongoing position control processes support having a capable and competent WF with necessary skills to [balance the needs of our WF and the organization](#) (Area 5.1a[1]). To [ensure continuity and prevent WF reductions](#), we employ various tactics including: 1) cross training in the clinical areas; 2) succession planning for key positions; 3) use of temporary personnel in periods of significant demand; 4) use of volunteers in appropriate areas and 5) hiring only when long-term need is validated. As changes in [organizational structure and work systems](#) occur, necessitating [growth or reduction in the WF](#), we utilize our LS (Figure 1.1-1) and our Communication System (Area 1.1b) to [prepare the WF. To prepare for and manage any periods of WF growth](#), we determine, through our ongoing WF planning process, if the capacity and capability exist to meet the business objectives identified. To best match the right skills with the business needs based on our current WF, we make the decision to buy, build or borrow: hire someone with those skills; train someone on those skills; or hire temporary WF members. For example, ramping up quickly may require a combination of temporary workers, job reclassifications and redeployment. While we make every attempt to avoid a [reduction in WF](#), from time to time it is necessary and we follow our internal policy. To help WF members and to [minimize the impact of any necessary reductions](#), we provide the following: 1) listing of current vacancies; 2) referral to our Employee Assistance Program, 3) a severance package, including notice pay and benefits, 4) assistance in obtaining unemployment benefits; 5) referral to employment resources.

**COVID-19 Response:** This has tested our ability to manage WF capability and capacity during unexpected surges. We implemented an Alternate WF Solution Center to address capacity needs by systematically increasing capability and deploying staff where needed (full plan AOS).

**5.1a(4) Work Accomplishment** Our WF is [organized and managed](#) in keeping with our integrated work systems and work processes (Figure 6.0-1) where we define the work to be done with service lines that integrate across work systems. Our SPP

(Figure 2.1-1) and SDP (Figure 2.2-1) define the requirements to achieve the Vision through the FA. Work processes are defined in policies and procedures, and training is provided to support the accomplishment of standard work (Area 3.2b[1]) and through the Learning and Development System (LDS, Figure 5.2-2 ⑤). To help reinforce a patient/other customer and business focus, we track the achievement of action plans through the PRP (Figure 4.1-3) to owners who oversee the accomplishment of work. If any metric is not met for two consecutive months, an action plan with countermeasures is required (Area 2.2b).

Our VOC listening posts (external) keep us patient and other customer centered (Area 3.2c), and our innovation culture (Figure 2.1-4) enables the WF to exceed performance expectations. Not only is it safe for the WF to try new things, it is encouraged, recognized and rewarded. Performance that exceeds expectations is rewarded through our FA Recognition (FAR) which supports and capitalizes on our CC.

**5.1b Workforce Climate**

**5.1b(1) Workplace Environment** GBMC has a fully deployed incident command system that works collaboratively with local, state and federal emergency preparedness coalition partners. Hazard vulnerability assessments are completed for all three work systems. Top concerns include workplace violence, cybersecurity and health care surges to include behavioral health. These assessments, and subsequent mitigation of risk, systematically support workplace health, security, safety (Area 6.2c[1]), and accessibility for the WF. We use a closed-loop 6-step process, Workplace Environment System (WES, AOS). In the first phase we do an Environmental Scan ① which is a view of both internal and external factors, and a 13-step risk assessment ② with broad organizational involvement. Actions ③ are fully integrated with our Environment of Care (EOC) committee (and our EOC plans) as they are implemented ④. Changes include education and training ⑤ and are monitored ⑥ to assess/evaluate effectiveness ⑦. To ensure the process is closed-loop, findings from each cycle are tested (i.e., drills, exercises, simulations, and analysis) and used to improve the next cycle. The performance measures and goals are shown in Figure 7.3-10. In a recent cycle of improvement, several programs were put into place to meet our SO of Psychological Safety and to mitigate workplace violence, such as harassment training, additional security guards, and a Behavioral Health Response Team (BHRT).

**COVID-19 Response:** Our incident command system and our surge plans are fully deployed to mitigate risk to patients and the WF. One of the greatest challenges has been the national shortage of personal protective equipment (PPE). Leveraging our supply chain network, community support, and a carefully designed allocation process, we are currently meeting safety needs of the WF.

**5.1b(2) Workforce Benefits and Policies** Our benefits and policies are supported with a systematic 7-step Benefits process (AOS) which begins when we collect and analyze data and conduct an annual analysis of our Total Rewards. This helps us determine if changes are needed to support our WF via services, benefits, and policies. Voice of WF (VOWF, AOS) is an input to this process, and options are evaluated based on a review

of the needs, affordability, sustainability and the competitive marketplace. As an example, in response to feedback from the WF and in support of our aim of More Joy, we redesigned our core employee health plan to include 100% coverage (no coinsurance or deductible) for care received from our GBMC network of providers.

Figure 5.1-1 shows key benefits for WF segments. There are 38 benefits, all of which can be tailored to meet the diverse needs of the WF (Figure 7.3-15). **COVID-19 Response:** We immediately addressed childcare needs, emotional and financial support and preservation of time-off benefits to support the WF (full plan AOS).

Benefits	WF*	Volunteers
Medical/Dental	X	
Discounted Meals	X	X
Retirement Plans	X	
Short- & Long-term Disability	X	
Scholarship Program & Tuition Reimbursement	X	
Legal Plan	X	
On-site Fitness Center	X	X
Free Parking	X	X
Recognition (Monetary/Non)	X	X
*All may be tailored		

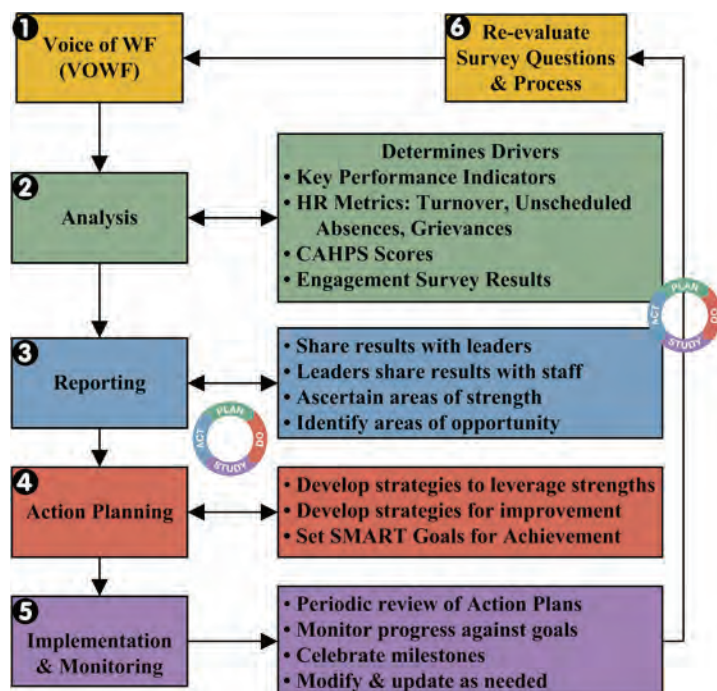
**Figure 5.1-1 Workforce Benefits (Full list of benefits AOS)**

**5.2 Workforce Engagement**

**5.2a Assessment of Engagement**

**5.2a(1) Drivers of Engagement** We use a systematic approach to determine the key drivers of WF engagement through an analysis (Figure 5.2-1 ②) of our employee engagement survey results (employees, volunteers, and physicians) with our vendor to identify the key drivers of engagement for the various WF groups and segments (Figure P.1-4). As needed, we may perform an internal regression analysis to validate and ensure our determination method is data driven. Key drivers are validated through rounding, focus groups and LDM and other VOWF means. In a cycle of learning based on the limitations of our survey vendor, we conducted a systematic evaluation and changed vendors, which provided better correlations and more meaningful and actionable comparisons. The new vendor also provides improved ease of use and more timely results with deeper analytics for meaningful electronic action planning.

**5.2a(2) Assessment of Engagement** We assess WF satisfaction and engagement systematically using the WF Engagement Process (Figure 5.2-1). The primary formal assessment is through a survey tool, administered with different versions tailored for each WF segment. The VOWF (Step ①) includes both formal and informal listening posts such as focus groups, staff meetings, rounding, etc. The data is analyzed in Step ② through regression analysis, and ongoing evaluation of other metrics. Other WF data measures and indicators used to assess and improve WF engagement include recruitment, retention, absenteeism, productivity, safety, WF Grievances, CAHPS and previous year’s engagement results. Once the data is analyzed ② results are shared with leaders who then meet with staff and in a systematic fashion to validate results, identify strengths and areas of opportunity ③. Action planning



**Figure 5.2-1 Workforce Engagement Process**

is done with the WF at the unit level and includes SMART goals to leverage strengths and create strategies for improvement ④. Action plans are reviewed, milestones celebrated, and modified as needed ⑤. Annually, the WF engagement process is evaluated for opportunities to improve and then the cycle is repeated. As a cycle of learning, our CNO, who leads the largest WF segment, engaged every nurse leader in conducting nearly 1000 “stay interviews” with both licensed and unlicensed employees in the nursing division.. Using standard questions, qualitative and quantitative data were gathered and used for employee engagement action planning (AOS). This has favorably impacted nursing turn-over (Figure 7.3-4).

**5.2b Organizational Culture**

We foster an organizational culture that is characterized by open communication (Area 1.1b), high performance (Figure 5.0-1 ③), patient safety (Area 6.2c[1]), and engaged WF (Area 5.2a) through our EOS (Figure P.1-2). The epicenter of our culture is our Vision Phrase and our FA (Figure P.1-2). Our culture is reinforced through a visible and engaged leadership, transparent communication, teamwork, and the empowerment of our employees. It starts at the top: our CEO personally reinforces the MVV at the very first encounter (orientation) and for every WF member in every communication forum (ongoing). John never gets tired of showing a picture of his daughter and asking, “What would you want if it were your daughter?” He explains that you would want the **Best Health** (outcomes), the **Best Care** (experience), with the **Least Waste** (efficiency), and the **Most Joy** (meaningful work) by those providing the care for your loved one (our FA).

Our culture goes beyond systematic processes. SL know that a pivotal component of WF engagement needed to achieve our Vision, can be done by providing opportunities for **More Joy**. SL creates diverse opportunities for WF fellowship to ‘play’ together through fun competition, such as karaoke (John himself) and hula hoop contests enhancing a social connectedness (AOS). A new program was created during

National Nurses Week, GBMC recognizes its nurses in a truly grand way: our **Art of Nursing** event. This "red carpet" celebration is an opportunity to trade scrubs for cocktail attire. GBMC employees throughout the system nominate their nursing colleagues in seven categories: **Diversity** in Nursing, Clinical Assistant Support, Evidence-Based Practice, Nurse Leader, Patient- and Family-Centered Care, Nursing Graduate and Nurse Clinician of the Year.

To promote high performance and patient safety, we use the Just Culture algorithm and the James Reason’s Swiss Cheese model (AOS) for analyzing incidents and sharing learning throughout the organization. Our Great Save Wednesday and Patient Safety Stories are shared widely. To reinforce our Values of *Teamwork* and *Excellence*, each clinical or practice manager has a physician partner. These dyad leaders meet monthly with the CMO and CNO to foster open communication, which supports patient safety and empowerment of the WF.

**Support of Vision and Values:** Our goals, actions, and performance evaluations are based on our values and the corresponding behaviors. It starts within the Leadership System (Figure 1.1-1 ①) and part of the PMS (Figure 5.0-1).

**Thinking and Diverse Ideas:** A Diversity and Inclusion Council was initially appointed by the BOD with participation and support by the chair of the Board, the CEO and the CHRO. This Council strengthens diverse thinking at all levels in the organization. It is one of the CEO’s KPIs (AOS). Our philosophy is summarized on our public website. This commitment has resulted in the appointment of a Director of Diversity and Organizational Development. Through her leadership with the guidance of the Council, we publish an annual Diversity and Inclusion Calendar of Events and sponsor many activities. Members of the WF who identify with a variety of backgrounds and cultures help plan and participate in these sessions to increase awareness and sensitivity. To further promote diversity of ideas, executives, and other leaders utilize Emergenetics©, a tool that evaluates thinking and behavioral attributes and is used in strengthening teams (though diverse viewpoints) and when planning group composition.

**Empowerment:** Our culture, through our vision, gives every member of the WF authority and responsibility to do what is right for the patient. During orientation, our CEO, John, empowers every new WF member: “If you are not sure what to do: “Let the Vision Be Your Guide, and ask yourself ‘What if it were your loved one?’” This is reinforced and celebrated as part of our LS (Figure 1.1-1 ② a and ⑦ a) and through various communications to the WF (Area 1.1b). In a recent Blog, John shared the importance of speaking up when something isn’t right, fostering the mindset, “if you see something, say something.” Following that blog, facilities reported a Great Save which was later published and shared with the organization. During an extreme cold spell, an employee noticed a broken pipe that, if not fixed, could have resulted in water pouring into the garage at a rate of 150 gallons a minute. In our Peer to Peer recognition program, we celebrate many other examples where employees feel empowered to speak up when they feel something is not right. In one example, a physician credited the nurse for speaking up and saving a patient’s life.

**5.2c Performance Management and Development**

**5.2c(1) Performance Management** Our PMS (Figure

5.0-1) is a systematic approach that supports high performance by cascading goals and actions down from the SPP, assessing performance, **compensating, rewarding, and recognizing** our WF. This 4-phase process is fully deployed and reviewed annually for improvement (Figure 5.0-1).

The SDP (Figure 2.2-1) action plans are cascaded with performance measures to local leaders who are responsible for achieving results, coaching, developing and evaluating each person (LS, Figure 1.1-1 **3-7**a). The assessment phase of the PMS (Figure 5.0-1, Step **3**) **reinforces intelligent-risk taking and is the basis for compensation, reward, recognition and incentives**. A **patient and business focus** are key to achievement of the SO, as well as the more detailed goals and **action plans**. New employees are assessed beginning 90 days after their date of hire (Figure 5.0-1 **2**). The 90-day assessment **2** determines if the employee is demonstrating the values and satisfactorily performing job duties outlined in their job description. Performance goals are established and assessed annually for tenured employees. Each employee is rated on their performance: “needs improvement, solid performer or role model.” Improvement measures or recognition and rewards are deployed. As a cycle of improvement, individual development plans **3** are part of the process to **support high performance and reinforce intelligent risk taking and the achievement of action plans**. Identified learning needs are an input into the environmental scan (Figure 2.1-2) **4**. Evaluation of the process and impact on strategic goals and process improvements occurs

on an annual basis. Ongoing performance management occurs at the LDM Boards where there is a line-of-sight focused on achieving SO through the FA. SL role model and coach real time problem solving, and ask local leaders if there is someone who should be recognized for intelligent risk-taking, achievement of goals, or exemplary behaviors that impact customers. SL send a thank you note to the employee’s home. Thousands of notes have been sent to reinforce positive performance and behaviors.

**5.2c(2) Performance Development** Our Learning and Development System (Figure 5.2-2) **supports the personal development of the WF and the organization’s needs**, permitting us to leverage our abilities toward a high-performing, continuous learning environment. WF capability needs are assessed during the EA (Figure 2.1-2); and WF values, capacity and capability needs are considered as the annual WF plan is developed. In a cycle of learning, to further understand the key drivers and WF needs, a Learning Needs Assessment **2** was deployed across the WF. The assessment was tailored to each WF segment allowing better understanding of the capability needs of each group. A multi-disciplinary learning advisory group promotes a continuous learning organization. An example that supports both the **development desires of the WF and the organizational needs**, is our Nursing Support Technicians (NST) Bridge Program. According to WF data, we were challenged in the recruitment/retention of our NST. Curriculum was created **5** and Certified Nursing Assistants hired and training provided to advance them into the new role of NST.

GBMC-U (Leadership Development) curriculum ranges from operational, financial and business processes to topics such as building trust, performance management, Just Culture and **ethical behavior in both healthcare and business practices**. Organizational PI/innovation sessions use PDSA to drive innovative thinking, **intelligent risk taking** that supports high performance. GBMC-U, the Center for Nursing Excellence, the Simulation Lab, learning collaboratives, off-site training and professional conferences are all examples of ways we meet the specific capability needs and **desires of the WF**. Our nurse residency program is designed to foster professional development, support a culture of **ethical behavior** and safety, and to promote retention and engagement of first-year nurses. Our program, one of only 61 worldwide, achieved *Accreditation with Distinction*, the highest level of recognition from the American Nurses Credentialing Center (ANCC). Curriculum requirements include that every new nurse conducts an evidence-based practice project (Figure 7.3-28) which is showcased and celebrated at their graduation as part of our KMS (Figure 4.2-3). An example was the recent collaboration between critical care nurse residents who implemented music therapy to decrease anxiety in intubated patients. This was accepted for

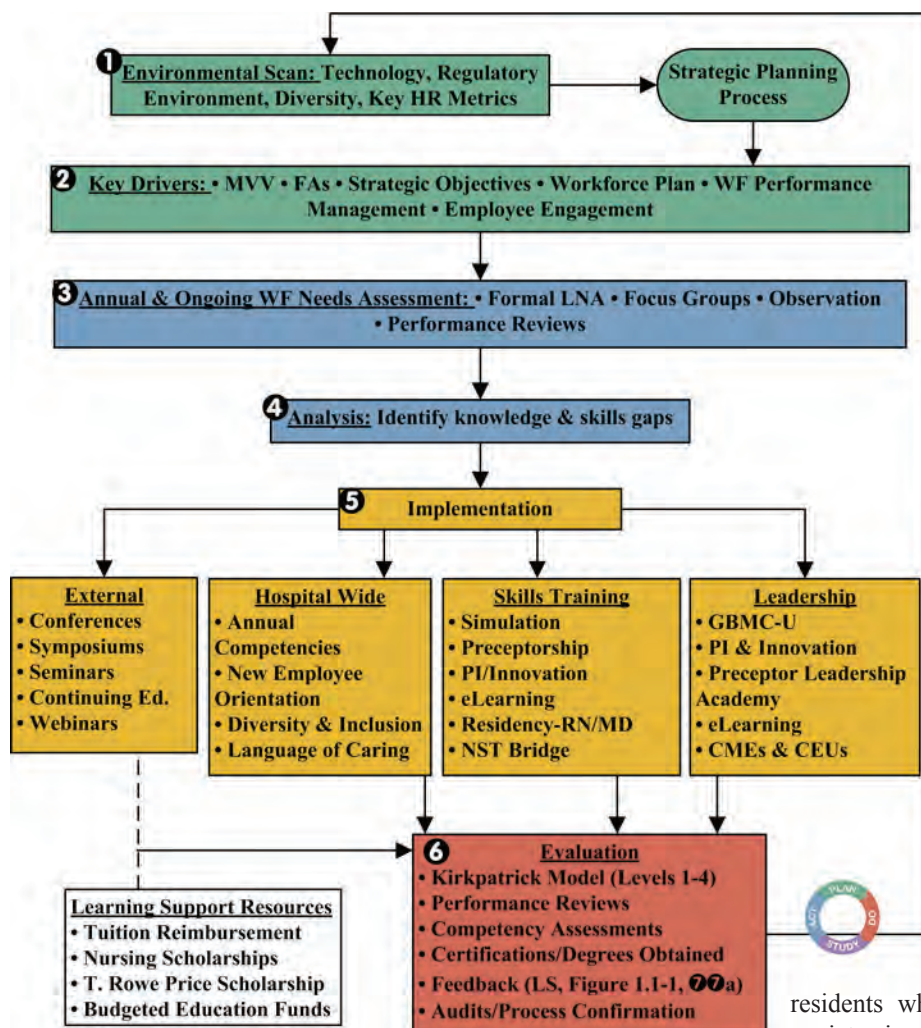


Figure 5.2-2 Learning & Development System



presentation at three national conferences. As an aside, a grateful patient, who was a part of the study, donated funds to purchase iPods for future patients as this practice was deployed.

**5.2c(3) Learning and Development Effectiveness** We have several measures which [evaluate the effectiveness and efficiency of the Learning and Development System](#) (Figure 5.2-2 **6**). All learning methodologies have an evaluation determination. Formal learning can be evaluated by degrees and certifications obtained. Unit based learning, such as how to do purposeful rounding (Area 3.2b[1]), can be evaluated through audits and process confirmation at the unit level. In our simulation lab, multi-disciplinary learning can include new skills and processes evaluated Kirkpatrick Levels 1-4. Classroom or eLearning evaluation methodology Kirkpatrick Levels 1-2 using surveys and quizzes. These evaluations are considered in the EA (Figure 2.1-2) **1** as an input into the SPP **2** (Figure 2.1-1). The output of the SPP **2** includes the SO and the WF plan, aligned and integrated with MVV and FA. Using this integrated approach, we correlate [learning and development outcomes](#) with the findings of [WF engagement](#) scores and [key organizational results](#). An example of how we used Kirkpatrick to evaluate Levels 1-4 learning is in our therapeutic heparin performance improvement. Data revealed delays in achieving therapeutic levels of heparin (anticoagulation necessary for prevention of patient harm related to Deep Vein Thrombosis and Pulmonary Embolism—DVT/PE). Every hospital RN was required to complete eLearning about a new protocol as a prerequisite for in-person simulation learning. Each RN logged into Epic playground and was assigned 3 patients at various therapeutic ranges. The RN had to apply the protocol, program the appropriate pump titration, and document accurately (Kirkpatrick Level 3). Results after one month improved time to therapeutic level from 20 hours to 9.8 hours, reducing risk of harm (Level 4) (Figure 7.1-24).

**5.2c(4) Career Development** We [manage the career development for the WF and future leaders](#) through a

combination of self- and leader-identification of candidates for training and promotion to support the organization's needs. SL conducts leadership mentoring with their direct reports (LS, Figure 1.1-1 **7**). As an example, several departments created clinical ladders, and the nursing department deployed a Professional Excellence Model. SL placed specific focus on mentoring young leaders, several who now fill director and senior director positions in all three work systems.

We carry out [succession planning for management, leadership, and other key positions](#) in a systematic process integrated across all three work systems. We recognize that [succession management](#) enables business continuity and WF development (see Sustainability Area 1.1c[1]), and a leadership pipeline. Succession planning is led by the CHRO. Each year, SL's identify and evaluate current and future leaders using Korn Ferry Leadership Competencies, which have been tailored to each position. Potential successors are evaluated for leadership growth. The steps in succession planning are: 1) the executive team selects the positions requiring succession; 2) for each position, an interim successor is identified in the event of an unexpected vacancy; 3) key competencies necessary for each position/role are identified; 4) for each position, it is determined whether there is a potential permanent successor internally. If so, that person is mentored to ensure they have the skills for the position.

In a cycle of learning, SL's began a process of evaluating their talent inventory. Each SL identified essential competencies for their role and critical roles in their division by completing a Healthcare Succession Talent Inventory Worksheet (AOS). This worksheet plotted the identified competencies, and graded current talent as: Interim, Ready Now, or Ready in 1–3 years. Each person's competencies were evaluated as strength, appropriate, development needed, or untested. This set a baseline as well as informed action plans to create documented development opportunities. This process is cascaded throughout the director and key manager levels of the organization. HR tracks and trends the succession cover for key positions.

## 6: Operations

### 6.1 Work Process

Our Enterprise Systems Model (ESM, Figure 6.0-1) shows how our Systems that Work **2**, Guide **1**, and Support **3** interrelate. Using VOC and VOXM **9** (Figure 3.1-1) we determine if we are meeting our patient and WF requirements and expectations. Outputs from that listening help us improve how we deliver on our FA **6**. Also shown are the inputs, which include suppliers, partners, regulators, and others. The ESM helps us define the entire organization as an aligned and integrated process, and shows the key linkages.

### 6.1a Service and Process Design

**6.1a(1) Determination of Service and Process Requirements** Process requirements are [determined](#) by listening to the customer of the process. For our [key healthcare service and work process requirements](#), the customers are external (patients). Their requirements are determined through our listening posts (Figure 3.1-1) and the analysis performed on what we learn. This is the input from the customer in a COPIS

(Customer ⇒ Output ⇒ Process ⇒ Input ⇒ Supplier) design flow (Process Design and Management Process [PDMP], Figure 6.1-2), where the design of a process (Area 6.1a[3]) begins with the customer, and the use/management of a process ends with the supplier. The factors related to efficiency and effectiveness discussed in Area 6.2a are designed into our process.

**6.1a(2) Key Work Processes** Our key work systems in the ESM (Figure 6.0-1) are: 1) GBMC Health Partners; 2) GBMC Hospital; and 3) Gilchrist. Under each key work system are our three [key work processes](#) of Care Access, Care Delivery, and Care Transition. Their [requirements](#) are shown in Figure 6.1-1.

**6.1a(3) Design Concepts** To [design health care services and work processes to meet requirements](#), we use a COPIS model starting with customer requirements (PDMP, Figure 6.1-2 **9**). This begins with: 1) the process owner asking the first three questions in the Model for Improvement followed by PDSA. (**Plan**) (Figure P.2-2) In the design process the process owner

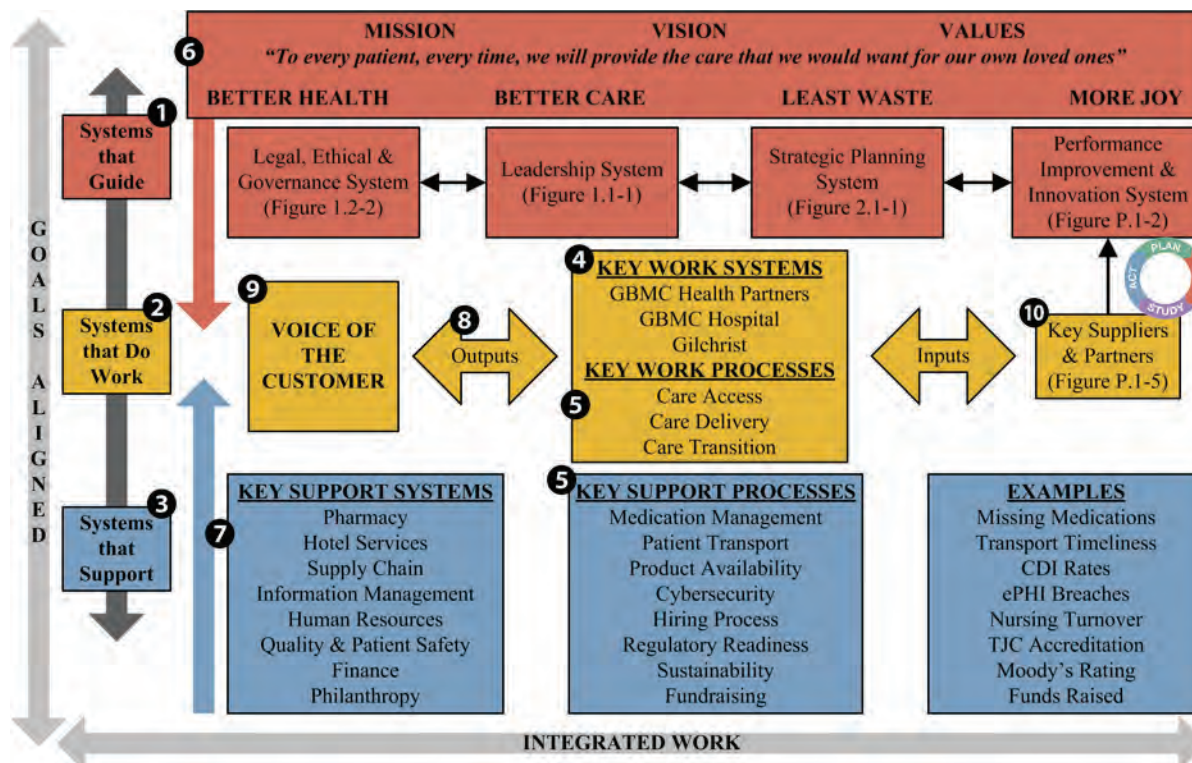


Figure 6.0-1 Enterprise System Model

meets with the process customer and considers a wide range of factors (Area 6.2a), which can impact the process. These

design requirements are established, the process owner is responsible for designing the process to meet these parameters, and reviewing the design with the process customer (internal

Key Work Processes	Key Requirements	Measures	Metric*	Results
Care Access	Timeliness	LWOBs Comfort within 18 hours	(I) (O)	7.1-40 7.1-35
	Ease of Access	Extended Hours Primary Care Surgeon Satisfaction	(I) (O)	7.1-42 7.1-41
Care Delivery	Evidence-Based	Healthcare Associated Infections (HAL)	(O)	7.1-4
	Respectful	Training in Respect/Participation	(I)	7.1-37
Care Transition	Coordinated/Communicated	Communication after Discharge	(I)	7.2-2
	Appropriate	Readmissions Palliative Care Consults	(O) (I)	7.1-3 7.1-51
Key Support Processes (Full List AOS)	Organizational Support Requirements	Measures	Metric*	Results
<b>Work System Key Requirements are addressed by each key support system</b>				
Pharmacy	Evidenced Based, Capacity, Efficient, Safe, Value, Joyful	Missing Medication	(O)	7.1-61
		High Risk Antimicrobials	(I)	7.1-53
Hotel Services		Transport Turnaround Time	(O)	7.1-54
		Reducing Energy Consumption	(I)	7.4-19
Supply Chain		EDI - GHX Ranking	(O)	7.1-59
		EDI Order Rate	(I)	7.1-60
Information Management		Epic Gold Star Rating	(O)	7.1-5
		ePHI Breaches	(O)	7.1-55
Human Resources		Meaningful Work (More Joy)	(I)	7.3-18
		Total Organizational Turnover	(O)	7.3-2
Quality & Patient Safety		Culture of Safety	(I)	7.3-11-12
		CMS Star Rating	(O)	7.1-1
Finance		Moody's Rating	(O)	7.5-1
	Days Cash on Hand	(I)	7.5-4	
Philanthropy	Grateful Donations	(O)	7.4-20	

\*(I)= In Process Metric, (O)=Outcome Metric

Figure 6.1-1 Key Work Processes & Key Support Systems & Processes

include new technology, organizational [and customer] knowledge, evidence-based medicine, health care service excellence, patient and other customer value, consideration of risk, agility, cycle time, productivity, and other efficiency [in-process] and effectiveness [outcome] measures.

2) Once the design requirements are established, the process owner is responsible for designing the process to meet these parameters, and reviewing the design with the process customer (internal or external) to ensure the key requirements have been addressed. 3) At that time an implementation plan is reviewed and refined. (Do) After implementation the results are reviewed (Study) and adjusted (Act), as appropriate. An example of how we redesigned care using this model, was when the pharmacy (system that supports) deployed larger, state-of-the art medication storage and dispensing machines (Omnicell). A customer requirement of systems that do work included: medication availability (capacity) improved workflow (efficient), enhanced technology (evidence-based), ease of use (joyful) and accuracy (safety). The implementation plan was built according to these requirements.

**6.1b Process Management and Improvement**

**6.1b(1) Process Implementation** Our

approach to ensuring that the day-to-day operation of work processes meet key process requirements (Figure 6.1-1) is through the use of key performance measures or indicators and in-process measures to control and improve our work processes and to ensure the outcome we expect. This begins with determining process customer requirements through the PDMP (Figure 6.1-2) COPIS (Area 6.1a[1]) and designing the process (Area 6.1a[3]) considering the requirements of process and the process customer.

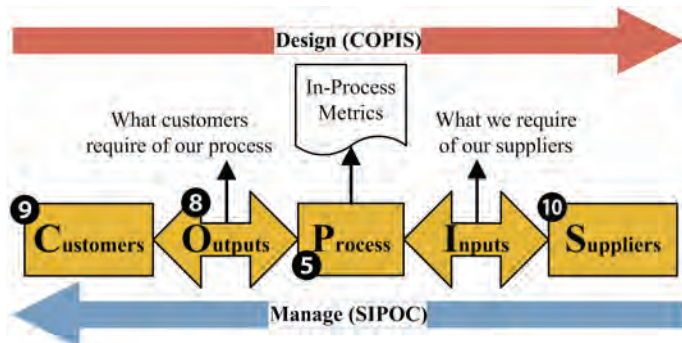


Figure 6.1-2 Process Design & Management Process

These measures relate to the quality of outcomes and measures of the performance of our health care services through a direct linkage (Figure 6.0-1) between meeting the customer requirements (VOC/VOWF) and Customer Requirements (Figure P.1-4) ⇒ to our three Key Work Systems ⇒ to our three Key Work Processes ⇒ to our outcome measures ('O' in Figure 6.1-2) ⇒ to our in-process ('I' in Figure 6.1-2) measures.

In implementing and managing processes, we use the opposite of COPIS, or a SIPOC, where management of the process begins with the supplier and ends with the customer. As shown in Figure 6.1-2, implementation is focused around the Supplier, Intput (what we need from them), our Process, Output (from our process), which is delivered to the Customer. In simple terms, we start designing using the customer's requirements (Area 6.1a[3]) and end by providing (Area 6.1b[1]) those products and services to the customer.

**6.1b(2) Patient Expectations and Preferences** At the organizational level, patient expectations are determined, considered and addressed through using VOC. During each phase of the patient experience (Figure 3.2-1), patient expectations/requirements are determined through listening, education, and explanation. This includes explanation of the treatment course, likely outcome, and mutual agreement on the treatment plan in order to set realistic patient expectations. For example, at Gilchrist during the first contact, a mutual plan of care is established, which is centered around the patient and family desires, merged with our clinical assessment and recommendations. This transparency of communication allows us to factor patient decision-making and patient preferences into the delivery of healthcare services (Figure 7.1-6).

At the individual patient level, we consider patient preferences and patient decision-making in all three phases:

**Before the Visit (Care Access)** There are many ways that we use to understand the patient's requirements and their upcoming procedures: 1) we call patients to gather information; 2) we provide education regarding their health and/or upcoming procedures; 3) patients can access their providers

to ask questions; and, 4) schedule appointments either by phone, or through our patient portal. During the pre-admission/admission process, patient decision-making and individual patient preferences are gathered in Epic, consent process and treatment for surgery and advanced medical directives. We have a systematic process for orienting patients upon admission through two-way communication and, where appropriate, an individualized welcome packet to ease their transition.

**During the Visit (Care Delivery) Inpatient:** Daily goals are discussed and written on the white board in their rooms as a communication and feedback method for meeting expectations. We conduct leader and nursing purposeful rounding every day (Area 3.1b[1]). **ED:** Physicians, nurses, and staff discuss patient/family preferences and special needs and involve them in decision-making. **Ambulatory:** Location preferences and appointment availability are considered for decision-making and to engage patient preferences. Patients can express expectations, preferences, and questions through our patient portal, MyChart.

**After the Visit (Care Transition)** We maintain our relationship with patients throughout the continuum with a wide range of tools to validate the effectiveness of the experience (Figure 3.2-1). For example, in our patient-centered medical homes, nurse care managers are assigned to patients with complex needs to support their health and progress towards achievement of disease-specific goals (Figures 7.1-18 and 7.1-19).

**6.1b(3) Support Processes** Our key support processes found in Figure 6.0-1 5 are determined through the voice of the key work process owner (Figure 6.0-1). Where 6.1a(1) discusses external VOC listening and how our key work systems must be internally supported, a similar process is used to listen to the internal customers. Their requirements are determined through our internal listening posts, and the analysis performed on what we learn. In a cycle of learning, to better understand the key organizational support requirements of our work systems, we developed and implemented a cross-needs assessment. The survey was conducted between Systems that Do Work 2 and Systems that Support 3 and Systems that Guide 1. Results are analyzed and used to identify opportunities for improvement. This is the input from the customer in a COPIS model (Figure 6.1-2). This listening process includes factors such as cycle time, productivity, preventing errors, cost control, and balancing cost vs. customer needs (Area 6.2a). These requirements then drive the design and continuous improvement of key support systems and processes (Figure 6.1-2). The day-to-day operation of these processes use in-process and output measures to ensure they are meeting key organizational requirements. These are listed in Figure 6.1-1.

An example is our work with medication availability at the bedside. The customer, our nursing staff (a key work process owner for care delivery), reported a negative impact on care delivery by the pharmacy (key support system). Nursing could not locate medications when needed because there was no standard work related to medication delivery and storage on the unit. A multi-disciplinary committee was formed to determine the root cause and conduct real-time problem solving. Improvements included a redesign of the process including a bar code tracking system, optimization of the medication inventory on the units, standardization of medication storage locations,

and the creation of standard work in the use of the EMR system to locate the medications at any given time. These changes resulted in an improvement in the measure that was impacting care delivery (Figure 7.1-60).

**6.1b(4) Service and Process Improvement**

The performance improvement cycle (Figure 2.1-5 (2-4b, 5)) in the Performance Improvement and Innovation Determination Process describes how we approach improving our work processes and support processes to improve health care services and performance. Using PDSA we determine a SIPOC (process management) or COPIS (process design) approach that applies to either performance improvement or innovation (IMP, Figure 6.1-3). Either of these could result in achieving the CC, Redesigning Care. With service and process improvement we reduce variability, and we directly link our measures, processes, and systems (Figure 6.0-1).

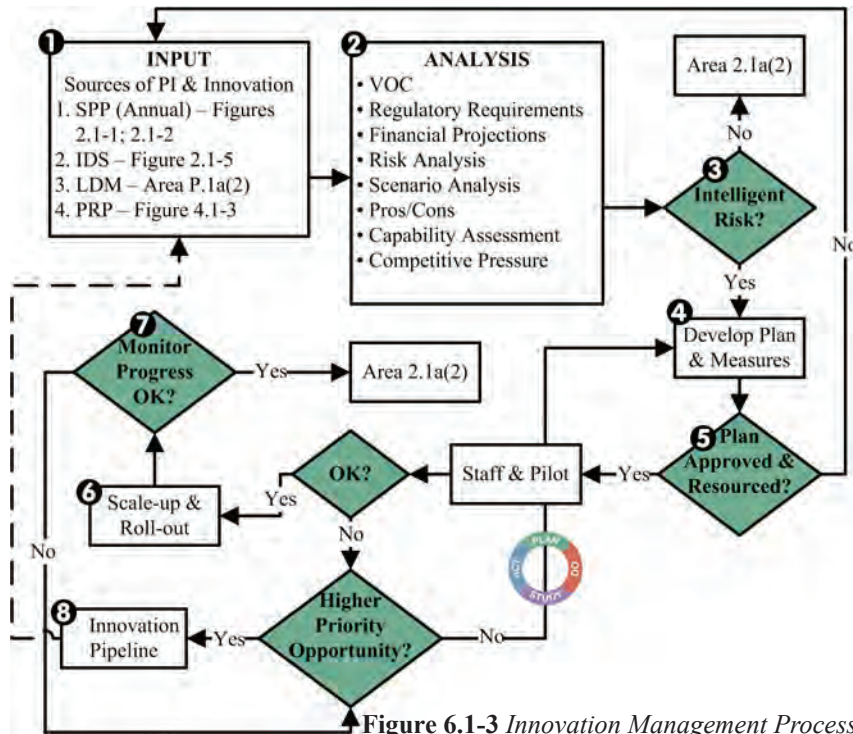


Figure 6.1-3 Innovation Management Process

**6.1c Supply-Network Management**

We manage our supply network through our 10-step Supplier Management Process (SMP, Figure 6.1-4). It begins with input from the 10-step Make/Buy process (AOS). The Make/Buy process is initiated from the innovation triggers described in Area 1.1c. All three work systems evaluate their need to determine if the requirement can be met through internal or external means. Once that process has determined that the product or service should be sourced outside, our SMP is followed to finalize requirements, and evaluate suppliers, considering our CC, and their core competency (Steps

1-2). This includes value analysis (with 4 multi-disciplined customer-led committees, Area 6.2a) to compare the supplier requirements with a supplier’s capabilities based on established criteria to ensure they are qualified and positioned to meet our operational needs. Once we select a supplier 3, KPIs are finalized. These metrics generally include fill-rates, on-time delivery, pick accuracy, lead time (to ensure agility), and defect measures 4. We then execute the contract 5.

In working with suppliers, alignment and collaboration are ensured to meet cost/schedule/quality needs as we conduct formal and informal evaluations with two-way communication (Figure 6.1-4 6) to enhance our performance and support our objectives. A supplier’s performance is measured and evaluated as daily, weekly, and monthly metrics are reviewed by end-users and the Supply Network Department. Supplier Quarterly Business Reviews (QBR) are conducted with larger stakeholder groups to align strategic vision, innovation opportunities, and to ensure the partnership is yielding the expected results.

All suppliers must honor our MVV. Since some deal directly with patients this is key to their ability to enhance our patient and other customer satisfaction. To ensure agility, we work together and track the supplier’s ability to respond to changes in patient, other customer, market and organizational requirements. We clearly communicate performance expectations, measure and evaluate suppliers’ performance on a daily, weekly or monthly basis (as needed), and provide feedback. We meet to review any changes in the VOC or market requirements that necessitate a rapid modification to the product or service (Figure 6.1-4 6). To provide feedback and help them improve, KPIs are evaluated during the QBR to ensure contractual compliance. If performance is acceptable 7 we continue to manage the relationship. If performance is not acceptable 8 we deal with poorly performing suppliers by implementing countermeasures to help them improve 9 and/or reevaluate the relationship

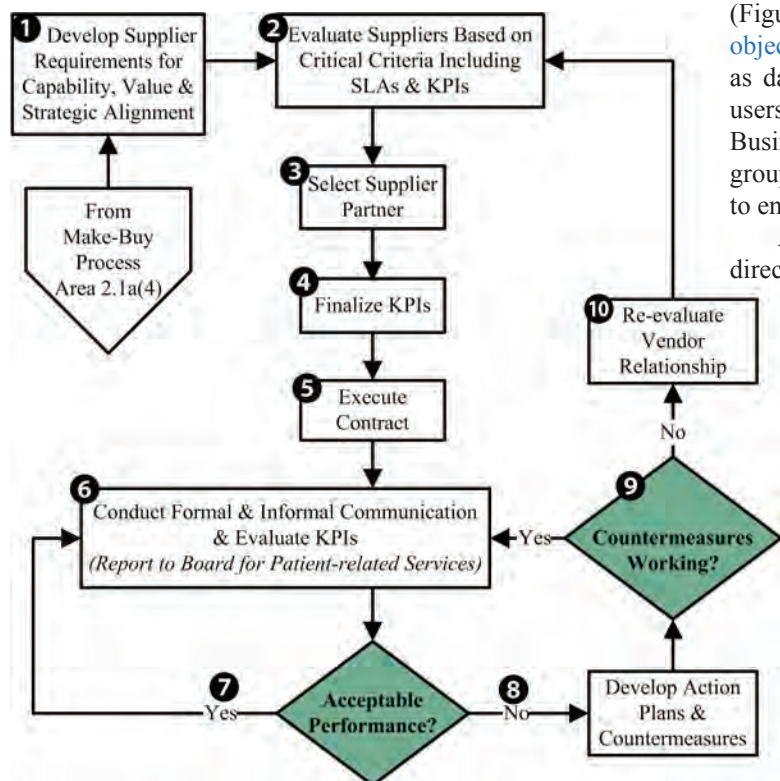


Figure 6.1-4 Supplier Management Process

10. For example, our primary supply distributor began having problems meeting our required KPIs. After several rounds of action plans and failed countermeasures, we reevaluated the vendor relationship 2 and selected a new distribution partner through the SMP. This fully aligned and integrated our internal and external stakeholders.

To ensure excellence we receive National Best Practices from Premier Inc., our group purchasing organization (GPO) for medical supplies (and data analytics, product screening, innovation ideas, etc.), and from Sodexo, a key supplier of managed hotel-type services including EVS, Patient Transport, and Food Services (Figure P.1-5) [who promote alignment and collaboration between GBMC and our supply network.](#)

### **6.1d Innovation Management**

Innovation is in our culture and drives our CC. Innovation at any level, or from any source (Figure 6.1-3 1) can drive **Redesigning Care**. We [pursue opportunities for innovation](#) through our IMP (Figure 6.1-3). Determining that an innovation is needed we use four sources (1). The development of innovations uses the PDSA process (Figure P.2-2). The innovation itself may be a new or revised approach that brings meaningful change to [pursue the strategic opportunities](#). Analysis is performed 2 that balances the needs of the customer, the resource requirements and support of SO to [determine](#) if the innovation is an [intelligent risk](#) 3. If it is, the innovation is pursued, piloted, and [financial and other resources](#) are made [available](#) 4 5 through innovation funding (giving us the agility to implement these at any time) or through the SPP (annually). If it is an unanticipated event, the SL use their regularly scheduled meetings to assess what has occurred, and what needs to be done. This process ensures that we are quick to assess the need for innovation 1 monitor progress assertively 7 and, based on data, be agile to make a fact-based decision to scale up the process and continue the roll out 6, or to [discontinue](#) and place in the Innovation Pipeline 8 (AOS).

## **6.2 Operational Effectiveness**

### **6.2a Process Efficiency and Effectiveness**

Our systematic approach to [manage the cost, efficiency and effectiveness of our operations](#) is achieved in the design and implementation of health care services and [work processes](#) to meet our customer requirements (Area 6.1a[3]). We [incorporate cycle time, productivity, and other efficiency and effectiveness factors in our approach to work process design](#). These characteristics we want in our processes are considered in the original design.

We [prevent rework and errors, including medical errors](#), by having 1) defined processes, 2) standard work, and 3) performance measures that ensure standard work is achieved.

1) Finding the errors and waste is performed through multiple means daily, including, LDM (Area P.1a[2]), the Communication System, (Area 1.1a[2]), VOC (Figure 3.1-1), and the Safety Event reporting system. Once found, 2) the opportunity to improve is analyzed. 3) After the analysis phase, PDSA changes are implemented. Next, 4) Actions are implemented and monitored which have been designed around creating and sustaining high-reliability.

Health care has a lot of places where the equipment, practices, and protocols help to mistake-proof anything which

could have a patient, cost or other impact to our FA. Our Just Culture and our commitment to the Vision fosters transparent communication as we continually look for systematic mistake-proofing tools to [prevent rework and errors, including medical errors](#). This systematic approach helps ensure the process stays in-control and [minimizes the costs of inspections, test, and process or performance audits](#). When our [cost control needs differ from our patients' and other customers' needs](#), we begin our [balancing](#) approach using our MVV and FA as the foundation. In this balancing we have a clear hierarchy of priorities. This is supported by the value analysis committees' (surgical, clinical, pharmaceutical, linen) cross-functional membership including physicians, nursing, quality and safety/risk management, infection prevention, and supply chain members. **Better Health (FA)** requires that patient safety is always the first consideration. For example, the surgical value analysis committee evaluated high-value implants for clinical outcomes, cost-effectiveness, patient safety, accessibility and physician requirements. As a result of this **Redesign of Care**, we achieved better health (Better Health) outcomes through our Enhanced Recovery After Surgery (ERAS) (Figure 7.1-4) (joint replacements), and by reducing costs (Least Waste) by over \$2 million, achieving stakeholder requirements (Figure P.1-4).

### **6.2b Security and Cybersecurity**

As the baseline for our security/cybersecurity approach we have adopted the NIST Cybersecurity Framework. We attended the workshop and applied the NIST Cybersecurity Builder Tool, an industry best practice.

To [Maintain Awareness](#) and [Address Emerging Threats](#) (Figure 6.2-1 4, full grid AOS), we: [Identify and prioritize key information technology and operational systems to Secure](#) 5; [Protect](#) 6; [Detect](#) 7; [Respond](#) 8; and [Recover](#) 9. We have mapped a comprehensive process which shows (for each of these factors) the: 1 Safeguards in place; 2 Measures used; and 3 Mechanisms to Evaluate Effectiveness. A multi-disciplinary committee led by SL and including IT, nursing, legal and compliance oversees the security and cybersecurity process (Figure 6.2-1).

[Security and cybersecurity of sensitive or privileged data and information of key assets](#) starts with how we [manage physical and electronic data, information and key operational systems](#). To ensure its confidentiality and only appropriate physical and electronic access we: identify the applicable information systems and practices, as described in Figure 6.2-1 and the NIST framework. To ensure that our [WF, patients, other customers, partners, and suppliers understand and fulfill their security and cybersecurity roles and responsibilities](#) we employ awareness, training and the other processes detailed in the table. For example, we will email “fake” cyber attack attempts to reinforce learning. In a cycle of improvement, as part of Legal and Ethical Behavior system (Figure 1.2-2 2), we have implemented a process to assure security of our data when entering contracts with vendors.

### **6.2c Safety and Emergency Preparedness**

**6.2c(1) Safety** As described in Area 5.1b(1), we have a systematic approach to ensure workplace security, accessibility and safety through our Workplace Environment System (WES, AOS). We [provide a safe and secure operating environment](#)

	Safeguards ①	Measures ②	Mechanism to Evaluate Effectiveness ③
<b>Maintain Awareness</b> ④	<ul style="list-style-type: none"> <li>Annual 3rd Party Assmts</li> <li>Real-time Vulnerability Scans</li> <li>0 Day Vulnerability Protection</li> </ul>	<ul style="list-style-type: none"> <li>Threat &amp; Vulnerability Reports</li> <li>Daily Vulnerability Metrics</li> </ul>	<ul style="list-style-type: none"> <li>Industry Benchmarking</li> <li>Industry Certifications</li> </ul>
<b>Identify</b> ⑤	<ul style="list-style-type: none"> <li>Identify Data</li> <li>Risk Assessment</li> <li>Risk Management Strategy</li> </ul>	<ul style="list-style-type: none"> <li>Maturity Level Peer Comparison</li> <li>Cybersecurity Dashboard</li> <li>Breach Reports</li> </ul>	<ul style="list-style-type: none"> <li>Industry Benchmark</li> <li>Industry Certifications</li> </ul>
<b>Protect</b> ⑥	<ul style="list-style-type: none"> <li>Access Control</li> <li>Awareness &amp; Training</li> <li>Data Security</li> </ul>	<ul style="list-style-type: none"> <li>Role Based System Access</li> <li>IT System Change Control</li> <li>Phishing Awareness Metrics</li> </ul>	<ul style="list-style-type: none"> <li>End User &amp; Customer F/B</li> <li>IT Steering Committee</li> <li>IT Support/Projects</li> </ul>
<b>Detect</b> ⑦	<ul style="list-style-type: none"> <li>Anomalies &amp; Events</li> <li>Continuous Monitoring</li> <li>Detection Processes</li> </ul>	<ul style="list-style-type: none"> <li>Real Time IDS Alerts</li> <li>Real Time SIEM Alerts</li> <li>Real Time IoT Alerts</li> </ul>	<ul style="list-style-type: none"> <li>NIST Cybersecurity Framework</li> <li>Vendor Best Practice</li> <li>Annual Assessments</li> </ul>
<b>Respond</b> ⑧	<ul style="list-style-type: none"> <li>Response Planning</li> <li>Mitigation</li> <li>Improvements</li> </ul>	<ul style="list-style-type: none"> <li>Disaster Plan</li> <li>IT Service Level Agreements</li> <li>Highly Available Systems</li> </ul>	<ul style="list-style-type: none"> <li>IT Service Levels</li> <li>End User Surveys/Feedback</li> <li>Escalation process</li> </ul>
<b>Recover</b> ⑨	<ul style="list-style-type: none"> <li>Recovery Planning</li> <li>Improvements</li> <li>Communications</li> </ul>	<ul style="list-style-type: none"> <li>Enterprise Disaster Plan</li> <li>IT Department Policy &amp; Proc</li> <li>FMEA Process for Learning</li> </ul>	<ul style="list-style-type: none"> <li>Business Continuity Goals</li> <li>End User Feedback/Learning</li> <li>FMEA</li> </ul>

Figure 6.2-1 Security & Cybersecurity (Full Table AOS)

through our commitment to the overall culture of safety and a proactive Environment of Care. In the WES (see also Area 5.1b[1]), Steps ① through ⑤ are proactive to ensure we effectively assess where we are, [accident prevention](#), and prepare the organization, facilities, and WF. Step ⑥ ensures our workplace effectively protects our patients and WF on an ongoing basis. Where there are opportunities to improve, a [Root Cause Analysis of failures](#) is conducted, and corrective actions ([recovery](#)) are implemented. Step ⑦ is our process to ‘step-back’ and assess [accident inspection](#) and the effectiveness of the system, and make overall improvements in our organizational level approach to safety. This process has been deployed and modified based on business needs throughout all three work systems. In a cycle of improvement, reference guides with easy-to-follow instructions have been placed throughout in prominent locations.

In alignment with our *More Joy* aim, through cycles of learning and as a result of our risk assessment ① ② we have improved safety preparedness in all three work systems. In the hospital, we have increased our use of contracted armed security to ensure the safety of patients and staff. In Baltimore City, where violence has been escalating, we added a security presence and escorts for staff located in our Gilchrist Center Baltimore. In our physician practices, we have conducted scenario-based training to prepare staff to respond safely in the event of a threat or a violent situation. WF safety is a leadership focus and is reported daily in our executive LDM communication.

Through [Redesigning Care](#), in Steps ① and ② (WES), we identified risks related to slips, trips and falls. As a PDSA, we implemented Safety Spill Stations located throughout the hospital to immediately address spills and slippery areas leading to reduced WF injuries (Figure 7.3-7).

**6.2c(2) Business Continuity** Success now and in the future was discussed in Area 1.1c(1). This addressed both strategic and operational considerations for [continuity of operations](#). Each of the 13 factors has an owner who is responsible for ensuring we are sustainable both short-term and longer-term. A key part of our planning is addressing: 1) disaster preparedness (and

[prevention](#)); 2) disaster recovery; and 3) ongoing operations. To ensure that we are prepared for disasters or emergencies, we use a 6-step Healthcare Emergency Operations Plan (EOP, AOS). Steps ① and ② provide the fundamental guidance for emergency incidents and disaster operations by performing a vulnerability analysis and the development of the EOP Management Plans. In Step ③ all hazards are assessed, and plans for mitigation are developed. Step ④ prepares our WF (in collaboration with [partners, supply network](#), and others in the region and state, as

appropriate) through education and training, which is tested and evaluated in Step ⑤. This is a closed-loop system, and Step ⑥ is an After Action Review and an improvement plan which ensures effective cycles of improvement and drives standard work. Further, considering our [reliance on WF, supply network, and partners](#), the plan uses a tiered approach to mitigate critical shortages.

One of the key sustainability factors addressed in Area 1.1c(1) is data. Security and cybersecurity are described in Area 6.2b above. In both cases we ensure that our [information technology systems continue to be secure and available to serve patients and customers and to meet business needs](#).

We have a fully equipped, dedicated Command Center, vital to mitigation, response and recovery efforts during actual events and drills. Recovery processes are addressed through the annual hazardous vulnerability assessment to identify human, technological and natural vulnerability risk. Our EOP includes a 96-hour sustainability matrix that is updated annually during SPP. We are a member of state and regional emergency management coalitions and participate collaboratively in training activities.

**COVID-19 Response:** Our EOP has been effective in managing our response to this long-term crisis and ensures safety for patients and staff, flexibility and agility in operations and logistics. It has proven effective as we meet the leadership and communication demands and respond to the rapidly changing regulatory requirements, supply chain shortages for critical equipment and WF capability and capacity needs. SL appointed a command team in mid-February before the situation became a national crisis. Using the FEMA Hospital Incident Command System (including various section chiefs across all work systems and disciplines) they manage, in concert with SL, all internal activities, action plans, resources, and education, as well as coordinating efforts with county, state, and federal agencies. The team’s top priority is creating plans for surge in patient volumes, which includes developing new policies and workflows, securing additional locations for care and reallocating WF members. To date, we are planning recovery and after action review (full plan AOS).

## 7: Results

### 7.1 Health Care and Process Results

Item 7.1 is a complex criteria. To answer the breadth and depth of the criteria, we have presented data (blue is where the requirement comes from in the criteria or application) as follows:

**7.1a(1) Health Care Results (Service Offerings and Care Integration – Area P.1a[1] Text) [Figures 7.1-1 to -20]**

**7.1a(1) Customer-Focused Service Results (Figure P.1-4) [Figures 7.1-21 to -38] – These also link to Customer Satisfaction and Engagement in Item 7.2**

**7.1b(1) Process Effectiveness and Efficiency (Criteria and Description Area 6.1b[1] and Figure 6.1-1) [Figures 7.1-39 to -57]**

**7.1b(2) Safety and Emergency Preparedness (Criteria and Description in Area 6.2c) [Figure 7.1-58]**

**7.1c Supply-Network Management Results (Criteria and Description in Area 6.1c) [Figures 7.1-59 to -61]**

### 7.1a Health Care and Customer-Focused Service Results

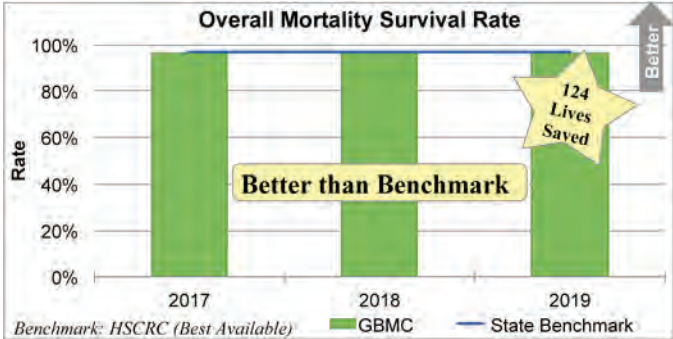
#### 7.1a(1) Health Care Results (Service Offerings and Care Integration –Area P.1a[1] Text)

CMS Star rating is a composite of numerous outcome-related metrics focused on a summary of quality measures. GBMC has achieved the highest rating of 5 Stars (Figure 7.1-1). CMS developed this methodology to summarize the results of publicly reported data available on Hospital Compare. The seven measures in the composite Star Rating are: Mortality; Safety of Care; Readmission; Patient Experience; Effectiveness of Care; Timeliness of Care; Efficient Use of Medical Imaging. Hospitals that earn the 5 star rating have better scores in heavily weighted categories that include mortality, patient experience, safety and readmission. It assures consumers that the organization provides high quality care. GBMC was 1 of 407 Nationwide and 1 of 8 of the 45 Maryland Hospitals to achieve a 5 Star rating.



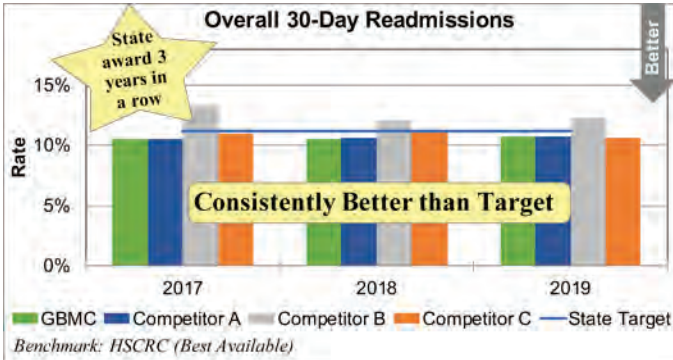
**Figure 7.1-1 CMS 5-Star Rating**

An overarching healthcare quality measure (a segment of the 5 star rating) is mortality (Figure 7.1-2). Care redesign, through the creation and implementation of evidence-based practices and standard work, contributes to this excellent outcome.



**Figure 7.1-2 Overall Mortality Rate**

An overall measure of quality and a commitment to population health is the effectiveness in providing patient care that does not result in a return to the hospital (Figure 7.1-3). GBMC considers this an important outcomes measure in both our Care Delivery and Care Transition work processes.



**Figure 7.1-3 Overall 30-Day Readmissions**

The Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN) developed and uses standardized infection ratios (SIRs) to measure healthcare-associated infection (HAI) incidence. Each SIR is a summary statistic that compares the number of observed HAIs to the number of predicted HAIs based on a national baseline. The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility. When the SIR is less than 1.0, fewer infections were observed than predicted indicating progress in HAI prevention. GBMC has consistently performed better than predicted in the following HAIs (Figure 7.1-4): Catheter Associated Urinary Tract Infections (CAUTI); Methicillin Resistant Staph Aureus (MRSA); Total Knee and Total Hip Arthroplasty (TKA) (THA); Ventilator Associated Events (VAE).

Health Outcome	Measure	Target	GBMC 2017	GBMC 2018	GBMC 2019
CAUTI	Standardized Infection Ratio	<1.0	Met	Met	Met
MRSA		<1.0	Met	Met	Met
TKA		<1.0	Met	Met	Met
THA		<1.0	Met	Met	Met
NHSN VAE		<1.0	Met	Met	Met
<b>Consistently Better than Predicted</b>					
<i>Benchmark: CDC-NHSN</i>					

**Figure 7.1-4 Healthcare Outcomes – Infections**

The Epic Gold Star program measures health record system capabilities that drive clinical and financial improvement. GBMC has progressively improved in Star Rating performance and is now in the Top 3% of all Epic hospitals internationally (Figure 7.1-5) Tiers 8-10 represent the cutting-edge and leading practices.

Epic Gold Star Rating <span style="float: right;">Better →</span>										
# of Stars	1	2	3	4	5	6	7	8	9	10
% of Participating Epic Orgs.	0.3%	7%	10%	11%	26%	22%	11%	9%	3%	0.3%
GBMC (Cal. Yr.)							'17	'18	'19	
Average Epic Org.					X					
<b>Sustained Top Decile Performance</b>										

Figure 7.1-5 Epic Gold Star Rating

An overall home/facility measure of quality is the CMS Hospice Information Set (HIS) composite which includes several items that need to be addressed in the first 24 hours: pain, shortness of breath (dyspnea), treatment preferences, beliefs/values, bowel regimen for patients receiving opioids. Since the measure's inception in 2017, Gilchrist has consistently exceeded the national comparison (Figure 7.1-6).

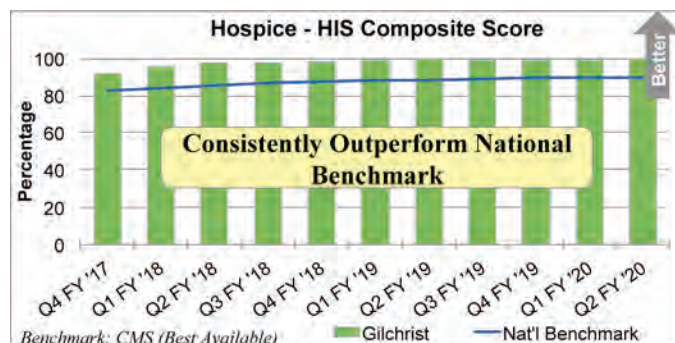


Figure 7.1-6 Hospice – HIS Composite Score

**Service Line: Medicine**

Figure 7.1-7 shows 100% of GBMC stroke patients receiving antithrombotic therapy at discharge, an evidence-based practice shown to reduce stroke mortality and stroke-related morbidity.

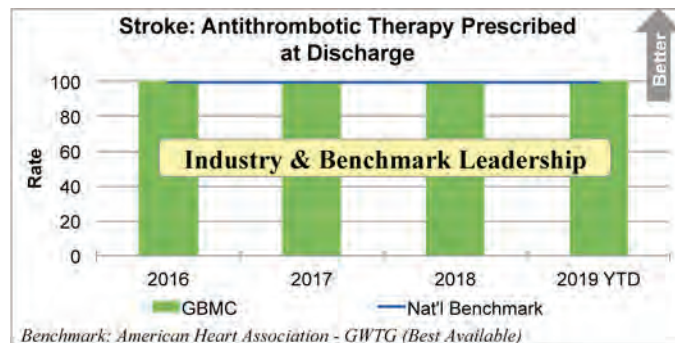


Figure 7.1-7 Antithrombotic Therapy Prescribed at Discharge

GBMC identified opportunities to reduce incidents of hyper and hypo-glycemic events for diabetic hospitalized patients (Area 4.2a[2]). This internal measure (Figure 7.1-8) does not

have a benchmark. Another measure of Medicine is Figure 7.1-43 where we have significantly impacted the length of stay for medicine inpatients.

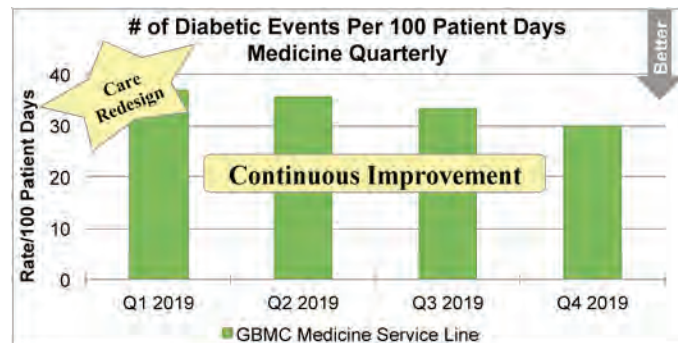


Figure 7.1-8 Diabetic Events Per Patient Days

**Service Line: Surgery**

GBMC participates in both the National Surgical Quality Improvement Program (NSQIP) for general surgery and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for bariatric surgery. Both are programs of the American College of Surgeons. They provide nationally validated, risk-adjusted, outcomes-based data and comparisons to improve the quality of surgical care. The programs are built by surgeons and used by surgeons to make informed decisions about improving quality of care. Figure 7.1-9 shows surgical infections compared to the odds ratio of observed vs. expected (similar to the SIR—above). The Semi-Annual Reports (SAR) consistently demonstrates better than expected for surgical site infections (SSI). Figure 7.1-10 shows improved health demonstrated by reduction in the use of diabetes medication after bariatric surgery.



Figure 7.1-9 NSQIP Surgical Site Infections

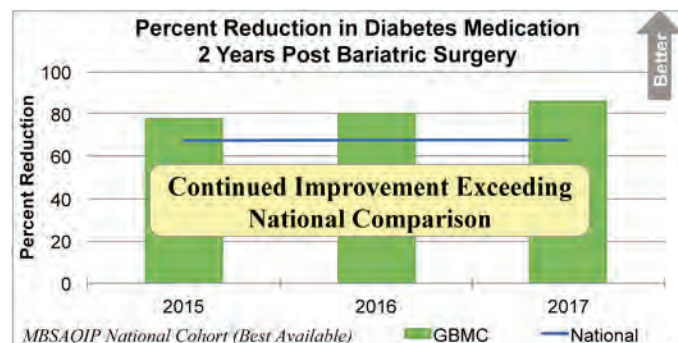


Figure 7.1-10 Bariatric Surgery Outcomes

**Service Line: Women/Children**

Safe quality care is particularly important in childbirth, both for



the mother and the baby. When either are not tolerating labor, delivering the baby safely is critical: minutes count. Through **Redesigning Care** using our sim lab, we have consistently exceeded American College of Gynecology’s time for “decision to incision” (Figure 7.1-11) This measure captures the minutes between when an emergency caesarean section is needed to when it occurs for patients at highest risk. Providing Antenatal Steroids for high-risk mothers is an evidence-based practice to reduce the incidence and severity of respiratory distress in the infants (Figure 7.1-12).

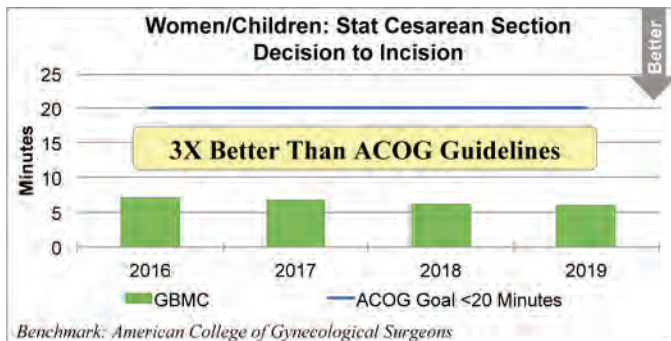


Figure 7.1-11 Decision to Incision



Figure 7.1-12 Antenatal Steroids

**Service Line: Oncology**

According to the National Cancer Institute, breast cancer is the most common cancer with nearly 300,000 new cases expected in 2020 in the U.S. Our comprehensive breast care center, accredited by the National Accreditation Program for Breast Centers, received commendation by the Commission on Cancer from the American College of Surgeons for breast conservation surgery (Figure 7.1-13).

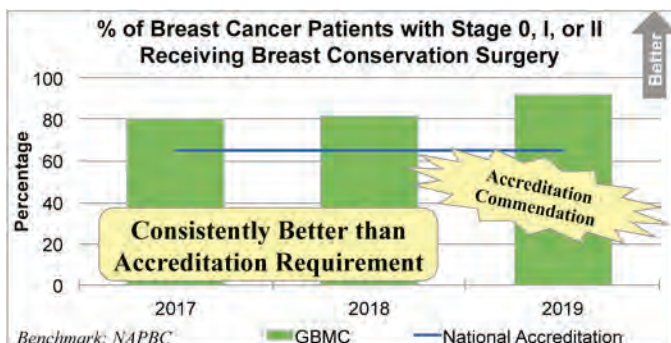


Figure 7.1-13 Percentage of Breast Cancer Patients with 0, I, or II Receiving Breast Conservation Surgery

The National Cancer Database (NCDB) recommends a combination of chemotherapy be administered within 4 months

of diagnosis for women under 70 with Stage IB to III hormone receptor negative cancer (Figure 7.1-14).

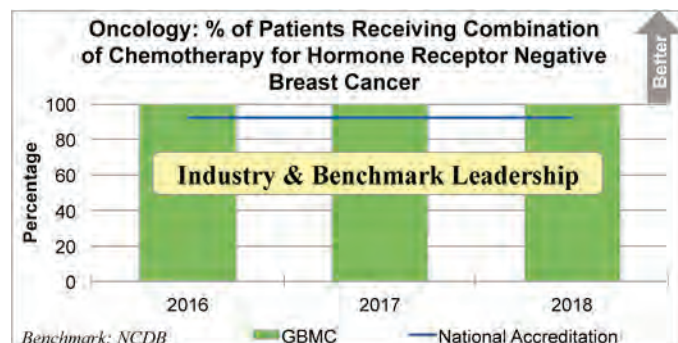


Figure 7.1-14 Percentage of Patients Receiving Combination of Chemotherapy for Hormone Receptor Negative Breast Cancer

Colorectal cancer is among the top 5 cancers in the U.S. and has a high survival rate if identified and treated early. Correctly staging patients with colon cancer requires meeting evidence-based standards for lymph node dissection (Figure 7.1-15). GBMC exceeds the NCDB recommendation that at least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer for 85% of the patients.

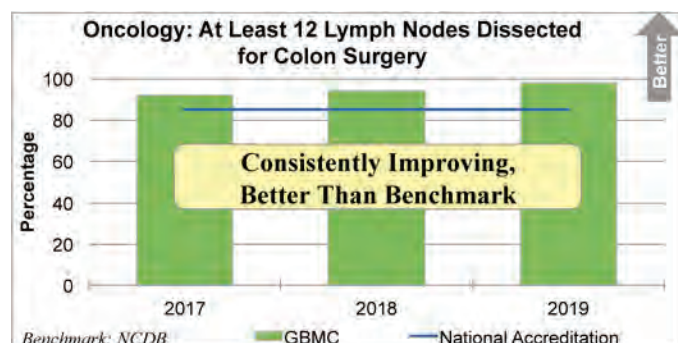


Figure 7.1-15 At Least 12 Lymph Nodes Dissected for Colon Surgery

**Service Line: Gilchrist**

Getting patients into hospice care earlier can help patients and families take full advantage of the services offered so they can live life to the fullest. We helped our patients skydive as part of a remaining bucket list. We assisted a dying child climb aboard a fire truck and ring the sirens, an experience that brought he and his father incredible joy. Hospice enhances patient quality of life and helps loved ones deal with the grief and loss they’ll experience when losing a loved one (Figure 7.1-16).

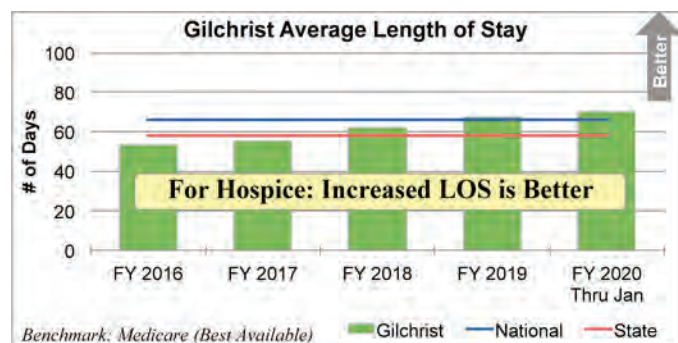


Figure 7.1-16 Gilchrist Average Length of Stay

Gilchrist provides an array of services for patients experiencing complex illness, advanced illness, and hospice care for the dying (Figure P.1-1). The goal of a hospice program is to have appropriate utilization of hospice care. If patients are “discharged live,” it is a measure indicating they could have been served better in another setting. Reducing these “live discharges” (Figure 7.1-17) is a measure of the appropriateness of admission.

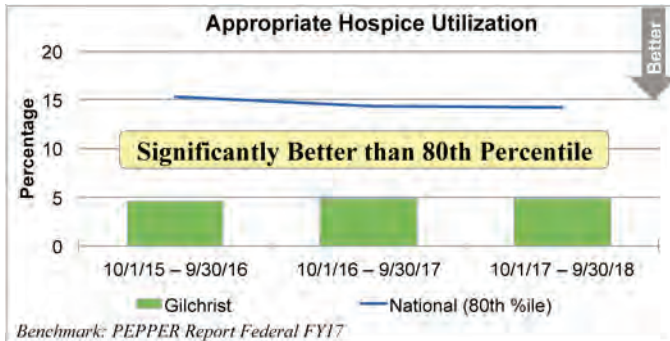


Figure 7.1-17 Appropriate Hospice Utilization

**Service Line: Primary Care**

Our primary health process results are measured as part of the CMS MIPS (Merit Incentive Payment System). Population health measures for primary care include: Blood Pressure Control (Figure 7.1-18); Reducing A1C a long-term marker of glucose control for diabetic patients (Figure 7.1-19); and Administration of the Pneumonia Vaccine for both high risk patients and those meeting age criteria (Figure 7.1-20).

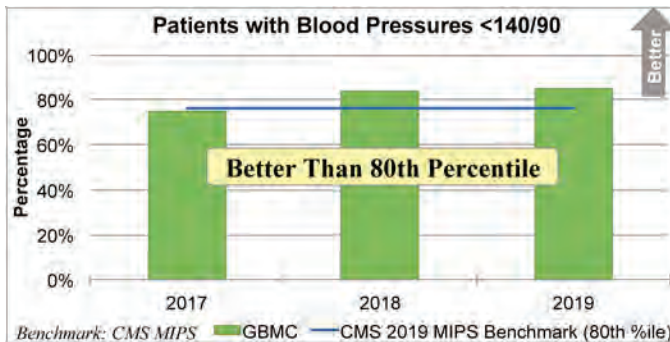


Figure 7.1-18 Hypertension Patients with BP <140/90

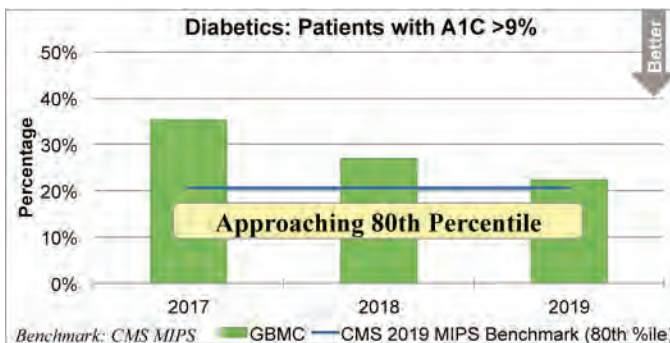


Figure 7.1-19 Diabetics: Patients with A1C >9%

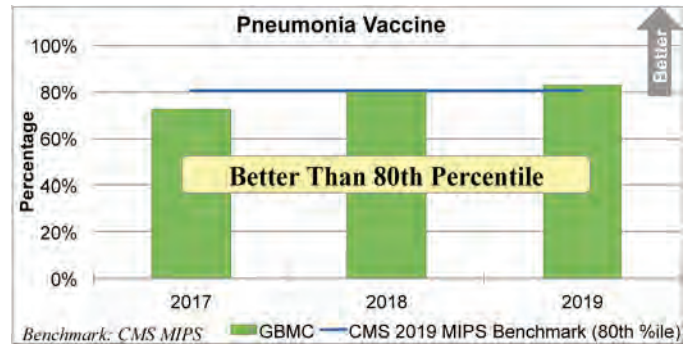


Figure 7.1-20 Pneumonia Vaccine

7.1a(1) **Customer-Focused Service Results (Figure P.1-4)** In addition to the measures shown in Figures 7.1-1 to 7.1-20, other customer quality measures include.

**IP Key Requirement - High Quality and Safe Care**

High quality safe care is supported by a culture of safety and reliability which begins with WF training and competencies (Figure 7.1-21). Upon hire, and annually, the WF completes an eLearning module with test which includes: 1) an overview of safe behaviors; 2) Just Culture; 3) the James Reasons Model of System Failures; and 4) the “what and how” to report safety events into our on-line system. Clinical staff receive additional safety training through scenarios in the Simulation Lab (multi-disciplinary codes, surgical fire safety, OB hemorrhage).



Figure 7.1-21 WF Competency Training in High Quality Safe Care

**IP Key Requirement – Communication**

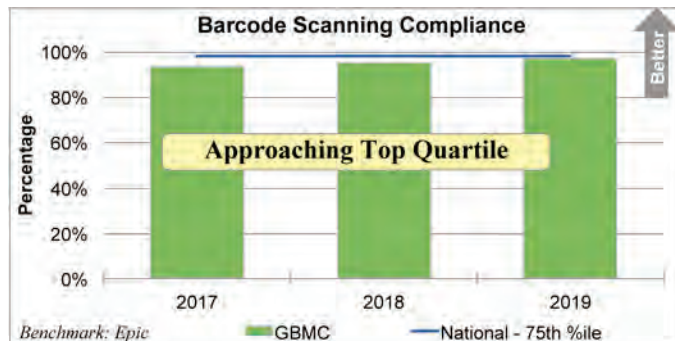
Effective communication requires skills that are introduced to the WF at orientation. Customer service training is part of orientation and in 2018 Language of Caring was added to this module. (Figure 7.1-22) Results are measured through CAHPS communication (Figures 7.2-2, 7.2-3, 7.2-8).



Figure 7.1-22 Workforce Customer Service Training

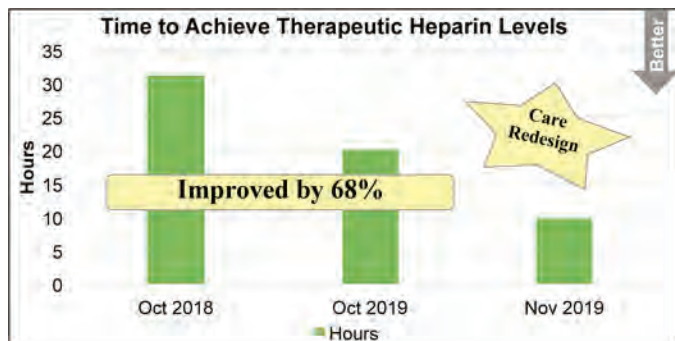
**IP Key Requirement – High Quality Safe Care**

To ensure high reliability in the medication administration process, we have implemented technology to reduce human error. An important measure is our compliance with barcode scanning to ensure the right medication is given to the right patient. LDM is used to study barriers to this electronic process. For example, during LDM report-out, a nurse in postpartum learned that placement of the label was preventing barcode scanning on a certain medication. Through real-time problem solving with SL, the issue was mitigated by changing the labeling process (Figure 7.1-23).



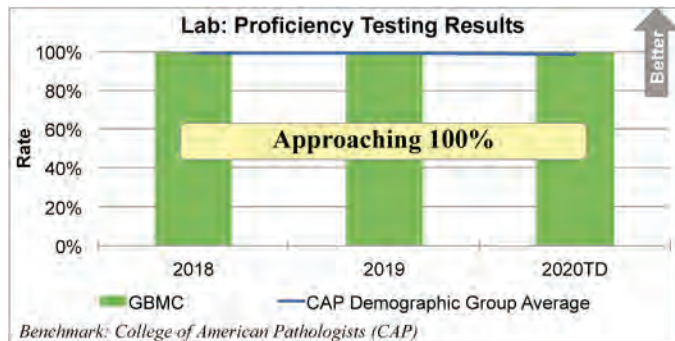
**Figure 7.1-23** Bar Code Scanning Compliance

Improvement in Time to Achieve Therapeutic Heparin Levels (reducing risk of harm) (Figure 7.1-24) demonstrates the effectiveness of the Learning and Development system as described in Area 5.2c(3).



**Figure 7.1-24** Time to Achieve Therapeutic Heparin Levels

Every laboratory test that is performed at GBMC meets the high standards for proficiency established by the College of American Pathologists (Figure 7.1-25).

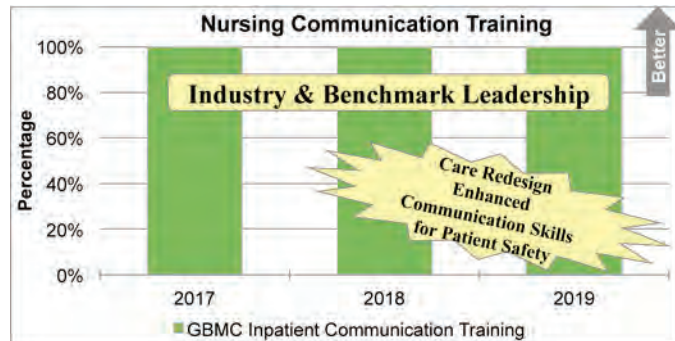


**Figure 7.1-25** Laboratory Proficiency Testing

**IP Key Requirement – Communication**

Communication is the primary root cause of most sentinel events

in healthcare. Ensuring our clinicians are trained effectively starts with our first-year new-to-practice RNs. Providing skills training in the simulation lab, we use evidence-based methods to help new nurses build confidence and expertise in safe and effective communication (Figure 7.1-26). Other measures for this requirement include Figures 7.1-21–22.



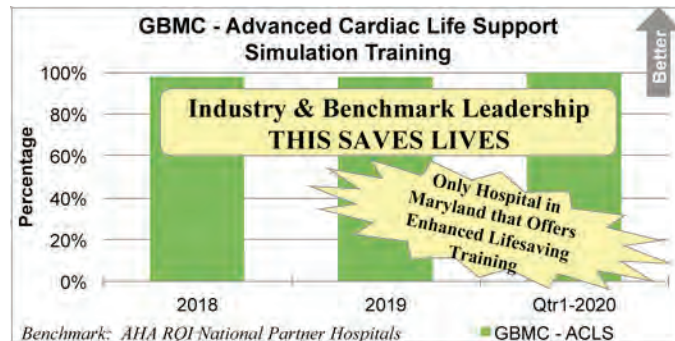
**Figure 7.1-26** Nursing Communication Training

**IP Key Requirement – Responsiveness**

As part of **Redesigning Care**, we have changed our training and competency validation approach in responding to sudden cardiac events. Historically, competency validation occurred every two years. Evidence shows a degradation of skills within months of this competency validation. American Heart Association’s Resuscitation Quality Improvement Program (RQI) has become their Gold Standard with quarterly knowledge and skills validation. GBMC is the only hospital in Maryland and one of 555 nationally that require this training for all Basic Life Support, Advanced Cardiac Life Support and Pediatric Advanced Life Support (Figures 7.1-27–7.1-29). An example of how this program saves lives was when a visitor to GBMC experienced sudden cardiac arrest in a hallway. An RN responded confidently, crediting his recent RQI training. The patient’s wife nominated this RN for several of our recognition programs (Area 5.1a[4]).



**Figure 7.1-27** Basic Life Support



**Figure 7.1-28** Advanced Cardiac Life Support



Figure 7.1-29 Pediatric Advanced Life Support

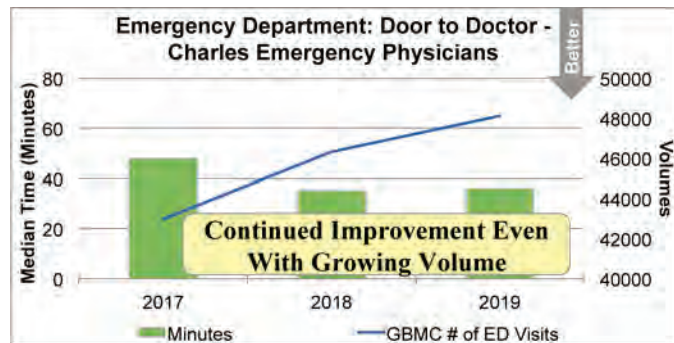


Figure 7.1-32 Door to Doctor Time

**Emergency Key Requirement – Timeliness and High Quality Safe Care**

“Time is brain”—treating patients with the clot-busting drug, t-PA within recommended timeframes can prevent loss of brain and help maximize the opportunity for recovery and quality of life. Figure 7.1-30 shows the rate of tPA administration for eligible stroke patients within 3 hours of “last known well.”



Figure 7.1-30 Thrombolytic Therapy Initiated w/in 3 Hours of Last Known Well

Figure 7.1-31 measures how quickly we administered the tPA. Care redesign helped us exceed national guidelines from the American Heart Association Get with the Guidelines (GWTG).

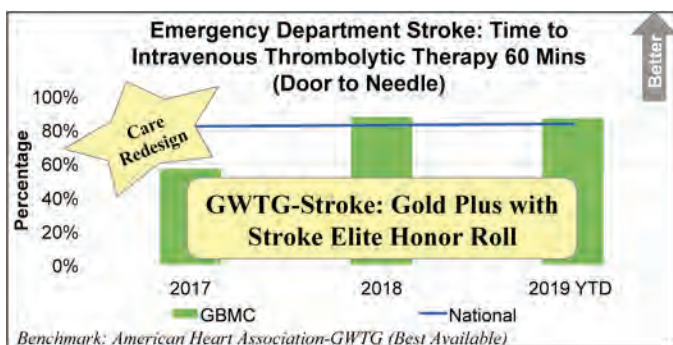


Figure 7.1-31 Time to Intravenous Thrombolytic Therapy 60 mins (Door to Needle)

A high-quality plan of care is established once the physician has rendered a diagnosis for ED patients. The sooner the patient sees the physician, the sooner the required assessments and interventions are initiated (Figure 7.1-32).

**Ambulatory Key Requirement – Access and High Quality, Safe Care**

Patients who have activated their electronic medical record through Epic MyChart have immediate access to their health record and the ability for bi-directional communication with their provider (Figure 7.1-33).

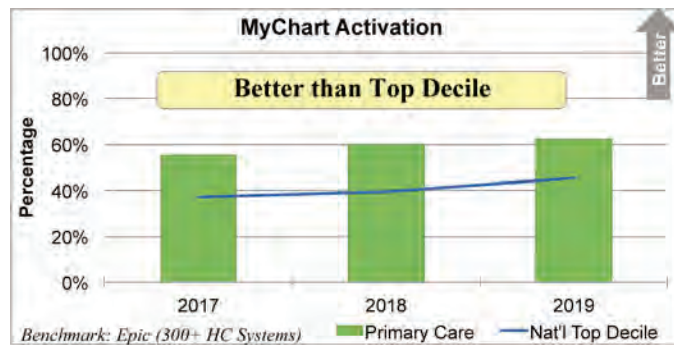


Figure 7.1-33 MyChart Activation

Using My Chart, patients can schedule their next appointment with their provider (Figure 7.1-34).

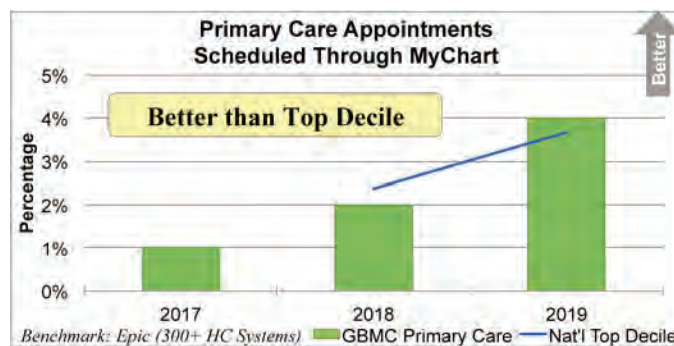


Figure 7.1-34 Appointments Scheduled through MyChart

**Home Facility Key Requirement – Comfortable**

Managing pain to make sure patients are as comfortable as possible provides quality care during the end of life. This is important to both patients and their loved ones. The National Hospice and Palliative Care Organization recommends that patients in hospice achieve comfort within 48 hours. **We don’t believe that’s good enough.** Our internal goal is to get patients comfortable in the facility setting within 18 hours. We achieve this 99% of the time within 18 hours (Figure 7.1-35). Comfort is also measured by the Hospice Information Set (HIS, Figure 7.1-36).



Figure 7.1-35 Comfort within 18/hours

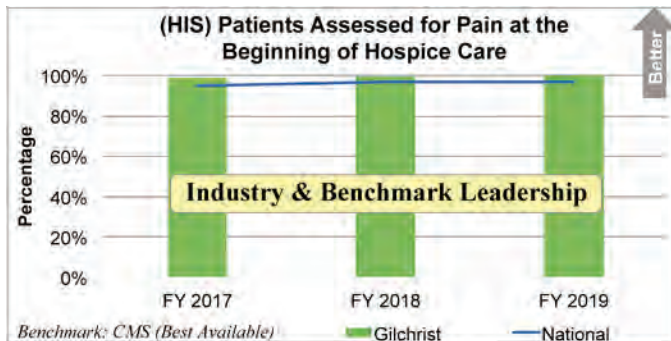


Figure 7.1-36 (HIS) Patients Assessed for Pain at the Beginning of Hospice Care

**Home Facility Key Requirement – Respect/Participatory**

All new clinical members of the WF who provide care in the home/facility service line undergo additional training (Figure 7.1-37) focused on “meeting the patient where they are” and learning skills around respect and participation (Area 5.1a[2]).



Figure 7.1-37 Gilchrist WF Training in Respect

**Home Facility Key Requirement – Access**

A key measure of access is our average daily census (Figure 7.1-38) which continues to improve over time indicating access to hospice services for our community.

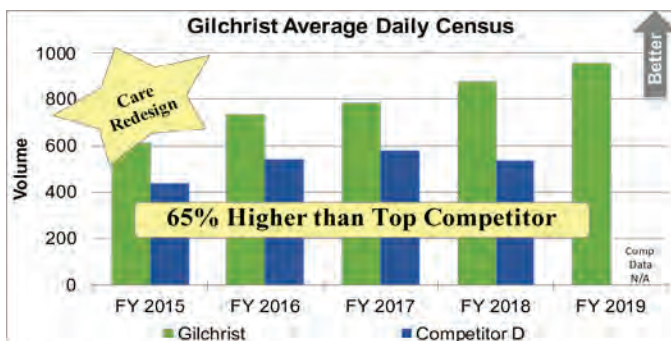


Figure 7.1-38 Average Daily Census

**7.1b Work Process Effectiveness Results**

**7.1b(1) Process Effectiveness and Efficiency (Criteria and Description Area 6.1b[1] and Figures 6.1-2 and 6.1-3)**

Figure 6.1-2 describes our key work processes defined as care access, care delivery and care transitions. Operational performance results for these key work processes are described with the measures labeled in the legend below.

Work Processes			
▲	Productivity	●	Efficiency (In process)
●	Cycle Time	◆	Innovation
■	Effectiveness (Outcomes)		

**Key Work Process - Care Access**

An important metric of care access is moving patients quickly from the ED to an inpatient unit. This is a measure of patient satisfaction and quality and is a Pay for Performance Metric under the HSCRC in Maryland. Achieving or exceeding the benchmark (the top decile) will result in financial reward. Significant improvement has been achieved in the last three quarters due to cycles of improvement and daily focus on the LDM (Figure 7.1-39).

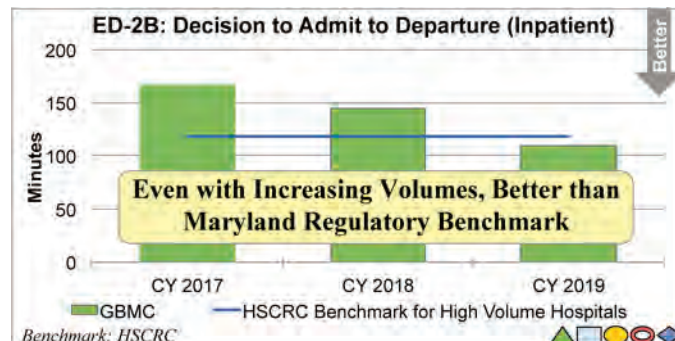


Figure 7.1-39 Time to leave ED following Decision to Admit

In the emergency department, where care access often begins, an in-process measure is the rate of patients that left without being seen (LWOBS). Figure 7.1-40 shows that we exceed the national comparison while volumes steadily increased.

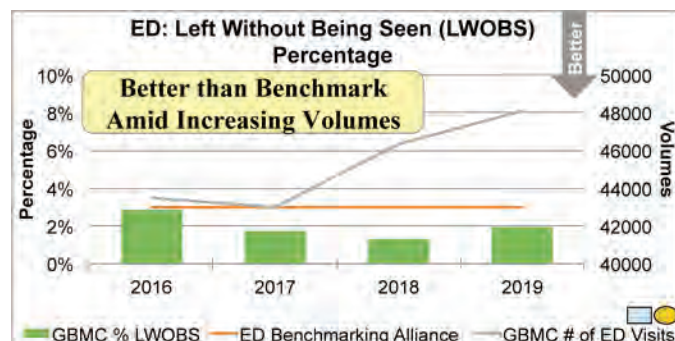


Figure 7.1-40 LWOBS

Following a **Care Redesign** process for on-line surgical scheduling, Surgeon Satisfaction showed statistically significant improvement (Figure 7.1-41).



Figure 7.1-41 Surgeon Satisfaction

A key measure of innovation for care access is the number of primary care practices where we offer extended hours to our patients. We offer care access during early morning hours, evenings, weekends and holidays (Figure 7.1-42). None of our competitors offer this care access for primary care.

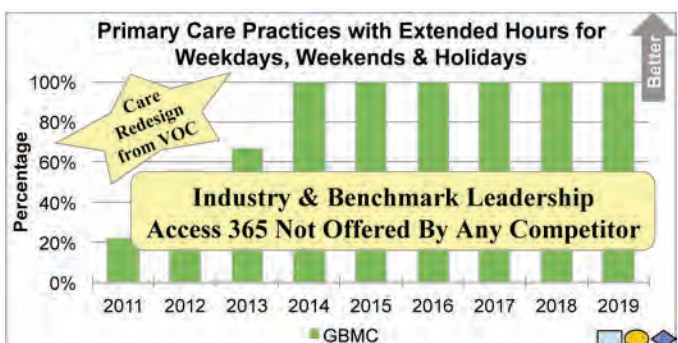


Figure 7.1-42 Primary Care Practices with Extended Hours

**Key Work Process – Care Delivery**

Providing efficient care can be measured by length of stay (Figure 7.1-43) Effectiveness can be measured by Readmissions (Figure 7.1-3). A major focus in **Care Redesign** and a Least Waste Strategic Objective was targeted at reducing length of stay for the medical patients.

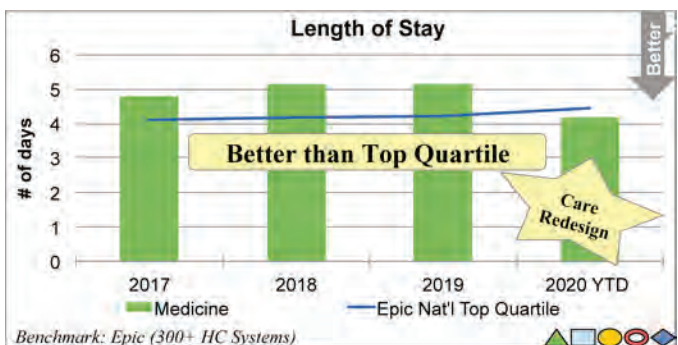


Figure 7.1-43 Length of Stay

For patients presenting to the ED or for inpatients who develop stroke symptoms, timely administration of tPA (Figure 7.1-44) can prevent loss of brain and maximize the opportunity for recovery and quality of life (see also Figures 7.1-30 to 7.1-31).

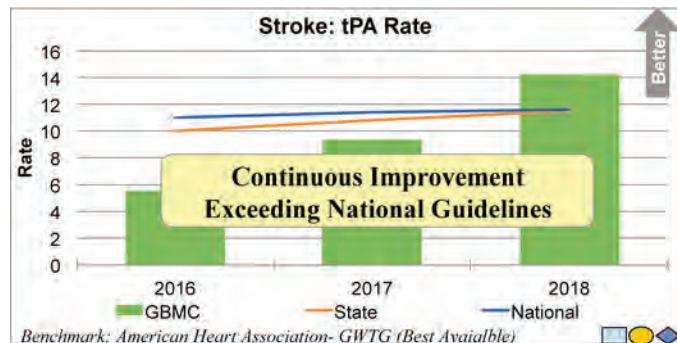


Figure 7.1-44 tPA Rate

A measure of productivity for care delivery is the number of patients seen in our primary care practices. This industry standard, Relative Value Units (RVU), measures the time and skill levels of a provider. Slight variations can occur when onboarding new physicians begin their work without an existing panel of patients. We are growing while maintaining better than recommended productivity (Figure 7.1-45).

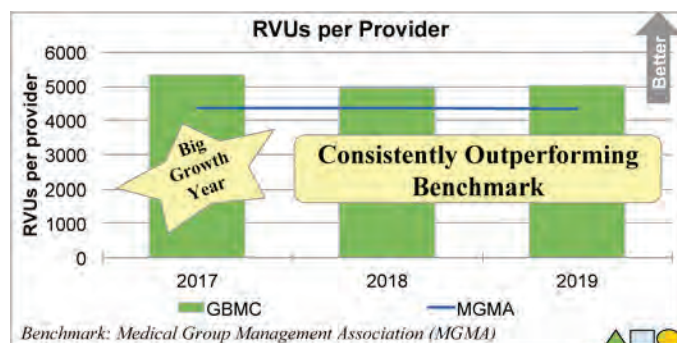


Figure 7.1-45 RVUs Per Provider

Reducing harm in ventilated patients includes several best practices like keeping the head of the bed elevated 30–45 degrees, oral care, waking trials, spontaneous breathing trials, peptic ulcer prophylaxis and deep vein thrombosis prophylaxis. We also work to reduce the length of time a patient is on a ventilator. We consistently exceed the CMS-NHSN standardized infection ratio (SIR, benchmark) for complications (Figure 7.1-46) (see SIR explanation, Figure 7.1-4).

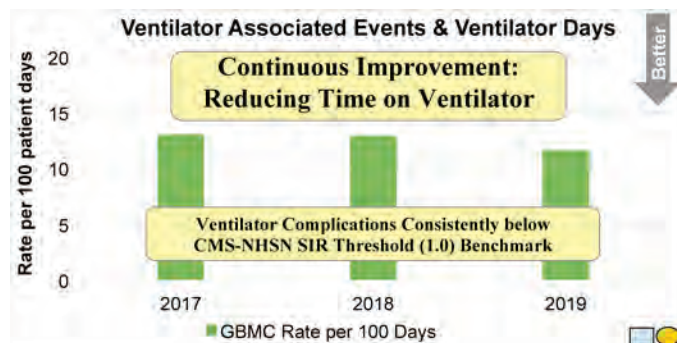


Figure 7.1-46 Ventilator Associated Events (VAE)

The Joint Commission National Patient Safety Goals recommend timely communication of critical results. Figure 7.1-47 shows near perfect performance when a critical imaging result is read. GBMC set the target at 30 minutes for internal improvement.

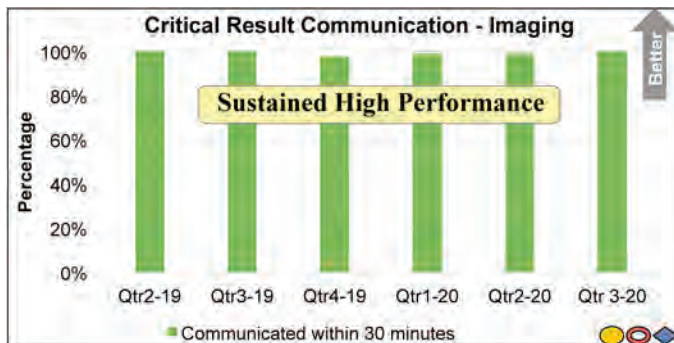


Figure 7.1-47 Critical Results Communication - Imaging

Surgical Site Infection in patients undergoing spine laminectomies is at zero (Figure 7.1-48).

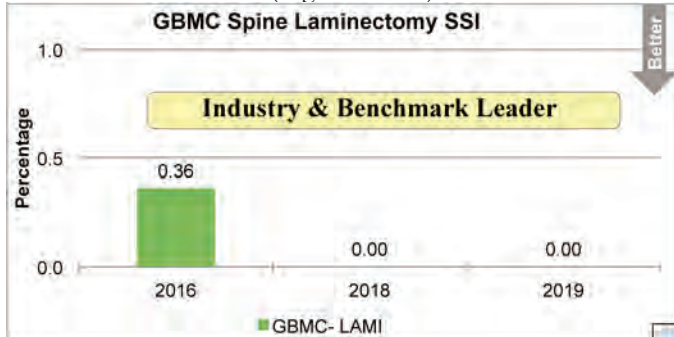


Figure 7.1-48 SSI Spine Laminectomy

A measure of innovation for our key work process of care delivery is providing behavioral health care and screening in real time in our primary care offices (Figure 7.1-49).



Figure 7.1-49 Behavioral Health Visits in Primary Care

**Key Work Process – Care Transition**

Key work process for care transition is readmissions (all cause) within 30 days (Figure 7.1-3). A measure of cycle time is the turn-around time (TAT) for critical lab results. The national standard is 90% of all tests have a TAT of 60 minutes. These key results are critical for both care transitions and care



Figure 7.1-50 Lab Turnaround Time (TAT) within 60 minutes

delivery and include important indicators such as glucose (for diabetes), Prothrombin time (PT), troponin (for cardiac) and white blood cell count (for infections) (Figure 7.1-50).

In order to ensure patients are getting appropriate care, we have improved our process of providing palliative care consults (Figure 7.1-51). Our palliative care team consults with all patients meeting specific criteria (AOS) to support the approximately 5% of patients represented in the lower portion of the Care Integration System (Figure P.1-1). These patients include those with complex or advanced illness or end of life. The palliative care team helps to ensure that patients have the opportunity for the best care approach to support their individualized needs leading to quality of life (what matters to the patient/family).



Figure 7.1-51 Palliative Care Consults

Tamoxifen, a selective estrogen receptor modulator (SERM), is recommended by the FDA to treat hormone receptor-positive breast cancer by blocking the effects of estrogen in the breast tissue but acting like estrogen in the uterus and bone. GBMC consistently exceeds national standards from the National Comprehensive Cancer Network (NCCN) which is 90% (Figure 7.1-52).

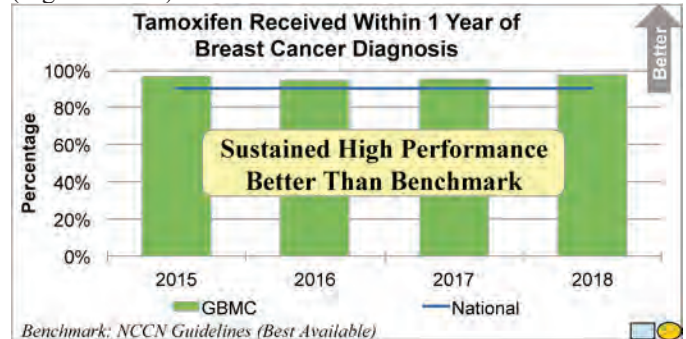


Figure 7.1-52 Tamoxifen Received within 1 Year of Breast Cancer Diagnosis

**Pharmacy**

As a major support system of “Systems that do Work” (Figure 6.0-1), pharmacy measures are critical to achieving customer requirements. For the requirement of high-quality care, reducing healthcare acquired infections relies on antibiotic stewardship. The Maryland Department of Health’s SPARC (state-wide prevention and reduction of c.diff) commended us as having best practices in executive leadership and infectious disease-trained pharmacists in antimicrobial/antibiotic stewardship. Figure 7.1-53 shows a decrease in high-risk antibiotics known to increase the occurrence of clostridium difficile (c.diff) a serious infection. There are no available benchmarks for this measure.

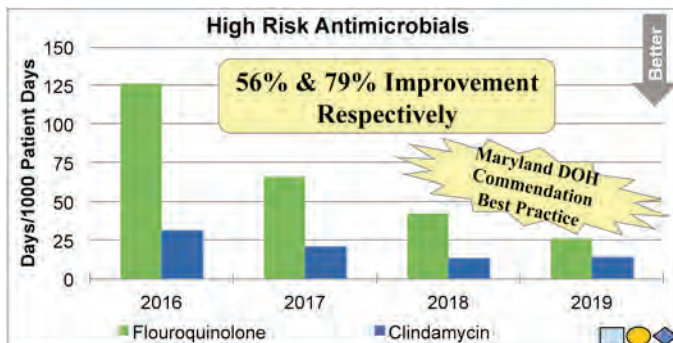


Figure 7.1-53 High Risk Antimicrobials

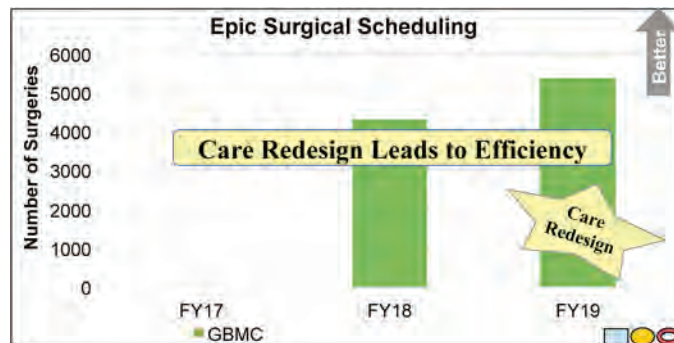


Figure 7.1-56 Epic Surgical Scheduling

**Hotel Services**

A key measure for Hotel Services (Figure P.1-5) is how efficiently we transport patients throughout the hospital (following admission to the floor from the ED, to and from tests, treatments, etc.) This is an important metric related to patient throughput and was a driver of ED Decision to Admit to Departure (Figure 7.1-39). Through redesign and continuous improvement, we exceed national comparisons (Figure 7.1-54). This is a measure of “Systems that do Work” (Figure 6.0-1).



Figure 7.1-54 Transportation Turnaround Time

**Human Resources**

HR is a critical support system that helps meet the staffing needs for “Systems that do Work” (Figure 6.0-1) A recent strategic objective was to reduce the dependence on agency nurses. Figure 7.1-57 shows how through redesign, we have significantly reduced the number of agency nurse FTEs. While cost was a factor, ensuring a consistent GBMC employed workforce reduces risk and increases patient experience and employee engagement.

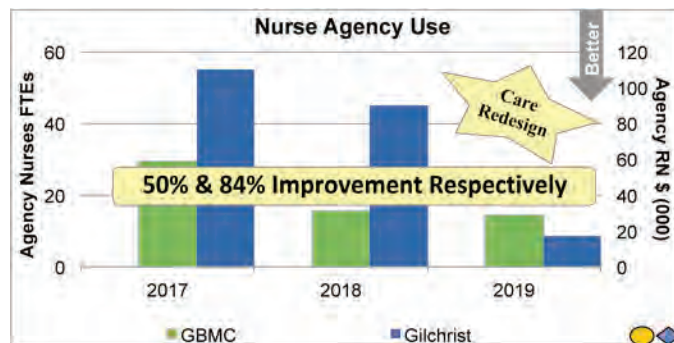


Figure 7.1-57 Nurse Agency Use

**IT**

In addition to our Epic Gold Star Rating (Figure 7.1-5), a second measure of support is the integrity of our IT support systems. Ensuring security and confidentiality of patient information is paramount. Figure 7.1-55 shows that there have been zero electronic protected health information (PHI) breaches for the past 5 years.

Year	IT Security ePHI
<b>Goal: Zero Documented Instances of a System ePHI Breach</b>	
2015	0 Breaches: Goal Met
2016	0 Breaches: Goal Met
2017	0 Breaches: Goal Met
2018	0 Breaches: Goal Met
2019	0 Breaches: Goal Met
<b>Industry &amp; Benchmark Leader - No Breaches</b>	

Figure 7.1-55 PHI Breaches

**7.1b(2) Safety and Emergency Preparedness (Criteria and Description in Area 6.2c)**

We consistently meet or exceed preparedness for emergency and disaster requirements (Figure 7.1-58). **COVID-19 Response:** Full report AOS.

Emergency Preparedness	2016	2017	2018	2019	Required # of Drills
<b>Drills/Exercises</b>					
Active Shooter	1	2	2	1	1
Abduction/Elopement	1	1	1	1	1
Fire Drills	37	37	37	37	37
Cyber-Security/IT Downtime	0	0	1	1	1
Emergency Operations Preparedness	1	1	1	1	1
County Emergency Preparedness	1	1	1	1	1
Regional Emergency Preparedness	1	1	1	1	1
State Emergency Preparedness	1	1	1	1	1
<b>Meet or Exceed Regulatory Requirement</b>					

Figure 7.1-58 Emergency Preparedness

Epic has supported efficiency and effectiveness for our surgeons by affording their offices the ability to schedule surgeries directly (Figure 7.1-56). This has also resulted in surgeon satisfaction (Figure 7.1-41). This is an important measure for “Systems that do Work” (Figure 6.0-1).

**7.1c Supply-Network Management Results (Criteria and Description in Area 6.1c)**

Global Healthcare Exchange Rate (Figure 7.1-59) is a measure of overall supply chain efficiency compared to 900+ national



healthcare organizations using GHX Global Healthcare Exchange.

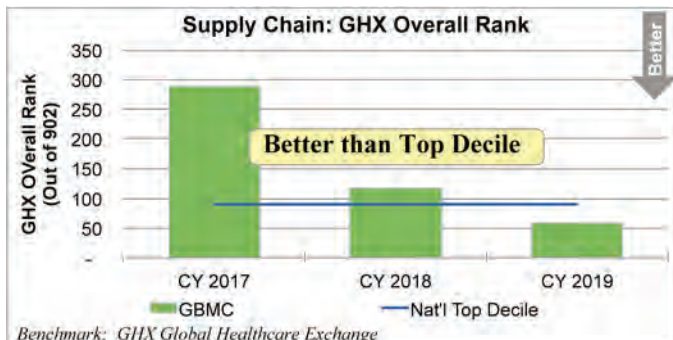


Figure 7.1-59 GHX Overall Rate

The Electronic Data Interchange (EDI) order rate represents the percentage of supplies purchased through EDI (Figure 7.1-60).



Figure 7.1-60 EDI Order Rate

Having the right medication at the right time is a key measure of supply chain management and patient safety. It has been measured via LDM (Figure 7.1-61). GBMC is better than a similarly sized Maryland hospital.

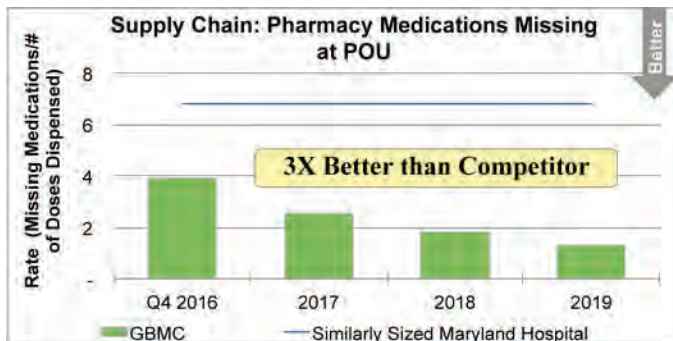


Figure 7.1-61 Missing Medications

7.2 Customer Results

7.2a Patient- and Other Customer-Focused Results

7.2a(1) Patient and Other Customer Satisfaction

**Inpatient**

We measure patient satisfaction through various CAHPS surveys. GBMC consistently performs in the top 10 compared to the 44+ Maryland hospitals for patients responding to the HCAHPS Overall Question. Nationally, we exceed the CMS Threshold (Figure 7.2-1).

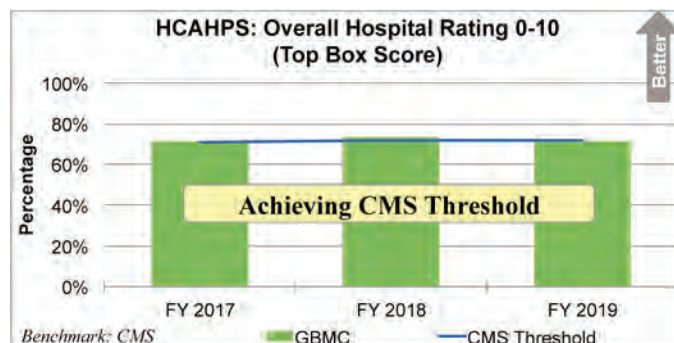


Figure 7.2-1 HCAHPS Overall Rating Top Box Score

Inpatient requirements for communication and responsiveness are measured by HCAHPS questions: the Discharge Domain which measures patient’s satisfaction with communication of care after discharge and Communication with Doctors measures patient satisfaction with how well they understood their physician (Figures 7.2-2 – 7.2-3).

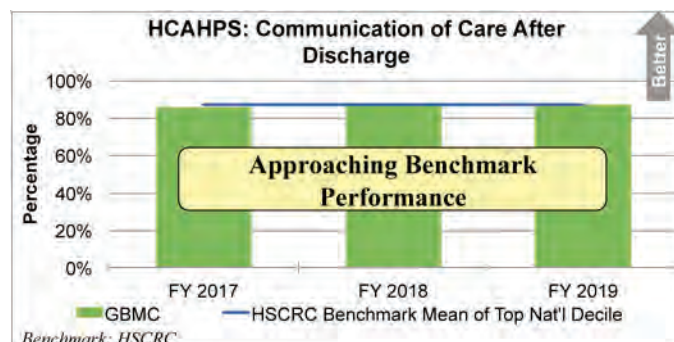


Figure 7.2-2 HCAHPS Communication Care After Discharge

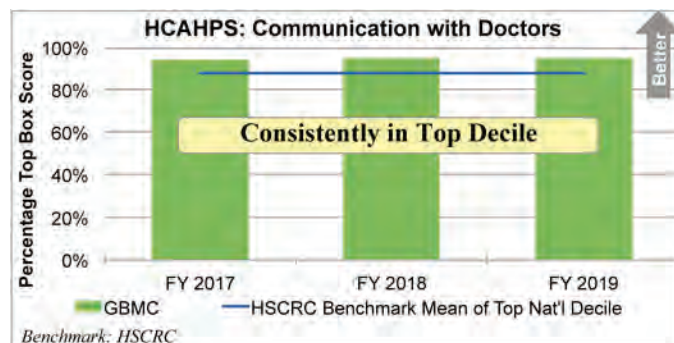


Figure 7.2-3 HCAHPS Communication with Doctors

Inpatient dissatisfaction is measured by the rate of negative comments received per patient day and is derived from our Press Ganey satisfaction surveys (Figure 7.2-4).

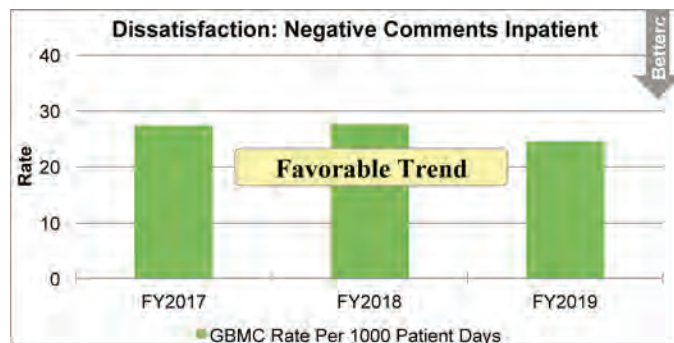


Figure 7.2-4 Dissatisfaction: Negative Comments

**Emergency**

The GBMC emergency department measures patient satisfaction through its ED CAHPS (Figures 7.2-5) Patients requirements are for communication and high quality safe care. This is measured by the question, “Physician Took Time to Listen.”

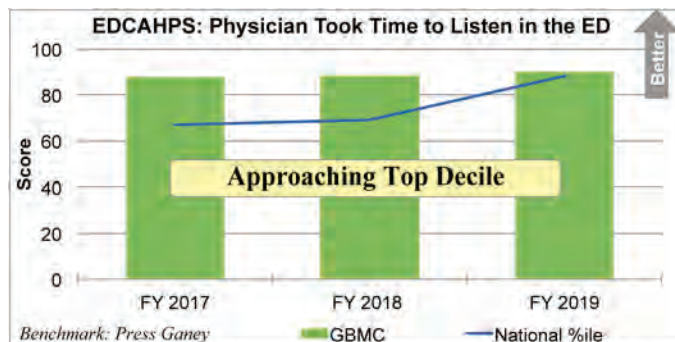


Figure 7.2-5 ED Physician Took Time to Listen

Patient dissatisfaction is measured by the rate of negative comments per 1000 patient visits received via patient satisfaction surveys (Figure 7.2-6). Best available comparison is a previous Baldrige Award recipient.

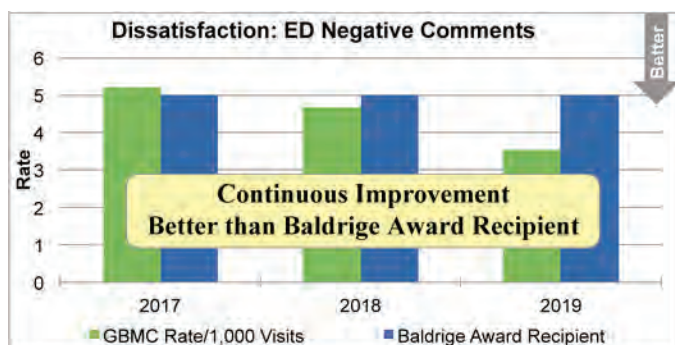


Figure 7.2-6 Dissatisfaction: ED Negative Comments

**Ambulatory**

Customer requirements for satisfaction in the ambulatory setting are access, communication and high quality, safe care. We measure this respectively from our CAHPS Surveys (Figures 7.2-7–7.2-9).

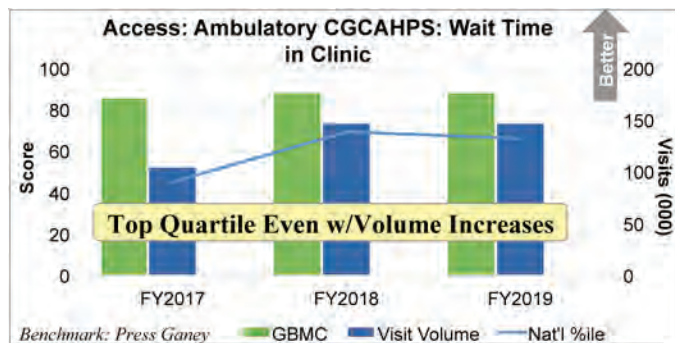


Figure 7.2.7 Access - Ambulatory Wait Time in Clinic

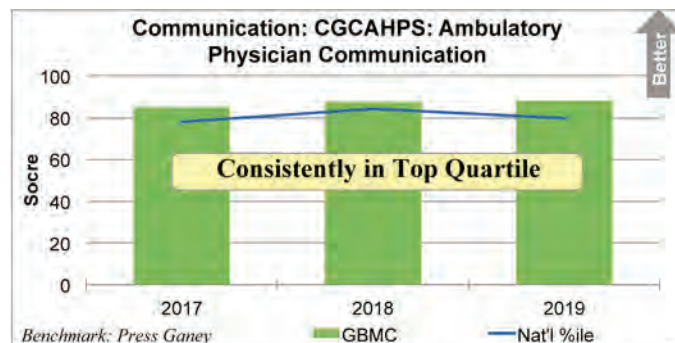


Figure 7.2-8 CGCAHPS Ambulatory Physician Communication

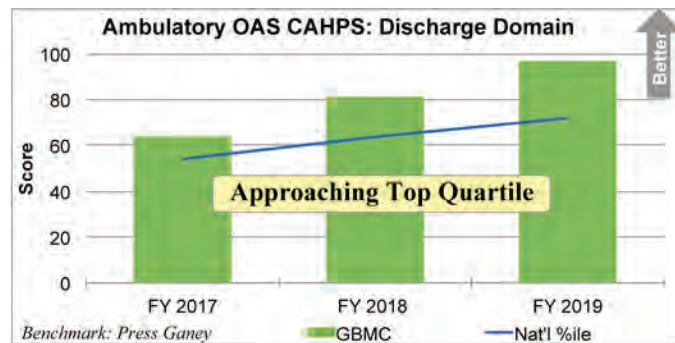


Figure 7.2-9 OAS CAHPS Discharge Domain

**Home/Facility**

For hospice patients we measure satisfaction by their perception of how well our staff treated family members with respect and is derived from Hospice CAHPS (Figure 7.2-10).

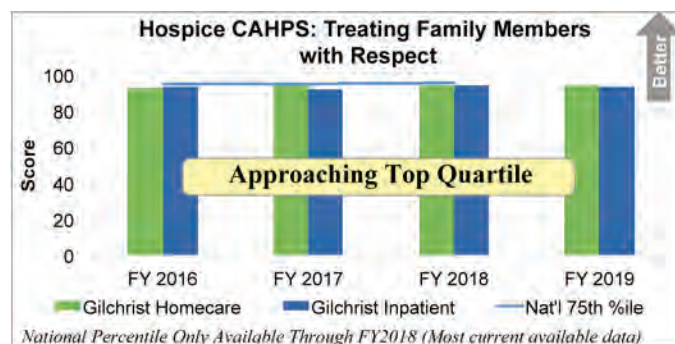


Figure 7.2-10 Hospice CAHPS Treating Family with Respect

**7.2a(2) Patient and Other Customer Engagement**

**Inpatient Engagement**

The Willingness to Recommend (Figure 7.2-11) score is a key measure of our patients’ commitment to GBMC and their stage in the Customer Relationship System (Figure 3.2-2) and is derived from an HCAHPS Question.

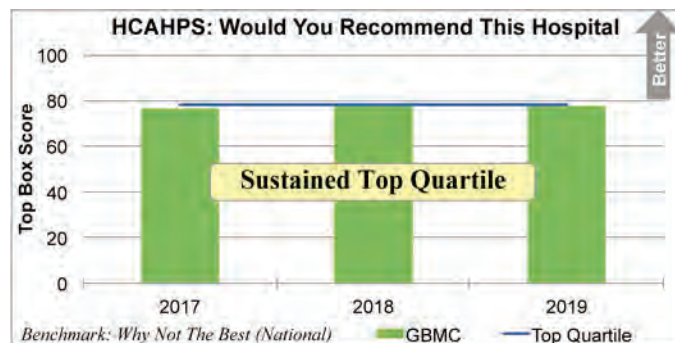


Figure 7.2-11 Willingness to Recommend

**Outpatient Engagement**

Our patient engagement measures are derived from our CGCAHPS Surveys (Figure 7.2-12 – 7.2-13).

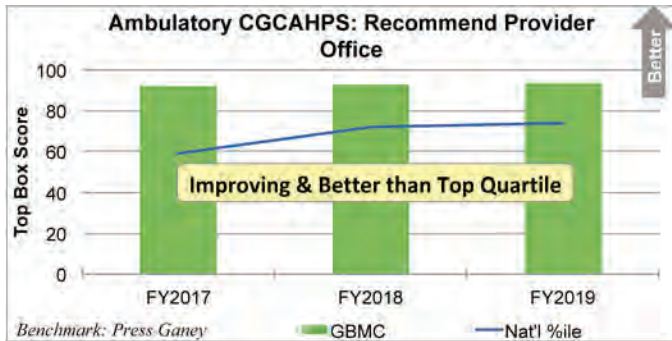


Figure 7.2-12 CGCAHPS Recommend this Provider Office

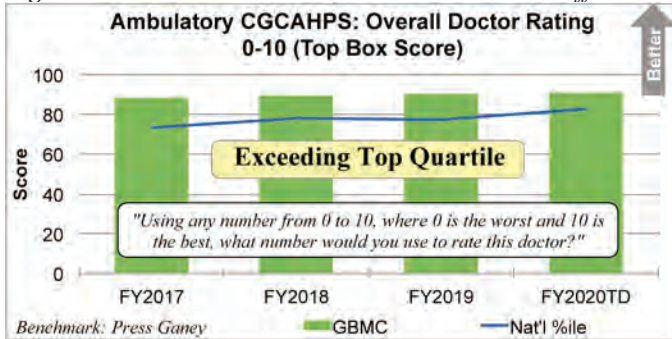


Figure 7.2-13 CGCAHPS Doctor Rating Top Box Score

**ED Engagement**

The measure for engagement for emergency department patients is derived from ED CAHPS surveys (Figure 7.2-14).

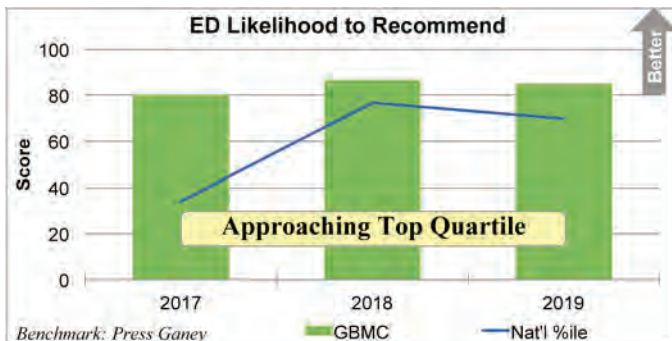


Figure 7.2-14 ED Likelihood to Recommend

**Home/Facility**

Our hospice engagement is derived from the Hospice CAHPS Figure 7.2-15. Gilchrist Hospice family members complete surveys after a patient has died. The measure is the percentage



Figure 7.2-15 Hospice CAHPS Recommend this Hospice

of family members who would recommend this hospice. We consistently score high and exceed performance compared to our competitor as measured by CAHPS.

**7.3 Workforce Results**

**7.3a Workforce-Focused Results**

**7.3a(1) Workforce Capability and Capacity**

One key measure for **capability** is annual competency completion, required for both employees and volunteers. Annual competencies include key educational sessions and knowledge assessment (Kirkpatrick Level 2) that include courses such as workplace safety, compliance, ethics, infection control, emergency preparedness, etc. (Figure 7.3-1).



Figure 7.3-1 Annual WF Competency Completion

Turnover is a key metric for **capacity** and helps meet the strategic challenge of supply/demand for provider (Areas 5.2a[1] and 5.2a[2]) (Figures 7.3-2 to 7.3-4). In 2019, we saw an increase in first-year turnover attributed to entry-level positions. Retention was adversely affected by record low unemployment rates (prior to COVID-19) which created more turnover for that WF segment. Despite these challenges, we remain better than top decile nationally.



Figure 7.3-2 First Year Turnover - All Employees

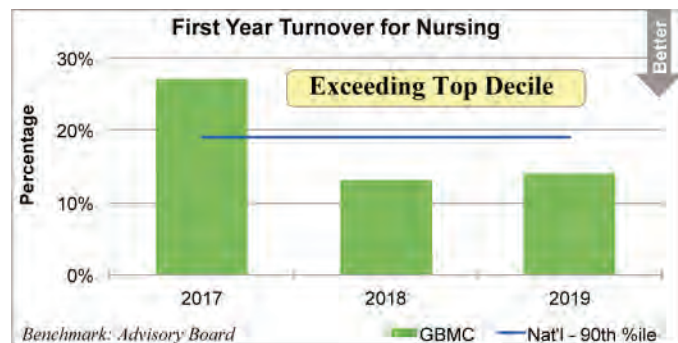


Figure 7.3-3 First Year Turnover – Nursing

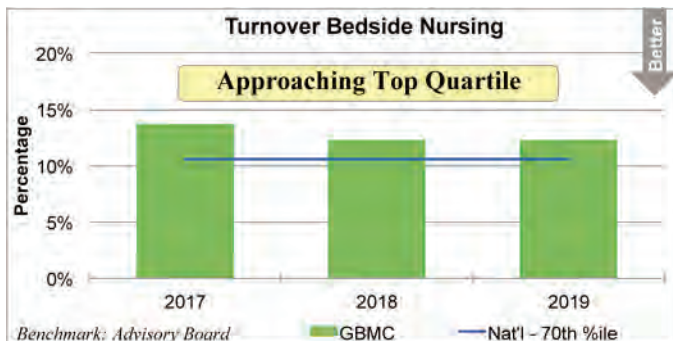


Figure 7.3-4 Turnover – Bedside Nursing

Capacity for volunteers is measured by the turnover rate from year to year and shows very little turnover among this dedicated segment of the workforce (Figure 7.3-5).

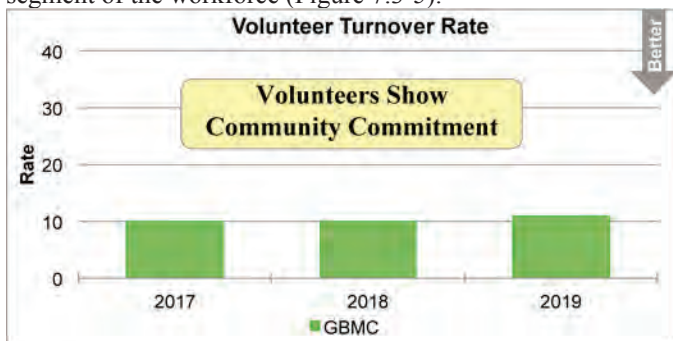


Figure 7.3-5 Volunteer Turnover

Capability and capacity for the physician segment is derived from the Physician Engagement Survey (Figure 7.3-6).



Figure 7.3-6 Physician Satisfaction: I get the tools and resources I need to provide the best care for our patients

7.3a(2) Workforce Climate

A key measure of workforce climate is employee injury. We have been focused on reducing harm for several years under our *More Joy* aim. We use both the rate of OSHA recordable cases (Figure 7.3-7) and the DART (Days Away Restricted and Transferred) rate, a measure of injury severity (Figure 7.3-8).

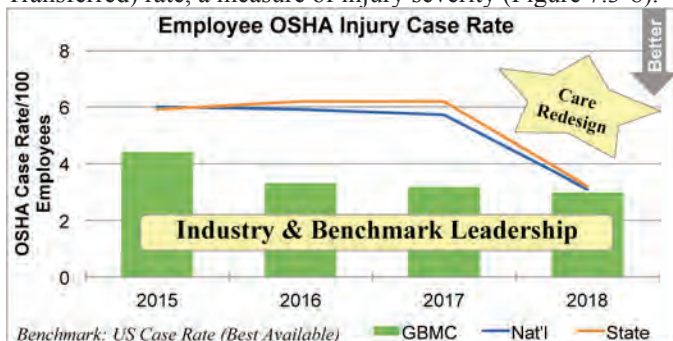


Figure 7.3-7 Employee OSHA Injury Case Rate

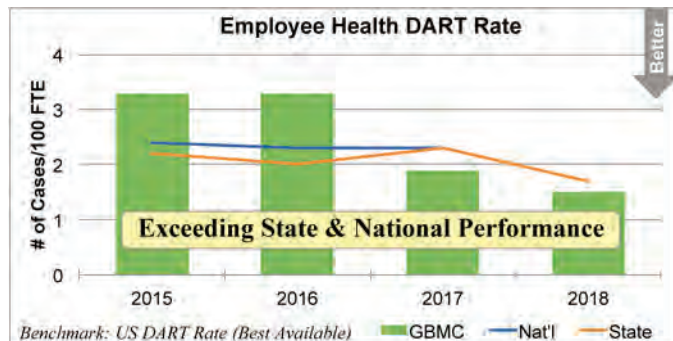


Figure 7.3-8 Dart Rate

GBMC requires all eligible members of the WF to obtain influenza vaccinations (Figure 7.3-9). Other measures of employee health and safety relate to tuberculosis (TB) testing, and Pre-employment physicals (Figure 7.3-10).

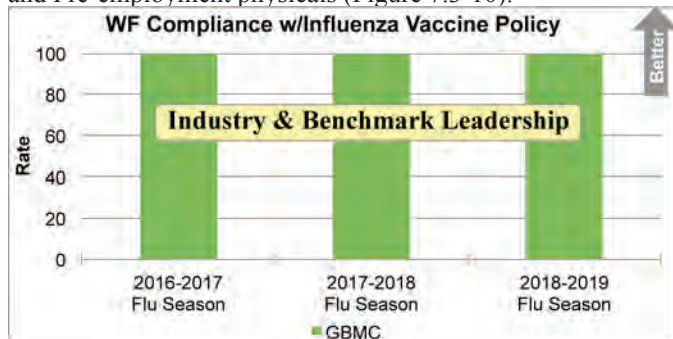


Figure 7.3-9 WF Influenza Vaccination Rate

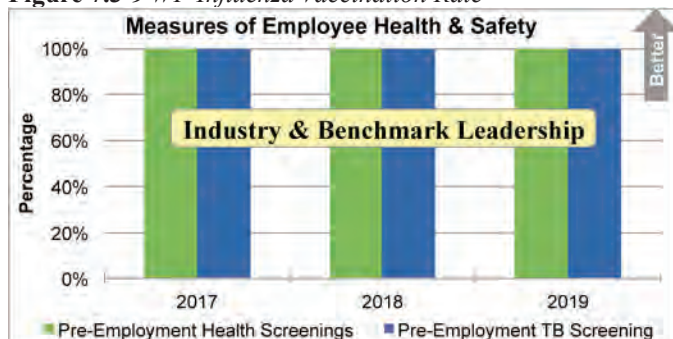


Figure 7.3-10 Measures of Employee Health & Safety

Figure 7.3-11 demonstrates our excellence in perception of patient safety. Other safety culture data can be found in item 7.4 that show that we are making progress on WF perception of our commitment to safety. Figure 7.3-12 demonstrates our culture as it relates to our aim of *More Joy* and the employee's perception that their work makes a difference. These are derived from our Employee Engagement Survey.

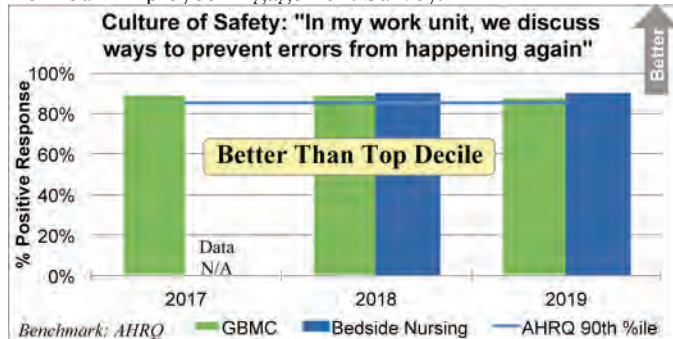
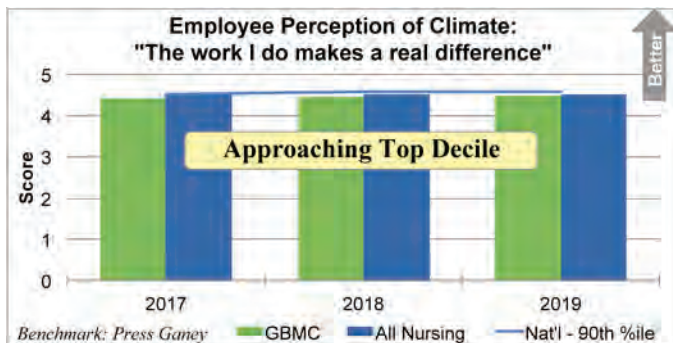
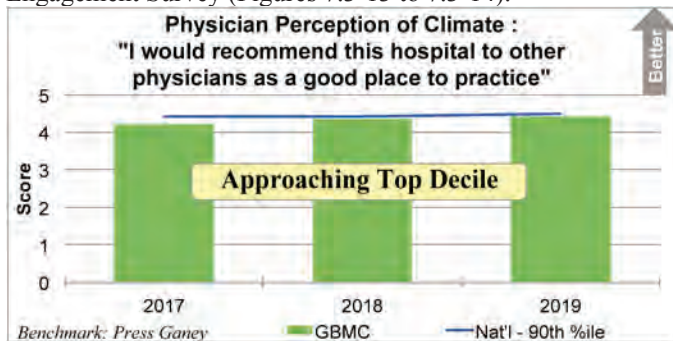


Figure 7.3-11 Culture of Safety: In my work unit, we discuss ways to prevent errors from happening again

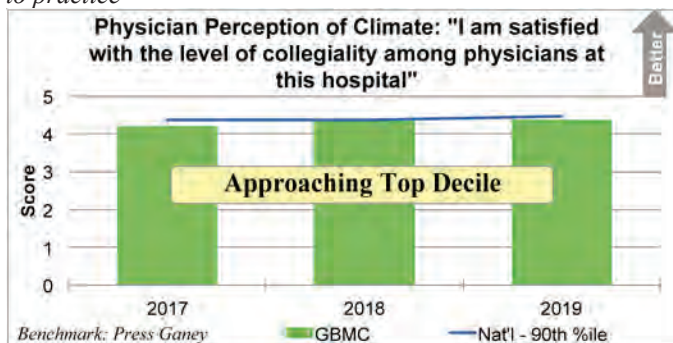


**Figure 7.3-12** Employee Perception of Climate: The work I do makes a real difference

Physician perception of climate is derived from the Physician Engagement Survey (Figures 7.3-13 to 7.3-14).

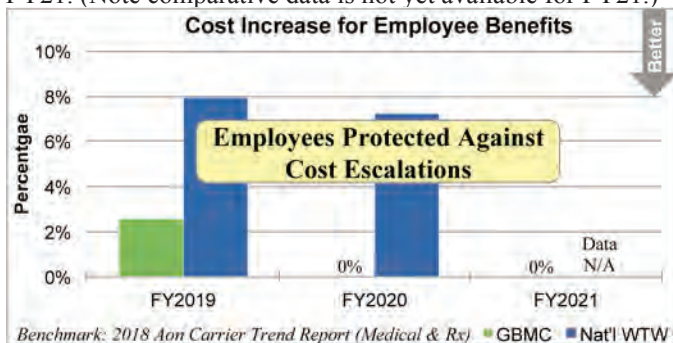


**Figure 7.3-13** Physician Perception of Climate: I would recommend this hospital to other physicians as a good place to practice



**Figure 7.3-14** Physician Perception of Climate: I am satisfied with the level of collegiality among physicians at this hospital

We are unique in our approach to benefits as are committed to keeping costs lower for our workforce. Figure 7.3-15 shows the premium increase for benefits compared to national trends. Most organizations increase premiums costs by 8% or greater. GBMC is offering benefits at ZERO additional costs going into FY21. (Note comparative data is not yet available for FY21.)



**Figure 7.3-15** Cost Increase for Employee Benefits

**7.3a(3) Workforce Engagement**

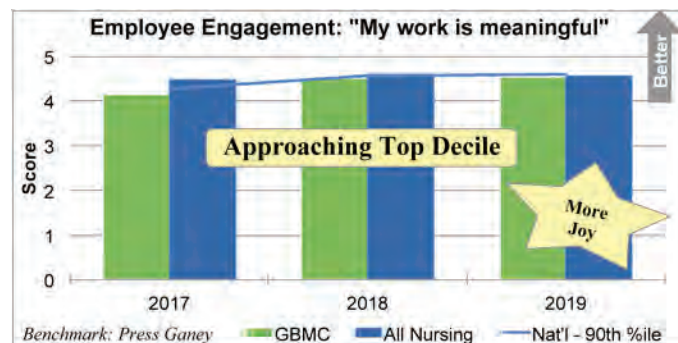
Results from our annual Employee Engagement survey is used to show workforce engagement in Figures 7.3-16 to 7.3-19.



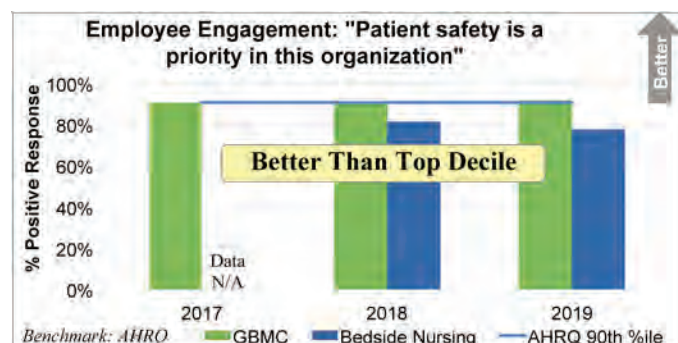
**Figure 7.3-16** Employee Engagement: I would recommend this organization as a good place to work



**Figure 7.3-17** Employee Engagement: I would recommend this organization to family and friends who need care

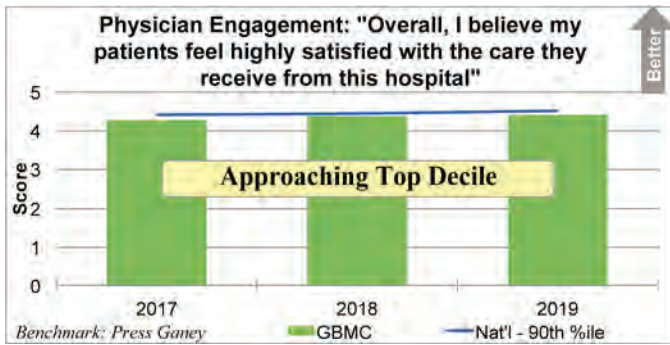


**Figure 7.3-18** Employee Engagement: My work is meaningful

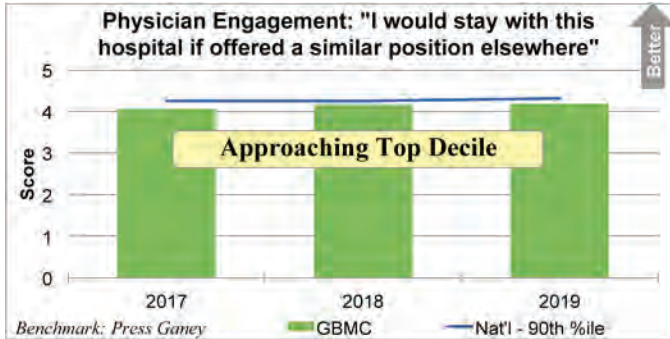


**Figure 7.3-19** Employee Engagement: Patient Safety is a Priority in this Organization

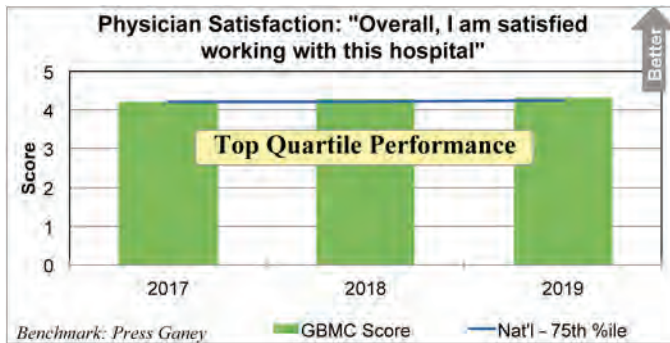
Physician Engagement Results are derived from our annual Physician Engagement survey (Figures 7.3-20 to 7.3-22).



**Figure 7.3-20** Physician Engagement: Overall I believe my patients feel highly satisfied with the care they receive from this hospital

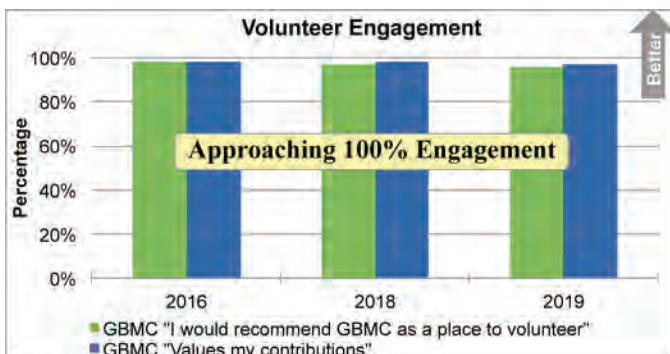


**Figure 7.3-21** Physician Engagement: I would stay with this hospital if offered a similar position elsewhere



**Figure 7.3-22** Physician Satisfaction: Overall, I am satisfied working with this hospital

Volunteer engagement is measured through an internal satisfaction survey (Figure 7.3-23). During a cycle of change we standardized the survey and now conduct it annually.



**Figure 7.3-23** Volunteer Engagement: GBMC values my contributions & I would recommend GBMC as a place to volunteer

**7.3a(4) Workforce Development**

Workforce satisfaction with training necessary to do a good job (Figure 7.3-24) and career development (Figure 7.3-25) are derived from our WF engagement survey data.

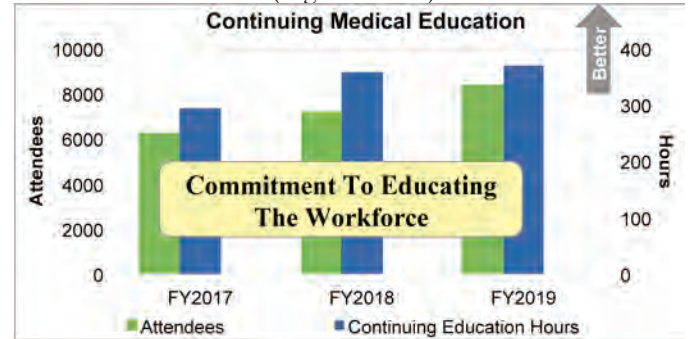


**Figure 7.3-24** WF Satisfaction: I get the training I need to do a good job



**Figure 7.3-25** WF Satisfaction: This organization provides career development opportunities

We provide a wide range of educational programs from our medical staff measured by number of attendees and continuing education hours offered (Figure 7.3-26).



**Figure 7.3-26** Continuing Medical Education

Our state-of-the-art simulation lab, provides numerous programs to multidisciplinary attendees (Figure 7.3-27).



**Figure 7.3-27** WF & Leaders Simulation Training & Development

GBMC is one of the 43 hospitals in the Maryland Nurse Residency Collaborative (Figure 7.3-28). GBMC requires every nurse resident to fully implement an evidence-based practice project as a requirement for graduation. Developing this skill early in a nurse’s career, helps assure that future nursing practice decisions are grounded in science. This fosters professionalism, builds confidence and supports a culture of safety and reliability (Area 5.2c[2]).

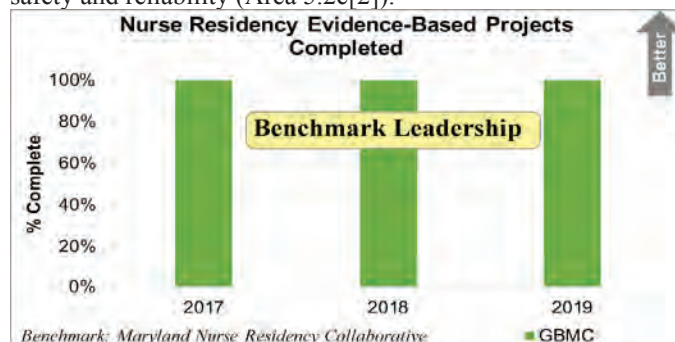


Figure 7.3-28 Nurse Residency Evidence-Based Projects Completed

GBMC invests considerably in workforce development. An overall measure of investment in learning and organizational development is the dollars spent on conferences and training outside of the organization (Figure 7.3-29).



Figure 7.3-29 Employee Learning & Organizational Development

We also make significant investment in our volunteer program as measured by dollar investment in volunteer per adjusted admission (Figure 7.3-30).

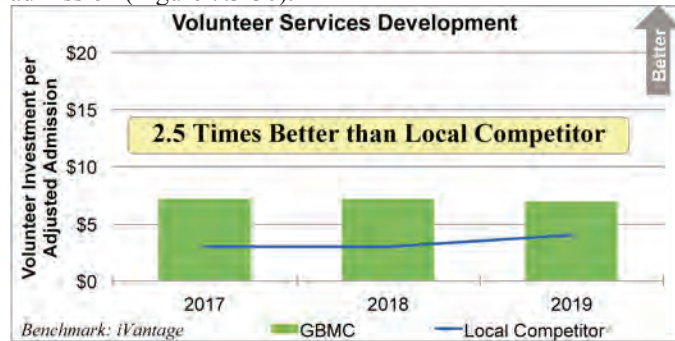


Figure 7.3-30 Volunteer Services Development

7.4 Leadership and Governance Results

7.4a Leadership, Governance, and Societal Contribution Results

7.4a(1) Leadership

SL communication and engagement with the WF demonstrate

SL’s role modeling of the MVV. Figure 7.4-1 is derived from our Employee Engagement Survey and Figure 7.4-2 is derived from the Physician Engagement Survey.

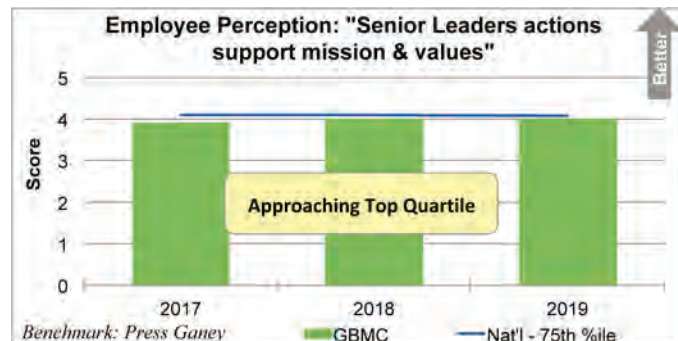


Figure 7.4-1 Senior Leaders Actions Support Mission & Values



Figure 7.4-2 Physician: Senior Leaders Actions Support Mission & Values

Evidence of the LS (Figure 1.1-1) and its impact on connecting the mission and values to frontline staff by their leader is derived from our Employee Engagement Survey (Figure 7.4-3).



Figure 7.4-3 My Leader’s Actions Support Mission & Values

Measures that demonstrate our results for SL communication and engagement that create a focus on action, encourage two-way communication and deploy the values, including our culture of improvement and safety are in Figures 7.4-4 to 7.4-7.

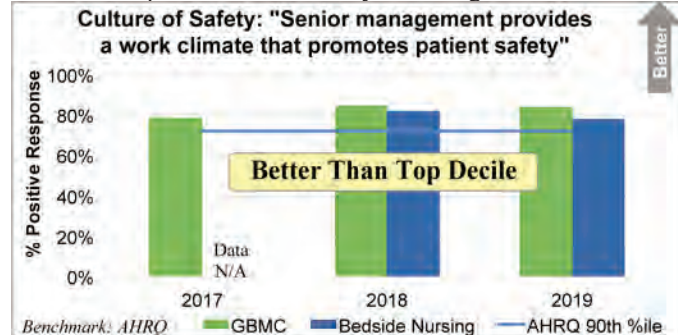


Figure 7.4-4 Culture of Safety: Senior management provides a work climate that promotes patient safety

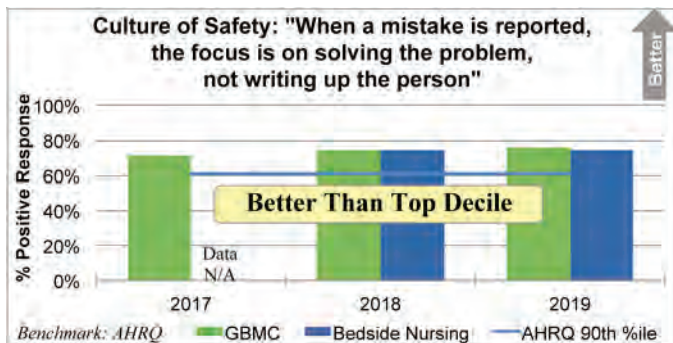


Figure 7.4-5 Culture of Safety: When a mistake is reported, the focus is on solving the problem, not writing up the person



Figure 7.4-6 Culture of Safety: Mistakes have led to positive changes here



Figure 7.4-7 Culture of Safety: Patient safety is a priority in this organization

LDM is embedded in our culture. Senior leaders are expected to participate in LDM every day. On holidays and weekends, the SL who is on call conducts the rounds (Figure 7.4-8).

Senior Leadership Participation in Lean Daily Management	
CY 2014	100%
CY 2015	100%
CY 2016	100%
CY 2017	100%
CY 2018	100%
CY 2019	100%
<b>All SL Committed to LDM</b>	

Figure 7.4-8 SL Participation in LDM

Communication with customers and other stakeholders is measured through results of social media (Figure 7.4-9). Social media is an important means of communicating with our community, patients and other customers.

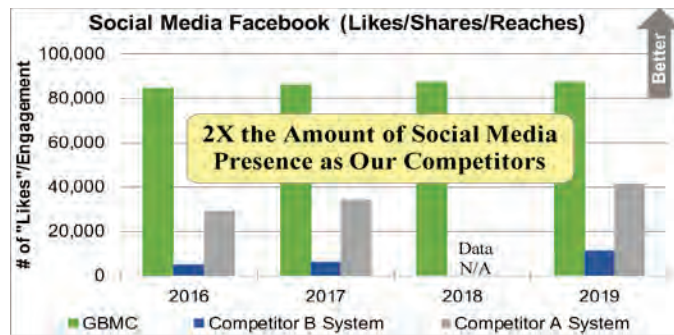


Figure 7.4-9 Social Media

7.4a(2) Governance

Results of governance accountability is assessed through an annual BOD survey. The BOD holds the CEO accountable for the results of the organization and its direction towards achieving strategic objectives (Figure 7.4-10). Sufficient information is provided to the BOD to ensure effective governance of internal and external fiscal accountability (Figure 7.4-11).



Figure 7.4-10 CEO Evaluation

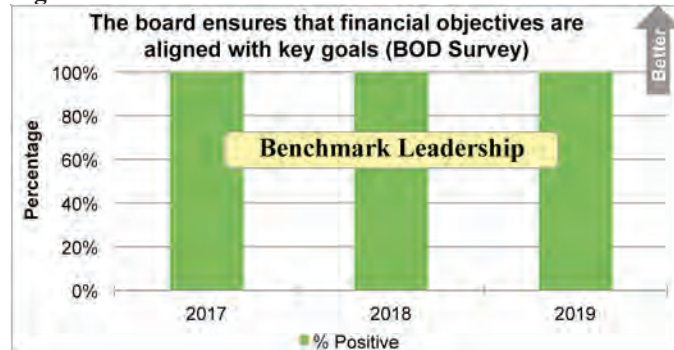


Figure 7.4-11 Financial Objectives Aligned with Key Goals

Measure	2017	2018	2019
Cash to debt ratio (Figure 7.5-5): Unqualified opinion last 5 years	Met	Met	Met
Healthcare Outcomes: Surgical Site Infections Better than Target (Figure 7.1-4)	Met	Met	Met
Strong Safety Culture (Figure 7.4-4-7.4-7)	Met	Met	Met
Internal Audits (AOS): Improved strategic planning process (2016)	Met	Met	Met
BOD Self Assessment Survey Completed & Analyzed	Met	Met	Met
CEO Evaluation (Figure 7.4-10)	Met	Met	Met
SL Succession Planning (AOS)	Met	Met	Met
Governance Oversight & Fiscal Accountability (Figure 7.4-11)	Met	Met	Met
<b>Effective Governance Across Multiple Measures</b>			

Figure 7.4-12 Governance Process Results



Governance is a systematic process at GBMC. Figure 7.4-12 shows the process results that address all key areas of governance. Both internal and external audits validate that the governance controls expected are actually achieved.

Changes in governance have led to increased Board Education topics (Figure 7.4-13). Board members are committed to GBMC and attendance is consistently well above required quorum (Figure 7.4-14).

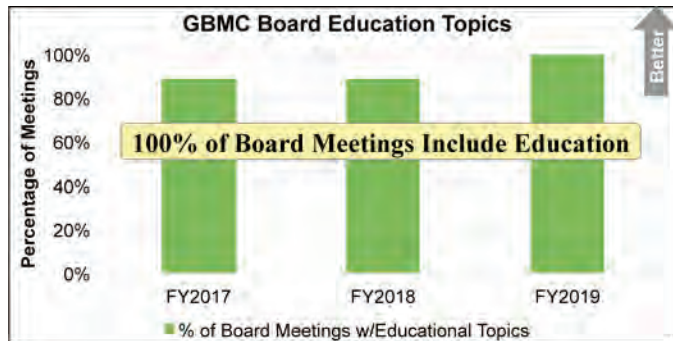


Figure 7.4-13 Board Education

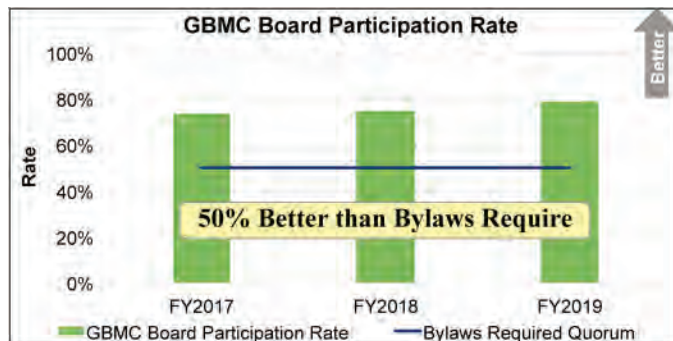


Figure 7.4-14 Board Participation

**7.4a(3) Law, Regulation and Accreditation**

We meet or surpass all legal, regulatory and accreditation requirements (Figure 7.4-15).

**7.4a(4) Ethics**

GBMC takes its ethical responsibility very seriously and requires systematic, well-deployed processes. Our key processes for both ethics and risk management are shown in Figure 7.4-16 (on the following page). Health Information Technology for Economic and Clinical Health Act (HITECH) is similar to HIPAA, but considers more current factors (Figure 7.4-17).

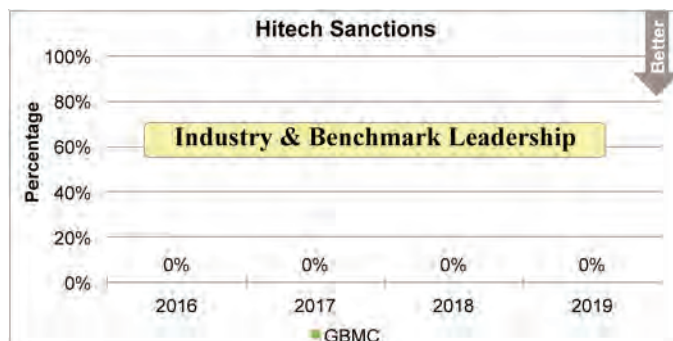


Figure 7.4-17 HITECH Sanctions

Program Accreditations, Certifications & Regulatory Legal Compliance			
Processes	Measure	Target	GBMC Results 2017, 2018, 2019
<b>Accreditation/Licensure</b>			
Joint Commission	Accreditation	Full	Full
Joint Commission Stroke	Certification	Achieved	Achieved
Joint Commission - Joint Center New Designation 2019	Certification	Achieved	Achieved for the first time
Joint Commission Perinatal	Certification	Achieved	2019 1st in Maryland
ACoS Commission on Cancer	Accreditation	Achieved	Achieved with commendation
American College of Radiology	Accreditation	Achieved	Achieved/ Center of Excellence
College of American Pathologists (CAP)	Accreditation	Achieved	Achieved
Quality Oncology Practice Initiative	Accreditation	Achieved	Achieved
State Licensure	License	Issued	Issued
NCQA Patient Centered Medical Home	Recognition	100% Primary Care Practices Certified	100% Primary Care Practices Certified
Gilchrist- CHAP (Community Health Accreditation Partner)	Accreditation	Full	Full
<b>Regulatory/Legal Compliance</b>			
Policy--Mandatory training in HIPAA	% Attendance	100%	100%
OSHA reporting	% Compliance	100%	100%
EPA compliance management	% Compliance	100%	100%
<b>Sustained Accreditation, Licensure, and Regulatory &amp; Legal Compliance</b>			

Figure 7.4-15 Program Accreditations/Certifications & Regulatory/Legal Compliance

Results of these processes are evident by our workforce as measures in Figure 7.4-18.

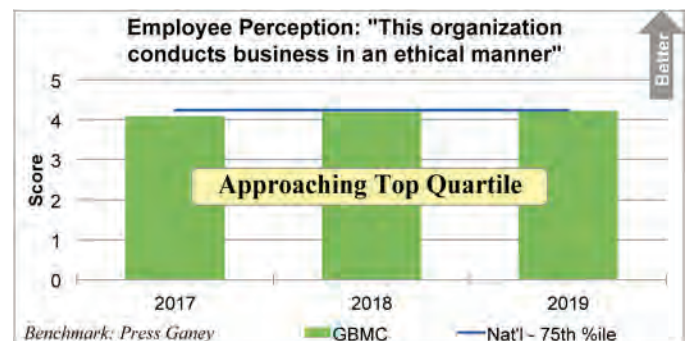


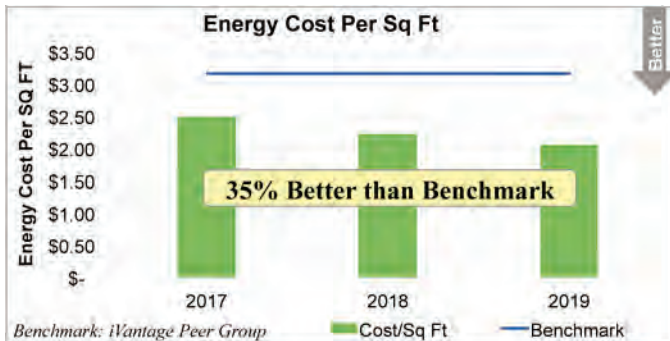
Figure 7.4-18 Employee Perception: This organization conducts business in an ethical manner

Key Legal, Regulatory & Compliance Measures, Targets & Results			
Processes	Measure	Target	GBMC Results 2017, 2018, 2019
<b>Risk Management</b>			
Compliance risk assessment	Completion	Complete	Complete
Medical equipment / technology training	Conducted	100%	100%
Patient safety training	Conducted	100%	100%
Emergency & code drills	Conducted	100%	100%
<b>Ethics Management</b>			
BOD COI Disclosure	% Submitted	100%	100%
Annual Ethics Training (WF)	Training Completed	100%	100%
Annual Confidentiality of Information Training (WF)	Training Completed	100%	100%
CMS Sanctions Checking (All Entities)	% Checked	100%	100%
Criminal Background Checks (WF)	Completed	Complete	100%
Annual HHS Breech Reporting	Completed	Complete	100%
Employee Compliance Hotline/Communication	Investigated	100%	100%
Compliance of Hotline Investigations	Material Findings	0%	0%
IRB reviews	% Completed	100%	100%

**Figure 7.4-16** Key Legal, Regulatory and Compliance Measures, Targets & Results

**7.4a(5) Society**

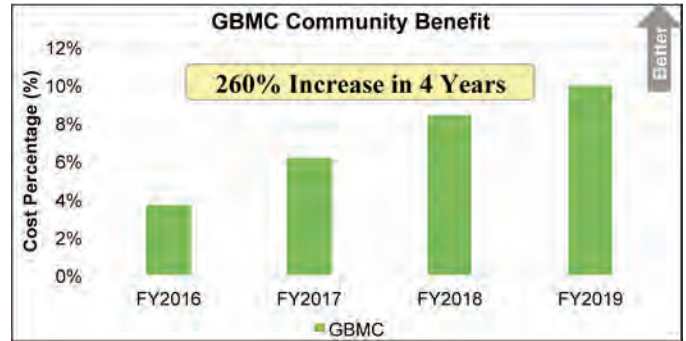
We have been focused on reducing our carbon footprint through reducing energy consumption (Figure 7.4-19).



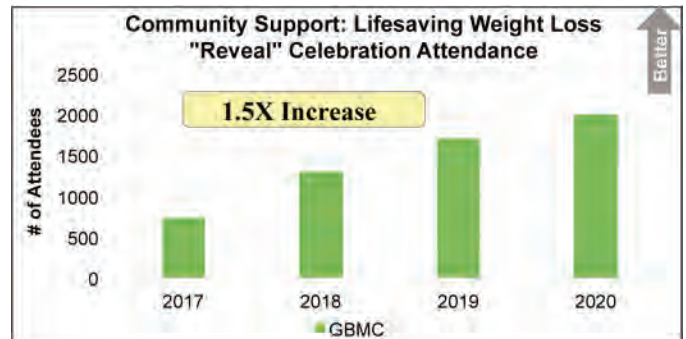
**Figure 7.4-19** Energy Cost per Square Foot

Figure 7.4-20 Philanthropic Donations. This chart has been redacted as it contains sensitive business information.

GBMC’s Community Benefit program includes support to local organizations and initiatives that align with the priorities in our CHNA (Area 1.2[c]). Dollars are calculated as a percent of total cost (Figure 7.4-21). Funds provided can be small or large—examples include: funding a local elementary school for children to “Run a Mile” every day before class, Moveable Feast—providing healthy meals to chronically ill patients; supporting the Weight Loss Reveal Celebration. Attendance at the Reveal has increased each year (Figure 7.4-22).

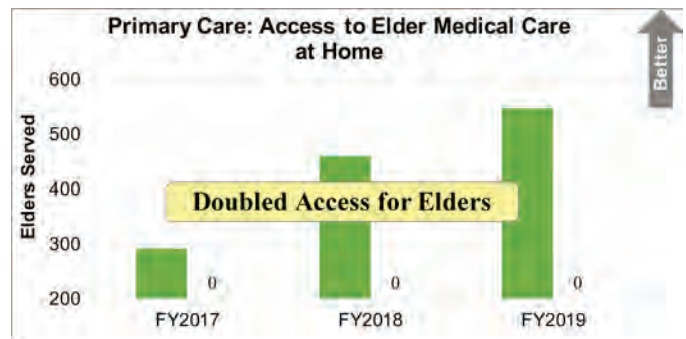


**Figure 7.4-21** Community Benefit Dollars



**Figure 7.4-22** Community Support: Life Saving Weight Loss Reveal Attendance

Our analysis of patients who were assessed for hospice identified an unmet need for elder care at home (Figure 7.4-23). We provide in-home primary care for home-bound frail elders. This service is not offered by our competitor.



**Figure 7.4-23** Access to Elder Medical Care at Home

**7.5 Financial, Market, and Strategy Results**

**7.5a Financial and Market Results**

**7.5a(1) Financial Performance**

GBMC, an independent healthcare system, maintains a positive margin year over year. In FY17, the investment in a \$50+ million electronic health record (Epic) did not result in a negative margin as it has with similar conversions in other organizations. GBMC has enjoyed a strong rating with Moody’s demonstrating our financial strength. Compared to the three other independent healthcare systems in Maryland, GBMC performs higher (Figure 7.5-1). Our closest competitors are part of large healthcare systems that do not provide a comparable comparison.

Maryland Independent Healthcare Systems (Higher is better)	
Moodys Rating	Organization
A2, Stable (Highest)	GBMC Healthcare
A3, Stable	Independent Healthcare System 1
Baa1, Stable	Independent Healthcare System 2
Baa2, Positive	Independent Healthcare System 3
<b>Best Rating of Similar Healthcare Systems in Maryland</b>	

Figure 7.5-1 Maryland Independent Healthcare Systems

Net Cash from Operations represents funds generated through provision of healthcare services which are available to support capital purchases. This strong financial indicator allows GBMC to make capital investments, such as Epic, without bond financing. Figure 7.5-2 shows cash from operations exceeding capital spend year over year.



Figure 7.5-2 Net Cash from Operations/Capital Spend

Our balance sheet reflects strong liquidity, financial flexibility and low debt levels. The Cash to Total Debt metric is significantly above similarly rated hospital as shown in Figure 7.5-3. Days Cash on Hand (Figure 7.5-4) is significantly better than comparison and is a solid indicator of financial stability. This metric shows that GBMC could go nearly a year without any revenue yet still meet its financial obligations.

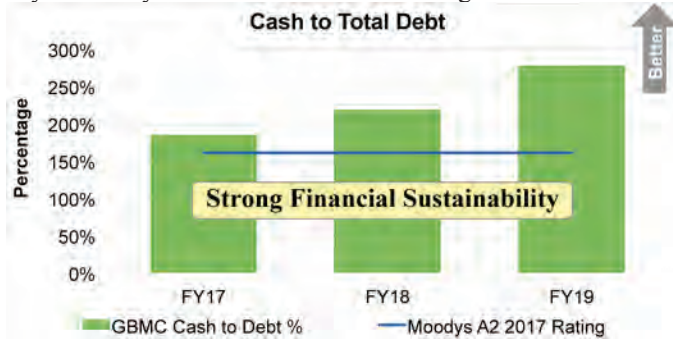


Figure 7.5-3 Cash to Total Debt

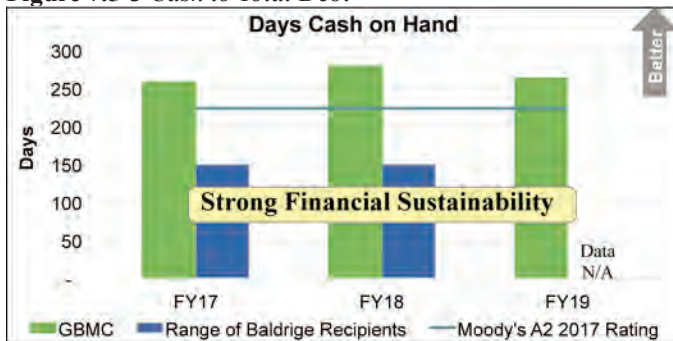


Figure 7.5-4 Days Cash on Hand

Managing Accounts Receivable is another measure of strong financial performance (Figure 7.5-5). Despite the significant change in all our systems when we moved to Epic, we continued to improve and have now achieved results better than before Epic. According to Becker's, many hospitals and systems experience a negative financial impact when implementing an electronic health record.

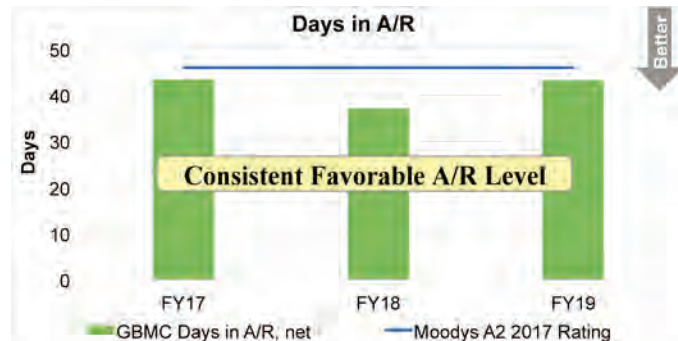


Figure 7.5-5 Days in A/R

When reviewing both three and ten-year investment returns, GBMC consistently outperforms the AON, Composite Benchmark (a leading global risk and insurance firm,) showing excellent financial management by our CFO and BOD Finance Committee (Figure 7.5-6).

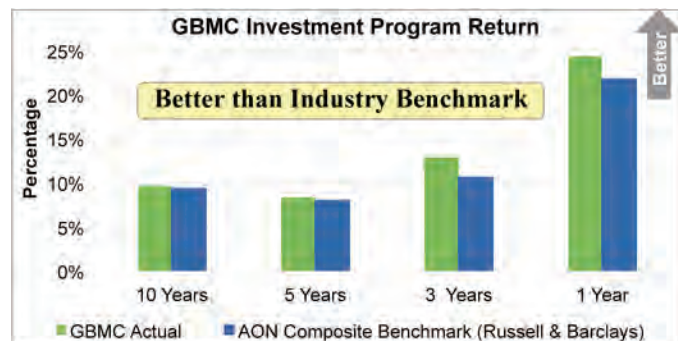


Figure 7.5-6 Investment Program Return

7.5a(2) Marketplace Performance

GBMC hospital is leading in market share and improving year over year from FY16 to FY19. GBMC is the only hospital among its competitors that is growing (Figure 7.5-7).

	FY17	FY18	FY19	% Change (FY18-FY19)
GBMC	10.8%	11.9%	12.9%	1.0%
Competitor A	9.7%	9.6%	9.5%	-0.1%
Competitor B	14.5%	14.8%	14.1%	-0.7%
Competitor C	10.0%	9.8%	9.5%	-0.3%
<b>Increased Service to Our Community</b>				
Benchmark: MSA Market Share Analyst				

Figure 7.5-7 Inpatient Market Share Change in PSA

We are capturing the greatest percent of market share compared to our competitors for ED volume. GBMC is the only ED that is growing (Figure 7.5-8).

	% Change FY16 to FY17	% Change FY17 to FY18	% Change FY18 to FY19
GBMC	-5%	4%	6%
Competitor A	-1%	-4%	-1%
Competitor B	-7%	-2%	-8%
Competitor C	-7%	-2%	0%
<b>Increased Service to Our Community</b>			

Figure 7.5-8 ED Volume Year over Year Change

Gilchrist Hospice has a strong lead in market share compared to its competitor capturing nearly half of the market share in all the 5 counties we serve (Figure 7.5-9).



Figure 7.5-9 Gilchrist Hospice Market Share

The measure of market share for GBMC Health Partners is the number of covered lives which shows steady improvement (Figure 7.5-10). No available benchmark comparison.

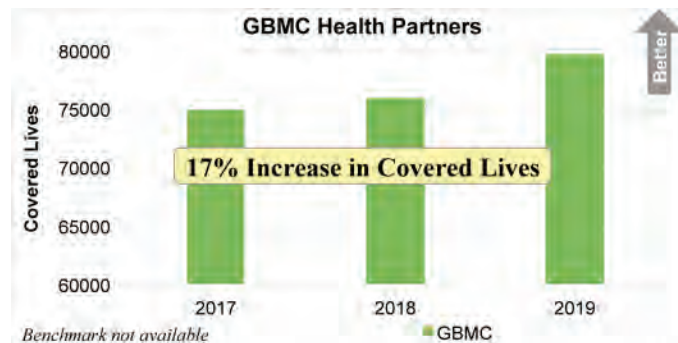


Figure 7.5-10 GBMC Health Partners

**7.5a(3) Strategy Implementation Results**

As discussed in Category 2, our strategy implementation results are segmented by our FA and includes goals and TTIs (Figure 7.5-11).

Aim	Strategic Objective (3 Yr Goals)	Annual Goals	Performance Measures/ TTIs for Annual Action Plan	Reference Results
Better Health	1. Redesign care to provide value to our patients/community	Redesign the key work processes for medical patients admitted to the hospital	Reduce the ED Admit Decision to Departure time	7.1-39 +
		Readmission reduction within 30 days	Readmission rate	7.1-3 +
	2. Lead in addressing key elements of the Behavioral Health needs of our community	Increase political awareness & advocacy for Behavioral Health needs at state & county levels	LOS in ED for Crisis Patients	N/A
Better Care	4. CAHPS by health service entity	Achieve targeted customer service measures (CAHPS)	Recommend this provider office	7.2-12 +
		Continuously adjust & align the Master Facility Plan with Strategic Objectives*	Hospital Overall	7.2-1 +
	5. Expand, modify, or create new GBMC Healthcare offerings	Expand the services of GBMC Health Partners*	Increase in covered lives	7.5-10
Least Waste	6. Improve critical systems	Improve critical Baldrige systems	ADLI by system	N/A
		Operating budget	Days cash on hand	7.5-4 +
	7. Improve operational efficiency & effectiveness	Supply Chain	GHX Overall Rank	7.1-59 +
Liquidity		Cash to Total Debt	7.5-3 +	
More Joy	8. Workforce engagement	Improve Employee Engagement	Meaningful Work	7.3-18
		Physician Satisfaction Scores	Satisfied Working	7.3-22
	9. Safe work environment	Reduce workplace injuries	OSHA Injury Case Rate	7.3-7 +

\* Denotes results for Intelligent Risks; + “GBMC is better than”; = “GBMC is equal to”; N/A “Not available”

Figure 7.5-11 Strategy Implementation Results