BRONSON

Bronson Methodist Hospital
601 John Street
Kalamazoo, MI 49007

2005 Malcolm Baldrige National Quality Award Application Summary

AACVPR: American Association of Cardiovascular and Pulmonary Rehabilitation

ACEI: angiotensin-converting enzyme inhibitor

ACR: American College of Radiology

ACS: American College of Surgeons

ADL: activities of daily living

AHA: American Hospital Association

AMI: heart attack

AMU: adult medical unit

ANCC: American Nurse Credentialing Center

AORN: Association of Operating Room Nurses

AR: accounts receivable

Arbor: Arbor Associates, Inc.

ASA: aspirin (acetylsalicylic acid)

BAC: Bronson Athletic Club

BB: beta-blocker

BCBSM: Blue Cross Blue Shield of Michigan

BDD: business development division

BHG: Bronson Healthcare Group

BIO-ID: fingerprint identification system for safe medication administration

BLS: Bronson Leadership System

BMH: Bronson Methodist Hospital

BOD: Board of Directors

BP: best practice

BRIC: Bronson Referral and Information Center

BSS: Bronson Staffing Service

CAP: College of American Pathologists

CASE: Customer & Service Excellence (corporate strategy)

CBL: computer-based learning

CCO: corporate compliance officer

CDC: Centers for Disease Control

CE: Clinical Excellence (corporate strategy)

CEO: chief executive officer

CFO: chief financial officer

CIO: chief information officer

CIS: Department of Consumer and Industry Services

CLD: chronic lung disease

CME: continuing medical education

CMO: chief medical officer

CMS: Centers for Medicare and Medicaid Services

CNE: chief nurse executive

CORE: Corporate Effectiveness (corporate strategy)

COTH: Coalition of Teaching Hospitals

CPOE: computerized provider order entry

CRP: customer research program

CRT: cathode ray tube

Cs: the hospital's three corporate strategies

CS: CareScience

CSF: critical success factors

CSSE: Customer Service Standards and Expectations

CT: computed topography

DLNC: Divisional Level Nursing Council

DMP: disaster management plan

DOL: Department of Labor

DRG: diagnosis related group

EAP: employee assistance program

EDI: electronic data interchange

EEOC: Equal Employment Opportunity Commission

EMR: electronic medical record

EOC: environment of care

EOS: employee opinion survey

EPA: Environmental Protection Agency

ER: emergency room/department

ERI: employee relations index

ET: executive team

FDA: Food and Drug Administration

FMEA: failure mode effects analysis

FTEs: full-time equivalents

GMU: general medical unit

GSU: general surgical unit

H&P: history and physical

H2E: Hospitals for a Healthy Environment

HDI: Help Desk Institute

HEICS: hospital emergency incident command system

HF: heart failure

HHS: U.S. Department of Health and Human Services

HIM: health information management department (medical records)

HIPAA: Health Insurance Portability and Accountability Act of 1996

HOT Report: Human Resources Organizational Trends Report

HR: human resources

HSD: Human Services Department

ICAEL: Intersocietal Commission for the Accreditation of Echocardiography Laboratories

ICAVL: Intersocietal Commission for the Accreditation of Vascular Laboratories

IHI: Institute for Healthcare Improvement

IMS: Information Management Strategy

IRS: Internal Revenue Service

IT: information technology

IT-SOPs: information technology standard operating plans

JCAHO: Joint Commission on Accreditation for Healthcare Organizations

KWH: kilowatt hour

LCD: liquid crystal display

LCP: Leadership Communication Process

Leaders: executives, directors, managers, supervisors (supervisor level and above)

LI: LEADERship initiative

LLM: listening and learning methods

LOS: length of stay

LPMS: listening post monitor system

LT: long-term

LVF: left ventricular function

LVSD: left ventricular systolic dysfunction

MDCH: Michigan Department of Community Health

MGMA: Medical Group Management Association

MHA: Michigan Health and Hospital Association

MI-OSHA: Michigan Occupational Health and Safety Administration

MOP: medical office pavilion

MPRO: Michigan Peer Review Organization

MRI: magnetic resonance imaging

MSA: Management Science Associates

MSU/KCMS: Michigan State University Kalamazoo Center for Medical Studies

MVP: mission/values project

MVV: mission, values, and vision

MWR: minimum working requirements

NAHCR: National Association Health Care Recruiters

NDNQI: National Database of Nursing Quality Indicators

NICHE: Nurses Improving Care for Health System Elders

NICU: neonatal intensive care unit

NNIS: National Nosocomial Infection Surveillance System

NQF: National Quality Forum

NRC: Nuclear Regulatory Commission

OB: obstetrics

OCR: Office of Civil Rights

OIG: Office of the Inspector General

ONU: orthopedics/neuroscience unit

OP: outpatient

OPI: organizational performance indicator

OPT: outpatient testing

OR: operating room

OSHA: Occupational Safety and Health Administration

P&P: performance & profitability

PACS: picture archiving and communication system

PC: personal computer

PDCA: Focus Plan-Do-Check-Act model for improvement

PFE: Plan for Excellence

PIC: performance improvement committee

PICU: pediatric intensive care unit

PRC: Professional Research Consultants, Inc.

PSA: primary service area

PVI: pulmonary vein isolation

QSIR: quarterly system indicator report

QSP: quarterly strategic planning

RCA: root cause analysis

RN: registered nurse

ROA: return on assets

ROI: return on investment

RWJ: Robert Wood Johnson University Hospital at Hamilton (2004 Baldrige recipient for healthcare sector)

SBAR: situational briefing model (S-situation, B-background, A-assessment, R-recommendation)

SHRM: Society for Human Resource Management

SID: strategic input document

SIP: surgical infection prevention

SL: service line

SMM: Strategic Management Model

SOT: strategic oversight team

SPMS: Staff Performance Management System

ST: short-term

SWOT: strengths, weaknesses, opportunities, threats

TAT: turnaround time

TB: tuberculosis

UW: United Way

VAP: ventilator acquired pneumonia

VHA: Voluntary Hospitals of America

VON: Vermont Oxford Network

VPHR: vice president of human resources

VPMM: vice president of materials management

WDP: Workforce Development Plan

Preface: Organizational Profile

P.1 Organizational Description

P1.a Organizational Environment

Bronson Methodist Hospital (BMH) is a tertiary medical center, providing inpatient and outpatient care from a central location in downtown Kalamazoo, Michigan. Yes, there really is a Kalamazoo, and it is the fifth largest city in the state of Michigan. Established in 1900, BMH has a long history of providing high quality medical care to people throughout a nine- county southwestern Michigan region. The region served by the hospital has approximately one million residents and about 60% of its patients come from the primary market in Kalamazoo County. Figure P.1-1 provides an overview of 2005 annualized hospital performance.

P.1-1 2005 Hospital Performance (Jan-Oct Annualized)

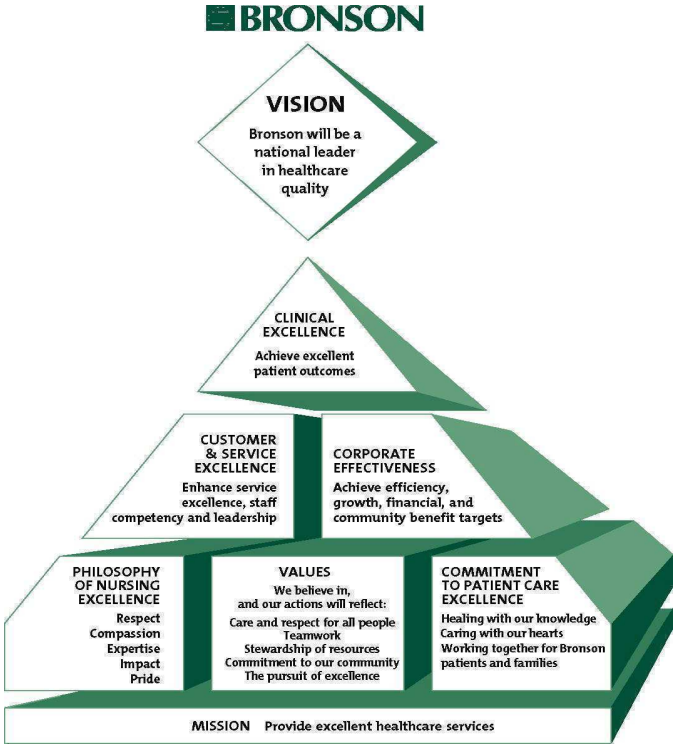
Annual Gross Patient Revenue	$751M
Inpatient % Revenue	65%
Outpatient % Revenue	35%
Annual Discharges	21,728
Annual ER Visits	77,728
Campus Size	28 acres
Number of Beds	343
Number of Employees	3,182
Medical Staff	780

BMH is the flagship organization in the Bronson Healthcare Group (BHG) system. BHG is a not-for-profit healthcare system consisting of BMH, an inpatient rehabilitation hospital, 20 physician practices, a healthcare staffing service, lifestyle improvement and research center, athletic club, outpatient radiology center, health plan, and hospital foundation. Currently BHG has a workforce of more than 3,900 employees making it the second largest employer in Kalamazoo. BHG supports the hospital in the following areas: administration, human resources (HR), compliance and regulatory, public affairs, financial services, strategic planning, marketing, business development, information technology (IT), purchasing and property management. A wholly-owned subsidiary of BHG, BMH is the focus of this Baldrige application. BMH shares the same executive team (ET), Board of Directors (BOD), and Plan for Excellence (PFE - Figure P.1-2) as BHG.

P.1a(1) Main healthcare services: BMH delivers a comprehensive array of healthcare services directly to its patients through inpatient and outpatient service delivery mechanisms on its main campus. Key inpatient services include: cardiology (Heart Hospital at Bronson), general surgical services, orthopedics, neurosciences, obstetrics (The Bronson Birthplace), pediatrics (The Children's Hospital at Bronson), medical services, and adult critical care services. Key outpatient services include: emergency services (Emergency Department and Express Care), outpatient testing and diagnostics, ambulatory surgery, and home health. As a tertiary care center, BMH provides the following specialty services: Level I trauma center; high risk pregnancy center; Level III neonatal intensive care unit (NICU); pediatric intensive care unit (PICU); and a JCAHO-certified primary stroke center.

P.1a(2) Organizational culture: The BMH culture is built upon a focus and passion for excellence. The hospital's purpose and reason for existence is stated in its mission to *provide excellent healthcare services*. This statement reflects what BMH does and why it exists. The mission, values, commitment to patient care excellence, and philosophy of nursing excellence provide the foundation that supports the organizational strategy, which is illustrated in the vision to *be a national leader in healthcare quality* and the three Cs or corporate strategies: *Clinical Excellence (CE), Customer and Service Excellence (CASE),* and *Corporate Effectiveness (CORE).* Excellence is the thread that ties together the vision, mission, values, commitment to patient care excellence, philosophy of nursing excellence and overall strategies. These elements, comprising the *Plan for Excellence* (PFE - Figure P.1-2), form the culture and guide decision-making.

P.1-2: BMH Plan for Excellence



Annually, the ET and BOD engage in the strategic planning process, referred to as the Strategic Management Model (SMM - Figure 2.1-1), requiring review of the key elements in the PFE. Numerous enhancements to the PFE have occurred over the past several years as the ET and BOD strive to improve and strengthen the organization's focus on performance excellence. With two competitor hospitals in Kalamazoo, BMH is the only locally governed, community-owned hospital and the state's largest Medicaid provider outside of the greater-Detroit area. The mission, values, and vision (MVV) direct the organization to serve patients irrespective of their ability to pay for the care provided.

P.1a(3) Staff profile: BMH's 3,182 employees bring its culture of excellence to life each day by providing customer-focused, high quality patient care services. The hospital recognizes that employees are the key contributors to organizational success and achieving the vision. First and foremost, employees are recruited and selected based on their commitment to providing superior customer service. All employees are trained and held accountable to follow the

Customer Service Standards and Expectations (CSSE). This statement, a supportive element in the PFE, outlines the personal accountability that every staff member has every day, with every interaction, with every customer. The CSSE, along with service recovery, the interaction process, and scripting, give staff the tools they need to meet patient requirements and expectations.

Since the mid-1990s, the hospital has been on a journey in pursuit of workplace excellence, aiming to be the employer of choice in the region. As a top employer, BMH is able to attract the best and brightest employees to care for its patients. With a primarily female workforce, BMH has developed creative strategies to address the unique needs of working women. This commitment to workplace excellence, and providing work/life balance, has resulted in being named to the list of *100 Best Companies for Working Mothers* by Working Mother magazine and Fortune's *100 Best Companies to Work For* the past two consecutive years. There are no employees represented by labor organizations. BMH values the 412 community members who served as volunteers in 2004, providing more than 48,000 hours in 32 different service areas as helping hands to the workforce and patients.

P.1-3 Staff Profile

Leadership	Management: 5%	Non-Management: 95%				
Gender	Female: 82%	Male: 18%				
Position	Nursing: 32%	Technical: 17%	Professional: 14%	Other: 37%		
Tenure (years)	<1: 12%	1-4: 37%	5-10: 20%	11-25: 20%	26+: 11%	
Education	High School: 45%	Diploma/College: 50%	Graduate: 5%			
Age (years)	<20: 1%	20s: 25%	30s: 26%	40s: 27%	50s: 18%	60s: 3%
Shift	Day: 72%	Evening: 18%	Other: 10%			
Approved Hours	Full-time: 74%	Part-time: 17%	On-call: 9%			
Ethnicity	Caucasian: 91%	African American: 5%	Hispanic: 1%	Other: 3%		

Diversity is evident in the staff profile illustrated in Figure P.1-3. BMH strives to maintain a diverse and skilled workforce. The organization believes the active pursuit of diversity strengthens its efforts to be the best place to work and receive healthcare services. BMH defines diversity in broad terms, recognizing that it is more than physical differences. Diversity is what makes each individual and group unique. BMH has a comprehensive diversity strategic plan that is very deliberate in focusing the organization on delivering high quality healthcare to a growing multi-cultural population. A key element of the diversity strategy is the diversity commitment statement: *To provide an environment that values the strengths and talents of every person in the organization, reflects the community it serves, and celebrates its similarities and differences.* BMH monitors organizational performance related to diversity on the organizational scorecard.

The medical staff has 780 physicians and allied health professionals with admitting privileges to the hospital. All members of the medical staff are credentialed to perform in their areas of expertise based on training, experience and certification. BMH employs 50 physicians, 14 allied health professionals, and contracts radiologists, anesthesiologists, pathologists, pediatric gastroenterologists, neonatologists, emergency physicians, and trauma panel coverage. BMH has developed, in conjunction with the medical staff, a multi-year Medical Staff Development Plan, that guides future physician recruitment efforts.

Staff meets all organization-wide safety requirements, including general health and safety screenings, proof of immunization against common diseases, and tuberculosis testing upon hire and annually through the completion of minimum working requirements (MWR). Staff must annually complete computer-based learning (CBL) modules on all aspects of safety training, including hazardous materials, emergency management, environment and life safety, clinical safety, and ergonomics, in order to continue to be eligible for employment.

P.1a(4) Technologies, equipment and facilities: As healthcare continues to evolve into a competitive, information-rich industry, investment in technology, equipment and facilities becomes critical to success. For 2005, BMH has dedicated over $28 million to capital investment in IT, equipment and facilities. This is 7.6% of total budgeted expenses, and 1% more than the annual 6.6% profit margin. In December 2000, BMH opened a new $181 million facility with all private patient rooms adjacent to the previous downtown campus. This was a major milestone in assisting the organization in the pursuit of excellence as a healthcare provider and employer of choice. The new BMH was designed to create a state-of-the-art, easily accessible healthcare campus, bringing together inpatient care, outpatient care, and physician offices in a patient-focused, healing environment.

BMH has become a best practice site for facility design innovation. Hundreds of healthcare professionals and architects from across the U.S. and overseas have toured the new BMH since it first opened in 2000. Due to significant growth in BMH services, the investment in downtown Kalamazoo continues as BMH plans for another campus expansion project, beginning in 2005, that will cost an additional $50 million. This project brings the investment in the development of its downtown campus to approximately one-quarter of a billion dollars since 1995.

Located on a 28-acre urban campus, the current facility includes a Medical Office Pavilion (MOP), Ambulatory Care Pavilion, Inpatient Pavilion, and flat-deck parking ramp. The three pavilions come together around an indoor garden atrium that, with its multi-story glass windows, lush trees and plants, and bubbling water feature, creates a healing environment for patients and visitors from the moment they enter. An underground tunnel connects the new facility to the organization's north campus, which has one patient care pavilion, a flat-deck parking ramp, and three buildings housing administration, support services and classrooms for community and staff education.

Equipment on campus includes state-of-the-art technology to improve patient safety and key healthcare processes, including: fixed magnetic resonance imaging (MRI), 64-slice CT scanner, bi-plane interventional suite, drug-coated stents for cardiac catheterization, three-dimensional electrophysiological mapping, invasive and minimally invasive surgical instruments, and an automated pharmacy robotics system.

Over the past five years, BMH has doubled the percentage of the organization's operating budget specifically devoted to IT in order to improve access and availability of data and information. This commitment to maximizing the benefits of technology, enables high quality, safe, efficient care delivery, effective decision-making, and enhanced communication. Technologies include: picture archiving and communication system (PACs) in radiology and cardiac catheterization labs, electronic medical record (EMR), document imaging, BIO-ID (a fingerprint identification system for safe medication administration), secure Internet-enabled physician access to patient records and diagnostic images which allow physicians to provide patient care from off-site locations, email and Internet access for all staff, corporate-wide intranet for communication and knowledge sharing. In addition, two geographically-separated data centers provide a high degree of disaster recovery protection. The deployment of free wireless Internet access across the campus allows external customers, patients, families and visitors to remain productive and connected while they are in the facility. In 2005, BMH began to implement computerized provider order entry (CPOE) to help avoid errors and reduce practice variation, providing physicians with a powerful clinical tool.

P.1a(5) Legal and regulatory environment: Healthcare is a highly regulated industry with specific requirements related to patient care, compliance, and ethical business practice. BMH is licensed to operate by the state of Michigan and is subject to numerous state agency regulations dealing with safety, licensure, fair employment practices, land use, and state charitable agency provisions. Key agencies for state regulation are MDCH, MI-OSHA, OCR and CIS. On the federal level, BMH is subject to regulations of OIG, HHS, FDA, CMS, OSHA, NRC, DOL, EEOC, EPA, and CDC. In addition to government regulatory requirements, BMH participates in numerous accreditation programs, including JCAHO, ACS, ACR, CAP, ICAVL, ICAEL, and AACVPR. In 2004, BMH achieved a superior JCAHO survey accreditation rating with no recommendations for improvement. BMH tracks charity care and community benefits to ensure that it is true to its mission and values as it maintains tax exempt status as a not-for-profit healthcare organization under IRS financial regulations.

P.1b Organizational Relationships

P.1b(1) Organizational structure and governance: The BOD, 20 highly qualified local community leaders, governs the hospital and the BHG system. The BOD is charged with providing the overall governance according to the hospital bylaws that outline the specific purpose and powers of the BOD, including but not limited to, the appointment, assessment and compensation of the CEO. Similarly, the medical staff is governed by medical staff bylaws approved by the BOD. The BHG/BMH CEO, the chief of staff and immediate past chief of staff are ex-officio voting members of the BOD. Several other senior members of the ET participate, facilitate, and collaborate with the BOD at all board and committee meetings.

P.1b(2) Key patient, customer, stakeholder groups, requirements, market segments: At the center of the Bronson Leadership System (BLS - Figure 1.1-1) are our key customers – patients. Annually, through the SMM using a customer research program (CRP) that includes listening and learning methods (LLM - Figure 3.1-1), the ET reaffirms the key patient, other customer, stakeholder groups, healthcare market segments and requirements illustrated in Figure P.1-4. The patient requirements apply to both inpatients and outpatients, although the level of importance may vary and the requirements are more specifically defined based on the point of care delivery.

P.1-4 Key Customer & Stakeholder Groups, Requirements, Market Segments

Customer Group	Requirements	Market Segment
Patients (including families)	• Quality outcomes • Communication • Empathy • Responsiveness • Efficiency	• Inpatients and outpatients • Geographic location (service area) • Service lines • Age demographics
Stakeholder Group	**Requirements**	**Market Segment**
Community	• Leadership and support • Access to healthcare services • Health information • Quality outcomes	• Type of organization • Geographic location

P.1b(3-4) Suppliers and partners: Suppliers and partners play a key role in BMH's success because the products and services procured directly impact the quality of care and effectiveness of care delivery. Without involvement and support from key suppliers and partners, BMH would be limited in its ability to make significant, innovative change in its processes. The important relationship with suppliers and partners is fostered through effective communication and clear performance requirements.

BMH's most important partners are physicians (medical staff). As partners, physicians work in concert with the hospital to achieve a common goal, the delivery of high quality medical services to patients. Important to a successful partnership is a clear understanding of individual and mutual roles and benefits to both parties. As such, BMH has specific requirements of physicians and physicians have requirements of the hospital. Figure P.1-5 lists the requirements related to the partnership relationship between BMH and physicians.

Physicians are a primary referral source for patients, and BMH provides the facilities and resources that enable the medical staff to use their medical expertise to achieve optimal clinical outcomes. The hospital/physician partnership is strengthened by having physicians

serve on the hospital BOD. Within the medical staff, both elected and appointed leaders play a significant role in strategic planning, decision-making, performance improvement, and organizational innovation processes.

P.1-5 Partnership Requirements

Physician Requirements of BMH	BMH Requirements of Physicians
• Access • Efficient processes • Communication • Responsiveness • Competency • Education • High patient satisfaction	• Patient admissions & referrals • Excellent outcomes • Collaboration • High patient satisfaction • Resource management • Competency • Use of evidence-based medicine

This partnership is maximized through effective two-way communication, involvement on administrative and operational committees, and access to BMH's electronic and traditional communication tools. The hospital/physician partnership has emerging complexities because BMH is simultaneously partnering and competing with physicians as area physicians develop their own ambulatory surgery and outpatient diagnostics centers.

A subset of the medical staff is resident physicians. Michigan State University Kalamazoo Center for Medical Studies (MSU/KCMS), is a medical education joint venture between BMH, Borgess Medical Center, and the Michigan State University College of Human Medicine. Through MSU/KCMS, BMH has ten residency programs and 150 residents on rotation each month providing care to patients. In addition, through MSU/KCMS, the hospital meets the educational requirements of physicians by offering continuing medical education (CME) approved courses.

Suppliers play an important role in key healthcare and support processes. The most important suppliers to the hospital support processes provide medical and surgical supplies, healthcare equipment, pharmaceuticals, lab and radiology products, and, management of food and nutrition services. Other key suppliers contract directly with BHG for IT products and services, self-funded insurance administration, and concierge services. The most important supply chain performance requirements are: quality, cost, and timely delivery. Regularly scheduled (daily, weekly, monthly, quarterly) and ongoing communication with partners and suppliers takes place in a variety of forums using: one-on-one and group meetings, email, telephone, fax, EDI technologies, and written communication (correspondence, newsletters, contracts, purchase agreements).

P.2 Organizational Challenges

P.2a Competitive Environment

P.2a(1) Competitive position: By achieving high quality clinical outcomes and superior service, BMH builds customer loyalty. The hospital has experienced exponential growth in the last five years and has attained market leader status. For seven consecutive years, BMH has been named *Kalamazoo's Leading Hospital* in the annual Adam's Outdoor survey. Also, BMH has been the Consumer Choice Award winner as the top hospital in the Kalamazoo area according to National Research Corporation for the past two years.

Although the vision challenges the organization to achieve national levels of performance for clinical quality outcomes, BMH remains focused on serving patients in the nine-county region. Competition is defined within the local area market and includes five major competitors. BMH has worked collaboratively with others for many years to provide the necessary services to the community, reducing unnecessary duplication of services. Joint efforts include: the West Michigan Cancer Center (a premier outpatient treatment facility for cancer patients and their families), West Michigan Air Care (a medical air transport service), and MSU/KCMS (medical education and residency programs). Other key collaborators are the regional hospitals that provide referrals for tertiary services provided by BMH.

P.2a(2) Principle success factors: The vision and mission would be unkept promises were it not for the top-level commitment of BMH staff, who believe in the values and demonstrate them every day to patients. BMH's success depends upon the ability to achieve the three Cs as evidenced by key measures in the organizational scorecard. Through cycles of improvement and integration of the Baldrige criteria, BMH identified critical success factors (CSF) that have contributed to its competitive position and serve as a key element for the strategic planning process along with the PFE. Figure P.2-1 illustrates the principle factors critical to BMH success.

P.2-1 Critical Success Factors

CLINICAL EXCELLENCE (CE)
• Achieve national best practice performance in clinical outcomes • Use evidence-based medicine to achieve excellent patient outcomes • Be recognized as a safe environment for patients
CUSTOMER & SERVICE EXCELLENCE (CASE)
• Distinguish BMH as an employer of choice • Be recognized for a culture of service excellence • Foster a culture of excellence that values diversity while encouraging teamwork, learning and innovation
CORPORATE EFFECTIVENESS (CORE)
• Provide strong financial performance to allow for capital reinvestment, growth and sustainability • Partner with physicians, the community and others to achieve common objectives • Use the Baldrige Criteria for Performance Excellence to improve processes and organizational performance

A key market change affecting BMH's competitive position and opportunities for collaborating includes:

- Over the past 12 months, the primary service area has become extremely competitive. Private physician groups have entered the more profitable healthcare market, with ambulatory surgery services and outpatient diagnostics.
- Other changes have not been listed due to competitive reasons.

P.2a(3) Sources of comparative and competitive data: Key sources of comparative and competitive data from within the healthcare industry and outside include: AHA, MHA, MGMA, VON, CareScience, Arbor, Gallup, PRC, MPRO, JCAHO, Healthgrades, Leapfrog Group, CMS, COTH, CDC, Southwest Michigan Utilization Report, Solucient, VHA, MSA, ANCC, NDNQI, HDI, Advisory Board, Moody's, Great Place to Work Institute, Working Mother 100 Best Companies, IHI best practices, community perception surveys, as well as benchmarking visits to Baldrige recipients. Limitations in obtaining data include access to comparisons for outpatient services, volume and outcome data for free-standing facilities and physician practices, and regulatory restrictions prohibiting competitors in the local market from providing comparative financial data.

P.2b Strategic challenges: BMH aligns strategic challenges with the three Cs (Figure P.2-2). This approach supports development of key action plans to address these challenges. The items in Figure P.2-2 are not only current challenges addressed by the annual strategic planning process but also long-term (LT) challenges associated with organizational sustainability. Achieving high quality patient outcomes, meeting growing patient needs, developing a high quality diverse workforce, meeting customer service expectations, managing capacity and maintaining profitable growth are challenges associated with organizational sustainability.

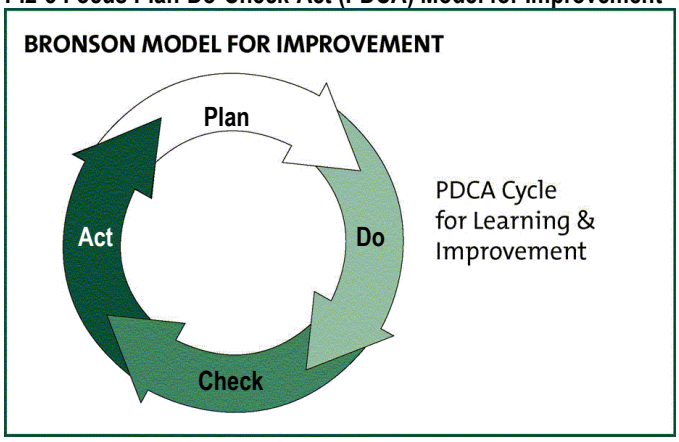
P.2c Performance improvement system: The Bronson Leadership System (BLS - Figure 1.1-1) provides the systematic mechanism for the BOD and ET to maintain an overall focus on organizational performance improvement and learning. The ET reviews and adjusts organizational performance with a system of daily, weekly, monthly, and quarterly, reviews using the organizational scorecard and other data sources. The ET continuously facilitates improvement using the SMM's continuous planning cycle. BMH is committed to learn and innovate through the BLS. The Focus Plan-Do-Check-Act (PDCA) model for improvement (Figure P.2-3) creates the mechanism for improvement of key processes and continuous organizational learning. The BLS promotes alignment and integration of all plans, processes, information, decisions, actions and results that support the hospital's strategic direction. BMH uses the collective knowledge of employees' intellectual assets as a competitive advantage. Organizational learning, for example, is achieved through the LEADERship initiative (LI) to develop and share organizational knowledge assets between leaders (supervisor level and above).

P.2-2 Strategic Challenges

CLINICAL EXCELLENCE (CE)
• Consistent application of evidence-based medicine practices to achieve high quality patient outcomes • Meeting the needs of the growing number of patients with increasingly complex healthcare conditions
CUSTOMER & SERVICE EXCELLENCE (CASE)
• Recruiting, retaining, and developing high quality leaders, staff and physicians due to healthcare workforce shortage and aging of current workforce • Creating appropriate diversity management strategies • Managing customers' heightened service expectations
CORPORATE EFFECTIVENESS (CORE)
• Addressing capacity constraints as the demand for healthcare services continues to grow • Maintaining profitable growth and meeting capital needs while reimbursement continues to be reduced by all payors

In the late 1990s, BMH began to use the Baldrige criteria for performance excellence as a tool for improvement and self-evaluation. Since 2000, the Baldrige framework has been used to redesign the culture and organizational leadership system. BMH completed a Baldrige self-assessment in 2000. In 2001, the hospital was the sole recipient of the *Michigan Quality Leadership Award*, the state equivalent to Baldrige. The journey to excellence continued with the deployment of key processes in the newly revised BLS in 2004. The hospital's PFE, driven by the Baldrige criteria, serves as the foundation for the organization's strategy development. The criteria are a business management tool that has moved BMH from a very good organization to a great one.

P.2-3 Focus Plan-Do-Check-Act (PDCA) Model for Improvement



1 Leadership

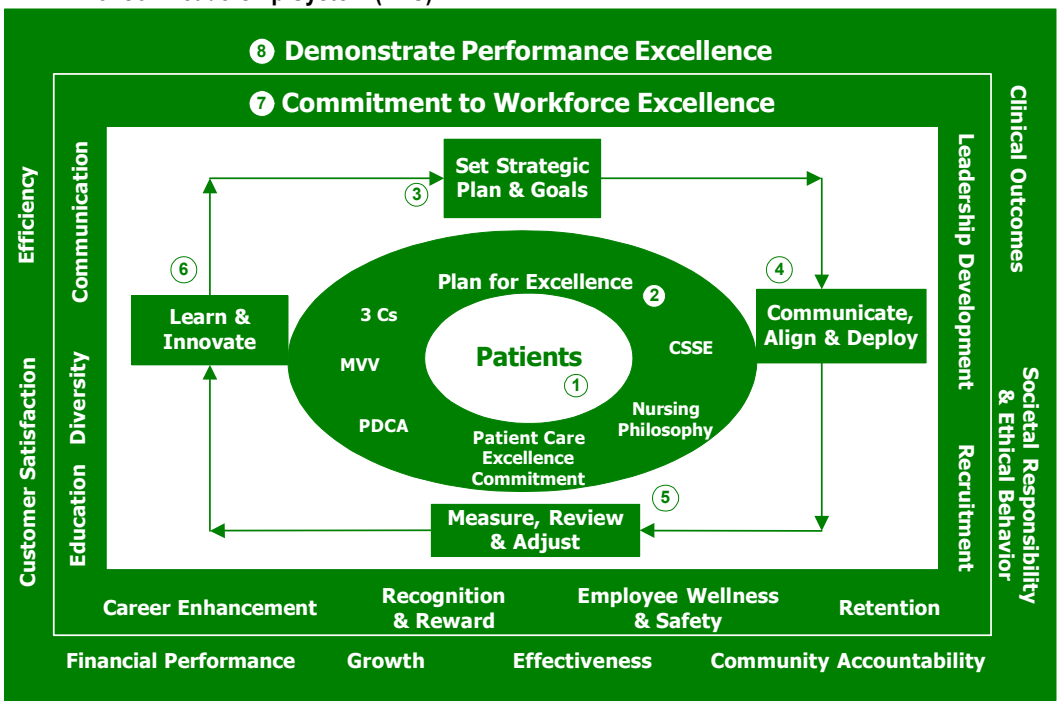
1.1 Senior Leadership

1.1a Vision and Values

1.1a(1) Set and deploy values and vision: The Board of Directors (BOD) and the executive team (ET) systematically establish, communicate and deploy the BMH mission, values, and vision (MVV) through the Bronson Leadership System (BLS - Figure 1.1-1). After examining multiple organizational leadership systems, BMH developed its BLS as a combination of several best practices. At the heart of the leadership system are our key customers – patients❶. Patient requirements drive all leadership actions in alignment with the Plan for Excellence (PFE - Figure P.1-2)❷. This one-page document is distributed to all employees and contains the hospital's MVV, strategic objectives (three Cs), philosophy of nursing excellence, commitment to patient care excellence, PDCA model for improvement, and Customer Service Standards and Expectations (CSSE). In addition, it includes other tools focused on service excellence such as service recovery, interaction process, scripted phrases, and telephone answering. On a daily basis, all employees have visibility to the PFE, which is a constant reminder of the principles critical to BMH in the delivery of high quality care and excellent service. The result is reflected in the culture of excellence and daily operations in the hospital.

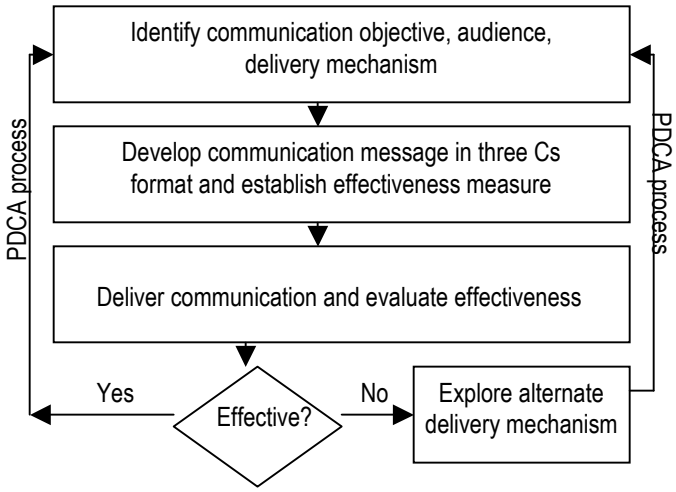
Building on the foundation of the PFE, the ET and BOD, annually develop the strategic plan❸ with a focus on patient requirements. The Strategic Management Model (SMM - Figure 2.1-1) collects multiple internal and external inputs, establishes performance expectations with both a short- and long-range view, and creates a balanced strategy. During the spring activities of the SMM, the ET reviews the entire PFE, including the current vision and values statements. If changes are warranted, the ET gathers input from employees, physicians, patients, suppliers, and the community. The BOD annually reviews and approves the MVV statements at a BOD meeting in late fall.

1.1-1 Bronson Leadership System (BLS)



Effective communication, alignment and deployment❹ are essential for achievement of organizational strategy. Using the Leadership Communication Process (LCP - Figure 1.1-2), the ET communicates values, plans and expectations in the three Cs format throughout the organization and to the community.

1.1-2 Leadership Communication Process (LCP)



BMH organizational plans represent the translation of the hospital's MVV. Alignment and deployment of these organizational plans is achieved through an enhanced strategic plan cascade (Figure 2.2-1). This process includes the alignment of scorecard and organizational performance indicators (OPI) with secondary scorecards at the department, service line and key process level. The Staff Performance Management System (SPMS - Figure 5.1-3) aligns individual performance with organizational objectives and action plans. Leader goals and individual employee goals support the three Cs. The gainshare program financially rewards staff for achievement of organizational and department-specific objectives. Through the organized medical staff structure, the ET deploys the MVV and strategy to physician partners. New supplier scorecards are a formal mechanism to align supplier performance with organizational objectives. Alignment keeps leaders, employees, physicians, and suppliers focused on what is most important. It builds relationships and trust at all levels of the organization by connecting the values and strategies with individual activities. In addition, and perhaps most importantly, alignment sets clear expectations which reduces unnecessary work and duplication of efforts.

The ET believes that actions truly speak louder than words. To reflect their personal commitment to the organizational values, in 2005, the ET developed the leader commitment statement

and leadership accountability minimum working requirements (MWR). These two documents outline specific actions that begin with the ET and apply to all leaders. By annually signing these documents, the ET members are role models and make a personal commitment to support organizational values. The open door policy, leader rounds, CEO/CNE open office hours, and thank you notes hardwire the behaviors that bring the BMH values to life every day.

1.1a(2) Environment for legal and ethical behavior: The BOD establishes governance policy that supports an environment of legal and ethical behavior at the highest standard. The ET has translated this commitment to ethical behavior into a "zero tolerance" culture outlined in the code of conduct policy. The policy covers all transactions and interactions involving suppliers, physicians, patients and the public. Compliance with the code of conduct is an ongoing requirement for employment or doing business with BMH. Staff and all stakeholders are required to review the policy and provide acceptance acknowledgement of their compliance. For suppliers, compliance with the code of conduct is a contractual requirement for all who do business with BMH.

1.1a(3) Create a sustainable organization: The hospital BOD is driven to create a sustainable organization that can meet the healthcare needs of the community today and in the future. Through the MVV, the BOD creates a patient focus, clear and visible values, and high expectations that balance the needs of all stakeholders. Following the systematic and deliberate steps in the BLS, the ET ensures the creation of strategies for achieving excellence. The SMM planning process allows the ET to balance short-term (ST) and long-term (LT) needs for organizational sustainability. The annual strategic plan and the hospital's 10-year financial plan, create a roadmap that ensures fiscal responsibility as well as innovative programs and services. The Workforce Development Plan (WDP – Figure 5.1-1) addresses the development needs of the workforce that are directly tied to achievement of organizational strategy and the MVV. With clear expectations and accountability, the BOD measures accomplishment of strategy using the organizational scorecard. The ET measures, reviews and adjusts❺ organizational performance and continuously facilitates improvement using the SMM's continuous planning cycle and the Focus PDCA model for improvement (PDCA - Figure P.2-3). PDCA is part of the PFE, and has become engrained in the BMH culture through communication, education and knowledge sharing. Through the BLS, the ET is committed to learn and innovate❻. Learning is any new knowledge acquired through evaluation, study, experience or innovation. Innovation at BMH is defined as creating an idea, practice or object that is perceived as new and is of significant value. The BLS creates the mechanism for continuous organizational learning, learning from our own successes and opportunities, as well as best-in-class organizations.

A key element of creating organizational sustainability is being sure that there are strong leaders today and in the future. The ET takes a lead role in the development of future organizational leaders. The BOD and CEO annually review a formal succession plan for the executive-level staff, including emergent or ST and LT plans for replacement of the CEO. The ET annually reviews performance appraisal results and formally discusses potential succession opportunities for high achievers. Through active oversight and participation in the LEADERship initiative (LI), the ET guides the process for developing and growing BMH leaders. ET members actively participate in the new management mentor program as executive coaches. Through the SPMS, each executive talks with his/her leaders about career progression and future succession opportunities.

1.1b Communication and Organizational Performance

1.1b(1) Communication, empowerment, staff motivation, reward and recognition: The LCP facilitates consistency in the ongoing delivery of key messages throughout the BLS. The three Cs communication format establishes a framework for communication and assists leaders in creating and balancing value. The ET uses a variety of mechanisms (Figure 5.1-2) that reinforce two-way communication and feedback. Examples include leader rounds, department meetings, CEO/CNE open office hours, shared governance, and access to email for all employees. BMH fosters a culture of employee involvement and empowerment through a commitment to workforce excellence❼(Figure 5.1-1). The ET creates an environment where employees understand their role and are empowered to achieve personal and organizational goals through innovative approaches. The approach used by BMH to facilitate empowerment and staff motivation incorporates several key elements including:

- *Leadership decision-making:* Decision-making is driven into the organization through delegation to the appropriate level. The foundation created by a common understanding of the MVV and strategic direction, combined with empowerment, motivates staff to high levels of performance. The organizational structure is reviewed annually by the ET, through the SMM, to ensure the structure supports effective decision-making and action plan deployment.
- *Workforce Development Plan:* The WDP, updated annually during the strategic planning process by the ET, addresses staff learning and motivation through the SPMS, annual education plan, and a robust array of recognition and reward mechanisms (Figure 5.1-4). The SPMS is a process to motivate staff to see how their personal goals and actions can contribute to overall organizational performance measures.
- *Diversity Council, teams, committees:* Input from employee groups supports and drives organizational decision-making and process improvements. The Diversity Council is championing the hospital's diversity efforts. The Divisional Level Nursing Council (DLNC) gives nurses greater decision-making authority and overall accountability for care delivery and support processes to improve patient care.
- *Listening post monitor system:* Recognizing the importance of understanding employee needs, the new listening post monitor system was developed to aggregate employee input from various listening posts. This system provides timely and actionable information for the ET to use in developing employee programs and services that are directly responsive to their needs.
- *A culture of fun and fabulous prizes:* Effective reward and recognition of all employees reinforces a culture of excellence. The ET has cultivated a culture that celebrates success with fun and fabulous prizes. Be it the annual service awards banquet, employee picnic, or a special occasion, employees may receive pre-paid gas

cards, delicious treats, or the chance to spin the BMH Wheel of Fortune for a $500 voucher. The ET participates in all formal and informal recognition events, administers key contributor bonus pools, allots department-specific recognition funds, and writes thank you notes to recognize staff for their efforts.

1.1b(2) Create a focus for action and balancing value: Through the annual strategic planning process, the BOD and ET focus specifically on how BMH creates value for patients, physicians, staff, suppliers, and the community. Through the SMM, the BOD continuously challenges the ET to demonstrate value in all that BMH does. The three Cs create a sense of balance for the organization as the ET develops plans to focus on quality outcomes, superior service, efficiency, and growth, as well as financial and community benefit targets. The organizational scorecard, in the three Cs format, balances organizational performance expectations. Through the strategic plan cascade (Figure 2.2-1), the ET creates a focus for action through alignment of strategic objectives at every level of the organization.

1.2 Governance and Social Responsibilities

1.2a Organizational Governance

1.2a(1) Key factors in governance: The BMH governance system creates accountability for management actions and financial performance beginning with the BOD and cascading to all leadership team members. The BOD, made up of independent community representatives who govern and oversee operation of the hospital in furtherance of its MVV, is responsible for the protection of all stakeholder interests. Following approval of the annual strategic plan, scorecard measures, and CEO performance goals, the BOD assigns accountability to the ET for carrying out organizational strategies defined in the strategic planning process. To involve the BOD more actively in the oversight of the strategic plan implementation, the SMM was revised so that each of the three Cs, lead by a strategic oversight team (SOT), reports quarterly to a committee of the BOD. On a quarterly basis, the BOD reviews organizational performance relative to the strategic plan, holding the ET accountable for results that are tied directly to the executive compensation system.

The BOD and ET participate in systematic reviews of organizational financial performance. Annually, the BOD approves the budget in the fall as part of the SMM. The finance committee and full BOD review financial performance monthly. Audits are strictly independent and stakeholders' interests are always at the forefront of consideration. The BOD exercises fiduciary responsibility through annual review of executive compensation. The independent audit committee hires the external auditors and ensures all actions follow generally accepted accounting principles. The BOD has voluntarily adopted many of the standards required by Sarbanes-Oxley. The corporate compliance officer (CCO) regularly reports to the BOD on accreditation, legal, regulatory compliance, ethics, and governance issues. Annually, all board members provide a detailed conflict of interest statement that is reviewed by legal counsel and the entire BOD. A summary of all conflicts is included in the monthly board meeting materials, allowing for reference during board deliberations when necessary.

1.2a(2) Evaluating performance: At the end of the annual planning cycle, a written report is prepared for the BOD that summarizes accomplishment of the strategic objectives. The vice chair of the BOD coordinates the annual review of CEO performance using a formal evaluation process that includes performance relative to the organizational scorecard as well as personal goals. The remaining members of the ET have 70% of their performance evaluation tied directly to the organizational scorecard measures, using a well-defined meets, exceeds, far exceeds format. Organizational performance reviews (Figure 4.1-3) include review of ET, governance, and leadership system effectiveness. The ET is evaluated through the annual employee opinion survey (EOS) which provides specific feedback regarding leadership effectiveness. The BLS is evaluated as part of the annual strategic planning process. The BOD employs a robust process for annual governance evaluation which includes self evaluation of the collective BOD, individual member evaluation, as well as monthly meeting evaluation. The BOD processes for new member orientation and ongoing education have been recognized as a best practice by the American Governance & Leadership Group. BMH practices have been featured in a monograph as well as Trustee magazine.

1.2b Legal and Ethical Behavior

1.2b(1) Addressing adverse impacts and anticipating public concerns: Serving as a public responsibility role model in the Kalamazoo community is inherent in the MVV and CORE strategy, thereby it is directly integrated with strategic plans and business purpose. BMH uses the SMM as a systematic, proactive approach to prevent and address adverse impacts of our services and operations on society. During the spring session of the SMM, the ET completes a comprehensive external assessment. This information, along with knowledge gained through ET involvement on numerous community boards, is used as the ET considers the community that BMH interfaces with in relation to current and future services. This proactive approach allows BMH to address issues of public concern before they develop or grow into major issues. In some cases, such as legal requirements, the CCO continually monitors events that could affect BMH. BMH also employs other less formal approaches, such as membership on community groups, professional societies, and other public organizations. These types of activities provide BMH with the insight needed to anticipate public concerns and to assess possible societal impacts of our facilities, services, and operations.

Using the H2E Sustainable Environmental Leadership criteria as guidelines, the BOD and ET committed to reduce the environmental impact of the hospital by implementing innovative programs and setting industry standards for waste reduction and pollution prevention. As resource sustaining processes, energy conservation and waste recycling are key components of the hospital's waste management plan, positioning the hospital as an environmentally friendly organization. A summary of key compliance practices, measures, and goals for achieving and surpassing regulatory, accreditation, and legal requirements and addressing risks is presented in Figure 1.2-1. BMH uses the PDCA model to address any current societal improvement opportunities.

1.2-1 Legal and Ethical Behavior

Key Process	Measure	Goal
Corporate Compliance & Ethics	OIG workplan compliance	100%
	Employees trained	100%
	Independent board members	100%
Accreditation	JCAHO survey	Full acc.
	CAP survey	Full acc.
	ACS survey	Full acc.
	CMS conditions of participation	Full part.
	ACR	Full acc.
	ICAVL survey	Full acc.
	ICAEL survey	Full acc.
	AACVPR survey	Full acc.
	Certification results	Full acc.
Licensure	Staff licensure	100%
Fiduciary Responsibility	Independent auditor results	0 irregularities
Legal Consult	Physician contract compliance	100%
Medical Waste Management	Employees trained	100%
	Recycled waste	40%
Emergency Management	Employees trained	100%
	Drill scores	100%

1.2b(2) Ensuring ethical behavior: The BMH focus on ethical behavior begins with the corporate compliance plan that is approved annually by the BOD along with the strategic plan during the annual planning process. All BOD members sign the code of conduct and complete an annual conflict of interest statement. Ethical conduct expectations for employees are discussed during orientation, reviewed annually as a MWR, and reinforced daily through the hospital culture. All potential breaches of ethical practice are investigated and could result in discipline or termination of employment. The principles of ethics are built into the CSSE to ensure integrity in every encounter. The pre-employment process includes criminal background checks. All employees are encouraged to contact their supervisor, call the CCO, or use the confidential compliance hotline to report any potential breaches of ethical standards. Clinical ethical concerns are addressed by the multi-disciplinary ethics committee, which reports to the BOD through the joint conference committee. The patients' bill of rights is posted throughout the hospital and is included in the bedside guest services books. To monitor ethical behavior, BMH conducts regular and random audits of employee, supplier and physician partner interactions to ensure ethical practice. A summary of key processes, measures and goals related to legal and ethical behavior is listed in Figure 1.2-1.

1.2c Support of key communities and community health: BMH's values of *commitment to our community* and *care and respect for all people* translate into BMH meeting community health needs through collaborative efforts with area health, educational and social agencies. Through active participation in broad community initiatives, such as those that include the local United Way (UW) and its 40 agencies or the county Human Services Department (HSD), BMH collaborates in identifying the evolving health and human service needs of the community. Since 1996, community collaboratives involving BMH, have addressed childhood immunization rates, access to dental care, child safety, primary care access, infant mortality, flu prevention for seniors, and childhood asthma. Working collaboratively with community partners, areas of emphasis in the community for organizational support are identified by the ET annually in the SMM.

BMH's key community includes residents of Kalamazoo County, where the hospital is located. On-going community health efforts are aimed at ensuring primary healthcare access for everyone in the community and addressing childhood safety. Through MSU/KCMS, BMH co-funds graduate medical education primary care clinics that schedule 70,000 patient visits per year. A member of the ET serves as a board member, and BMH is a financial contributor, to the local federally-qualified Family Health Center, which has 35,000 patient encounters annually. BMH is Michigan's largest Medicaid provider (as a percent of total inpatient volume) outside the metro-Detroit area.

The ET and staff at the Children's Hospital at Bronson, have been community leaders in promoting a Safe Kids coalition and addressing childhood safety and injury prevention. The hospital co-funded a community collaborative body known as Healthy Futures, which has:

- addressed sub-standard infant immunization rates in Kalamazoo County,
- secured six years of federal grants to fight infant mortality, and
- has supported an asthma coalition aimed at identifying and treating children.

During the 2004-2005 school year, BMH and the Pfizer Corporation have funded a pilot project placing a school nurse in an at-risk elementary school.

BMH conducts an annual, organization-wide inventory to monitor involvement in community health activities (defined as community benefit) and contributions. The hospital received state and national recognition for this approach to planning, measuring and reporting community benefit initiatives that support local health priorities. The ET uses the social accountability model as a tool to educate employees about the hospital's mission-based organizational and community goals. It is also understood within BMH that community benefit programs and activities go beyond what is reasonably expected of the hospital in provision of quality health services to sick individuals. The social accountability model challenges BMH to engage in community change efforts that keep people well. Leaders are encouraged and supported in their efforts to provide leadership on community boards, including healthcare and non-healthcare related organizations, or to serve as volunteers in general, to improve quality of life for area residents. BMH is extremely generous with our time and talents within the community, as leaders and staff serve on over 100 community boards and organizations.

Strategic Planning

2.1 Strategy Development

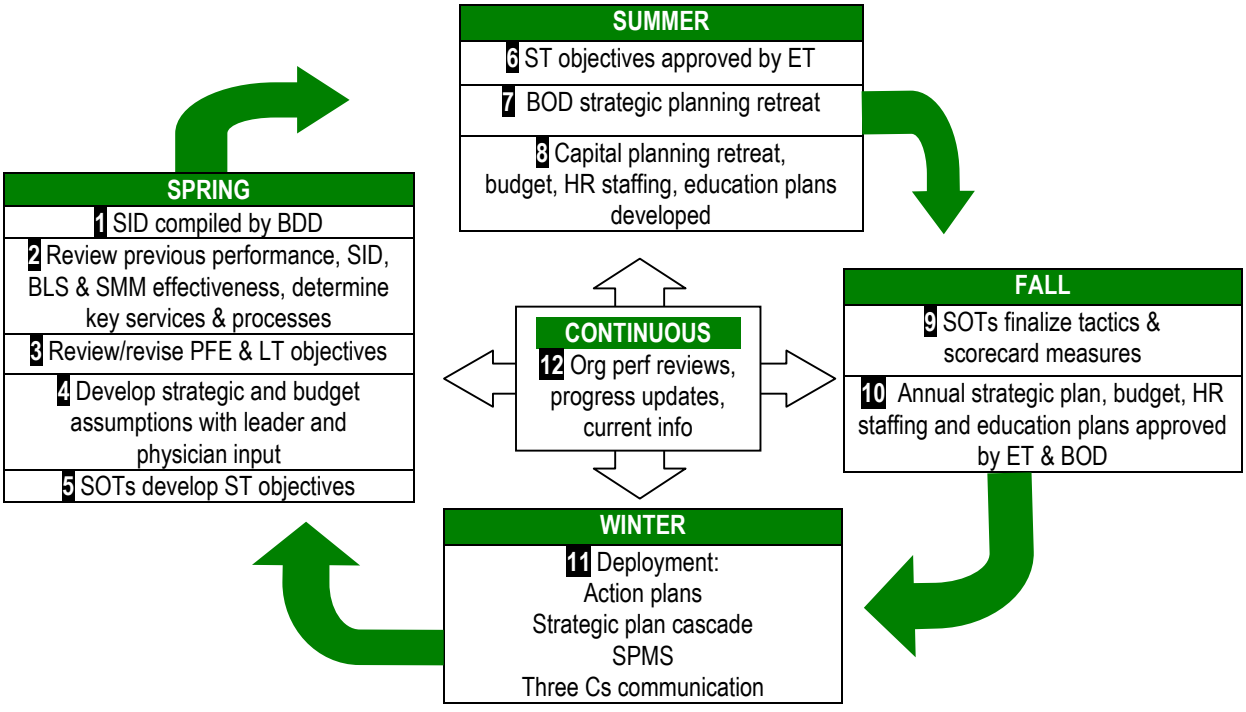
2.1a Strategic Development Process

2.1a(1) Strategy planning process: Strategic planning at BMH is a continuous process driven by the mission, values, and vision (MVV). Based on Baldrige feedback, the planning process was reevaluated and enhanced, integrating the strategic, financial, human resource (HR) staffing, and education plans into a very robust Strategic Management Model (SMM). The SMM, with its continuous planning process, allows for greater agility than a traditional, static approach to strategic planning. A key element of the Bronson Leadership System (BLS), the SMM is the mechanism for developing organizational strategies, both short-term (ST) strategic objectives and long-term (LT) goals, and to ensure the strategic objectives cascade throughout the organization. Through the SMM, the Board of Directors (BOD) and executive team (ET) determine the overall strategic direction for BMH. The ET develops and deploys annual plans to achieve it.

The key steps of the SMM and the timeframe for executing each step, are shown in Figure 2.1-1. Key participants in the process include: the BOD, ET, quarterly strategic planning (QSP) retreat attendees, and business development division (BDD). Leaders and physicians participate in several steps of the SMM process and provide input into planning through membership on organizational teams (strategic oversight teams, Clinical Practice Council, service line teams, etc.). 1 The planning cycle kicks off in the spring with the BDD preparing the strategic input document (SID) using the input sources detailed in Figure 2.1-2. 2 A day-long QSP retreat, which includes the ET and key directors, is held to review the SID along with a summary of the previous years' performance. At this time, the BLS and SMM effectiveness are evaluated and improvements are identified for the upcoming annual cycle of planning. Key healthcare services and delivery processes are determined. 3 At the QSP retreat, the elements of the Plan for Excellence (PFE), including the MVV, as well the organization's LT goals, are reviewed and revised, if warranted. In 2004, BMH completed the mission/values project (MVP). Using input from employees, physicians, suppliers and the community, the BOD and ET refreshed and simplified the mission and values statements (Figure P.1-2). 4 Using a SWOT analysis gathered in steps 1-3 of the SMM, the ET develops key strategic and budget assumptions that are tested at a series of planning meetings with leaders and physicians. The ET assigns responsibility to the appropriate strategic oversight team (SOT). Three SOTs are aligned to support each of the corporate strategies (three Cs): Clinical Excellence (CE), Customer and Service Excellence (CASE), and Corporate Effectiveness (CORE). Each SOT is chaired by an ET member, other team members include physicians as well as leaders from key operational and support departments. 5 The SOTs develop preliminary ST objectives.

6 At the summer QSP retreat, the SOTs present ST objectives for approval and begin tactic development. 7 During the summer, the strategic assumptions are revisited with the BOD at the annual strategic planning retreat. This review enables the BOD to validate the strategic challenges based on current information and provides the necessary foundation for the organization to prepare for strategic plan and budget approval later in the year. 8 During the summer, HR and finance use the SOT tactics and leader input to formulate the HR staffing, education, and budget plans. In 2005, an enhancement to the SMM was added. A day-long capital planning retreat will afford the opportunity to focus on both ST and LT capital planning needs. 9 The SOTs finalize tactics and the scorecard measures in the fall. 10 The strategies, LT goals, ST strategic objectives, organizational scorecard, budget, HR staffing and education plans are approved by the ET at the fall QSP retreat and by the BOD at a monthly meeting in late fall. 11 Deployment begins in the winter and is described in section 2.2.

Figure 2.1-1 Strategic Management Model (SMM)



12 In between each QSP retreat, the ET meets to review organizational performance and progress in achieving the strategic objectives. Regular updates at the weekly ET and monthly or biweekly SOT meetings, support the continuous planning process and ensure that the most current information is integrated into the SMM. A systematic review of organizational performance (Figure 4.1-3), review of the Quarterly System Indicator Report (QSIR), along with regular environmental scanning, mitigates the potential for blind spots caused by factors that may have changed since the initial development of strategic objectives and tactics. The BDD maintains a compilation of competitive events in the marketplace. This information assists in identifying possible market trends that could impact BMH. The ET establishes planning horizons based on the analysis of market dynamics. Market analysis and intelligence resources indicate that one-year is currently appropriate for ST plans to remain responsive to market forces and synchronized with the budget cycle. The LT planning horizon, three to five years, is determined by evaluating constraints, such as the time to introduce new services, the optimum life cycle of existing services, as well as market intelligence related to competitive strategies and plans. This approach enables BMH to be responsive to changing factors in the marketplace while maintaining stability of the LT strategic focus. The SMM results in the development of ST strategic objectives and LT goals that support achievement of the vision. During the SMM, consideration is given to the necessary action plans that must be completed to make progress in each corporate strategy. Through the integration of operational, clinical, financial, and HR perspectives, the enhanced SMM facilitates the allocation of adequate resources to complete the action plans in support of the ST strategic objectives and LT goals.

2.1a(2) Addressing key factors: The SID contains relevant information related to all of the key factors recognized by the Baldrige Criteria for Performance Excellence. Review of the SID during the spring QSP ensures that strategic planning addresses these key factors. Each key factor is presented and discussed, creating the foundation for the planning process. Source inputs (Figure 2.1-2) are aggregated for development of the SID. Individual executives, SOTs, or the BDD are accountable for gathering relevant information for inclusion in the SID. Revisions and updates to the source inputs are monitored and considered throughout the planning cycle. At the beginning of each QSP session, the QSIR is reviewed. The QSIR contains the most recent information related to organizational performance and the key factors. Weekly ET meetings include a standing agenda item to ensure discussion of any new intelligence. Necessary plan changes are deployed through the SOT action planning process. This approach allows for timely plan revisions supporting organizational agility. Through the annual review of SMM effectiveness, the ET is able to assess its ability to execute the strategic plan and make the necessary changes to the strategic plan cascade referred to in item 2.2.

2.1b Strategic Objectives

2.1b(1-2) Key strategic objectives and addressing challenges: Key ST objectives and LT goals as well as the timetable for accomplishing them are shown in Figure 2.1-3. The strategic challenges are identified during the planning process, and aligned with organizational strategies to ensure that all challenges are addressed. Once finalized by the ET, the challenges are included in the final SID, which serves as an important reference used throughout the strategic planning process. The strategic challenges are mapped to relevant strategy in Figure 2.1-3. The capability to balance ST and LT challenges and opportunities is built into the SMM. Through the SMM, the ET first identifies the LT goals. Next the ST objectives are developed which are considered the annual milestones toward achievement of the LT goals. A one-page planning document containing both the LT goals and ST strategic objectives in the three Cs format, is used to communicate plans to employees, physicians, suppliers and the community. Balance is achieved throughout the SMM by aligning strategic objectives with the three Cs and the strategic challenges. The process draws on input from patients, employees, physician partners, suppliers and the community to ensure needs of all stakeholders are considered and effectively balanced.

2.1-2 Inputs Aggregated for Development of the SID

Key Factor/Source Inputs	Ownership
Patient/Healthcare Market Needs	
• Listening & learning inputs (Figure 3.1-1)	**BDD, CASE**
• Customer research program	**BDD, CASE, CE**
• Demographic & utilization trends	**BDD**
• Clinical quality requirements	**BDD, CE**
• Market segmentation analysis	**BDD**
Competitive/Collaborative Environment	
• Marketshare analysis	**BDD, CORE**
• Competitor profiles	**BDD, CORE, CE**
• Collaborative relationships SWOT	**BDD, ET**
• Community relations intelligence	**BDD, CORE, ET**
• Physician level intelligence	**BDD, CMO, CE**
Technological/Innovation Changes	
• Emerging technologies	**BDD, CORE, CIO**
• Market adoption analysis	**BDD**
• Physician level intelligence	**BDD, CMO, CE**
• Utilization rates	**BDD, CE**
Strengths/Weaknesses/Opport./Threats	
• Workforce analysis	**CASE, VPHR**
• Marketshare trends	**BDD**
• SWOT analysis	**BDD, ET**
• Baldrige feedback	**ET**
• Emergency preparedness assessment	**CE, VPMM, ET**
Financial/Societal/Regulatory/Ethical	
• Risk analysis of emerging requirements	**CORE**
• Corporate compliance issues	**CCO**
• Reimbursement trends & risk ident.	**CFO**
Economic Environment	
• Local & regional market analysis	**CFO**
• National economic outlook	**CFO**
• Performance & profitability analysis	**CFO**
Supplier Needs/Strengths/Weaknesses	
• SWOT	**CORE, VPMM**
Physician Needs/Strengths/Weaknesses	
• Physician sat. & feedback analysis	**CASE, CMO**
• Physician requirements	**CASE, CE**
• Physician SWOT analysis	**CASE, ET, CE**
• Physician supply/demand	**CASE, CMO, CE**

2.2 Strategy Deployment

2.2a Action Plan Development and Deployment

2.2a(1-2) Developing and deploying action plans: The SOTs oversee development of detailed tactics and action plans that include timelines, responsibility, and measurements, beginning in the fall phase of the SMM. Financial resources are allocated through the resource allocation process. During the planning process, the resources required to implement the strategic plan tactics (staffing, operating, and capital dollars) are identified by all leaders and consolidated by the finance department. The ET reviews all requests, prioritizing items with the strategic objectives as well as the 10-year financial plan. The result is the annual operating budget that supports all operations, staffing and education needs. Capital allocation begins with a day-long capital planning retreat in the summer phase of the SMM. At the retreat, all requests for facility, technology, and IT capital are reviewed, prioritized using weighted criteria, and factored into the long-range capital financial plan. The ET, key operational and service line directors, as well as the chief and vice chief of staff participate. The final operating and capital budgets are approved by the BOD along with the strategic plan in the late fall. The facility, capital, and IT committees meet monthly to review project return on investment (ROI) and approve specific projects. This provides tremendous flexibility in redirecting resources as priorities change. Each SOT also meets monthly to determine shifting priorities in terms of operational and staff resources. SOT chairs bring these changes to the weekly ET meeting for approval and support by other executives.

Once the ET and BOD approve the annual strategic plan and budget, deployment of action plans begins in the fall. Effective deployment is essential to achievement of the strategic objectives. In 2004, the ET developed an enhanced strategic plan cascade (Figure 2.2-1) in an effort to strengthen alignment across the organization. The annual strategic plan, with specific tactics and action plans aligned by the three Cs, is deployed to the organization through this robust cascade.

2.2-1 Strategic Plan Cascade

Plan for Excellence (MVV, Three Cs)
Annual strategic plan (tactics, action plans)
BMH scorecard & organizational performance indicators
Secondary scorecards (dept., service line, key process)
Staff Performance Management System
Leader and salaried professional goals Individual employee goals
Gainshare (organizational, leader, department-specific)

The ET and SOTs ensure that the BMH scorecard measures are supported by the organizational performance indicators (OPI) and aligned with the secondary scorecards. This alignment ensures that department, service line, and key process measures support the strategic objectives. Through careful monitoring of scorecard performance (at all levels), the ET ensures that key process changes that support achievement of action plans are sustained. The Staff Performance Management System (SPMS - Figure 5.1-3) aligns individual performance with organizational objectives and action plans. In 2005, 70% of individual leader performance is based on achievement of the strategic objectives as measured by the organizational scorecard. The remaining 30% is based on individual goals that must also support the strategic plan. The 90-day action planning process defines the necessary steps for execution of plans. This process allows for agility and rapid change or development of new plans, if required. At the individual staff level, employees develop three personal goals that support the three Cs. Finally, the gainshare program involves quarterly bonus payouts based on achievement of organizational and department-specific performance indicators, tied directly to the three Cs. Lastly, using the Leadership Communication Process (LCP - Figure 1.1-2), a comprehensive communication plan in the three Cs format is developed to share the strategic plan with employees, physicians, suppliers and the community.

2.2a(3) Key short- and long-term action plans: Figure 2.1-3 documents key organizational ST and LT action plans to support strategic objectives. Key changes in services, programs, operations, customers and markets are also listed. Action plans are aligned with strategic objectives through prioritized department, leader and individual employee goals that cascade through the organization (Figure 2.2-1). BMH carefully plans new services to ensure they are implemented timely, address patient needs, and are current with the healthcare industry and local market. The annual strategic plan tactical grid, including specific action plans, is reviewed at least monthly by the SOTs, and quarterly by the ET, to monitor progress toward achieving the organization's objectives. The quarterly plan progress and organizational scorecard results are communicated to the BOD, leaders, medical staff leadership, and staff.

2.2a(4-5) Key staffing plans and tracking action plans: During step 8 of the SMM, the ET develops the HR staffing and education plans to support the strategic objectives. These annual plans, focusing on the workforce and staff development, are then incorporated into the Workforce Development Plan (WDP - Figure 5.1-1), which is one of the key tactics for the CASE SOT. The WDP includes innovative strategies related to current workforce needs and addresses the strategic challenge related to future staff recruitment, retention, development and diversity. During the deployment step 11 of the SMM, the strategic plans are translated into performance requirements and deployed throughout the entire workforce through the SPMS (Figure 5.1-3). A summary of the key HR staffing and education plans is provided in Figure 2.1-3. Key performance measures for tracking progress relative to action plans are listed in Figure 2.1-3. The strategic plan cascade, and specifically the organizational scorecard and OPIs, reinforce and ensure alignment of the action plan measurement system.

2.2b Performance Projections: A summary of performance projections for key ST and LT measures is shown in Figure 2.1-3. Included is 2004 past performance, 2005 ST projections, 2010 LT projections, and LT projected performance compared to our competitors. These comparisons demonstrate that by 2010, BMH will be the regional market leader in all key services and will also fulfill the vision of being a national leader in healthcare quality. Targets are set based upon national best practice. In some cases, this may create a gap in performance between local competitors or organizations of similar size nationally. When a gap is identified, the ET assigns appropriate accountability to an SOT, who develops and deploys action plans and related measurement to address the gap.

2.1-3 Strategy Summary (NOTE: Performance Projections have been removed for competitive reasons.)

Strategies & Strategic Challenges	ST Objectives	LT Goals	Key Tactics & Action Plans	Changes	HR & Education Plans	Key Performance Measures	Past Perf. 2004 Results	Performance Projections 2005	2010	Proj. Comp.
CE: Achieve excellent patient outcomes SC1 SC2	Medicare mortality at CS top 15%, Recognized by Leapfrog as safe environment, Exceed national standards for core indicators	Top 100 hospital, 5 stars for targeted areas, Third party recognition for patient safety	Decrease VAP, Optimize Medicare mortality & morbidity, Optimize core indicator performance, Build CPOE, Optimize communication among providers	Hospitalists admitting ortho patients. Medical management for adult patients w/ chronic diabetes & HF.	SBAR education. Fill CPOE team positions.	Medicare mortality	7.1-2			+
						VAP	7.1-11			+
						Patient falls	7.1-12			+
						Skin ulcers	7.1-13			+
						SIP	7.1-10			+
						Core measures (AMI, HF, pneumonia)	7.1-7, 7.1-8, 7.1-9			+ + +
						Hand washing	7.5-6			+
CASE: Enhance service excellence, staff competency, and leadership SC3 SC4 SC5	Magnet status, Leader in MD satisfaction, Overall turnover & vacancy better than national best practice, EOS diversity scores improve, Patient satisfaction scores improve from benchmark	Best practice customer & MD satisfaction, 100 Best Employer, Maintain Magnet status	Implement Respiratory care development program, Implement mentor program, Operationalize Diversity Council, Implement EOS and LPMS, Physical surroundings & discharge process recommendations	Gallup survey with national benchmarks. Campus expansion project moves some support services off campus.	Respiratory care development candidates. Mentor program education. Diversity education plan.	Vacancy	7.4-3			+
						EOS diversity score	7.4-19			+
						MD satisfaction	7.5-12 to 7.5-14			+
						Patient satisfaction	7.2-1 to 7.2-12			+
						Pat. sat. w/physical surroundings	7.2-7			+
						Pat. sat. w/discharge	7.2-4			+
						Overall turnover RN turnover	7.4-1 7.4-2			+ +
CORE: Achieve efficiency, growth, financial, and community benefit targets SC6 SC7	Meet growth targets for targeted service lines, Profit margin	X marketshare in targeted services, Profit margin, Baldrige recipient	Implement long-term campus expansion plan, Implement short-term technology/facility plan, Recruit key physician specialists	MD ambulatory surgery and outpatient diagnostics centers. Expansion of adult medical unit capacity.	Realign campus project leadership. "Change management" training for move. Hire staff for new capacity. Train on new technology.	SL marketshare	7.3-14			-
						SL marketshare	7.3-14			+
						SL marketshare	7.3-16			+
						SL marketshare	7.3-14			+
						Profit margin	7.3-1			+

Legend: SC1- Application of evidence-based medicine, SC2- Meet needs of growing number of patients with complex conditions, SC3- Workforce shortage, SC4- Diversity, SC5- Customer service, SC6-Capacity, SC7- Profitability, BP- best practice

3 Focus on Patients, Other Customers, and Markets

At the center of the BLS are our key customers – patients. BMH recognizes the important role that family members play in the delivery of healthcare services to patients. Therefore, family members are considered in conjunction with patients as the same key customer group. Patient requirements drive all leadership actions in alignment with the MVV. A critical success factor for BMH is to be recognized for a culture of service excellence, differentiating the hospital from the competition, and serving as a foundation for achieving the vision.

3.1 Patient, Other Customer, and Healthcare Market Knowledge

3.1a(1) Identifying patients, customers and market segments: The QSP retreats include the ET and key directors. These organizational leaders actively participate in the process to determine/target current and potential customers, customers of competitors, and healthcare markets. During the input step of the strategic planning process held each spring, the QSP participants review and analyze the SID and the QSIR. These documents contain an extensive compilation of industry trends and specific market data (Figure 2.1-2) including population demographics, marketshare by product line, utilization rates, discharges by geographic area, profitability, technology updates, customer satisfaction and preference data, physician referral and admission trends, and key competitor information. At the QSP retreat, the attendees review the final section of the SID, a SWOT analysis of the organization, to identify key strengths and opportunities for BMH, to determine changing customer requirements, and to define/redefine customer groups and market segments.

Guided by the MVV, the QSP attendees consider and discuss market: growth, needs or opportunities, competition, profitability, strategy, adjustments, and segmentation determinations. When a new market segment is identified at the QSP retreat, the appropriate service line (SL) administrator is charged with developing a formal business plan. This plan comes back to the ET for review and approval on or before the next phase of the SMM held in the summer. The formal business plan step ensures that all relevant data is researched and analyzed.

A significant change in strategy relates to the management of complex adult medical patients. In 2004, adult medical patients with chronic disease conditions were identified as a new market segment opportunity. The aging population, rise in prevalence of chronic diseases, and bed capacity constraints, resulted in operational changes related to how BMH manages these patients. A formal business plan for the adult medical SL was developed and approved by the ET. A new adult medical unit (AMU) was opened to meet the special inpatient needs of older, medical patients. BMH's Nurses Improving Care for Health System Elders (NICHE) program on the AMU was honored with the John A. Hartford Institute of Nursing/NICHE Award.

The BDD, which includes SL administration, regional services, planning, marketing and corporate communications, reports regularly to the CORE SOT. The BDD is responsible for continuous review of healthcare markets in order to take advantage of market opportunities and may develop a business plan for review by the ET at anytime during the year. In addition, the QSIR, which is presented at each QSP retreat, provides a quarterly systematic review of the relevant market information needed to determine/target customers and healthcare markets. This continuous planning cycle is a key characteristic of the SMM, creating agility and the capability to meet ever-changing market needs at anytime during the process.

As part of the SMM input, BMH uses feedback from current patients, potential customers, customers of competitors and the community. This valuable feedback is gathered through a variety of means. BMH contracts with independent survey organizations, including Arbor Associates, Inc. (Arbor) and the Gallup organization to collect survey data. Other feedback mechanisms include focus groups (with current patients and also "ghosted" where the sponsoring institution is not identified), networking with the community, formal participation by leaders and staff in local business and community groups, and from BMH medical staff members who also have admitting to competing hospitals.

BMH's only customer group is patients (and their families). The two primary patient segments are inpatients and outpatients. Patients are further segmented by geographic location (primary, secondary, tertiary market service areas), service lines, and age demographics. Through the SMM cycle, physicians were defined as partners rather than customers because that definition best describes the physician/hospital relationship. Staff is considered an important internal customer as described in Category 5. The community is defined as a stakeholder and, therefore, it is important for BMH to consider how the organization's services, actions, and success affect the community. The community is segmented by type of organization and geographic location. With regard to type of organization, BMH aligns most closely with other healthcare service organizations through collaborative partnerships to meet community health needs. From a geographic perspective, BMH has set priorities for community support and leadership. The geographic priorities listed from most to least important include: the neighborhoods surrounding the hospital, downtown Kalamazoo, the city of Kalamazoo, Kalamazoo county, and the nine-county region.

3.1a(2) Listening, learning and determining requirements: Understanding customers and their requirements is essential to achieving success. BMH utilizes both qualitative and quantitative listening and learning methods (LLM - Figure 3.1-1) for annual strategic planning as well as monthly reviews by the CASE SOT and the ET, to determine customer requirements. The primary source of customer information is the formal patient satisfaction survey, historically administered by Arbor, and now Gallup in 2005. Other sources of information used in the process include LLM as shown in Figure 3.1-1. Some LLM are different for current patients versus potential patients as identified. Current patients provide feedback regarding their direct patient experience with BMH, while potential patients have not actually used BMH services, but may have experience with other healthcare organizations. Potential patient information is related strongly to preferences and desired requirements.

3.1-1 Customer Listening and Learning Methods

Listening & Learning	Current Patients	Potential Patients
Patient satisfaction survey	**W**	
Post-discharge telephone calls	**D**	
Point-of-service satisfaction surveys	**D**	
Focus groups	**B, N**	**N**
Leader rounds	**D**	
Patient relations rounding	**D**	
Patient complaint management process	**D**	
Community attitude survey	**A**	**A**
Event/program evaluations	**M**	**M**
Newsletter surveys	**N**	**N**
Direct marketing	**N**	**N**
Website/email	**D**	**D**
Health Fair	**A**	**A**
Open houses	**N**	**N**
Physician satisfaction survey	**A**	**A**
Community organization involvement	**D**	**D**
D-daily, **W**-weekly, **M**-monthly, **B**-bimonthly **Q**-quarterly, **A**-annual, **N**-as needed		

Planning services is responsible for oversight of the BMH customer research program (CRP). The CRP includes research and external knowledge on customer needs, requirements and trends. Sources include IHI, Advisory Board, AHA, MHA, Gallup, and best practices from Baldrige recipients in the healthcare and service sectors. In addition, all inputs from the organization's LLM are aggregated. Planning services uses regression analysis of attributes that highly correlate to satisfaction and loyalty. The CRP information is used to determine patient requirements. The CRP data is reviewed monthly by the CASE SOT. Annually during the first quarter, the CASE SOT recommends the patient requirements to be included in the SID. During the input step of the SMM held each spring, the QSP participants review the recommended patient requirements and make the final determination. This is a very important step in the SMM to ensure that the strategic objectives are aligned with customer requirements. These patient requirements are validated by patient focus groups each quarter. Should new patient requirements be identified at other times of the year, the continuous planning cycle of the SMM allows for requirements to be added or modified at any time deemed necessary. In 2005, during the strategic planning process, the patient requirements were revised to include: quality outcomes, communication, empathy, responsiveness, and efficiency. BMH considered valuable input from IHI patient-centeredness research. This led to the addition of "empathy" as a requirement that addresses the interpersonal and psychosocial needs of patients.

The QSP attendees use the CRP data annually to determine patient requirements and to develop the CASE SOT objectives. Through consistent monthly review of CRP data, the CASE SOT creates action plans and tactics that are focused on meeting customer expectations and needs. The CASE SOT charters teams to use the PDCA model to improve organizational processes that impact the customer. Other specific action plans may be assigned to an individual leader who engages the appropriate department staff to make improvements.

3.1a(3) Keeping listening and learning current: The CRP and its LLM are kept current through the PDCA model used by the CASE SOT. This includes ongoing review and evaluation by the CASE SOT to determine whether a particular method yields actionable information to assist in performance improvement. Survey tools, techniques and questions are added or modified to ensure utility, based on market changes and customer needs. The frequency pattern of each LLM is re-evaluated to ensure customer information is available in a timely manner. An annual, formal evaluation of the effectiveness of the CRP and particularly the LLM, is completed by the CASE SOT during the spring component of the SMM to ensure listening methods capture new and changing customer requirements.

3.2 Customer Relationships and Satisfaction

3.2a Patient and Other Customer Relationship Building

3.2a(1) Patient/customer relationships: Central to the BMH culture is a focus on the customer. BMH's process for building and sustaining relationships with patients is fostered through the BLS by drawing organizational focus to our key customer, patients, and their requirements. In pursuit of excellence, BMH has moved beyond monitoring patient satisfaction to measuring patient loyalty. Since loyalty is a predictor of future behavior, it is central to achieving the BMH mission and vision. BMH believes that loyalty is fostered by providing high quality patient outcomes in a safe, consistent manner, while delighting patients with superior customer service, state-of-the-art facilities and technology, and innovative amenities. Figure 3.2-1 illustrates the varied and comprehensive strategies used to build patient loyalty to BMH.

Building patient loyalty begins with staff being recruited and selected based on their commitment to providing superior customer service. All employees are trained and held accountable to follow the CSSE, which outline the personal accountability that every staff member has every day, with every interaction, with every customer. The CSSE, along with service recovery, the interaction process, and scripting, give staff the tools they need to meet patient requirements and build customer loyalty. Positive patient relationship building is practiced by all employees as part of their daily work activities. Early identification of issues through leader and patient relations rounding most often neutralizes dissatisfaction and promotes loyalty. Customer requirements and expectations are formally included in the PDCA model ensuring that customer needs are considered.

BMH's most important partners are physicians, working in concert with the hospital, to achieve a common goal, the delivery of high quality medical services to patients. BMH recognizes the important role physician partners play in making positive patient referrals to the hospital for both inpatient and outpatient services. BMH is committed to building loyalty with physicians by understanding and meeting the key requirements physicians have of the hospital (as listed in the Figure P.1-5). Strategies to build physician loyalty are listed in Figure 3.2-1

3.2-1 Loyalty Strategies

Strategies	Patient	Physician
• Competent staff	✓	✓
• Cust. Svc Standards & Expectations	✓	✓
• Recovery, interaction, scripting	✓	✓
• Greeters & escorts	✓	✓
• Complimentary transport	✓	✓
• Information kiosks	✓	✓
• HealthAnswers & library	✓	✓
• Valet parking	✓	✓
• MOP adjacent to hospital services	✓	✓
• All private rooms	✓	✓
• Patient-focused healing environment	✓	✓
• Complimentary flat-deck parking	✓	✓
• Indoor garden atrium	✓	✓
• Comfortable family waiting areas	✓	✓
• Private family consultation rooms (OR)	✓	✓
• Indoor garden atrium	✓	✓
• Sleep sofas, pull out beds, sleep rooms	✓	✓
• Pediatric family kitchen	✓	✓
• State-of-the-art technology	✓	✓
• Free TV, phone, laptops	✓	
• Access to in-room DVD/VCR	✓	
• Family pagers	✓	✓
• Wireless access	✓	✓
• ATM access	✓	✓
• Intepreters & language line	✓	✓
• Concierge services	✓	✓
• Room service dining	✓	✓
• Patient gowns, robes, slippers	✓	
• SkyCourt Café & Coffee Shop	✓	
• Membership programs	✓	✓
• Integrative therapy	✓	✓
• Health information newsletters	✓	✓
• Educational offerings	✓	✓
• Bronson Center for Women	✓	
• Centralized outpatient testing	✓	✓
• Hospitality House	✓	✓
• Physician Service Center		✓
• Physician Ctr. for Medical Informatics		✓
• Electronic medical record	✓	✓
• Medical staff office training		✓
• Leadership academy		✓
• Physician & resident orientation		✓
• CME educational offerings		✓
• Physician involvement		✓
• Physician dining room		✓
• Diagnostic liaison		✓
• CEO open office hours		✓

3.2a(2) Access mechanisms, determining/deploying contact requirements: The BMH key patient access mechanisms (Figure 3.2-2) enable patients to seek information, obtain services and make complaints by being available 24x7. They include access through personal interaction, written communication, and web technology, to meet the access needs of all current and potential patients and their families. Bronson Referral and Information Center (BRIC) telephone operators, greeters, information desk volunteers, and registration staff are most often the first point of contact to the organization. All staff and volunteers are trained to use the BMH telephone standards to ensure professional, consistent, clear telephone communication. The house managers, administrator on call, and patient relations representatives are available 24 hours a day to enable customer contact and access. Using the CRP, including analyzed data from the LLM, the CASE SOT determines key access mechanism and contact requirements annually during the first quarter. The CASE SOT recommends them for approval by the QSP attendees during the spring component of the SMM to ensure alignment with new and changing customer requirements. Contact requirements are validated quarterly by patient focus groups.

3.2-2 Key Patient Access Mechanisms

Seek Information	Obtain Services	Make Complaints
• Direct contact	• Inpatient delivery	• In person
• Print material	• Outpatient delivery	• Telephone
• Correspondence	• In-home delivery	• Correspondence
• Website/email	• Web registration	• Website/email
• HealthAnswers	• Health Fair	• Surveys
• BRIC	• Comm. clinics	• Ed. evaluations
• Ed. Offerings		

The CSSE (Figure 3.2-3) are the organizational contact requirements for patients. These standards are deployed through orientation, training and daily coaching of staff to achieve consistent, superior customer service. Compliance with the standards is reviewed at least annually with each employee as part of their job performance review.

3.2-3 Customer Service Standards and Expectations

Our Commitment to Customers
BMH employees are personally accountable to:
• Offer **Assistance**
• Maintain **Privacy**
• Express **Empathy**
• Be **Courteous**
• Respect **Diversity**
• Protect **Confidentiality**
• Care for the **Environment**
• Behave **Professionally**
• Follow the **Appearance Standards**
• Ensure **Timely Follow Through**
• Create a **Great, Memorable Experience**

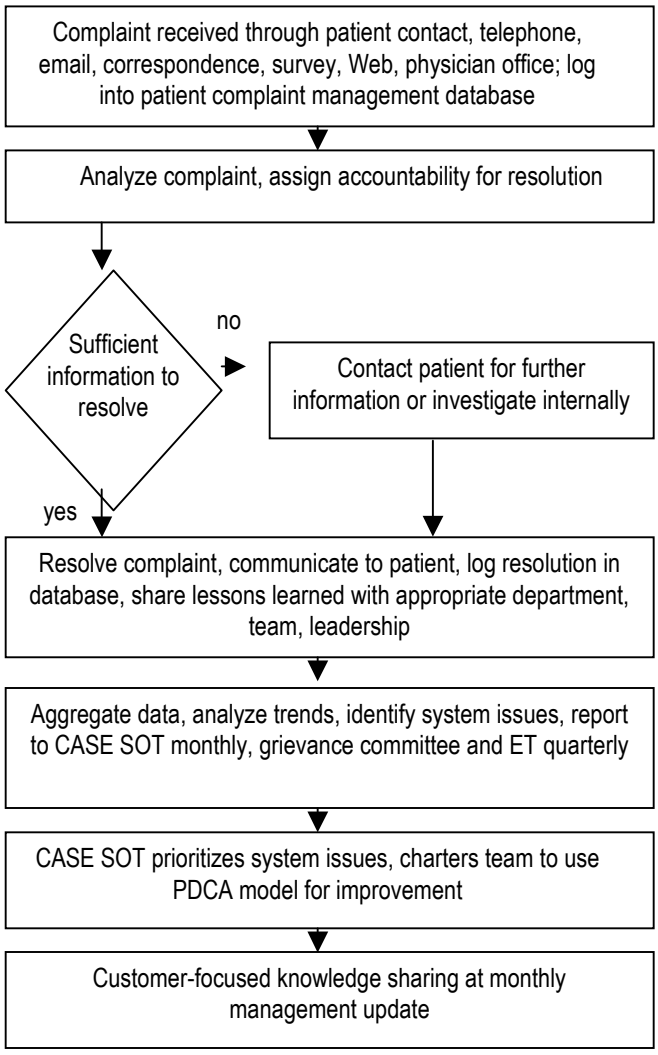
These standards are used to coach, counsel, and evaluate employees, and are monitored during leadership rounds. Formal training contributes to the creation of a culture that empowers individuals to deliver service excellence. The hospital's quarterly gainshare program reinforces that behavior, and rewards staff for meeting and exceeding patient expectations. Having well-trained employees, delivering a consistently high level of service, enables BMH to satisfy customers' needs and build loyalty, as well as generate positive word-of-mouth to attract new customers. Satisfied

customers have been depicted in testimonial ads for the hospital and their letters are printed in the bi-weekly employee newsletter to reinforce the positive outcome of service excellence. Patient satisfaction with contact requirements is measured through analysis of data from the CRP including LLM, as defined in Figure 3.1-1, as well as secret shopping facilitated by the BMH Customer Service Institute.

3.2a(3) Managing, resolving and aggregating complaints: The CSSE is a key tool for employees to provide excellent customer service and minimize dissatisfaction. All employees are empowered and expected to resolve patient complaints 24x7. Employees are oriented, trained and coached to proactively handle complaints using the service recovery process. The process includes specific steps to acknowledge, apologize, and amend. This approach is used to mitigate dissatisfaction and resolve issues at the bedside. In the event an employee is unable to resolve a patient concern, the concern is forwarded to department leadership, patient relations representatives, house manager or the administrator on call via face-to-face communication, telephone, email or pager. The individual who receives the complaint assumes responsibility for investigation, follow-up and resolution, according to the detailed steps in the patient complaint management process (Figure 3.2-4). Complaints are responded to promptly and according to defined timelines depending on how the complaint is received. Any delays in resolution are communicated to the patient along with a specific timeline identified for resolution completion. All complaints are recorded in the patient complaint management database. The director of customer service monitors the database on a weekly basis to determine specific root causes, trends and to monitor department-specific process improvements. On a monthly basis, a detailed report is provided to the CASE SOT for review and analysis. The CASE SOT prioritizes system issues and charters teams to improve system-wide processes using the PDCA model for improvement. The grievance committee, and the ET, review analyzed and aggregated quarterly patient complaint management reports and improvement team status reports. The ET uses this information to plan future services, customer requirements and establish department and individual performance goals. The patient complaint management process is a formal input in the LLM. This data becomes part of the CRP that is used during the strategic planning process.

3.2(4) Keeping relationship building approaches current: The relationship building approaches and customer access methods are kept current through the PDCA model used by the CASE SOT. During PDCA improvement, information is gathered from customer feedback, market and industry trends, feedback loops of organizational processes, conferences, and literature reviews as well as best practice benchmarking with Baldrige recipients. The CASE SOT is responsible for ongoing review and evaluation to determine whether the approach or access method meets customer requirement and yields actionable information to assist in performance improvement. Much like the CRP, an annual formal evaluation of the effectiveness of the relationship-building approaches, and customer access methods, is completed by the CASE SOT, during the spring component of the SMM, to ensure approaches and methods meet new and changing customer requirements.

3.2-4 Patient Complaint Management Process



3.2b Patient/Customer Satisfaction Determination

3.2b(1) Determining patient satisfaction: The process used to determine customer satisfaction/dissatisfaction is led by the CASE SOT, beginning with the CRP data, that includes analysis of the findings from the qualitative and quantitative LLM. The primary source of information is patient satisfaction surveys. Gallup measures patient satisfaction and loyalty utilizing a telephone methodology on randomly selected patients for both inpatient and outpatient services. The Gallup survey measures four major attributes (loyalty, overall evaluation, people and processes) for 11 service areas. Weekly patient satisfaction reports are available to all leaders via the *Inside*Bronson intranet each Friday. These cumulative reports provide timely access to patient satisfaction information segmented by inpatient, outpatient, and unit-specific data. The reports contain Gallup database and best practice comparisons as well as percentile rankings. The CASE SOT monitors patient satisfaction according to Gallup on a monthly basis. Cumulative quarterly reports provide customer service performance data that is part of the employee gainshare program.

During the PDCA improvement cycle related to customer satisfaction determination in 2003, the CASE SOT determined that it was necessary to change patient satisfaction survey administrators in order to achieve national best practice comparisons. Since 1990, BMH utilized Arbor as its patient satisfaction survey administrator. As BMH realized steady improvements in patient satisfaction through strategic initiatives, the hospital achieved consistent best practice in the Arbor comparative database. After extensive search and evaluation of patient satisfaction research tools, databases, and methodologies, BMH partnered with Gallup. The conversion to Gallup began in the fall of 2004, when consecutive surveys were performed for three months by both Gallup and Arbor. The concurrent measurement allowed BMH to align the results from the two surveys and set appropriate performance and gainshare targets for 2005. In January 2005, BMH converted to the new Gallup survey tool to measure patient satisfaction and loyalty.

At BMH, the LLM differ according to patient types (current or potential). However, the satisfaction determination methods for all current patients are the same with the Gallup survey as the primary tool. The specific variables measured by Gallup in the people and process attributes are customized for each patient group to relate specifically to their healthcare experience. For example, sense of urgency is unique for emergency room patients, wait time and efficiency of operation are unique measures for outpatients, under the measures for the process attribute. The Gallup survey tool includes behavior-based questions that provide actionable feedback to all leaders and the CASE SOT. The data can be segmented to be specific enough for individual leaders to verify improvement opportunities at the department, service or process level. Patients may request, via the Gallup survey, to be contacted by the patient relations representatives. This direct customer contact is a mechanism to solicit actionable feedback. Leaders and patient relations representatives also make rounds to collect timely and actionable feedback on services.

The CASE SOT is responsible for the monthly systematic review of the CRP, identification and prioritization of improvement opportunities, and appointment of leaders, departments, process owners or teams to use the PDCA model to improve healthcare service delivery. The CASE SOT ensures performance indicators are in place to track results and evaluates the impact of the improvement. From this review process, the CASE SOT chartered a team to work on patient dissatisfaction with the discharge process. Customer research indicated that the process often took longer than was expected or communicated. Beginning with the OB department, as these relatively healthy patients have more predictable plans of care, the team piloted an innovative approach to scheduling discharges. This process, following pilot phase and data analysis, will be replicated across the organization to impact patient dissatisfaction with the discharge process in all areas.

BMH uses Professional Research Consultants (PRC) to administer a physician satisfaction survey each year during the fourth quarter. Conducted via telephone, the survey measures physicians' satisfaction levels with various departments and services of the hospital. Physician survey feedback led to the addition of hospitalist and intensivist physicians to assist in managing length of stay (LOS).

3.2b(2) Obtaining prompt/actionable feedback: To ensure appropriate follow up with patients to receive prompt and actionable feedback, BMH has created systematic processes at various levels throughout the organization. The first occurs at the staff level during each interaction with patients at the time of care delivery. Staff is scripted to ask, "Is there anything else I can do for you." This enables caregivers to respond immediately to a patient's needs. The second level occurs during rounds where leaders and patient relations representatives make contact with patients to ask questions to address areas that need immediate resolution. The third approach is the prompt follow up that occurs with every patient complaint as described in Item 3.2a(3). Finally, post-discharge calls provide actionable feedback as well as the ability to assess the general well-being of the patient.

3.2b(3) Relating satisfaction to competitors: Satisfaction data relative to competitors in the local market is obtained in the CRP. LLM related to competitive information include focus groups, consumer perception surveys and benchmark data. Three consumer perception surveys are performed in our community by third party administrators that focus on consumers' perceptions of BMH's services as compared to those of competitors. These include the Adams Outdoor Survey, National Research Corporation Quality & Image Profile Survey, and a community attitude survey. The three surveys compare healthcare providers in our community relative to reputation, image, preference and quality. Quarterly focus groups conducted by BMH include questions for discussion regarding the performance of BMH as compared to other hospitals and healthcare services in the community. Gallup provides comparative information and benchmarks from over 380 hospitals across the nation on the weekly and quarterly reports. The comparative information is service as well as attribute specific. The CASE SOT uses the information to stay focused on the critical success factors that differentiate BMH from our competitors. In addition, the SOT identifies improvement opportunities as well as organizational strategic objectives, action plans and targets during the strategic planning process.

3.2b(4) Keeping approaches current: The CASE SOT is responsible for keeping approaches to determining satisfaction current with healthcare service needs and directions. This is accomplished monthly by the CASE SOT through use of PDCA cycles of improvement as well as annually through the strategic planning process, which includes formal evaluation of all customer processes and approaches. By contracting with industry leaders like Gallup to administer the patient satisfaction survey, BMH is effectively gathering the information needed to support its journey to become a national healthcare leader. Through Quest for Excellence and Baldrige benchmarking, BMH receives best practices and information relative to changing standards.

4 Measurement, Analysis, Knowledge Management

4.1 Measurement, Analysis, and Review of Organizational Performance

Effective decisions, executed well, contribute to successful organizations. Information derived from timely measurement and analysis of BMH performance, and the performance of others, supports effective decisions and implementing action plans to achieve the organization's strategies. Figure 4.1-1 illustrates BMH's robust Information Management Strategy (IMS) that distinguishes the hospital from other organizations within and outside of the healthcare industry. The requirements of the IMS are to provide accurate, reliable, timely, and secure information for organizational decision-making and improvement.

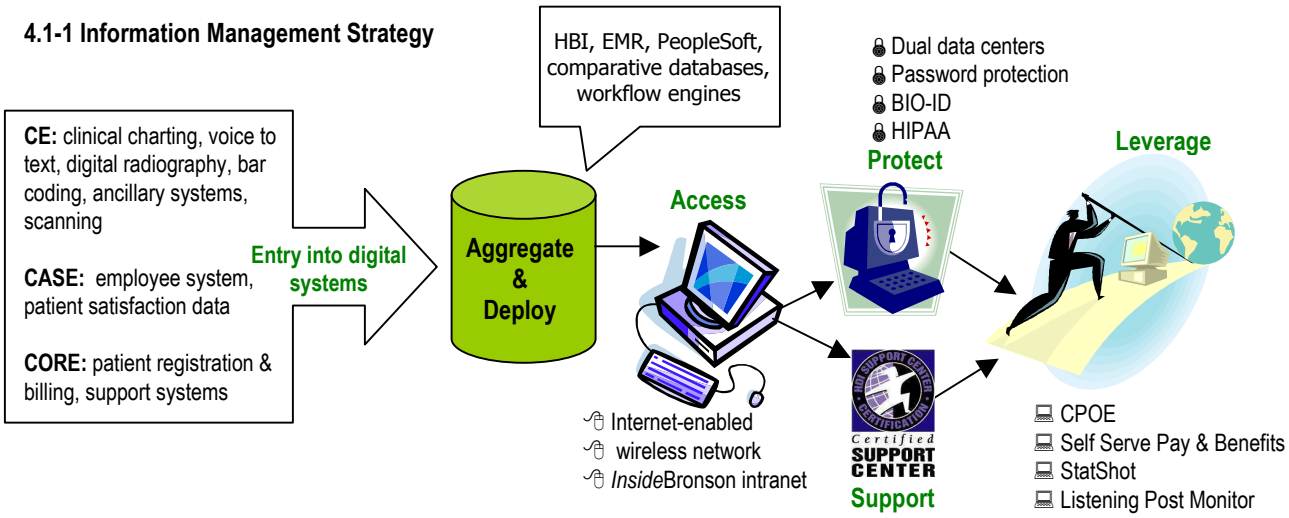
4.1a Performance Measurement

4.1a(1) Gathering, integrating and using data: The BLS requires an effective data collection and measurement system to monitor organizational performance and achieve the MVV. During the strategic planning process step 9, the ET determines the scorecard indicators that will measure the success of the organizational strategies (three Cs) and achievement of the specific strategic objectives. These measures, aligned by the three Cs, are displayed on an organizational scorecard using a stoplight approach, red (risk), yellow (moderate), green (meets) format. This enables all levels of the organization, to evaluate performance related to the strategic plan. In addition to the organizational scorecard, which includes measures of strategic importance, the ET annually determines the organizational performance indicators (OPI) necessary to track daily operations. The ET uses a systematic process to select and develop OPIs which includes assignment of ownership within the ET, validation of the data collection process, identification of best practice benchmark comparisons, and determination of appropriate reporting format and schedule. BMH's scorecard measures are displayed in Figure 4.1-2.

Once the organizational scorecard is finalized by the ET, during the fall timeframe of the strategic planning process, a series of secondary scorecards are created by the appropriate department, service line or process leader for the coming year. The SOTs approve the service line scorecards to ensure alignment of key healthcare services with the three Cs and the strategic objectives. Department and key process scorecards are developed by the appropriate leader and reviewed by the responsible ET member. The division of nursing, for example, shares common scorecard indicators for all nursing units. The nursing scorecard is developed and monitored by the Divisional Level Nursing Council (DLNC) with support from the Chief Nurse Executive (CNE) and the nursing leadership team. This builds scorecard ownership with nursing staff through the shared governance structure. All scorecard indicators must align and support achievement of the three Cs, strategic objectives and action plans.

BMH uses the robust IMS to ensure information is effectively collected, aggregated, and analyzed to track daily operations and overall organizational performance. The first step in the IMS is to digitize data from key healthcare and support processes. The clinical charting systems, PACS, and document imaging are examples of data digitization. Second, the data is aggregated into information and deployed in order to improve processes. For example, automated queues route digitized work documents from one process step to the next, allowing real-time measurement and management of workflows. The next steps in the IMS are to protect, support and provide access to information. Mission-critical transactions are simultaneously written to disk arrays in two geographically-separated data centers to provide a high degree of disaster recover protection. Similar efforts are used to protect data against intentional harm, to avoid breaches of confidentiality, and to ensure data integrity. Information users are supported by the first healthcare IT support center, and only one of 17 support centers across all industries, to earn the Help Desk Institute's (HDI) site certification for IT customer service. This reflects years of effort to improve the quality of IT help desk service provided to key internal customers – employees and physician partners. Secure access to data is granted through any Internet-enabled computer. Physicians, for example, can securely access patient records and diagnostic images, avoiding process delays and rework when the physician is not onsite at BMH. Deployment of free wireless Internet access across the campus allows physicians, staff, patients, families and visitors to remain productive and connected while they are on our campus. Last and most importantly, BMH uses the IMS to leverage information to achieve effective decision-making related to patient care. After two years of due diligence and planning, BMH is implementing

4.1-1 Information Management Strategy



computerized provider order entry (CPOE). This new technology will help to avoid errors and reduce practice variation by applying the data we already collect to best practice standards of care. CPOE will provide physicians with a powerful clinical tool. Using the IMS in conjunction with the scorecard/OPI approach, the ET, SOTs, leaders and departments use the timely performance data to support decision-making. BMH focuses on those measures that do not meet selected targets and uses the PDCA model to create specific action plans to bring performance into compliance with pre-set benchmarks.

4.1-2 BMH Organizational Scorecard Measures

Three Cs	BMH Organizational Scorecard
Clinical Excellence	Medicare mortality
	Leapfrog patient safety measures
	Ventilator acquired pneumonia rate
	Patient falls
	Hospital acquired pressure ulcers
	Hand washing compliance
	Core indicator performance
Customer & Service Excellence	Magnet status achievement
	Overall turnover, RN turnover, vacancy rates
	Physician satisfaction
	EOS diversity scores
	Patient satisfaction (overall top box, discharge process, physical surroundings)
Corporate Effectiveness	Growth (neuro, cardiac, surgery)
	Profit margin
	Inappropriate ER utilization

To support innovation as a healthcare provider, in 2004, all BMH leaders received focused training through the LEADERship initiative (LI) related to innovation and how it must be coupled with improvement efforts. In order to be a national leader in healthcare quality, BMH is focused on being both better and different. Innovation, doing what others have not done, is viewed as a key element of BMH's culture, BLS and the PDCA model. Through daily use of the PDCA model, BMH achieves improvement, learning and innovation.

4.1a(2) Selection and use of comparative information: During the strategic planning process, as scorecard indicators/OPIs are determined by the ET, a key step is the selection and use of comparative information. Once the need for comparative data is identified, the ET selects comparisons based on reliability, reproducibility, availability and resources required to collect the information. Comparisons are collected from many local, state and national sources for CE (JCAHO, CMS, NNIS, CDC, NDNQI, and CareScience), as well as for CASE (Gallup, PRC, MSA) and CORE (Moody's, COTH, Solucient). When available, BMH uses national databases for comparative sources due to the highly reliable nature of this type of information. However, literature from within and outside of the healthcare industry is also used for comparison purposes when necessary. Availability of both average and best practice levels provides the organization with an understanding of our position on a relative basis and the knowledge of what it takes to be a national leader. Key comparative data is reviewed at least annually during the development of the scorecard/OPI measures. BMH ensures the effective use of key comparative data by performing gap analyses with the scorecard/OPI measures. Once the gap analysis is complete, implementation of the PDCA process occurs to close the gap and improve performance. Benchmarking, evidence-based research, and best practice comparisons are all utilized in the PLAN phase of the PDCA model. This is a key tool used to not only improve performance, but to develop innovative processes and services at BMH.

4.1a(3) Keeping measurement systems current: BMH keeps its performance measurement system current with healthcare needs and directions through the continuous improvement process inherent in the PDCA model. The IMS, as well as the specific scorecard/OPI measures, are reviewed, evaluated and updated annually through the SMM. This validates alignment with organizational strategy, customer requirements, and industry trends. Performance measures are developed or changed through continuous monitoring of market and industry trends, regular updates from the Advisory Board, AHA, IHI and professional conferences. Through the SMM, the ET evaluates performance measures on a weekly basis. If immediate action is required to develop a new service or improve a current process, the process calls for a revision to the measurement system first so that pre-set targets can be deployed to leaders through the 90-day action planning process. Systematic review of the IMS and performance measurement system, as well as ET presence in professional organizations, assist the organization in recognizing and responding to rapid or unexpected organizational and external changes.

4.1b Performance Analysis and Review

4.1b(1) Reviewing organizational performance: Systematic review of organizational performance and capabilities enables BMH to maintain both stability and agility in the constantly changing healthcare environment. Figure 4.1-3 illustrates the organizational performance reviews used by the BOD and ET to assess and evaluate organizational success, competitive performance, and progress relative to ST strategic objectives and LT goals.

4.1-3 Organizational Performance Reviews

Organizational Performance Reviews					
Review Type	Conducted By				
	BOD	ET	QSP	SOT	Individual Executive
CE	Q	M	Q	B	O
CASE	Q	M	Q	M	O
CORE	Q	M	Q	B	O
Operational	M	W	Q	B/M	O
Governance	Y				
Leadership	A	Q	Q	Q	O
O-ongoing, Y-annual, Q-quarterly, M-monthly, B- Biweekly W-weekly					

The ET uses the scorecard/OPI to review organizational performance, capabilities and progress relative to the strategic objectives and action plans. The ET meets weekly and reviews the OPI and scorecard information. Each executive is assigned to an SOT, and some indicators are delegated to the appropriate SOT for review according to schedule. Individual executives are responsible for review of performance indicators, reporting to the entire ET when performance is not meeting targets. Through the strategic plan cascade, as well as the 90-day action planning process, BMH ensures agility to rapidly respond to changing organizational needs and challenges in the healthcare environment. Analyses performed to support review of organizational performance include: gap, trend, financial-ratio, root cause, cause and effect, and failure mode and effects analyses. Conclusions are validated after a system of data integrity, logic and reasonability checks are completed. The SOTs are responsible for monthly review of the annual strategic plan tactical grid, which includes specific action plans, with assigned accountability and timelines. Through review of the measures and tactical grid status, BMH regularly assesses progress relative to the strategic objectives and action plans.

4.1b(2) Translating organizational performance review findings into priorities: The ET translates organizational review findings into priorities for continuous improvement and opportunities for innovation. Through weekly monitoring of the scorecard/OPI, negative variations compared to best practice, historical or budgeted targets are identified. Indicators that are red or yellow trigger action plans as necessary to improve performance. Priorities for improvement are deployed by the SOTs, through multi-disciplinary teams using the PDCA model for organization-wide initiatives. Individual executives deploy department-specific teams for more specific issues. The LCP supports deployment, communication and knowledge sharing relative to organizational priorities. During monthly management meetings, as well as the day-long LI meetings, the ET provides a systematic review and discussion of the scorecard and the strategic plan. All leaders are accountable to communicate this important information to their staff members through staff meetings utilizing the prepared knowledge sharing documents that provide consistency of the key messages.

BMH priorities are deployed to physician partners through the formal medical structure of multi-disciplinary committees. First, the ET shares the strategic priorities with the chief and vice chief of staff during weekly meetings. Next, information is shared with the medical board each month. Here the clinical practice group representatives receive information they share with other physicians through the section meetings and related communication mechanisms. As a result of Baldrige feedback, supplier scorecards are being developed with key suppliers as a formal mechanism to better align their performance with organizational objectives. This provides a formal mechanism to deploy priorities to suppliers. In addition, BMH utilizes the LCP, targeting specific communication mechanisms with suppliers to communicate priorities and opportunities to ensure organizational alignment.

4.2 Information & Knowledge Management

4.2a Data and Information Availability

4.2a(1) Making information available and accessible: BMH makes needed data and information both available and accessible to staff, suppliers, partners and patients through the state-of-the-art IMS. Validation of data availability and accessibility are key elements of the processes that support the IMS. BMH maintains a computer network of digitally available data for all stakeholders. Access to the network is obtained through locally attached workstations, wireless-enabled devices, and the public Internet. Wireless-enabled laptops and other devices are available for checkout to patients, family members or physicians so they can remain productive and connected while on our campus. Interactive kiosks, integrated with the public BMH website, assist patients and visitors with facility maps, service directories, and other information useful while in our facilities. Email is provided to all staff, and is accessible from hospital PCs (including general-purpose "surf stations" for staff that do not use PCs as part of their day-to-day jobs), and is also available via the BMH wireless network and the Internet.

Non-digital information is made available through paper-based media (and, increasingly, by converting non-digital information into digital format via PDF files, document scanning, and other approaches). The HealthSciences library, found in a central and highly visible location of the hospital, provides easy access to both non-digital and digital health information. Information shared with suppliers is coordinated through the BMH purchasing department, and is performed via paper-based and electronic media (web, CD-ROM, electronic data interchange, etc.).

4.2a(2) Ensuring reliability, security, friendliness: The IT department ensures the reliability, security, and user-friendliness of the organization's computer systems through use of IT standard operating plans (IT-SOPs). Reliability is managed through the establishment and enforcement of hardware and software standards, round-the-clock system monitoring, preventative maintenance and redundant data storage. Security is protected using firewalls, anti-virus/anti-spam filtering, intrusion detection, and other technologies; however, policies and procedures, along with user education, are the most important methods to protect information. Web-enablement of legacy applications, intuitive documentation, pervasive user education, and a customer service-focused help desk are key methods used to make information technologies user-friendly. "Petting zoos" are standard practice for BMH as new systems are being investigated for future use. Demo software and hardware are made available in a test lab environment where potential users can play, touch, and become familiar with the technology.

4.2a(3) Ensuring continued availability: A robust technical infrastructure is required to ensure the availability of hardware and software systems. The IT department maintains an IT disaster management plan that is a subset of the organization's disaster management plan (DMP). BMH maintains two geographically-separated data centers (each with redundant networking, HVAC, power, etc.) on a continuous basis to provide a high degree of business continuity protection. Multiple-path networks, strict workstation management, and similar steps are used to avoid service interruption due to attempted internal/external system

attacks, utility interruptions, technology malfunctions, or other causes. In addition to these technical elements, manual downtime procedures are used to maintain the flow of information in the event of system outages, or in the event of internal/external emergencies.

4.2a(4) Keeping hardware and software current: At a tactical level, BMH uses a proactive lifecycle management process to upgrade/replace PCs and other hardware components on a regular schedule in order to keep the computer network current with technological changes. Application software and operating systems are updated, in accordance with vendor recommendations, through a weekly change management process in order to avoid inter-system conflicts with BMH's highly integrated IT environment.

As part of the annual capital planning process, step 8 on the SMM, the ET and IT department develop a capital plan to address information technology needs to support the organization's strategic direction. Once approved, purchases against the IT capital plan are completed through weekly IT capital meetings involving finance, purchasing, and the IT department.

4.2b Organizational knowledge management: Organizational knowledge is a critical asset as BMH pursues excellence as a healthcare provider. A two-step approach is used to manage organizational knowledge. First, the *Inside*Bronson intranet is set up to be a repository for all knowledge sharing, best practices, improvement tools, education and communication with employees and physician partners throughout the organization. Second, the SPMS (Figure 5.1-3) and the annual education plan with a wide range of skill and knowledge sharing mechanisms (Figure 5.1-2), provides a systematic approach to manage organizational knowledge. This supports deployment to all areas of the organization as well as alignment and accomplishment of strategic objectives. The LCP ensures that information is communicated with the appropriate audiences and its effectiveness is evaluated.

Knowledge transfer from patients, physicians and suppliers is accomplished through the effective communication methods in the LCP. Web-enabled technologies (public kiosks, web portals to access electronic medical records/PACS information, email, etc.) provide a 24x7 process to transfer knowledge between BMH and its patients and physician partners. Weekly value engineering meetings with key suppliers provide a forum for ongoing needs assessment and performance feedback. In-room patient/family education is used to transfer important self-care knowledge to help patients as they prepare for discharge. Follow-up contact with the patient after discharge provides a feedback loop to reinforce the prior knowledge transfer, and to solicit feedback on BMH performance during the patient's care episode.

Active participation in a wide variety of comparative databases (VON, IHI, etc.) gives BMH early insight into emerging best practices. These insights are identified and evaluated by the ET or the appropriate SOT. If an SOT determines the identified best practice should be pursued by BMH, the SOT communicates with appropriate stakeholders to generate organizational buy-in, and charges the appropriate group(s) to implement the necessary process changes using the PDCA model. The LCP, with scheduled sessions (LEADERship retreats, "lunch and learns," monthly management update meetings, skills fairs, continuing medical education (CME) and grand rounds programs for physicians, etc.) provides forums to share best practice information across large segments of BMH stakeholders. In addition, the *Inside*Bronson intranet provides resources (online articles, printable forms, chat rooms, etc.) for ongoing communication throughout the adoption of best practices.

4.2c Data, information, and knowledge quality: The IT department ensures the accuracy, integrity, reliability, timeliness, security and confidentiality of organizational information and knowledge through the IT-SOPs. Data and information are kept in consistent formats to reduce the chance of errors and/or inaccuracy. Data types are unique, non-redundant, and integrated. Hardware, software, operating systems and communication tools are used to assure that data and information is not altered or destroyed during use. Internal audits of procedures and systems involved in the collection, storage, access and dissemination of data and information are performed routinely. Consistency checks and editing on source data is done at the point of capture to prevent errors entering the information system. Automated data editing, cross-checking, redundancy, monitoring and anti-viral systems are also used to maintain a high degree of reliability. Use of online edits, database cross-checks, and process check-points, information protection security systems, and exception and error reports, also assure reliability.

To support timely delivery and availability of data, information and organizational knowledge, specific deadline accountability is established for internally collected scorecard/OPI measures. Although BMH cannot exercise that same level of control for externally collected information (such as comparative databases), proxy data is often used to achieve timely estimates between external data updates. In all cases, automation (such as electronic medical record technologies) is leveraged to reduce data collection and analysis cycle time.

To ensure security and confidentiality of information, each BMH system user has a unique sign-on and password for the systems he/she is allowed to access. Software and hardware systems provide audit trails that identify user, time and operation to allow for monitoring and analysis of data integrity and security issues. Physical security of the network and database servers is protected with a card entry system that contains an audit trail. Medication administration processes are secured through a variety of systems, including BIO-ID (biometric fingerprint identification) for access to patient medications. Confidentiality is the responsibility of every employee. New employees are oriented to this responsibility through the BMH code of conduct, and they must acknowledge this responsibility by signing a confidentiality agreement. This responsibility is reinforced annually via a CBL module.

5 Staff Focus

BMH's commitment to workplace excellence (Figure 5.1-1) is brought to life through implementation of the Workforce Development Plan (WDP). The WDP includes innovative strategies related to *current* workforce needs to ensure that BMH maintains its status as one of the nation's 100 best employers. In addition, the WDP is very forward thinking as it addresses the organization's strategic challenges related to *future* staff recruitment, retention, development and diversity.

5.1-1 BMH Commitment to Workforce Excellence

Workforce Development Plan
Developing the Current Workforce
Leadership Development, Career Enhancement, Succession Planning, Retention
Developing the Future Workforce
Partnerships with Schools & Community, Youth Strategies, Recruitment
Diversity
Diversity Strategic Plan, Diversity Council, Mentor Program
Understanding Employee Satisfaction & Well-being
Two-way Communication, Employee Input, Listening Post Monitor System, Workplace Health & Safety
Benefits & Services to Meet Changing Needs
Your Life, Your Time, Your Wealth & Financial Security, Your Professional Development, Your Health & Wellness
Recognizing & Rewarding Excellence
Competitive Compensation, Formal & Informal Rewards
Staff Learning & Motivation
Education & Training Plan, Career Development, Knowledge & Skill Sharing

Understanding needs through employee input is the first and most critical step when developing staff-focused programs and services. BMH has a vast array of formal and informal employee listening posts such as an annual employee opinion survey (EOS), CEO/CNE open office hours, focus groups, employee councils, etc. In 2005, a new intranet-based listening post monitor system (LPMS) aggregates all employee input from the various listening posts providing more timely and robust actionable information. This information provides the foundation for development of the WDP during the annual strategic planning process. The employee input symbol recognizes "you had a hand in the process." It is used as a visual reminder on internal communication whenever enhancement or change is due to feedback from employees.

5.1 Work Systems

5.1a Organization and Management of Work

5.1a(1) Organizing and managing work: BMH organizes and manages work and jobs using an organizational structure and a Staff Performance Management System (SPMS - Figure 5.1-3). This approach contributes to achievement of action plans and fulfillment of the MVV. The organizational structure includes jobs organized according to product or service lines, clinical or administrative departments, divisions, nursing units, cross-functional work teams, and multidisciplinary committees. During the strategic planning process, prior to the fall approval of the HR staffing and education plans, the ET reviews and modifies the organizational structure to ensure the necessary alignment of leadership, staff, resources and skills to support achievement of organizational objectives. This annual review keeps the structure and processes for managing work current. Through the continuous planning process, the ET identifies and implements work system and structural changes needed to promote organizational agility. The management of work in the organization is accomplished through the leadership structure, and SPMS, as well as through the use of policies, procedures, protocols and pathways. The value of teamwork is a key element of the organizational culture. Through teams, the hospital promotes communication, cooperation, initiative, empowerment and active participation in decision-making. The Divisional Level Nursing Council (DLNC) is a shared governance model that empowers nursing and ancillary staff to drive decision-making affecting patient care in an effort to achieve clinical excellence. Innovation is encouraged through solicitation of employee input and ideas, education, knowledge sharing, new technology acquisition, research, and best practice benchmarking.

5.1a(2) Capitalizing on diversity: A critical success factor for BMH is to foster a culture of excellence that values diversity. BMH believes the active pursuit of diversity strengthens its efforts to be the best place to work and receive healthcare services. Diversity is defined in broad terms going beyond physical differences. It is what makes each individual unique and can be measured through the three broad dimensions of human, cultural and systems diversity. Work systems capitalize on diversity through focused education aimed to raise awareness of diversity as a strategic imperative. Diversity is fostered through the make-up of teams that allow for diverse ideas, cultures and thinking to be expressed in team activities, decision-making and daily work. Diversity of team membership is promoted through the team member selection process. Team members can be nominated by a supervisor, may volunteer themselves, or be targeted for membership due to specific skill sets, knowledge or experience. Approximately 99% of the staff lives in the nine-county hospital service area, enabling BMH to represent the diverse dimensions of the patients and community that we serve. As a strategic initiative, the five-year diversity strategic plan is a key element of the WDP. One specific diversity action plan that was accomplished in 2004 was creation of the Diversity Council. This cross-functional team of employees, which includes the CEO and senior vice president of HR, is championing the organization's diversity efforts.

5.1a(3) Effective communication and skill sharing: Communication and skill sharing are recognized as being critical to organizational success. A systematic process to facilitate and ensure effective communication, skill sharing and knowledge transfer has been developed, incorporating formal and informal mechanisms (Figure 5.1-2). The pre-hire and selection process, new hire orientation and nursing core orientation are formal mechanisms to set the tone for promoting communication, skill sharing and knowledge transfer with the newest members of the BMH team. Systematic use of the LCP by all leaders makes planning, targeting,

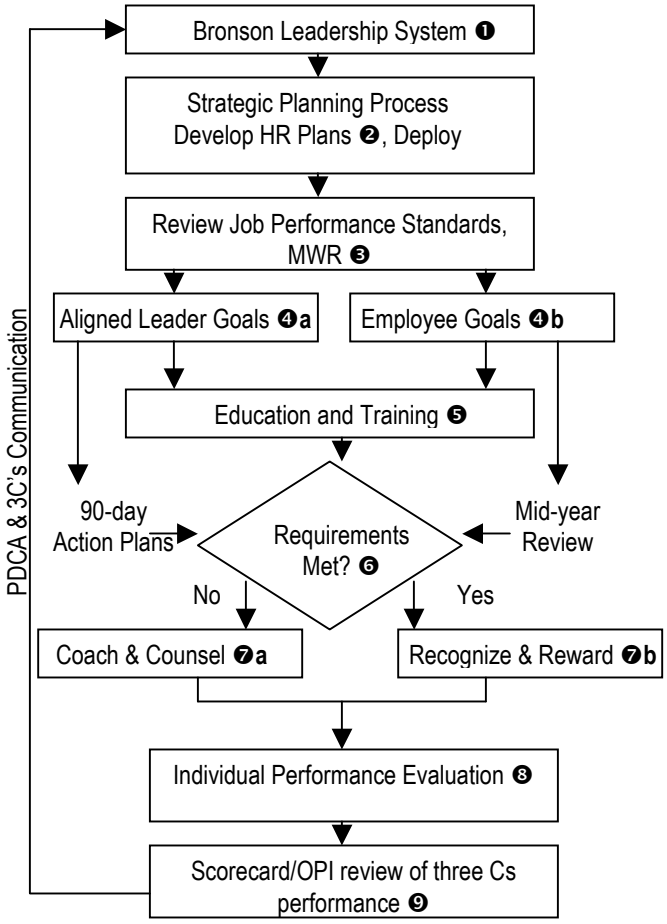
delivering, and evaluating communication part of the culture. Leaders are accountable to cascade information from all leadership communication forums (monthly management meeting, LEADERship retreats, etc.) to the department-level.

5.1-2 Mechanisms for Communication, Skill Sharing and Knowledge Transfer

Mechanisms for Communication, Skill Sharing and Knowledge Transfer	Type
• Pre-hire & selection process	**C, SK, ↔**
• New hire orientation	**C, SK, ↔**
• Nursing core orientation	**C, SK, ↔**
• Leadership Communication Process (LCP)	**C**
• Leadership communication forums	**C**
• Knowledge sharing documents	**C, SK**
• Department meetings	**C, SK, ↔**
• Bulletin boards	**C**
• Communication books	**C**
• Email for all employees	**C, ↔**
• Instant messaging	**C, ↔**
• *Inside*Bronson intranet	**C, SK, ↔**
• Department-specific newsletters	**C**
• Shared directories	**C**
• Daily huddles	**C, SK, ↔**
• *Healthlines* newsletter	**C**
• CEO/CNE open office hours	**C, ↔**
• LEADERship	**C, SK, ↔**
• Competency assessments	**C, SK, ↔**
• Workshops & educational courses	**C, SK, ↔**
• Employee forums & focus groups	**C, ↔**
• Employee neighborhood meetings	**C, ↔**
• Computer-based learning modules (CBL)	**C, SK**
• Leader rounds	**C, SK, ↔**
• Self-study modules	**C, SK**
• Skills fairs and learning labs	**C, SK, ↔**
• Safety champions	**C, SK, ↔**
• Preceptors	**C, SK, ↔**
• Externships/internships	**C, SK, ↔**
• Management mentor program	**C, SK, ↔**
• Shared governance (DLNC)	**C, SK, ↔**
• Teams, work groups, councils and committees	**C, SK, ↔**
• Staff Performance Management System	**C, SK, ↔**
C-communication, **SK**-skill sharing & knowledge transfer, ↔-two-way	

Leader communication tools, in the three Cs format, are provided through knowledge sharing documents, handouts and powerpoint presentations to ensure that consistent communication messages are deployed. At the department-level, various forms of communication occur depending on the nature of the information and the needs of the staff. Department-specific communication mechanisms include meetings, bulletin boards, communication books, email, instant messaging, department-specific newsletters, and daily huddles. The LEADERship initiative (LI), a key element of the WDP, is a mechanism for growth, communication and sharing. Other mechanisms include the safety champions, preceptors, and externships/internships. Through teams, work groups, councils and committees, communication and skill sharing occur on a daily basis. The Diversity Council, DLNC, and department-specific councils are examples.

5.1-3 Staff Performance Management System (SPMS)



5.1b Staff performance management system: The SPMS is designed to support organization-wide expectations of high performance work by all staff. It is the primary mechanism for the achievement of action plans. Using Baldrige feedback, the SPMS was enhanced in 2004. During the deployment phase of the SMM, strategic plans are translated into performance requirements and deployed (step ❷) throughout the entire workforce through the SPMS. In step ❸, the annual review of job performance standards, as well as minimum working requirements (MWR), is completed so that job standards are derived from the planning process. In step **❹a,** leader goals are aligned with the strategic objectives and scorecard/OPI measures. At the individual staff level, **❹b** employees develop three personal goals that support the three Cs. These goals are created based on the appropriate organizational, department- or service line-specific action plans that relate to the individual job duties of the employee. Personal goals, educational needs, and career progression plans are discussed with employees formally during a mid-year review and informally at staff meetings or on the job. In step ❺, education and training provides staff with the skills and competencies necessary to accomplish their goals and achieve

high performance. Through the annual performance review process and regular coaching sessions, employees are encouraged to use educational opportunities to improve their current skills as well as develop new skills for advancement within the organization. Leaders evaluate individual performance to determine if the job requirements are met ❻. If requirements are not met, coaching, counseling, additional training, and corrective action planning are put into place to improve performance ❼**a**. In step ❼**b**, reward and recognition mechanisms tied to organizational strategy (Figure 5.1-4), recognize employees who achieve high levels of performance and also motivate staff to contribute to overall organizational excellence. Annual performance evaluations, step ❽, provide a two-way feedback mechanism for staff to receive critical feedback on their performance as it relates to the expectations set by the ET through the BLS. In addition, staff can provide valuable feedback to their leader regarding job satisfaction, personal development needs, career aspirations and the refinement of job performance standards for the coming year. Results of staff competency and performance evaluations are reviewed by the ET and reported to the BOD annually. In step ❾, the overall effectiveness of the SPMS is evaluated through performance in the scorecard measures/OPI. Results are communicated throughout the organization using the three Cs communication format. The PDCA model provides a formal mechanism for continuous improvement of the SPMS.

5.1c Recruitment and Career Progression

5.1c(1) Identifying characteristics and skills: BMH's commitment to the patient begins with our ability to recruit, hire and retain an excellent workforce that is highly skilled, service oriented and diverse in thought, culture and ideas. As the ET formulates the strategic plan, as well as the HR staffing and education plans through the SMM, characteristics and skills needed by potential staff are identified. Using a comprehensive job design process, the HR department and the department leader first research the job requirements and competencies to define the skills needed. All jobs are designed around core competencies, as required by regulatory agencies such as JCAHO, including age-related competencies to meet the needs of the patient population served. This information is used to create a job description that lists the qualifications and skills while incorporating organizational expectations and values. The job description is used for recruitment and selection of the most appropriate candidate. Job descriptions are in place for all positions. They are evaluated annually through the SPMS to ensure they are current with industry, customer and organizational needs.

5.1-4 Recognition and Reward Mechanisms

Recognition and Reward Mechanisms
• Thank you notes • On the spot recognition • Leader recognition toolbox • Celebrations (tied to goal achievement) & fabulous prizes • Hospital Week, Nurses' Week, Employee Appreciation • Annual events: picnic, holiday banquet, children's holiday party • Service awards and annual recognition banquet • Nursing Excellence Awards • President's Team Awards • Bonuses (gainshare, key contributor, productivity, preceptor, certification/advanced degree completion)

5.1c(2) Recruiting, hiring and retaining staff: Based on HR needs identified through the SMM and organizational performance reviews, BMH recruits and hires new employees using a formal recruitment and selection process. First, the job description created through the job design process is reviewed to define the type of candidate and skills needed for the position. Second, HR recruiters identify and select the candidate sourcing options. Potential employees are recruited through a variety of internal and external mechanisms. Internal promotion and transfer is first. In 2004, 59% of all jobs were filled from within. The employee referral program resulted in 37% of new hires being identified by current staff in 2004. External recruitment sources include the public website, career fairs, community diversity events, direct mailing, and local media. The use of local advertising venues attracts potential candidates that reflect the nine-county region that we serve. The diversity strategic plan and the Diversity Council identify ways to increase the likelihood of recruiting potential employees that exhibit the various dimensions of diversity. These methods include focused advertising in media targeted at diverse populations, membership in the Institute for Diversity in Healthcare, and development of career pathways. Applications are reviewed and candidates are screened by HR recruiters to determine if there is a match with the job skills and customer-service expectations required of all employees. If the candidate meets the skill requirements, the hiring manager and a team of peers participate in the interview process. Using behavior-based interviewing as well as a candidate rating system during the interview process, each interviewer scores the candidate on various behavioral dimensions that are indicative of future job performance. If the candidate is a match for the position, the HR recruiter extends an offer pending a health and drug screen, extensive background check, and verification of licensure and education.

The WDP outlines strategies to develop and grow both the current and future workforce. To fill the critical and future need for respiratory therapists, the Respiratory Care Career Development Program, was developed. It provides a guided pathway and financial resources to develop respiratory therapists from the current employee population. Program participants receive full-time benefits, full payment for tuition and books, and a 24-hour per pay period stipend while attending classes full-time. To support organizational sustainability and overcome the strategic challenge of recruiting future staff, BMH developed innovative youth initiatives to create the healthcare employees of tomorrow. Summer camps (4th, 5th and 6h grade students), and middle school lock-in's at the BAC are annual events to increase youth knowledge, awareness and interest in healthcare careers. An annual career fair for high school students and parents provides information on healthcare occupations and related secondary education and training. Five scholarships are awarded annually to children of employees who are pursuing college degrees in healthcare and who intend to work at BMH upon graduation.

Physicians are recruited in accordance with the multi-year Medical Staff Development Plan, which uses the strategic planning process as its driving force, and takes into consideration the need for diversity, replacement of certain specialties due to projected retirements, and new healthcare services required. All applicants to the medical staff undergo a rigorous background check, a review of

malpractice history, and are credentialed in accordance with regulatory requirements, state licensure requirements, and medical staff by-laws, rules and regulations.

The WDP provides the systematic approach to retain qualified staff. Strong leaders, developed through the LI, play a key role in staff retention, bringing the BMH values to life in their daily interactions with staff. By showing care and respect, promoting teamwork, valuing diversity, and empowering staff, leaders create the BMH culture of excellence and high performance. It is a culture where employees want to grow along with the organization. Competitive compensation, a rich array of innovative benefits, and professional development opportunities are programs and services that support staff retention. Robust recognition and reward mechanisms (Figure 5.1-4), open communication, and solicitation of input through the LPMS, are formal approaches to retain staff.

5.1c(3) Succession planning and career progression: Succession planning utilizes formal and informal processes to ensure current and future executive and leadership needs are met. The BOD and CEO annually review a formal succession plan for the executive-level staff. Each executive is assessed based on present performance and future potential. More than 80% of the ET has been promoted from within the organization. As part of the formal executive level succession plan, the executive director position was created in 2004 to provide development opportunities for three new executives. The LI and management mentor program provide career progression for leaders. Since its inception in 2002, 23 individuals have been promoted to positions of increasing responsibility after participating in the LI. The ET annually reviews performance appraisal results and formally discusses potential succession opportunities for the high achievers. Career progression and succession planning for all staff is achieved through the SPMS during step ❹**b** and step ❾. Personal development and career progression is supported through extensive learning opportunities, tuition assistance, career ladders and the internal job posting process. Open positions are posted internally and any internal qualified candidate who is interested is encouraged to apply.

5.2 Staff Learning and Motivation

5.2a Staff Education, Training, and Development

5.2a(1) Contributing to action plans and balancing needs: Through deployment of work in the SPMS, staff education and training contribute to the achievement of organizational action plans. In step ❺, education provides staff with the skills and competencies necessary to accomplish their goals and achieve high performance. The annual education plan, a key component of the WDP, is developed during the SMM to facilitate alignment with organizational needs. Other inputs into development of the annual education plan include: survey results, needs assessments, regulatory requirements, performance evaluations, LPMS inputs, incident reports, job design process, educational evaluations, new technology and equipment. These inputs are analyzed and prioritized to determine the critical organizational education needs. The WDP, with focus on current and future workforce development, provides the balance for ST and LT staff education needs. Staff learning and career progression are supported by tuition assistance, in-service education, bonuses, and career ladders.

5.2a(2) Addressing organizational needs: The annual education plan includes programs to support key organizational needs and strategic objectives. The two-day new hire orientation program provides new staff with an overview of the PFE, organizational culture, and expectations for performance. The specific learning modules include: abuse and neglect, corporate compliance, diversity, confidentiality, customer service, employee handbook and HR policies, emergency preparedness, hazardous materials handling, fire safety, hand hygiene, patient safety, health literacy, infection control, regulated medical waste, SBAR communication, and workplace violence. The Diversity Council is championing the educational efforts to raise awareness of diversity as a strategic imperative. Ethical practice and corporate compliance are covered at new hire orientation and also annually through mandatory CBL modules. BMH develops strong leaders through the LI. It is the profound belief of the ET that dissatisfied employees do not leave an organization, rather, they leave an ineffective leader. LI, which includes a leader orientation pathway, all-day leadership retreats held three times per year, lunch 'n learn sessions, accountability homework, new management mentor program, management toolbox, and CBL modules, is a formal mechanism for leader growth and development. Safety education begins at new hire orientation, continues with department-specific training, and is required annually as a MWR. It is delivered through a rich menu of options to meet the diverse needs of the workforce including: one-on-one training with preceptors, skills fairs, annual safety day, workshops, classroom training, self study, videos, drills and the *Inside*Bronson intranet.

5.2a(3) Incorporating input from staff: During the strategic planning process, the education services department distributes an annual survey to all leaders, as well as the SOTs, requesting input into the annual education plan for the coming year. Internal resources or knowledge experts are identified at this time to assist with development and delivery of education programs. This allows BMH to leverage the internal expertise of leaders, employees, staff educators and physicians. The education survey data is aggregated along with information from other input mechanisms such as satisfaction surveys (EOS, RN satisfaction, Great Place to Work), annual leadership needs assessment, department-specific needs assessments, staff performance evaluations from the SPMS, LPMS inputs, and educational evaluations. The ET prioritizes the key educational needs to ensure alignment with the organizational strategies. Once finalized, the education services department champions the effort of deploying the annual education plan throughout the organization.

5.2a(4) Delivering education and training: Curriculum development incorporates organizational learning into a systematic process identifying the goal, objectives, content, delivery method, and evaluation process. Education and training are delivered through many methods tailored to meet the diverse adult learning styles of staff. At new hire orientation, all employees complete an assessment of individual learning style. This assessment helps them understand how they learn best and how to select the most appropriate delivery method for future educational offerings. The LPMS and employee input mechanisms listed in 5.2a(3) are also used to determine the appropriate delivery mechanisms for each educational program. BMH uses a variety of formal and informal delivery approaches such

as, CBL, self-study, demonstrations, lectures, poster sessions, team activities, skills fairs, paper/pencil format, video, one-on-one coaching, observation, and mentoring. The new management mentor program pilot in 2005 will determine if formal mentor programs are effective delivery mechanisms in the BMH culture.

5.2a(5) Reinforcing use of knowledge and skills: Leaders, preceptors, and educational instructors are formally charged with reinforcing the use of knowledge and skills on the job. This is accomplished through direct observation, immediate reinforcement of specific skills, annual competency assessment, and performance appraisal. A key role of the preceptor is to mentor and reinforce skills of new employees on a daily basis. Educational instructors complete the competency audits and assessments. Leader rounds are effective mechanisms to see staff in action and provide verbal reinforcement. Handwritten thank you notes are also sent to acknowledge accomplishments. The process for transferring knowledge from departing employees depends on the level of the position. For executive-level positions, there is an expectation of at least 90 days notice before departure. This allows for recruitment of a replacement, as well as preparation of a formal written transition plan. For salaried professional positions, four weeks notice is sufficient to allow time for knowledge transfer and transitioning of duties. Two weeks notice is standard for staff-level positions. BMH promotes cross-training and team education as part of the culture. This fosters ongoing knowledge sharing to ensure vital information and skills are not lost when any employee departs the organization.

5.2(6) Evaluating effectiveness of education and training: Effectiveness measures and the level of education evaluation are defined in the annual education plan. This makes it clear why the education is necessary and what are the expected outcomes as a result of the education. The PDCA model reinforces the need for evaluation of all education and training offerings. There are four different levels of evaluation: 1) program reaction, 2) knowledge confirmation and effective skill demonstration using paper/pencil testing, 3) application of skills after the program, and 4) the impact of training on organizational effectiveness. All programs complete the first level of evaluation. Other levels of evaluation are completed depending on the type of education program and the relevance to accomplishment of BMH strategy. Data from education evaluations and the effectiveness measures are collected, analyzed and reviewed by the education services department. A summary of the education program and the effectiveness measures is reported annually to the ET. Also, on a broader dimension the success of the education plan is measured by the overall performance of the hospital on the organizational scorecard.

5.2b Motivation and career development: The WDP provides the formal mechanisms to motivate staff to develop and utilize their full potential including: career ladders, tuition assistance, scholarships, department-specific education dollars, certification/advanced degree bonuses, and internal education offerings. Using this rich array of offerings, leaders assist staff in attaining their job and career-related learning objectives. Through the SPMS annual discussions, staff identifies and documents education needs, plans or personal development goals with their leader. The leader provides resources and encouragement to support achievement of personal career goals. The annual performance evaluation, mid-year review and daily dialogue about development needs make learning a continuous process.

5.3 Staff Well-Being and Satisfaction

5.3a Work Environment

5.3a(1) Improving workplace health, safety, security and ergonomics: BMH is highly committed to protecting the safety and health of its employees. The employee code of conduct incorporates expectations vital to maintaining a safe environment. The extensive employee safety education program provides staff with the skills they need to ensure a safe workplace. Employees are engaged in creating a safe environment through involvement on the environment of care (EOC) committee and the five related subcommittees. The collective goal of this comprehensive, internal committee structure is to improve workplace health, safety, security and ergonomics. Annual EOC management plans are created using key indicators of workplace health and safety as well as employee input. These plans provide the annual priorities and improvement plans for all areas of the organization to ensure that significant differences in the work environments (clinical, business occupancy, support areas) are addressed. A quarterly status report with key measures of performance (Figure 5.3-1) is provided to the patient safety committee, CE SOT, ET, and performance improvement committee (PIC) of the BOD. Departmental safety champions assist in the process of deploying safety training and safe practices throughout the organization. These highly skilled employees are role models and internal safety experts. They serve on the organizational safety subcommittees, host training, and collect data for the measurement of safety performance indicators. In addition, they complete environmental inspections, drills, hazardous material identification, infection control surveys, as well as assistance with ergonomic reviews. Weekly environment of care inspections allow for timely identification of issues and consistent monitoring of performance.

5.3-1 Work Environment Factors, Measures & Targets

Factor	Measure	Target
Health	Annual TB test compliance	100%
	BAC reimbursement	90%
Safety	Annual employee MWR	100%
	Safety drill completion	100%
	OSHA recordables/100 FTEs	9.54
Security	Infant abduction drill completion	100%
	Customer satisfaction	94%
Ergonomics	Dept. health & safety reviews	100%
	Sprains & strains/100 FTEs	5.86

Employees utilize an incident reporting hotline to report job-related injuries 24x7. The hotline call triggers communication and immediate action steps to address problems and ensure a safe work environment. The employee health and safety committee reviews employee incident data monthly to identify trends or patterns of injury and make recommendations for improvement. Every other year, the committee oversees a comprehensive review of all department-specific health and safety requirements. The review findings are incorporated into department-specific orientation, training, and job performance standards. The job site analysis process is used to

proactively address ergonomic needs. A general fund to cover costs related to workspace design and equipment was created so that department budgets are not negatively impacted by investments in creating a safer work environment. Employee wellness is promoted through the extensive list of reimbursable wellness/preventive benefits, including personal trainers, herbal therapy consultation, massage therapy, smoking cessation, Weight Watchers at Work, personal wellness profiles, just to name a few. All employees are eligible for half-off the initiation fee at the BAC. Primary members who visit the BAC at least eight times a month are reimbursed for monthly dues. Be Well Buddies offer at-work support for personal wellness goals and host the on campus lunchtime fitness programs. Free annual health risk appraisals encourage employees to "know their numbers" and modify their lifestyle based on their risk of heart or other related diseases.

5.3a(2) Emergency and disaster preparedness: The disaster management plan (DMP) ensures workplace preparedness for disasters or emergencies. Using findings from the annual hazard vulnerability analysis, the emergency preparedness committee creates the annual priorities for safety training, drills, emergency preparedness activities, and ensures alignment with the CE SOT patient safety action plans. Drills and emergency preparedness activities are held quarterly to test staff learning and knowledge gained through the safety education programs. Written objectives for all types of disasters are evaluated at each drill, using a criteria measurement of 1 to 5. Any scores under "3" require action plans and follow up using the PDCA model. The departmental safety champions serve a vital role in preparedness training, education and assessment. A select group of organizational leaders is specifically trained to be incident commanders in the hospital's state-of-the-art, best practice hospital emergency incident command system (HEICS). This system provides the necessary leadership structure, advanced communication technology, policies and procedures to manage any emergency situation.

5.3b Staff Support and Satisfaction

5.3b(1) Determining satisfaction factors: Through the formal and informal mechanisms in the LPMS, key factors affecting staff satisfaction and well-being are determined. The HR department champions this effort annually following the annual EOS each May. Standard questions on the EOS allow for comparisons to the Management Science Associates (MSA) database that includes over 1.5 million healthcare employees. Survey data is segmented in 11 different dimensions of diversity (department, length of service, marital status, age, education level, status, position, shift, gender, race, future intentions for employment) to ensure effective identification of differences among various categories and types of employees. In addition to the aggregated survey data, MSA identifies key themes from the written survey comments. The complete word-for-word comments are reviewed by the ET and made available to all leaders for confidential review. The comments provide rich feedback that is taken very seriously by the ET. The EOS results, validated by the LPMS inputs, provide the key factors that determine staff satisfaction.

5.3b(2) Services, benefits, and policies: Through the WDP, the hospital supports staff with innovative services, extensive benefits and appropriate policies. BMH recognizes that employee needs may change throughout the employee life cycle. Therefore, services and benefits are categorized to reflect these unique needs. The wide range of benefits and services provided are designed specifically to meet the needs of the diverse workforce, different types of staff, as well as changing needs. The HR department uses employee input gathered from the LPMS, annual EOS, and targeted focus groups, to identify new benefits and services. These are then added during the budget phase of the SMM. Examples of benefit enhancements recently added to the already robust array of employee benefits and services include: flexible child care options, pet insurance, phased retirement program, College Parents of America, paid paternity leave, long-term care insurance, vision and orthodontia enhancements, total compensation statements, and the self service pay and benefits system. In 2005, employees will have the opportunity to access their personal pay and benefit information via the *Inside*Bronson intranet. Employee focus groups confirmed that this new system would increase employee satisfaction by allowing 24x7 access to personalized information. To validate satisfaction with the new system, an automated survey is administered upon completion of the on-line benefits enrollment process.

5.3b(3) Assessing well-being, satisfaction and motivation: Staff satisfaction and well-being are assessed using the mechanisms in the LPMS to determine key factors affecting well-being, satisfaction and motivation. Three different survey mechanisms, EOS, RN satisfaction, and the Great Place to Work Institute, provide a rich array of results with different comparisons and benchmarks. All of the results are aggregated and analyzed by the HR department and the ET annually. The findings are used during the strategic planning process as new employee programs and services are developed. Other mechanisms for assessing satisfaction that are part of the LPMS include: CEO/CNE open office hours, leader rounds, safety inspections, department staff meetings, Diversity Council, DNLC, mid-year goal reviews, performance evaluations, and exit interviews. The LPMS, with varied input mechanisms, is designed specifically to capture input from the diverse workforce and different categories of staff. Key measures of satisfaction and well-being include employee satisfaction, retention, vacancy, employee incident reports, internal promotions, and employee referrals. The HR department reviews the input in the LPMS on a monthly basis in conjunction with other staff indicators. The ET is informed of any concerns or corrective actions that should be considered to improve employee satisfaction. To communicate these key measures, HR distributes the quarterly HR Organizational Trends Report (HOT) to all staff via email and posts it on the *Inside*Bronson intranet. This report tracks performance in employment, retention, job mobility, and staff satisfaction, comparing BMH to other best practice organizations.

5.3b(4) Relating assessment findings and improving results: The ET recognizes that employee satisfaction directly correlates with patient satisfaction and the quality of clinical outcomes. Therefore, overall effectiveness of the hospital's approach to staff satisfaction and well-being is evaluated through performance in the organizational scorecard/OPI. The CASE SOT is responsible for oversight of the patient and employee satisfaction measures as well as the related organization-wide action planning for improvement.

6.1 Healthcare Processes

6.1a Healthcare Process

6.1a(1) Key healthcare services and processes: BMH determines its key healthcare services and service delivery processes by identifying services and processes that support the MVV, strategic objectives, and meet healthcare market segment and customer needs. This determination is accomplished through the SMM. During the spring QSP retreat, the ET begins with a comprehensive analysis utilizing data from the SID. After the ET finalizes the healthcare market segments and growth strategies, the key healthcare services and service delivery processes are determined. Should new opportunities be identified at other times of the year, the continuous planning cycle of the SMM allows for healthcare services and processes to be added or modified at any time deemed necessary. Key services and service delivery processes are defined as meeting one or more of the following criteria:

- Affects a large majority of our patients;
- Identified as high-risk and/or problem prone;
- Improves patient care quality through evidence-based practice;
- Provides an opportunity for growth;
- Essential to the community;
- Enhances the ability to attract and retain top talent; and
- Balances profitable versus unprofitable services to maintain a positive bottom-line.

Key service delivery processes (Figure 6.1-1) create value and contribute to improved healthcare service outcomes for patients by delivering high quality, efficient services which meet defined patient requirements and expectations.

6.1a(2) Determining key healthcare process requirements: Key healthcare process requirements are determined by using input from the customer LLM (Figure 3.1-1) as well as physician partner and supplier inputs, in the PLAN phase of the Focus Plan-Do-Check-Act (PDCA) model (Figure P.2-3). This approach incorporates input received from patients, physicians, and suppliers early in the PLAN phase through direct contact, surveys, focus groups, and participation on teams and committees. Accreditation and regulatory requirements are identified through industry and professional association listening posts. All requirements are aggregated and analyzed during the input step of the SMM to ensure key process requirements are met and used to continually drive organizational process performance and improvements. Key requirements for BMH healthcare processes are listed in Figure 6.1-1.

6.1a(3) Designing key healthcare processes: BMH uses the PDCA model for process design and improvement. This improvement model is used to design, implement and measure the effectiveness of new or modified key processes and services. The first step in the design of new processes is FOCUS. During the spring QSP, the ET analyzes the SID and determines the key healthcare services and service delivery processes. Using a comprehensive business planning process, the ET carefully considers market research, competitive data, customer input, testing, analysis and planned implementation, before a new process or service is introduced. The ET fulfills the FOCUS step of the PDCA model by determining the need for a new service or delivery process and assigning oversight for design to the appropriate SOT. The SOT organizes the team, clarifies the scope of the work, and timeline requirements. The team is composed of key stakeholders of the service or process including staff, physicians, leaders, suppliers and patients, as appropriate. Physician partners play a key role in the development of new services and processes. For example, through active physician involvement in cardiac service line (SL) development, BMH was the first hospital in the region to introduce pulmonary vein isolation (PVI) for the treatment of atrial fibrillation, the most common heart rhythm problem in the U.S. affecting more than 2.2 million people.

6.1-1 Key Healthcare Service Delivery Processes and Measures

Key Process	Key Requirements	Key Measures
Admission: Patient Throughput, Scheduling, Pre-Certification, Registration	Quality Outcomes Communication Responsiveness Efficiency Empathy Cycle Time Productivity	Occupancy, Wait Time, Diversion, ER Door to MD, Registration Accuracy & Productivity, Pre-Registration Percentage, Average Wait Before Answered, Denials Due to No Authorization, Physician Satisfaction
Plan of Care: Assessment, Provision of Care, Implementing & Evaluating Care		Patient Satisfaction, Patient Loyalty, Adequately Informed, Mortality, Hospital Acquired Skin Ulcers, Falls, CORE – SIP, Handwashing, Verbal Order Read Back, Device Days, VAP Rate, Chronic Lung Disease, Pain Management, % of Babies Discharged Home on O2, RN Assessment, Plan of Care, Evaluation of Care, Responsiveness, Concern shown by staff
Discharge: Plan, Education, Billing, Coding		Willingness to refer, CHF Discharge Instructions, Appropriate Education, Length of Stay, Readmissions, Discharges, Days in HIM, Gross Days In AR, Bad Debt/Charity Care, Monthly Denials, Discharged but not final billed

The second step of the PDCA cycle is PLAN. In this step, the team builds upon the current business plan and designs the action plans. Because we strive to achieve exceptional healthcare outcomes for our patients, evidence-based research, benchmarking, and best practice comparisons are utilized in the PLAN phase. Action plans are developed, compliant with regulatory, accreditation bodies, payors, patient, and operational requirements. Operational requirements include in-process indicators to evaluate service delivery, as well as outcome measures to measure effectiveness and sustainability. Evaluation of technology as a means to decrease costs, promote efficiency, reduce cycle time, and enhance accuracy in the delivery of service is considered in this PLAN phase. The third step of the PDCA cycle is DO. In this step, we deploy and measure the plan against the identified and agreed upon targets developed in the planning stage. Communication and knowledge sharing are important elements of deployment; therefore, information regarding the plan and expected outcomes is shared with physicians, staff and patients, and we gain acceptance from the process participants. Pilots are conducted to test the plan prior to full deployment.

The fourth step of the PDCA cycle is CHECK. During this phase, we learn and innovate by evaluating results of the initial implementation and modifying the plans as needed to achieve sustained results. We assess whether the design requirements were met during the process implementation. Corrective action plans are put into place during this phase if process variations from the original design are identified. Alternative solutions are determined and implemented. The fifth step of the PDCA cycle is ACT. This is a critical phase for the organization in sustaining results over time. During this phase, lessons learned are reviewed and shared with the organization and other stakeholders. Based on the outcomes of the PLAN-DO-CHECK steps, implementation on a wider scale throughout the organization is initiated, and the PDCA cycle continues.

6.1a(4) Addressing patient expectations: Patient expectations, identified through LLM, are addressed and considered in the design, delivery, and improvement of healthcare service delivery processes. BMH analyzes information obtained from the customer LLM to identity patient needs and expectations. Healthcare services and processes are designed to address patient expectations in the PLAN phase of the PDCA model. Patient expectations are addressed in the delivery of key healthcare services by staff use of the CSSE and evaluated based on patient feedback. This feedback drives efforts to meet patient expectations using the PDCA model to improve current processes and services.

When patients enter the system, it creates an opportunity to assess and incorporate patient expectations into an individualized plan of care. Prior to delivery of healthcare services, patients are given a full explanation of the risks, benefits and alternatives related to their individual needs. The individualized plan of care is initiated during the admission process. During this time, there is an exchange of information between members of the healthcare team and the patient. Information is gathered from the patient regarding their previous and current health status, discharge needs, and financial information. Patient needs are identified, and the plan of care is designed to meet these needs. The plan of care includes a pathway with mutually agreed upon expected clinical outcomes and anticipated discharge-planning needs. Care pathways include evidence-based research that promotes patient progression through the care delivery process. The pathways are regularly evaluated and modified, if warranted, to reduce variation in care and outcomes, and to promote patient safety.

6.1a(5) Measuring and managing key healthcare processes: In-process and outcomes indicators are used for the control and improvement of healthcare processes. These performance measures are defined during the PLAN phase of the PDCA model whenever new healthcare processes are developed. Methods of data collection, frequency and accountability are assigned during the PLAN phase and results are reported to the appropriate group. Key performance measures are formatted in the scorecard format and systematically reported to the appropriate SOT assigned oversight for the process design. Examples of measures for BMH's key healthcare processes are listed in Figure 6.1-1. During the PLAN phase of the PDCA model, action plans are developed compliant with regulatory, accreditation bodies, payors, patient, and operational requirements. These are then piloted, deployed, assessed and monitored through the various steps in the PDCA model to ensure that requirements are met in the daily operation of the process.

Processes are maintained and monitored by department leaders. If the leader determines that a process is not working effectively, corrective action is taken using the PDCA model. If the problem is within the scope of the individual leader's responsibility he/she can immediately initiate steps to correct the problem. If the process is determined to be a system problem, the leader requests assistance from the appropriate SOT who will provide the necessary FOCUS and initiate the PDCA process. Patients, suppliers, and physician partners give input about process performance through direct interviews with the process owner or staff, focus groups, participation in satisfaction surveys, and patient rounds. These inputs are used by process owners to manage and improve processes using the PDCA cycle.

6.1a(6) Minimizing costs, preventing errors and rework: BMH minimizes overall costs associated with errors and rework through effective process design, focused on standardization and proactive identification of potential failures during the PLAN phase of the PDCA model. New services and products are piloted to identify and evaluate potential issues and to prevent errors and rework. Ongoing quality inspections and audits are reported to, and analyzed by, the accreditation and regulatory oversight committee and the patient safety committee. Through these committees, BMH reviews evidence-based research and conducts RCAs and FMEAs on key processes to determine further opportunities to reduce errors. BMH is committed to providing a safe environment for patients. Investment in technology and standardized processes are important to BMH's patient safety program as evidenced below.

- The use of a new MRI safe sigma pump allows patients with intravenous medications to safely utilize the MRI services. Previously the metal sigma pumps were incompatible with the MRI technology and critical care patients using the pumps could not benefit from it.
- BIO-ID is utilized in the pyxis system, an automated medication dispensing system that allows nurses to access the needed medication on the unit. BIO-ID was implemented to reduce the

potential for errors by preventing nurses from obtaining incorrect medications.

6.1.a(7) Improving healthcare processes, keeping current: Annually, during the spring QSP, BMH reviews key healthcare processes to determine if they are current, continue to meet customer requirements, and add value to the organization. During the year, methods to keep healthcare processes current include medical staff input, participation in professional organizations, attendance at conferences and seminars, site visits and sharing with Baldrige recipients, participation in IHI and NQF, formal research, and subscriptions to professional journals. Through SOT review of the key process performance measures on the scorecards, the SOTs challenge process leaders to achieve better performance and best practice standards. Comparative database sources (e.g. CareScience and Solucient) are used to benchmark best-in-class performance.

BMH uses the PDCA model to improve key healthcare services and processes, reduce variability and keep current with healthcare service needs and directions. Significant improvement opportunities identified through the SMM are prioritized and managed with SOT oversight and direction. Resources from the clinical operations improvement department are allocated to assist teams as they work with the PDCA model and other appropriate improvement tools to address system-wide process issues. Upon hire, and annually as a MWR, all employees receive training on the use of PDCA as the model for improvement. PDCA is a key element of the PFE and continuous improvement is part of the organizational culture.

BMH reduces process variability by determining standards of practice, operating guidelines, and protocols deployed through hospital policies. Process automation as well as documentation, training and procedure standardization, further reduce variability. A key element of every new hospital policy is the necessary training and competency check for employees so they have the knowledge and skills to administer the new process. Improvements and lessons learned are communicated and implemented throughout BMH using the three Cs format and LCP. Sharing "lessons learned" presentations at LEADERship, monthly management, DLNC, and department-level meetings, the employee *Healthlines* newsletter, the *Inside*Bronson intranet, skills fairs, and, an annual quality fair, are mechanisms for organizational learning.

6.2 Support Processes and Operational Planning

6.2a(1) Key business and other support processes: Key business and other support processes are defined as those processes that are most vital to BMH's business growth and success. Like key healthcare processes, BMH determines its key business and support processes by identifying those services that support the MVV, strategic objectives, and enable staff to deliver high quality, efficient healthcare services. This determination is also accomplished annually through the SMM during the spring QSP with review of the SID. Should new opportunities be identified at other times of the year, the continuous planning cycle of the SMM allows for key business and support processes to be modified at any time deemed necessary. Figure 6.2-1 illustrates key business and support processes.

6.2a(2) Determining key support process requirements: BMH determines key business and support process requirements through the same approach as key healthcare processes described in Item 6.1a(2). Key business and other support process requirements are illustrated in Figure 6.2-1.

6.2a(3) Designing key support processes: Consistent with the approach used to design healthcare processes, BMH uses the PDCA model for business and support process design and improvement. With direction from an SOT, business and support process owners charter a team to design and improve key support processes. During the PLAN step of the PDCA model, the team incorporates key requirements, new technology, organizational knowledge, the need for agility, efficiency and effectiveness factors, into action plans for designing the process. During the CHECK step of the PDCA model, the team learns and innovates by evaluating results of the initial implementation and modifying the plans as needed to achieve sustained results. The team assesses whether the design requirements were met during the process implementation. Corrective action plans are put into place during this phase if process variations from the original design are identified. Alternative solutions are determined and implemented.

6.2a(4) Measuring and managing key support processes: Measures for BMH's key business and other support processes are listed in Figure 6.2-1. In-process and outcomes indicators are developed during the PLAN phase of the PDCA model and used for the management and improvement of business and support processes. Methods of data collection, frequency and accountability are assigned during the PLAN phase and results are reported to the appropriate group. Like healthcare processes, key performance measures are formatted in the scorecard format and are reported systematically to the appropriate SOT assigned oversight for the business or support process design. During the PLAN phase of the PDCA model, action plans are developed compliant with regulatory, accreditation bodies, payors, patient and operational requirements. These are then piloted, deployed, assessed and monitored through the various steps in the PDCA model to ensure that the requirements are met in the daily operation of the process. Patients, suppliers, physician partners, and staff give input about process performance through direct interviews with the process owner or staff, focus groups, participation in satisfaction or customer service surveys, patient rounds, and leadership rounds on staff.

6.2a(5) Minimizing costs, preventing errors and rework: BMH minimizes overall costs associated with errors and rework through effective process design focused on process standardization and proactive identification of potential failures during the PLAN phase of the PDCA model. Like key healthcare processes, regular quality inspections and audits are reported to, and analyzed by the accreditation and regulatory oversight committee and the patient safety committee. Through these committees, BMH reviews evidence-based research and conducts RCAs and FMEAs on key support processes to determine further opportunities to reduce errors.

6.2-1 Key Business and Support Processes, Requirements and Measures

Key Process	Key Requirements	Key Measure
Materials Management	Quality, Low cost, Timely, Productivity, Cycle Time, Efficiency	Cost savings
		Total materials/total hospital expense
		Internal fill rate
		Linen fill rate
Environmental & Safety Management	Environmental Responsibility, Efficient, Clean, Safe, Prepared, Productivity, Cycle Time	Energy conservation
		Recycled waste
		Satisfaction with Security
		Cleanliness Satisfaction
		Empl. perception of safety
		OSHA injuries
		Sprains & strains
		Annual employee MWR
		Safety drill completion
		Infant abduction drills
		Dept. health & safety rev.
		Bed turnaround
Financial Management	Accurate, Timely, Efficient, Profitable, Productivity, Cycle Time	Gross days in AR
		Audit findings
		Return on assets
		Profit margin
		Current ratio
		Profit
		Profit margin by delivery mechanism
		Donations
		Community benefit
Human Resource Management	Competitive, Low cost, Timely, Competent, Work/life balance, Productivity, Cycle Time, Efficiency	Turnover
		Vacancy
		Internal referral
		Job growth
		Timely perf. appraisals
		Training hours per FTE
		Development investment
		Tuition assistance
		Satisfaction
		Job mobility
		TB test compliance
		BAC reimbursement
Information Management	Timely, Accurate, Efficient, Available, Effective, Productivity, Cycle Time	IT first call resolution
		Document delivery
		Doc. Delivery cycle time
		Med. record delinquency
		H&P transcription TAT
Guest Services Management	Timely, Responsive, Quality, Productivity, Cycle Time, Efficiency	Security satisfaction
		Concierge requests
		Food service quality
		Meal delivery time

6.2a(6) Improving healthcare processes, keeping current: To keep current with healthcare needs, improve key business and support processes, as well as share knowledge to drive organizational learning and innovation, BMH utilizes a systematic approach consistent with key healthcare processes as described in item 6.1a(7).

6.2b Operational Planning

6.2b(2) Ensuring adequate financial resources: A key improvement in the SMM was the integration of the strategic and financial planning processes. Using Baldrige feedback, these two processes have been integrated to ensure adequate financial resources are available to support operations, and to determine the resources needed to meet financial obligations for both the ST and LT planning horizons. BMH uses a 10-year financial plan which tracks debt outstanding and planned debt issuance (principle and interest payments), financial ratios, cash flows, major capital projects, consolidated balance sheet, and targeted net income for LT planning. The 10-year plan is updated at least annually in conjunction with the SMM but can be updated at anytime should changes or new financial obligations arise as part of the continuous planning process. The annual budget is designed to meet ST or current financial obligations, and the targeted annual bottom line flows from the 10-year plan. Through the SMM planning process, the BOD and ET balance priorities and plans to ensure that adequate financial resources are available to support major new business investments and to reach the targeted bottom line.

BMH assesses financial risks with current operations and new investments using a comprehensive business planning process that contains very detailed financial performance analysis including a payor mix review, contribution margin and profit (loss) comparisons and projections, physician contribution margin and profit (loss) trend, return on investment and payback period (if capital required). For new business opportunities that are not budgeted during the SMM, there are contingent funds available for new capital investments. This allows for agility and rapid implementation of new plans as part of the continuous planning process.

6.2b(2) Ensuring continuity of operations: BMH works in concert with other Michigan hospitals, state and local governments to assure that we are responsive to the needs of the community and prepared to handle any type of event or disaster. The hospital ensures continuity of operations in an event of an emergency through a robust four-phase planning process within the disaster management plan (DMP): mitigation, preparedness, response, and recovery. Key objectives of the plan include:

- to provide a solid framework and procedures for the safety and security of all patients, visitors and employees;
- to effectively respond to and recover from any disaster that might affect the hospital;
- to provide community accountability through preparedness plans to ensure the continuation of key healthcare services to the community in the event of an emergency or disaster.

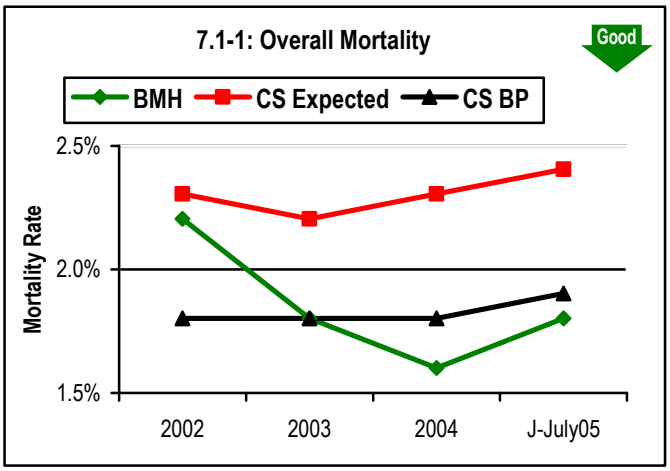
BMH's environment of care (EOC) is overseen by the environmental safety manager. In order to effectively manage all seven of the EOC functions, BMH invested in extensive training for the environmental safety manager. His credentials include: Michigan police officer, hazardous materials specialists, certified fire inspector, and JCAHO life safety code engineer surveyor (one of only 50). A key element of the mitigation phase is annual completion of the hazard vulnerability analysis by the emergency preparedness committee. In addition to local and regional issues, the analysis considers national and international events, such as bio-terrorism, terrorism, power outages, and weather-related events. BMH evaluates disasters and events around the country to test its readiness capabilities. The analysis findings define the preparedness phase of the plan, including annual priorities for quarterly safety training, drills, and emergency preparedness activities. BMH has a one-plus-one plan in place to ensure vital equipment, supplies, food and utilities can be supplied in an emergency situation. The plan looks at BMH's ability to provide services as well as the vendors that supply the hospital. There are redundant procedures in place for vital function such as oxygen, food service, information and data management, and utilities. Following the PDCA model, all emergency preparedness and safety drills are evaluated through cycles of improvement. The PDCA process lead to the development of BMH's state-of-the-art HEICS, including advanced communication technology (repeater towers, portable radios, web cameras, plasma televisions), well-trained incident commanders providing 24x7 coverage, a detailed and specific ER incident command structure, and a well-equipped decontamination process. Identified as a best practice, hospitals and government agencies from across the country have visited BMH to learn about the HEICS process.

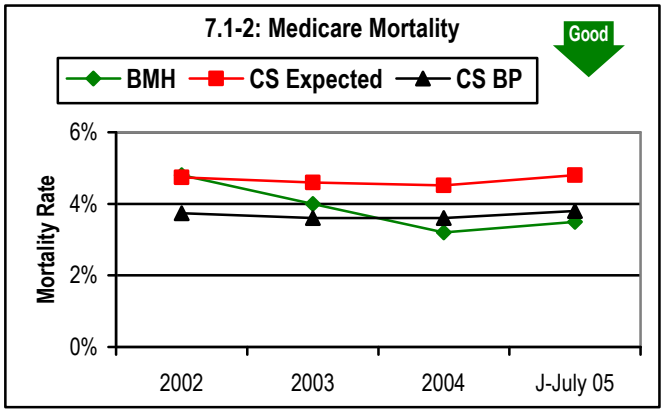
7 Organizational Performance Results

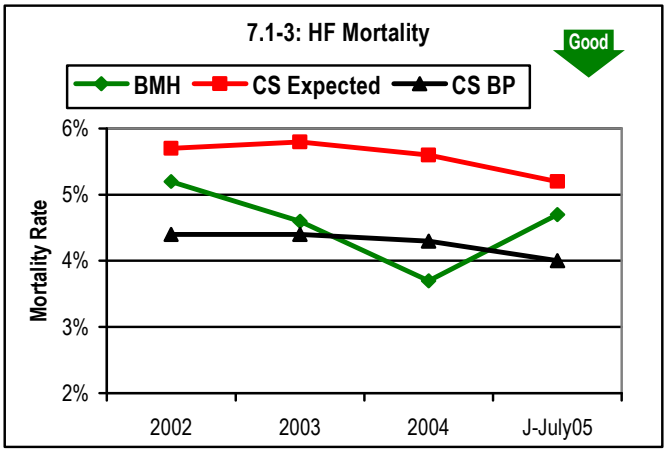
BMH's culture integrates a focus and passion for excellence. Since the late-1990's, the ET has been using the Baldrige criteria as a business tool to further the quest for excellence. The robust Baldrige feedback process has promoted breakthrough performance improvement, enabling BMH to "outperform" its vision statement to be *the system of choice in the region.* In 2002, the visionary BOD and ET developed a new organizational vision, *to be a national leader in healthcare quality.* This statement was developed as a challenge to achieve aggressive goals that focus on national best practice performance. BMH seeks to compare quality and service outcomes with other healthcare systems in the nation, while still competing for and serving patients in the regional market. The journey to excellence is evidenced by excellent clinical performance, unprecedented growth, strong financial performance, as well as superior customer service. BMH's overall performance meets or exceeds national comparisons in most key measures as demonstrated by results in this category. Comparisons reflect the latest available data.

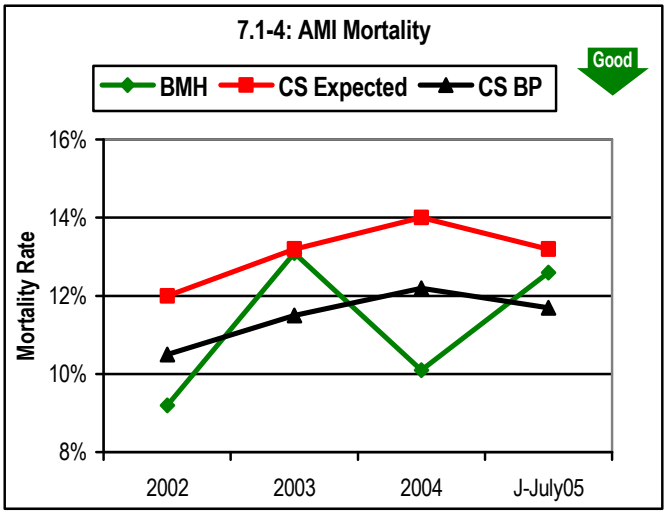
7.1 Healthcare Results

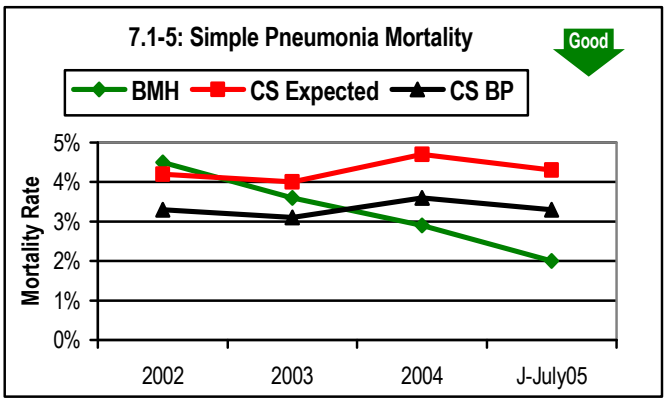
7.1a(1) Healthcare outcomes, service delivery and safety: As a healthcare provider, the premier strategy for BMH is CE, demonstrated by top placement in the pyramid-shaped PFE. The desire is to achieve excellent patient outcomes. The results of CE initiatives represent healthcare outcomes, service delivery and patient safety. BMH uses information from national databases to compare clinical performance with other organizations. One of the comparative sources used is CareScience (CS), a risk-adjusted database that provides outcomes for mortality, morbidity, length of stay (LOS), and charges. Based on the admitting diagnosis, complications and co-morbidities of inpatients, a predicted mortality rate, called the expected rate, is calculated. The database defines the best practice as the top 15% performing facilities with the lowest risk adjusted outcome rates for a given disease. Figure 7.1-1 is overall mortality. Figure 7.1-2, Medicare mortality rate, is segmentation of the aging population. Figures 7.1-3 through 7.1-5 are further segmented by patient diagnosis. Improvements were achieved by work teams partnering with physicians to implement evidence-based best practices, care standardization, and improved documentation of risk factors.



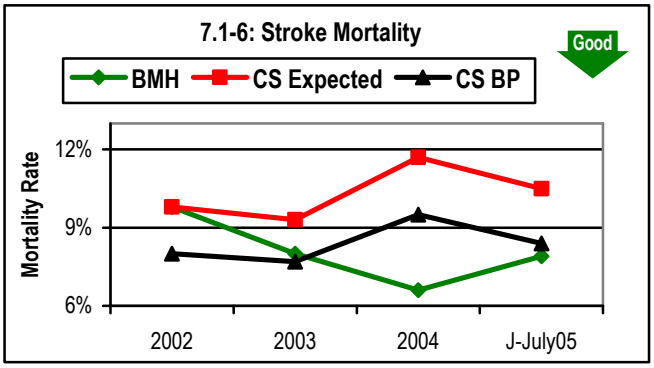








The in-process measures for heart failure (HF), pneumonia, and acute myocardial infarction (AMI - heart attack) in Figures 7.1-7 through 7.1-9 contribute to achievement of these positive mortality results. The slight increase in AMI mortality was investigated and it was determined to be due to random variation.

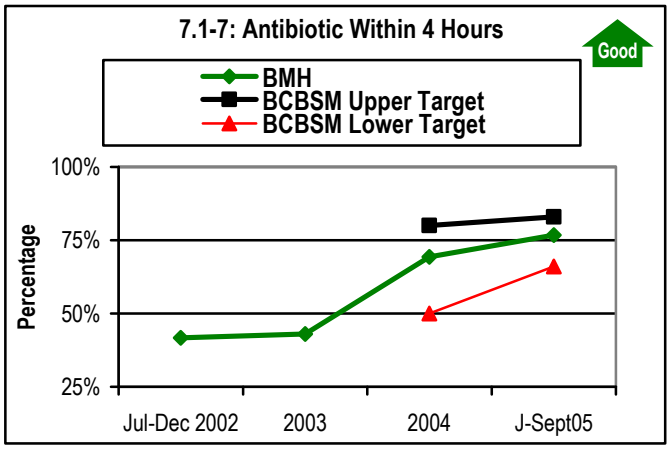


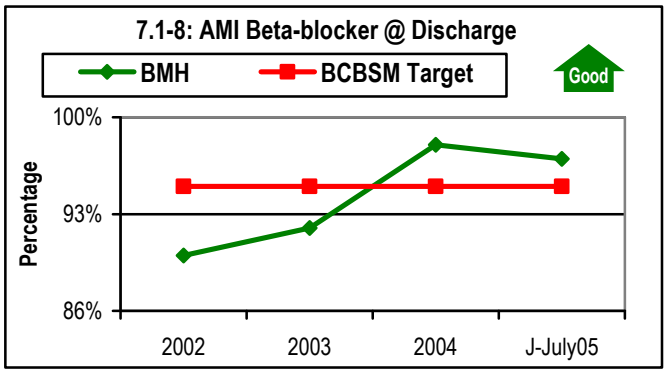
Stroke mortality, (Figure 7.1-6), was improved through a multidisciplinary team focused on implementation of best practice stroke protocols, including a new stroke call down process. Extensive internal and external communication about the signs and symptoms of stroke was provided to positively impact stroke outcomes. Our efforts focused on stroke care were validated when BMH received JCAHO primary stroke center certification in early 2005.

BMH partners with HealthGrades, a healthcare quality rating organization that rates 5,000 hospitals based on complications and mortality, to identify improvement opportunities using nationally recognized best practices. BMH's performance for AMI and hip replacement for 2001-2004 was significantly better than expected, resulting in a HealthGrades 5-star rating, the highest possible ranking. This performance was realized as a result of implementing utilization of aspirin and beta-blockers upon admission and at discharge, which are evidence-based protocols.

Figures 7.1-7 through 7.1-9 represent key in-process measures for improving outcomes for patients with AMI, HF and pneumonia as recommended by state and national regulatory agencies and Blue Cross Blue Shield of Michigan (BCBSM). Evidence indicates that antibiotics, administered within four hours of a pneumonia patient's admission, will reduce mortality. BCBSM, as part of an incentive improvement/payment program, set the target range for compliance in Figure 7.1-7. BMH sought the top of this range for its internal goal. The favorable trend is the result of a dedicated multidisciplinary team championed by ER physician leadership and the chief of staff. The team implemented new ER triage protocols that expedited the care of pneumonia patients. New pneumonia order sets were developed and readily accessible on the *Inside*Bronson intranet for physicians who send a patient as a direct admit to BMH. Root cause analysis (RCA) is completed for all patients that did not receive the antibiotic within four hours. Another important tactic for the team has been the education of all medical staff members. With the continued sharing of physician performance data, BMH anticipates achievement of BCBSM upper target performance in 2005 (Figure 7.1-7).

Evidence also indicates beta-blockers reduce the chance of a reoccurring heart attack, and improve overall heart health. To ensure the administration of beta-blockers at discharge, the discharge instructions were revised and performance is monitored on the cardiac service line scorecard as well as on physician performance reports (Figure 7.1-8).





The measures in Figure 7.1-9 were part of an organizational focus in 2004 and directly contribute to the mortality rates in Figures 7.1-3 & 7.1-4. The positive results are attributed to focused efforts through the cardiac SL, physician education, process enhancements for AMI and HF patients, as well as tracking and reporting of physician performance. For HF patients, there is a dedicated RN completing daily assessments of the plan of care and working with physicians to ensure compliance with best practice standards.

7.1-9 Core Measure Compliance Scores

Diagnosis	Indicator	BMH Jan-Sept05	BCBSM Range
HF	LVF assessment	96%	89-95%
	ACEI for LVSD	87%	84-95%
AMI	ASA @ arrival	99%	95%
	ASA @ discharge	98%	94-95%
	BB @ arrival	96%	92-95%

Infections resulting from surgery can prolong the patient's hospital stay and be costly. In-process indicators, called surgical infection prevention (SIP) measures, are evidence-based and have been shown to reduce the incidence of surgical infections at pilot hospitals (Figure 7.1-10). The key drivers of infections are reflected in three measures focused on the use of antibiotics, with comparative data at the state and national level. Improvements were achieved through the implementation of new pre-printed order sets in the OR, by

changing the role of the pre-admission RN to administer the antibiotic instead of the anesthesiologist, and by regularly monitoring and communicating performance results.

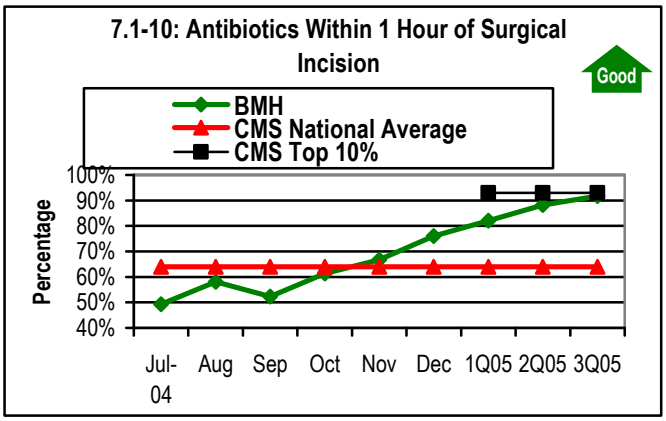
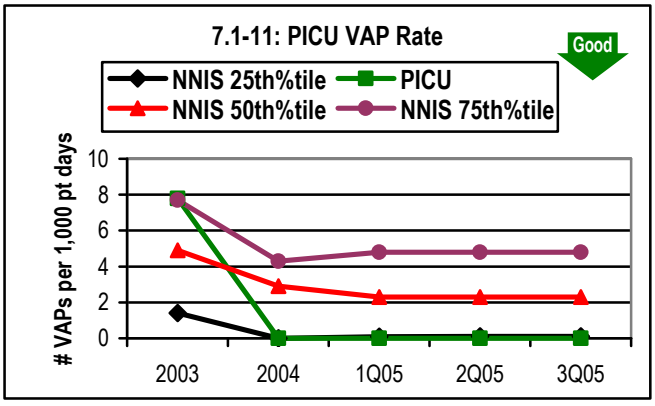
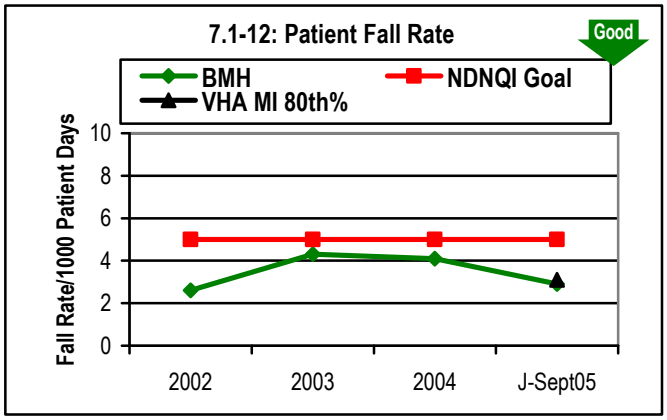


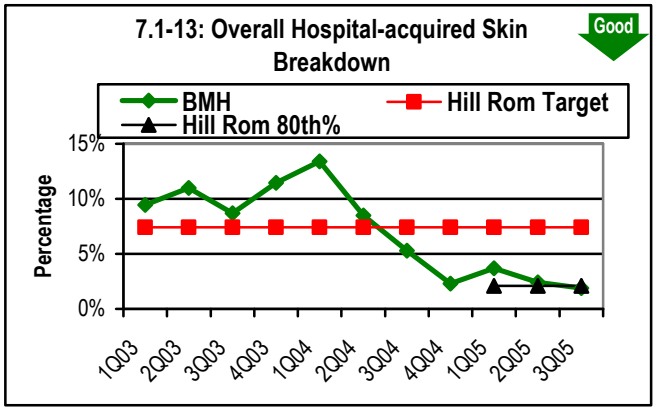
Figure 7.1-11 represents the ventilator-acquired pneumonia (VAP) rate. The Pediatric Intensive Care Unit (PICU) reduced the VAP rate from five in 2003 to zero in 2004, moving from the 75th percentile to the 25th percentile. Data for this measure is not available prior to 2003.



Organizational commitment to patient safety is reflected in the strategic priorities, organizational policies and practices. Patient safety is a strategic objective that supports the CE strategy, and the culture of safety is clearly ingrained in the commitment to excellence. BMH defines a culture of safety as continual identification of processes and systems that may pose a risk to patients. Prevention is a central element in patient safety action plans. BMH monitors patient perception of safety in the hospital using the patient satisfaction survey. Patient perception of safety at BMH has remained consistently high at 98%. Patient fall rate is a key indicator of patient safety and must be reported to regulatory agencies. BMH compares its fall rate with a national nursing database, NDNQI (Figure 7.1-12). With the growing patient census, the fall rate in 2003 experienced a slight increase. In response, a renewed focus on patient fall prevention was implemented. Patients are assessed upon admission and during each shift for their risk of falling. If the patient assessment indicates the patient is at risk for a fall, the bedside team initiates specific action steps. Actions include, but are not limited to, a bed alarm, activity vests, moving the patient to a room closer to the nursing station, and obtaining a patient companion. A weekly audit ensures that action steps were successful for patients at risk. Through participation in the NDNQI database, BMH has found best practice standards specific to each nursing unit.

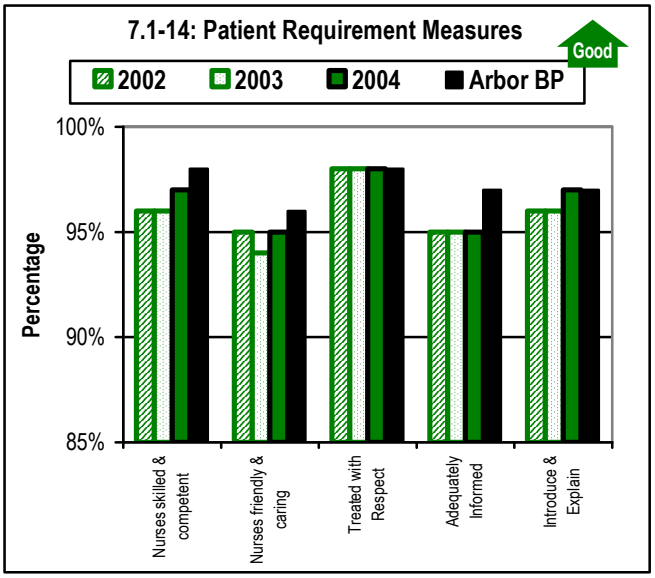


Hospital-acquired ulcers (skin breakdown) is a measure indicative of the nursing care provided (Figure 7.1-13). To manage hospital-acquired skin breakdown, every patient is assessed, upon admission and on every shift, to evaluate current skin condition and potential for breakdown during the hospital stay. If identified during the assessment process, a risk addendum, which defines the specific actions that need to take place, is initiated on the clinical pathway. Weekly audits validate that the actions have taken place. The DLNC conducts monthly point prevalence studies to evaluate breakdown and address issues as they arise.

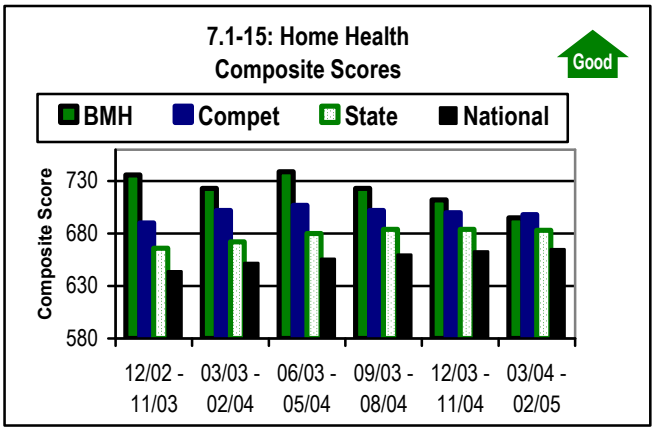


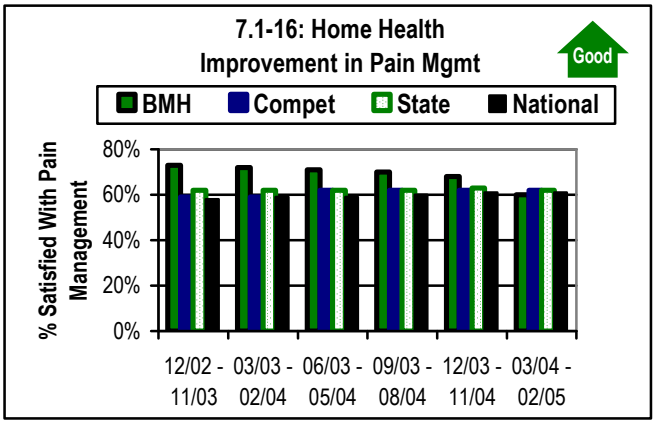
Annually, the Leapfrog Group releases results to the public for their Hospital Quality and Safety Survey, a national rating system. The Leapfrog Group is a coalition of commercial companies that have established a rating system for hospitals who voluntarily follow their guidelines. For the first time in 2004, the Leapfrog results provided a Safety Rating/Quality Index based on 27 National Quality Forum (NQF) measures, broken into 161 standards. BMH is in an elite group of hospitals that achieved full compliance with these measures. Only 21% of the 1,000 reporting hospitals received full compliance status.

BMH determines patient requirements through the CRP, which integrates information gathered from LLM. In addition to strong clinical quality outcomes, key patient requirements include communication, empathy, responsiveness and efficiency. Figure 7.1-14 includes patient satisfaction indicators, measured by Arbor through 2004, that directly correlate with patient requirements. The culture of service excellence is achieved by first hiring service-minded employees, and then training and creating accountability to follow the CSSE that drive excellence at BMH.

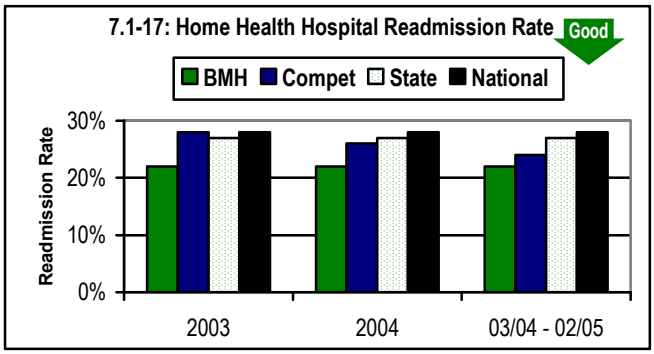


Home health is a Medicare-certified outpatient service provided in the patient's home. The quality of service provided by BMH home health has been measured through the CMS Home Health Quality Initiative since 2003. Figures 7.1-15 through 7.1-17 represent scores achieved from this. There are 11 areas of quality that fall into three categories: increase in functional status/activities of daily living (ADL), improvement in mental health, and management of medical emergencies. Figure 7.1-15 reflects a composite quality score across the 11 measurements. Since the initial rollout in 2003, BMH has been recognized as the leader in quality for southwest Michigan.

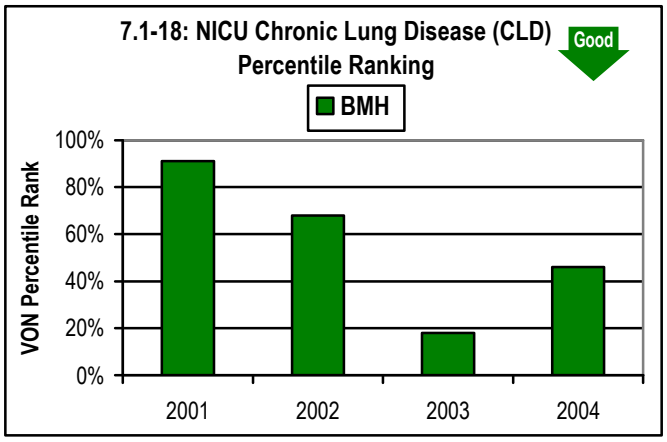




BMH home health has seen an increase in admissions for cardiac and orthopedic patients, making it imperative for pain to be managed. Controlling pain levels enables the patient to take a more active role in treatment, ADL and the recovery process (Figure 7.1-16). The patient is able to tolerate progressive therapy, which improves strength, movement and safety. Conversely, if pain is not adequately managed, it can adversely affect the patient's ability to perform ADL, increase anxiety, and prolong recovery. The staff has received focused education on pain and the impact it has on quality of care and improvement in outcomes.



BMH home health service provides an extension of the hospital into the community, playing an integral role in the continuum of care process. Through quality initiatives and alignment with hospital clinical strategies, home health is able to provide a higher level of quality care. The service uses high-tech tele-health equipment and has developed clinical pathways to assist the hospital in reducing acute care readmissions (Figure 7.1-17). Figures 7.1-15 through 7.1-17 will be updated this summer with the next data release of comparative information from CMS.

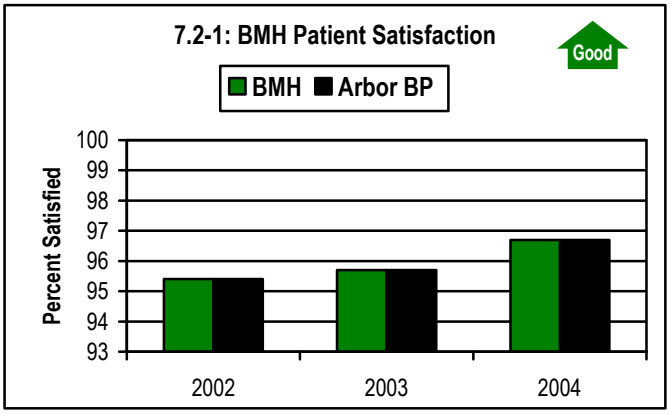


Since 1997, BMH's Neonatal Intensive Care Unit (NICU) has participated in the Vermont Oxford Network (VON), a worldwide group of 400 NICUs. BMH is now a Center of Excellence (top 25th percentile) in the VON database in four areas: chronic lung disease (CLD), morbidity, adjusted LOS, and total LOS. To achieve these results (Figure 7.1-18), the NICU team made changes in the respiratory management of their patients including: gentle ventilation in the delivery room with the use of the Neo Puff, and aggressive weaning off of ventilation. The management of CLD has significant impact on the wellness of these babies as they mature. The decrease in lung damage results in less susceptibility to respiratory infections during childhood. The percentile ranking provides BMH with the comparison within the VON database.

7.2 Patient- and Other Customer-Focused Results

7.2a(1) Patient and other customer satisfaction and dissatisfaction: BMH critical success factors related to the CASE strategy are to distinguish the hospital as the employer of choice, be recognized for a culture of service excellence, and foster a culture of excellence that values diversity. These differentiating factors are brought to life each day by staff that is committed to service excellence. Satisfied employees, working in an environment of teamwork, learning and innovation provide superior service to patients every day.

Figure 7.2-1 is overall patient satisfaction as measured by Arbor, comparing BMH to other hospitals of similar size in the database. Figure 7.2-2 reflects overall satisfaction, segmented by inpatient and outpatient services. BMH has been the best practice benchmark in the database since 2001, earning BMH the *Arbor Associates Award for Highest Overall Patient Satisfaction* four years in a row. Hiring for service, use of CSSE, and accountability are the building blocks to service excellence at BMH. Patient satisfaction is a component of the organizational gainshare program, rewarding staff for high patient satisfaction as well as other key performance indicators.



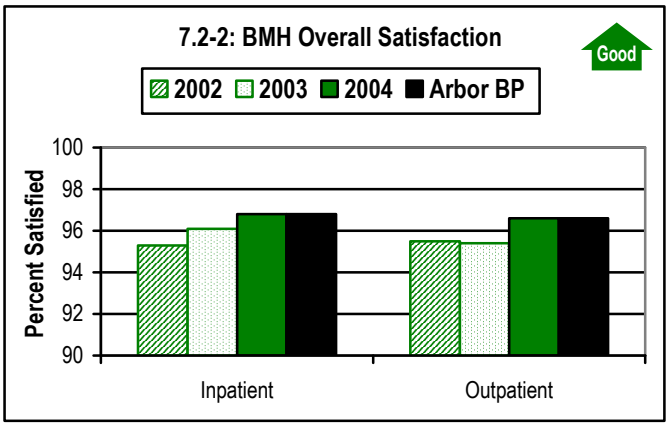
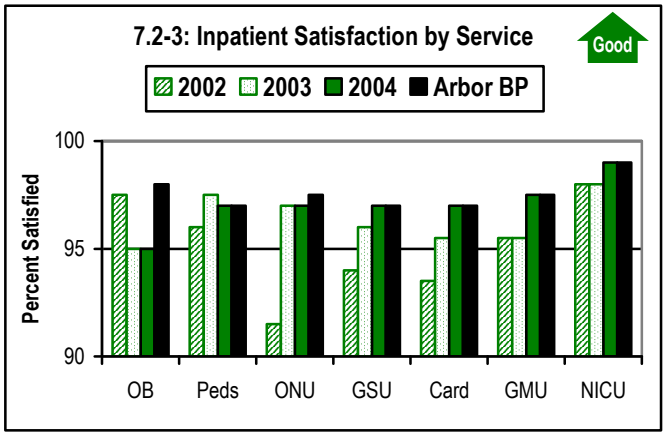
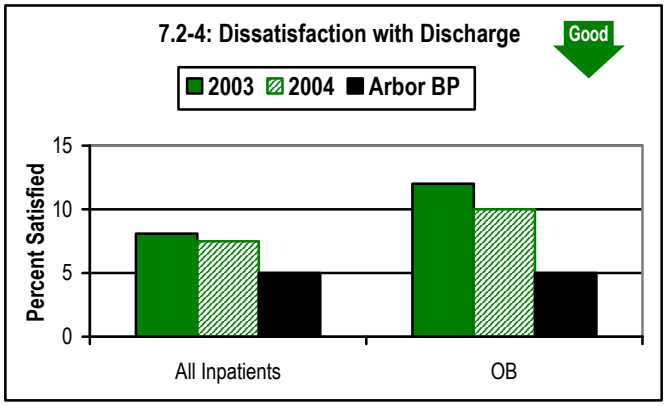


Figure 7.2-3 & 7.2-5 are segmented first by our two key delivery mechanisms, inpatient and outpatient delivery, then by clinical service area. OB satisfaction has declined slightly since 2003. The primary dissatisfier identified for OB patients is the discharge process (Figure 7.2-4). This question was added to the survey tool in 2003 because of its relative importance as a predictive indicator of patient satisfaction. To improve patient satisfaction with the discharge process in OB, a team is using best practices from IHI to improve patient flow. By scheduling discharges and monitoring achievement of targets, the OB staff is meeting patient expectations regarding discharge from the unit. The hospital's strong reputation as the Bronson BirthPlace has lead to steady growth of 11.2% in OB services since 2000. While many hospitals are choosing to close their birthing units, BMH remains committed by adding OB beds in a new facility development project started in 2005.





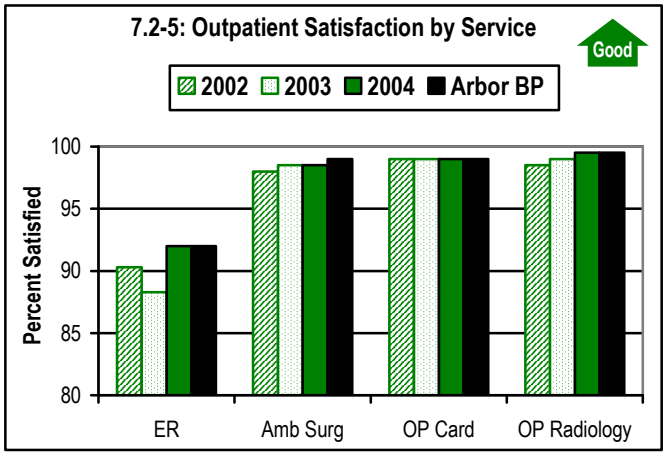
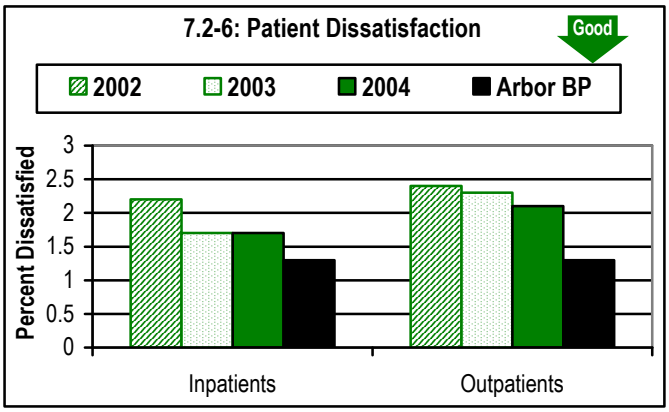
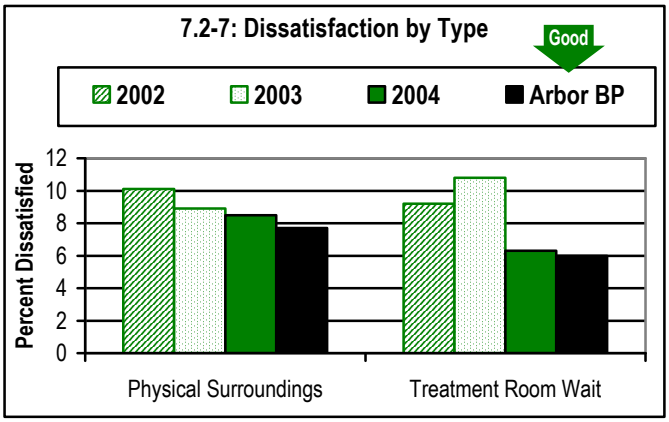


Figure 7.2-5 is outpatient satisfaction by service. ER satisfaction reached best practice level in 2004. BMH has experienced high growth in ER visits with a 23.3% increase since 2000 versus a negative growth in the overall market. Patients have a strong preference for BMH and they are choosing us for services over the competition. Inpatient growth has also been significant, causing capacity and wait time issues for inpatient admission. The result is a back-log of patients waiting in the already busy ER. To address this issue, BMH has implemented facility plans to add inpatient capacity

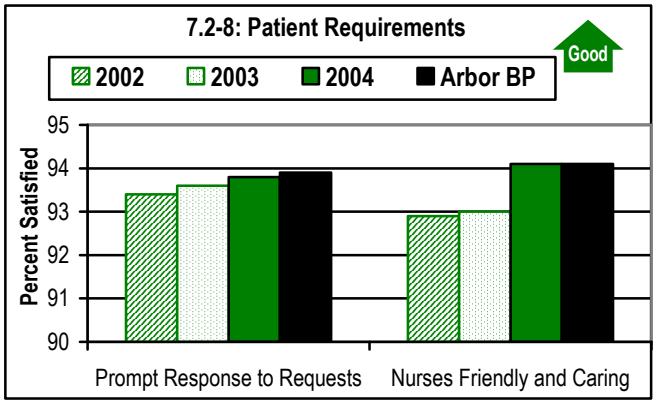
each year since 2002. Also, in 2004 a redesign of the ER department was completed to improve efficiencies. A team was chartered by the CASE SOT to specifically focus on improving patient satisfaction scores in the ER. Using the PDCA model, the ER Task Force enhanced responsibilities for the ER greeter and volunteer, increased environmental services coverage for cleaning public areas, revised the ER triage process, and added a plasma television to the patient waiting area.



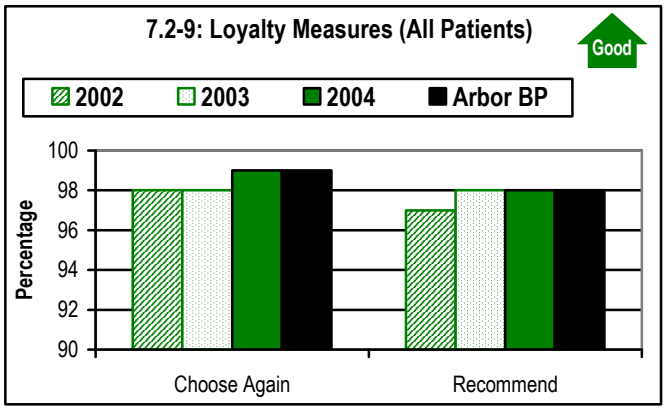
While working to improve patient satisfaction, BMH also seeks to minimize patient/customer dissatisfaction (Figure 7.2-6). Since BMH is a relatively new, state-of-the-art facility, patient expectations regarding the facility are very high. Issues with physical surroundings have been a focus for the CASE SOT to minimize dissatisfaction. Figure 7.2-7 includes two key areas of dissatisfaction for patients, physical surroundings (including noise, comfort of sleep sofas for family members, cleanliness, long walks from parking, room temperature) and wait times spent in ER treatment rooms. The CASE SOT chartered a team to address the physical surroundings opportunities. Actions taken to reduce noise levels include an internal noise awareness campaign along with establishment of official "quiet time" on patient care units. The ER Task Force, previously mentioned, implemented numerous tactics resulting in improvement in 2004.



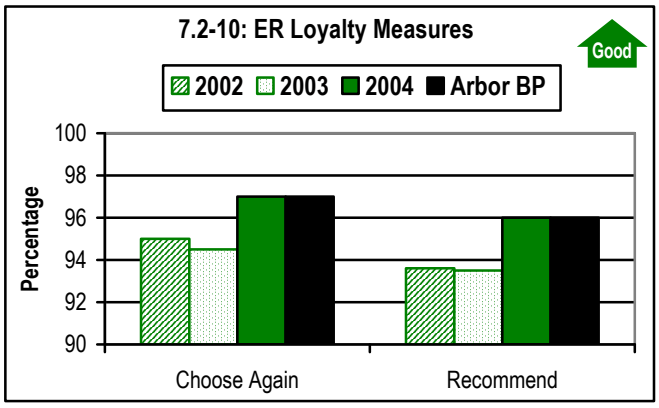
Understanding patient requirements and monitoring effectiveness in meeting expectations is part of BMH's commitment to customers. Another requirement of BMH patients is empathy, measured by the patient satisfaction question "nurses are friendly and caring." BMH's ability to meet both efficiency and responsiveness requirements of patients is reflected in (Figure 7.2-8) as "prompt response to requests."



7.2a(2) Perceived value, loyalty and retention: Patient loyalty is measured by two elements in the Arbor survey, a patient's willingness to recommend the hospital to family and friends and the patient's willingness to choose the hospital again. BMH uses this loyalty measure as an assessment of the overall patient experience (Figure 7.2-9). The quality of the overall experience with BMH, as well as the relationship that is established with the hospital, are key factors that drive loyalty. Through the organizational commitment to quality, safety and superior customer service, BMH builds loyalty with patients.

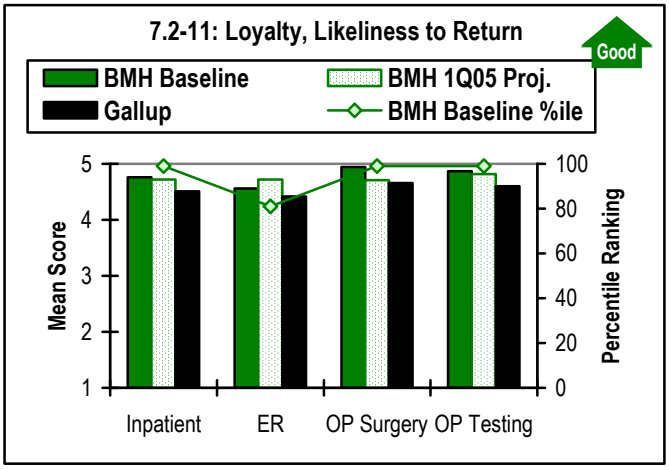


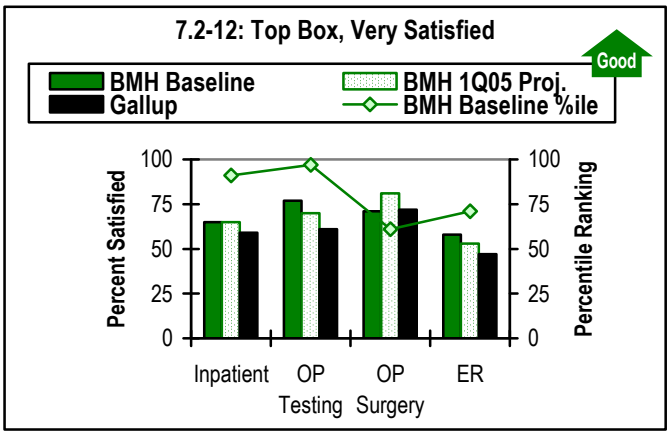
Improvements in meeting patient requirements have not only improved the overall satisfaction, but also the loyalty measures as shown for the ER in Figure 7.2-10.



As BMH strives to achieve its new vision to be a national leader, the ET continues to look at all benchmark comparisons to confirm that BMH is being compared nationally to other healthcare organizations. In the area of patient satisfaction, the Arbor database is limited to

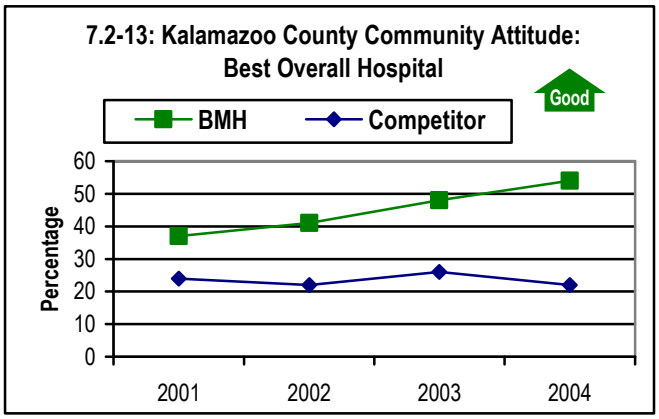
regional (Midwestern) hospitals. While this was sufficient in meeting our old vision, it did not support accomplishment of the new vision. Therefore, in 2005, BMH contracted with the Gallup organization, a leading national provider, to complete all patient satisfaction surveys. In preparation for conversion to the Gallup tool, a pilot sample survey was conducted in 2004 to establish a baseline of performance for 2005. Figure 7.2-11 shows that loyalty measures were in the top 1% for inpatient, outpatient testing and outpatient surgery, and ER loyalty was in the 81ST percentile. Use of the PDCA model, and facility planning, are making an impact in the ER. BMH is also working with the community FamilyHealth Center to provide primary care access to patients without a primary care provider in order to decrease unnecessary usage of the ER. Another measure, related to patient loyalty, is patient opinion of who is "best at treating your medical condition." BMH ranked in the 96th percentile with a mean score of 4.63, versus the Gallup mean of 4.38 for this measure in the baseline survey. First quarter 2005 projections for patient satisfaction, as measured by Gallup, are provided using preliminary data from the online cumulative survey reporting tool with 96% patients reporting. Complete first quarter reports will be available in late May.



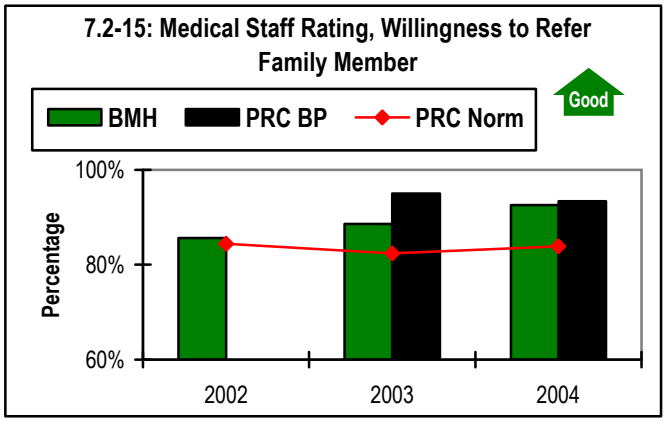


In 2005, BMH began to measure not just overall patient satisfaction but also "top box" rankings, the highest possible score on the satisfaction rating scale. Figure 7.2-12 is percentile data from the Gallup baseline survey in 2004 and first quarter 2005 projections for patient satisfaction, as measured by Gallup, with 96% patients reporting.

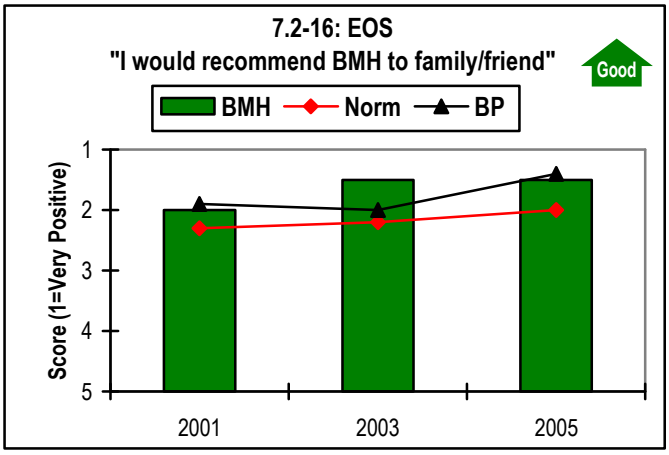
BMH does not have access to patient satisfaction comparative data for its major competitor in the primary market. However, community attitude is a strong indicator of the local community preference between BMH and the local competitor. BMH works with Arbor to measure its perceived value, relationship building effectiveness, and image in the community with an annual community attitude survey of residents in Kalamazoo County. For five years BMH has been rated the "best overall hospital", with the gap widening each year (Figure 7.2-13). BMH's pursuit of excellence in quality, service, efficiency, growth, financial performance and benefit to the community has contributed to the ever widening gap between BMH and the competitor. Figure 7.2-14 (which has been removed for competitive reasons) reflects community preference by service line. BMH continues to increase community preference in our services through partnerships with high quality physicians as well as outreach to the community.



BMH also measures the perceived value by physician partners and employees. Figure 7.2-15 reflects physicians' willingness to refer a family member to BMH as measured through a physician satisfaction survey conducted by Professional Research Consultants (PRC) annually, during the fourth quarter. This indicator directly relates to the physician requirement of the hospital for high patient satisfaction. 2005 data is not available at this time.



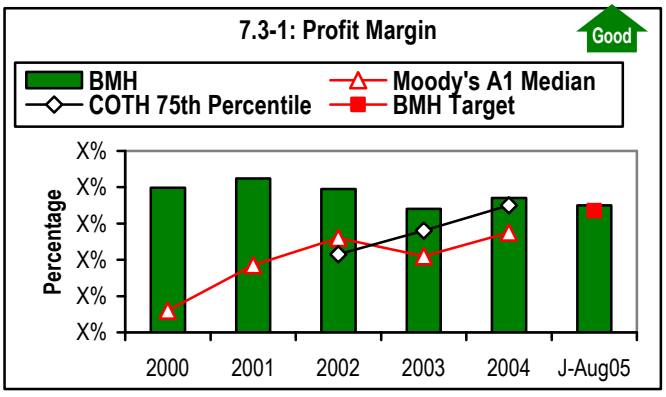
Employees have indicated on the EOS that they also would recommend BMH services to a family member or friend (Figure 7.2-16). This data is not available for 2002 and 2004 as this question was not asked.



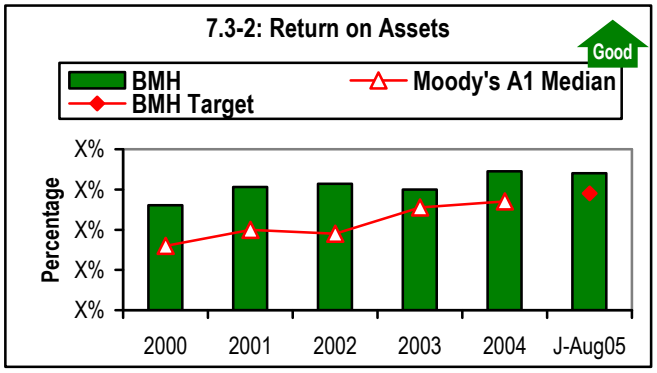
7.3 Financial and Market Results

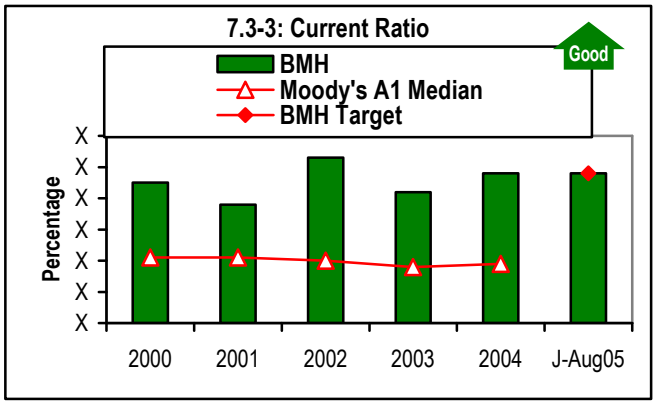
A critical success factor for BMH is to achieve strong financial performance to enable capital reinvestment, growth and sustainability. The hospital uses an annual budget process and a 10-year financial plan to manage and balance the hospital's ST and LT financial needs. Financial and market results are displayed with five-years of data for review and assessment of LT strategy.

7.3a(1) Financial performance: Moody's publishes ratings on approximately 570 not-for-profit healthcare issuers with over $112 billion of outstanding debt. BMH holds a positive position in Moody's ratings distribution of hospitals. Shrinking reimbursement rates for government payors, and increasing uncompensated care represent strategic challenges for BMH and all healthcare organizations. According to Moody's, providers with larger revenue totals tend to possess greater resources to withstand the industry pressures. The 2003 Moody's median total operating revenue for A1 hospitals was $300 million. BMH total operating revenue (vs. gross patient revenue listed in P.1-1) was $596 million in 2003 and $683 million in 2004. Profit margin is calculated as the difference between revenue and total expenses, divided by total revenue. Over the last several years, BMH's profit margin has exceeded the COTH 75th percentile and the Moody's median as seen in Figure 7.3-1. The Moody's median is used as a comparison for hospitals with A1 ratings.

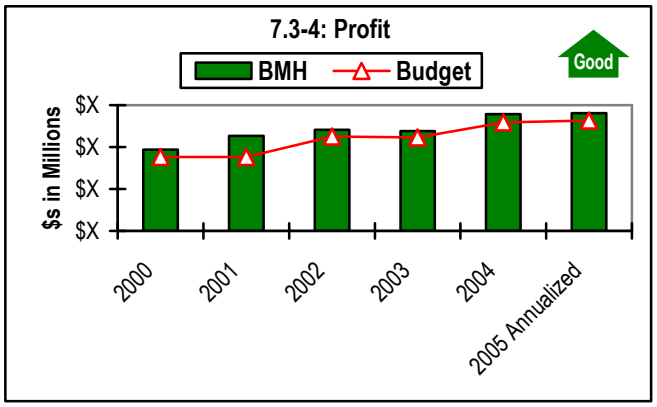


Net income divided by total assets, expressed as a percentage, is the calculation of the return on assets (ROA). ROA is a measure of a hospital's profitability. As indicated in Figure 7.3-2, BMH's ROA has improved by nearly 1% and the hospital has consistently achieved a higher ROA than the Moody's A1 median.

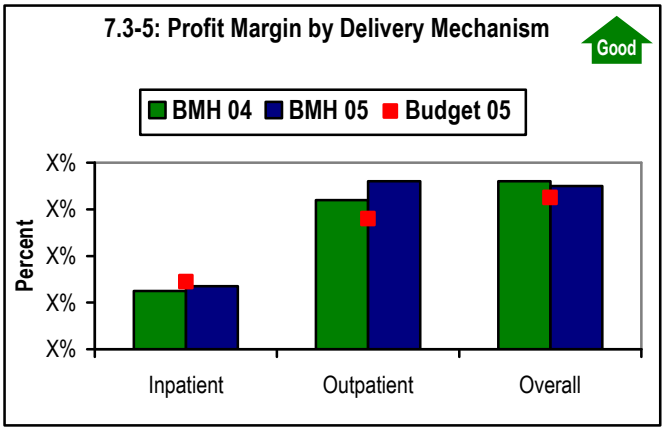




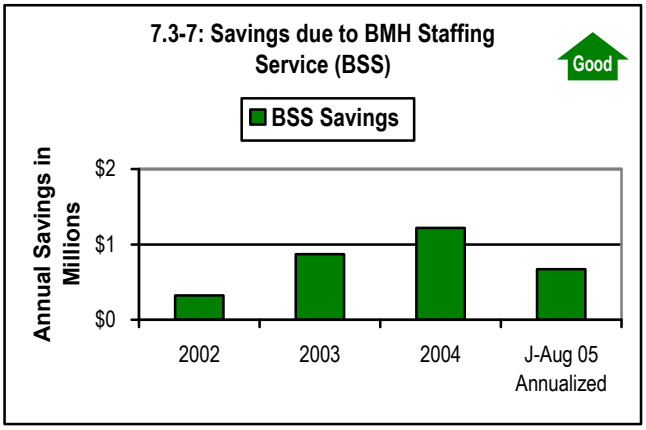
Current ratio, shown in Figure 7.3-3, is an indicator of a hospital's liquidity and ability to meet ST obligations. BMH's current cash position remains strong and exceeds Moody's median despite a significant outlay of cash in 2001 to fund the new facility. (The facility opened December 2000, in the beginning of 2001 we were still paying for the equipment and facility.) To ensure the LT financial health of the hospital pension plan, BMH infused cash into the plan in 2003. This cash infusion was due to the decline in investment income and market value of securities.



Profit, or excess revenue over expenses (Figure 7.3-4), has consistently met or exceeded the annual budget and the 10-year strategic financial plan. The profit margin is targeted at 7% in the 10-year strategic financial plan.

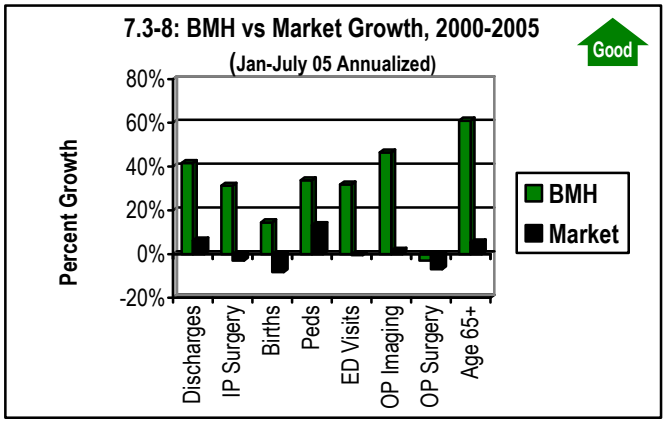


To continue to improve operational performance, BMH analyzes operating margin by healthcare service delivery mechanism. Figure 7.3-5 reflects operating margin by delivery mechanism compared to the annual budget. For further segmentation, Figure 7.3-6 (removed for competitive reasons) lists profit per case of the services targeted for growth and development. Despite BMH payor mix of 18% Medicaid, we are able to achieve profit in these key SLs. In 2001, the Performance & Profitability (P&P) team began to analyze operating margin data to identify opportunities for cost, process and quality improvements by department. In 2004, the team analyzed opportunities in specific diagnosis related groups (DRG). The assessment of cardiology services led to contract renegotiations with savings of $1.2 million per year.

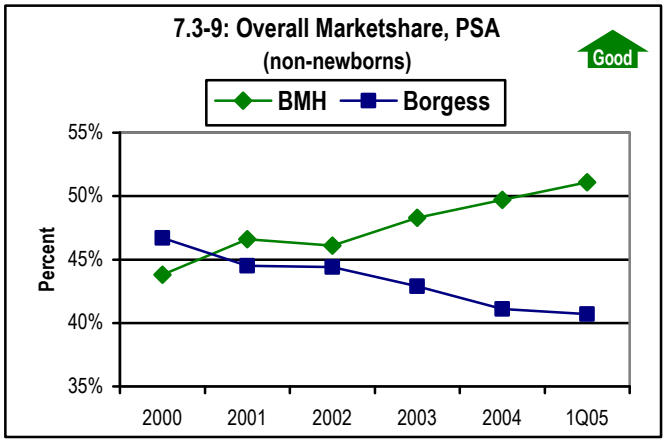


In 2002, BMH introduced a new service, Bronson Staffing Service (BSS), which provides temporary staffing to BMH internal departments. This new service has had a positive financial impact (Figure 7.3-7) as the organization no longer pays for external temporary staffing agency assistance. Also, BSS provides a unique staffing opportunity for employees who desire flexible positions but do not require full-time benefits. Since 2002, the total savings generated by BSS is $2,617,113. It is anticipated that 2005 savings will be much less as the BSS will not be utilized due to the low vacancy rate.

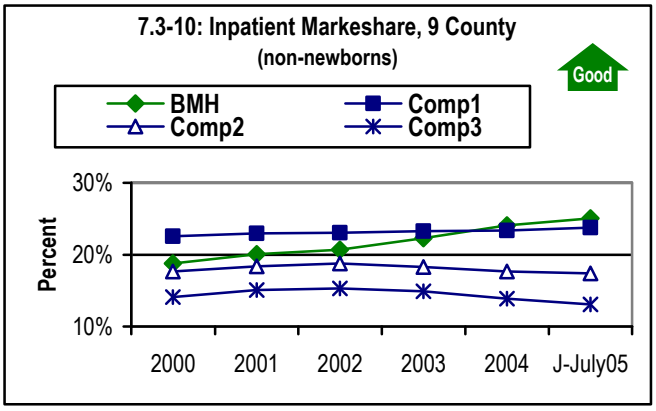
7.3a(2) Healthcare marketplace performance: By maintaining high quality clinical outcomes and superior service, BMH has experienced exponential growth in the last five years. This growth has outpaced the overall growth in the southwest Michigan nine-county market (Figure 7.3-8). Population growth in southwest Michigan has been moderately slow, with 2% growth from 2000 to 2004.

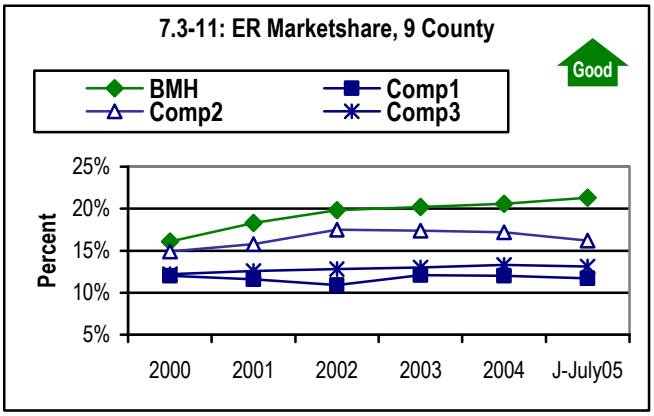


BMH is one of two major hospitals in the Kalamazoo County primary service area (PSA). BMH has been the leader in the PSA since 2000, and the gap between the local competitor and BMH continues to grow (Figure 7.3-9). Further segmentation by market area, delivery mechanism, and service has been provided.



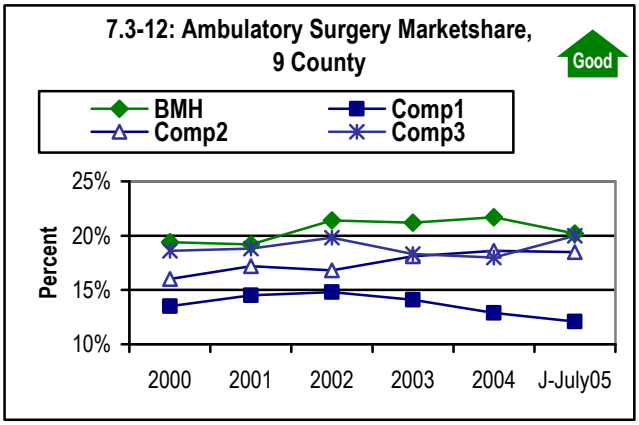
Since opening its new facility in 2000, BMH has experienced 34% growth in discharges (not including newborns) and 30% growth in outpatient visits. With 20,481 discharges in 2004, marketshare grew to 24% and BMH remains the market leader in the nine-county region of southwest Michigan (Figure 7.3-10). BMH is well positioned to maintain this market leadership role as evidenced by community attitude data that identifies BMH as the best hospital in the area. In 2004, community perception of BMH as the best hospital in the area grew to an all time high of 54 points with a 32-point gap between BMH and the nearest competitor. For seven years in a row, BMH has been named *Kalamazoo's Leading Hospital* in the annual Adam's Outdoor survey. BMH has also been the Consumer Choice Award winner as the top hospital in the Kalamazoo area according to National Research Corporation (NRC) for the past two years. It is clear that patient preference has contributed to the dramatic growth in discharges at BMH, outpacing the market growth.



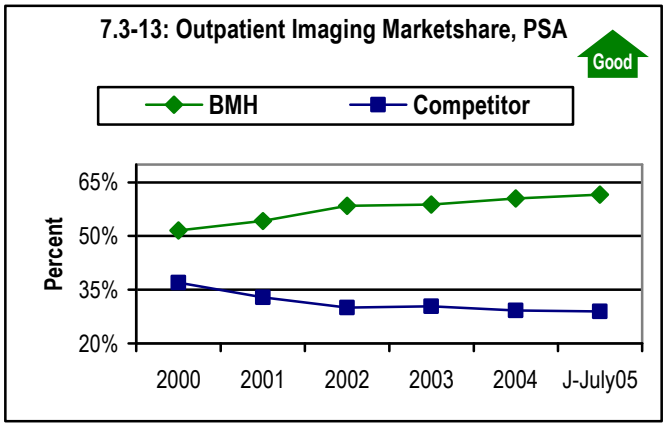


The new facility, ER, and Chest Pain Emergency Center in 2000, coupled with numerous improvement strategies identified and implemented by the ER Task Force to enhance customer service, have contributed to the results shown in Figure 7.3-11.

Despite the new competition from physician-owned freestanding ambulatory surgery centers, BMH ambulatory surgery marketshare in 2004 continued to grow but declined slightly in first quarter 2005 (Figure 7.3-12). Marketshare comparisons for the physician-owned centers are not available. BMH's outpatient surgery team prides itself on providing exceptional customer service. To position BMH as a leader in this service, the unit participated in a "delight unit" pilot project in 2004 to implement creative strategies to increase "top box" patient satisfaction scores. In addition, the state-of-the-art operating rooms, with capacity increases in 2002 and 2004, continue to meet surgeon and patient needs.



Outpatient diagnostic imaging is a primary service as opposed to a tertiary service, so the meaningful comparison is to the local competitor. Figure 7.3-13 illustrates the volume of outpatient imaging procedures performed by hospital-based facilities in Kalamazoo County. The centralized outpatient testing center (OPT) at BMH is literally a one-stop shopping destination for patients. Processes are efficient and staff is focused on eliminating patient wait time. Use of the latest technology, such as PACS and the clinical portal, increase timely access to diagnostic test results for physicians.



Through the strategic planning process, BMH has identified and targeted specific SLs for growth and development. These profitable services contribute to LT financial sustainability and allow BMH to continue to fund other, less profitable mission-driven services, as well as invest in new technology for the future. BMH has been successful in growing these targeted services as illustrated in Figure 7.3-14. Through strong physician partnerships, BMH has achieved excellent patient outcomes and continues to grow these services.

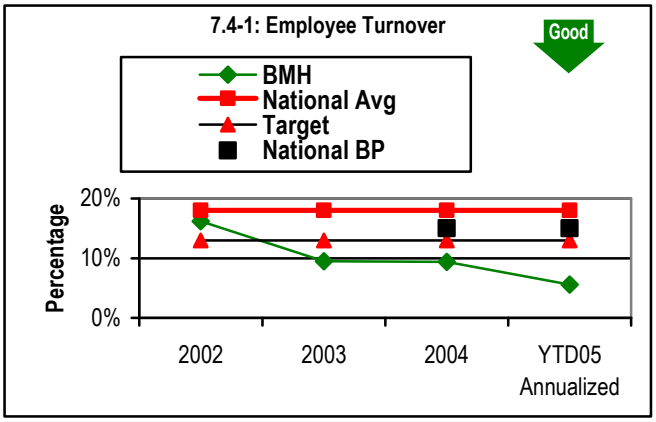
Figures 7.3-14 through 7.3-16 related to targeted growth areas have been removed for competitive reasons.

7.4 Staff and Work System Results

A key to BMH achieving its vision lies in the organization's ability to recruit and retain a highly competent, committed staff. BMH efforts related to workplace excellence and work/life balance have resulted in the following recognition:

- *100 Best Companies for Working Mothers* by Working Mother magazine (2003 & 2004)
- Fortune *100 Best Companies to Work For* (2004 & 2005)
- *West Michigan's 101 Best and Brightest Companies to Work For* "Best of the Best" Award (2003) and "Elite Winner" Award (2005) by the Michigan Business and Professional Association
- VHA Leadership Award for Operational Excellence (2005)

7.4a(1) Work system performance: Key measures of workplace excellence and employee satisfaction are employee turnover and vacancy rates (Figures 7.4-1 through 7.4-4). BMH workforce development initiatives contribute to the low turnover rate for RNs, the largest single job class at BMH, and for all job classes. Research indicates that low turnover is positively correlated with increased levels of patient satisfaction and higher levels of quality care. Recruitment, replacement, and training costs as well as temporary/agency usage are also avoided.



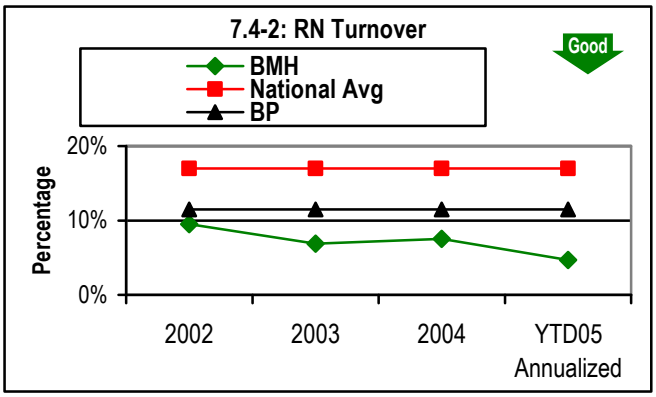
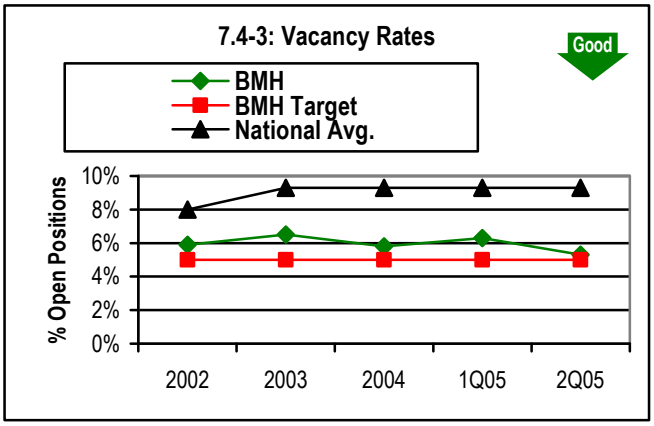
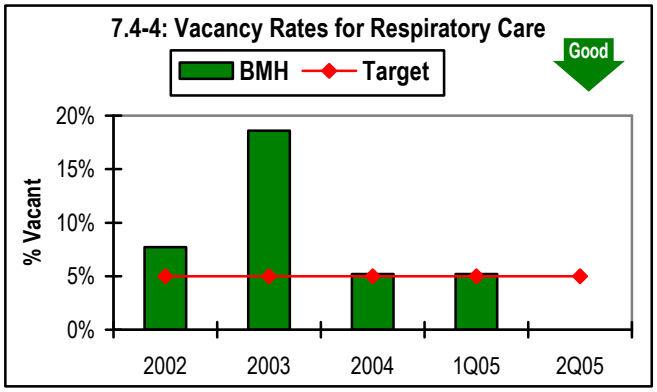


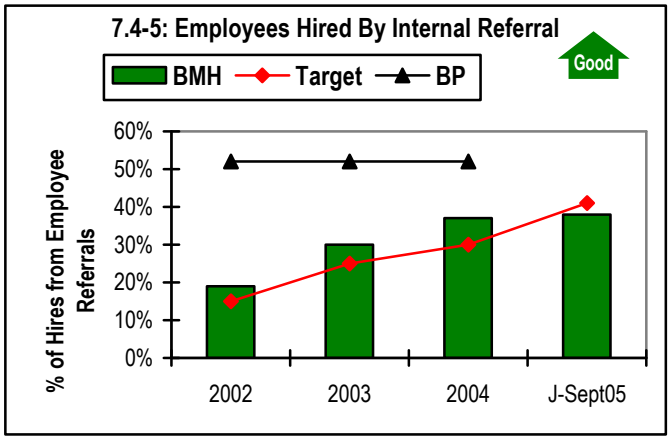
Figure 7.4-3 reflects open positions as a percent of approved positions. The consistent favorable trend over the past three years demonstrates the effectiveness of the workforce development initiatives. The BMH target is based on the industry definition of full staffing.



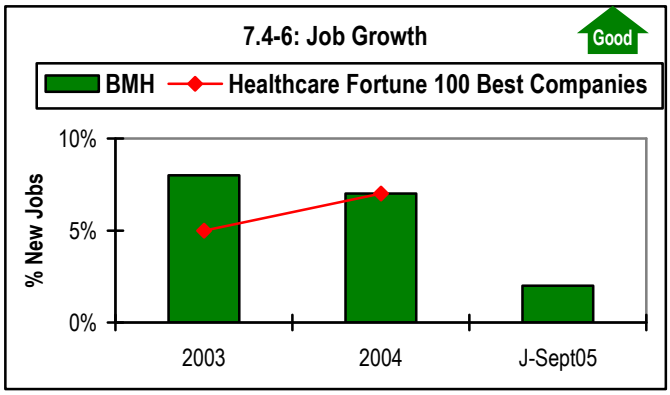
Respiratory care positions have been identified as critical need positions not only at BMH, but throughout the healthcare industry. In spite of this, the hospital has been able to maintain low vacancy rates (Figure 7.4-4). BMH is proactively addressing the future needs for these positions with the Respiratory Care Career Development Program. Growth in services created 18 new positions causing a temporary spike in vacancy in 2003.



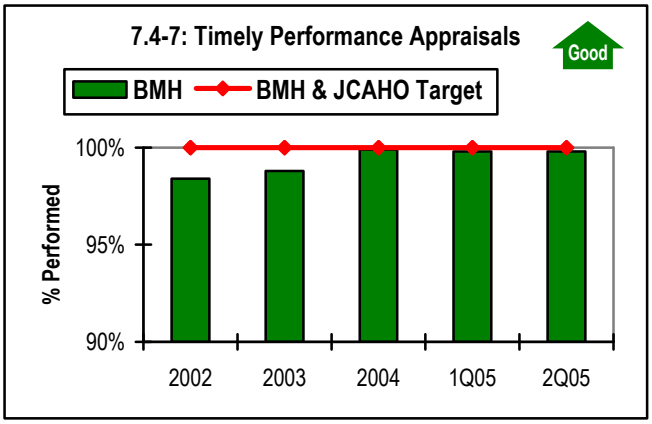
Internal data analysis indicates that new employees referred by current employees have lower 90-day turnover rates than others, resulting in lower overall turnover. BMH encourages staff to recruit future co-workers who have a strong commitment to superior customer service (Figure 7.4-5). Since inception of an employee referral program in 2002, internal referrals have increased by 105%.



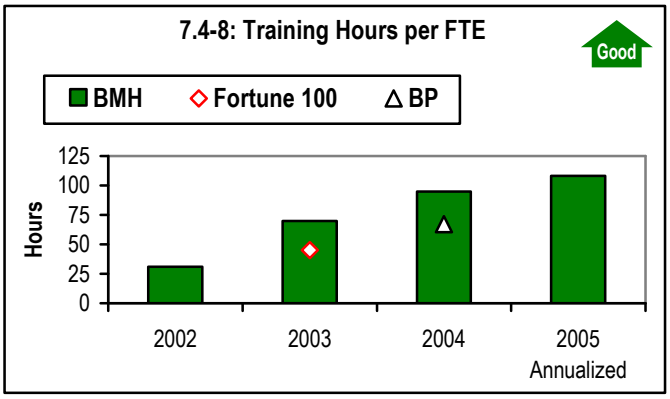
As one of the largest employers in Kalamazoo County, BMH is a community leader and looked to for employment opportunities by regional residents. Due to growth in services, BMH job growth surpasses that of other Fortune 100 best companies (Figure 7.4-6).

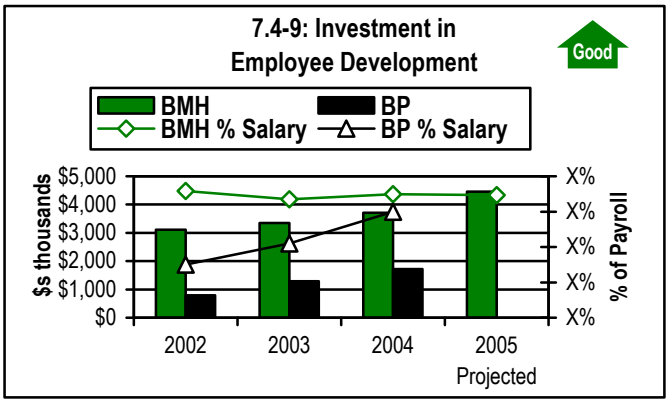


Providing feedback on employee performance through timely performance evaluation is crucial for employee performance improvement. In addition, orientation and annual appraisal meetings are valued opportunities for managers to receive feedback from their employees on how well they are doing as leaders. BMH has focused on reducing the number of employees who receive late evaluations (Figure 7.4-7).

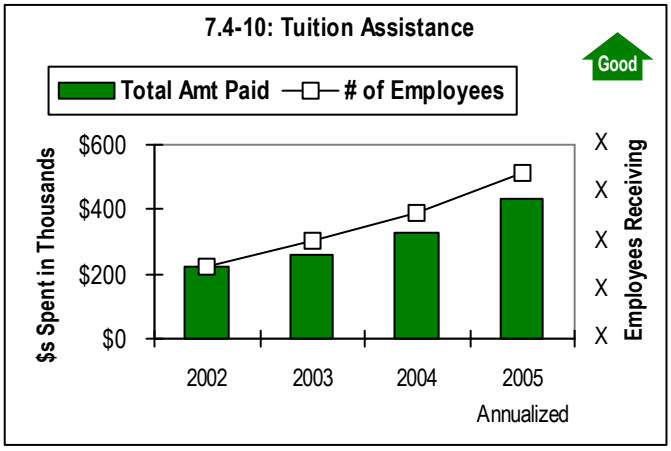


7.4a(2) Staff learning and development: Figure 7.4-8 shows continued growth in training hours per FTE. Investment in employee development as a percent of payroll has remained strong over the last three years (Figure 7.4-9).

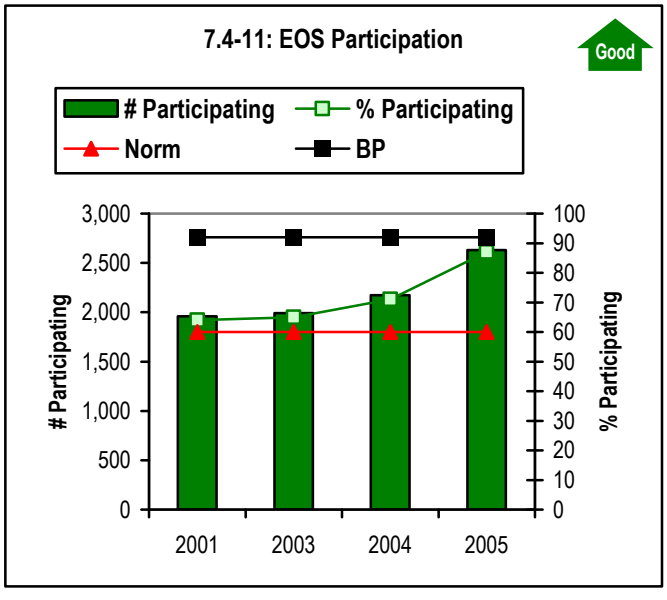


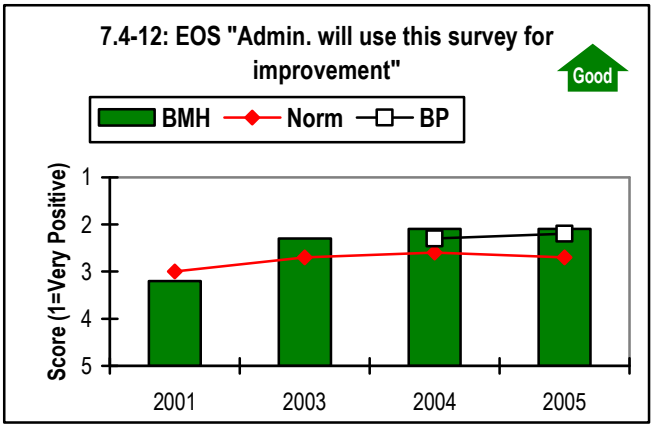


Tuition assistance is a mechanism for employee development and career progression (Figure 7.4-10). This popular benefit continues to grow and be used by more BMH staff members each year. In response to employee input, BMH increased the level of financial assistance for Master's level courses in 2005. To support accomplishment of educational objectives, BMH also has bonus incentives for certifications and advanced degree achievement.

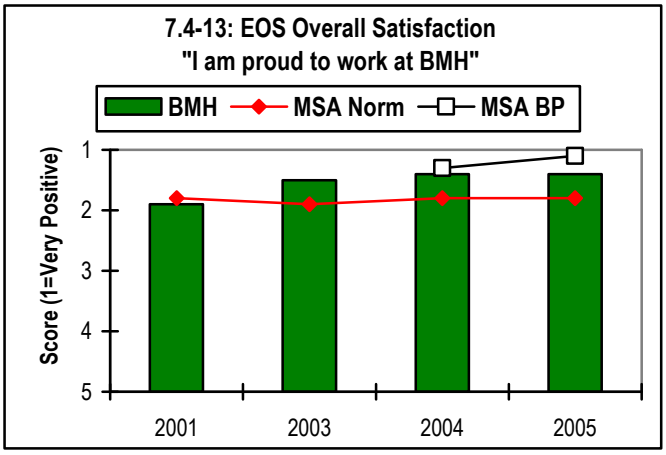


7.4a(3) Staff well-being, satisfaction and dissatisfaction: The primary mechanism for determining staff satisfaction is the annual employee opinion survey (EOS) administered each May. In 2002, the survey was focused on just those departments that had under-performed in 2001; therefore data for this time period is not available. Survey data is segmented in eleven different dimensions of diversity (department, length of service, marital status, age, education level, status, position, shift, gender, race, future intentions for employment) to enable effective identification of differences among various categories and types of employees. The survey is administered over a 10-day period on all shifts. The 87% participation rate in 2005 (Figure 7.4-11) can be attributed to ET commitment to use the EOS feedback for improvement (Figure 7.4-12). For 2005, the survey has been fully automated so employees can complete it online from home or work.

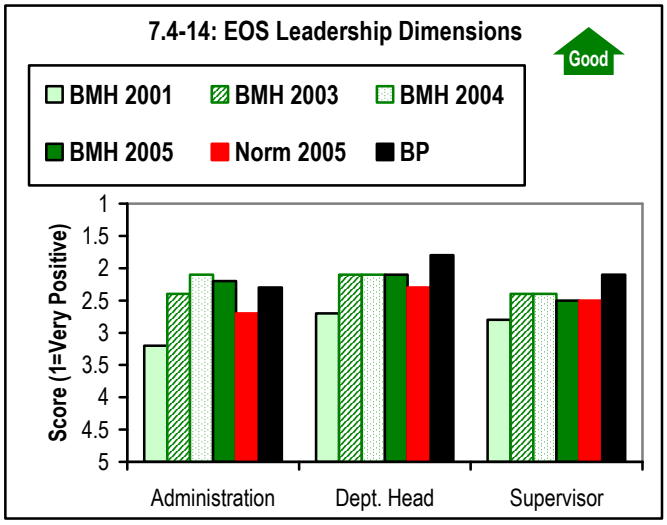




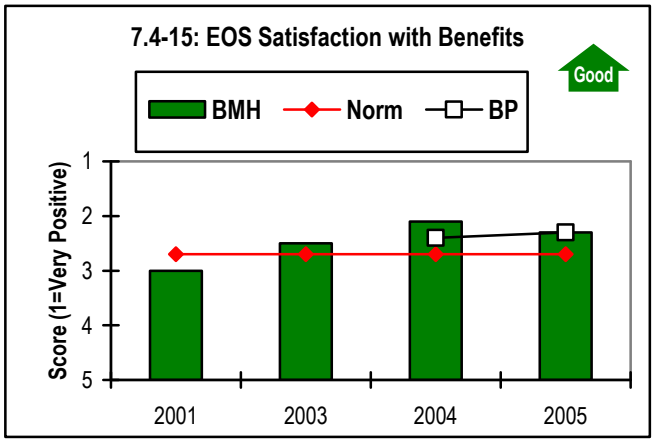
The objective of the EOS is to determine levels of satisfaction on 16 different workplace dimensions, identify issues that may be workplace dissatisfiers, develop action plans to address the dissatisfiers, and report findings and results to all employees. BMH achieved best practice performance in 38% of all dimensions measured (six of 16). Figure 7.4-13 reflects overall employee satisfaction as defined by the key question "I am proud to work at BMH."



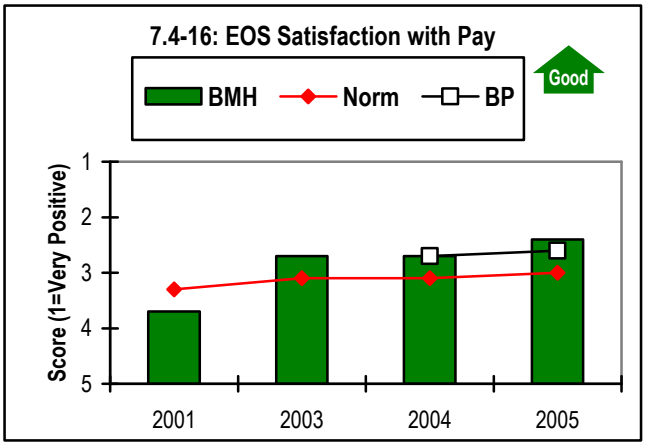
Another formal mechanism to monitor satisfaction is a survey tool administered by the Great Place to Work Institute. Almost 25,000 employees from across the nation are surveyed, including approximately 230 employees at BMH. BMH is provided with a Great Place to Work Trust Index that includes five dimensions (credibility, respect, fairness, pride, camaraderie). Of the 57 total survey questions, in 2004, BMH achieved at or better than the other surveyed companies, on 70% of them. Ninety percent of the employees surveyed rated BMH as a "great place to work" compared to 87% of all Fortune Best 100 companies. In 2004 BMH RNs completed an RN retention survey. BMH received 79% on the Employee Relations Index (ERI) versus the national benchmark of 63%. ERI is an indication of positive survey responses. The hospital's ERI was more positive than all other organizations surveyed within the national database of over 10,000 RNs. Twenty-six BMH nursing departments were surveyed, 16 were equal to or better than the 79% overall BMH score.

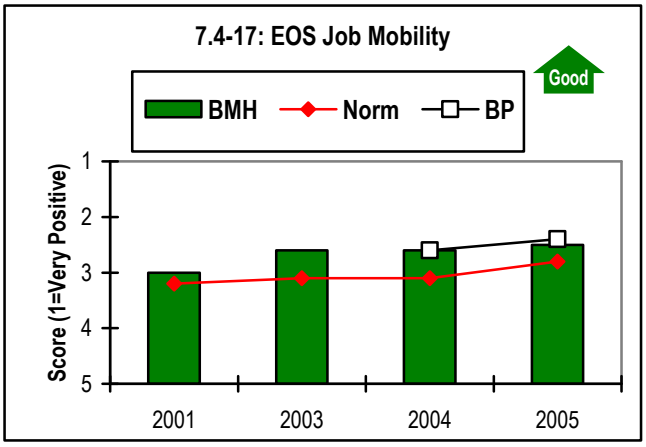


Using analysis from the annual EOS, and further validation by the LPMS, BMH determined the key factors that drive employee satisfaction: strong and competent leadership, competitive pay, benefits that meet employee needs, and job mobility within the organization. Through the LEADERship initiative (LI), BMH has devoted attention and resources on leadership development that has paid off in the strong leadership scores, reflected in the three dimensions in Figure 7.4-14.

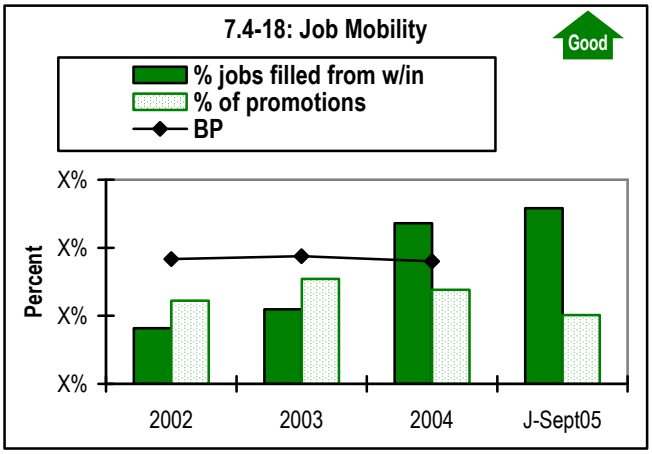


The EOS assists BMH in determining if the wide range of benefits and services offered meet the needs of its diverse workforce (Figure 7.4-15). Survey data, as well as employee focus groups, led to the offering of a wide variety of innovative new benefits including: flexible child care options, a phased retirement program, expanded employee parking, and paternity leave, to name just a few. Responding to employee feedback (Figure 7.4-16), BMH also made significant changes in compensation policies and practices.

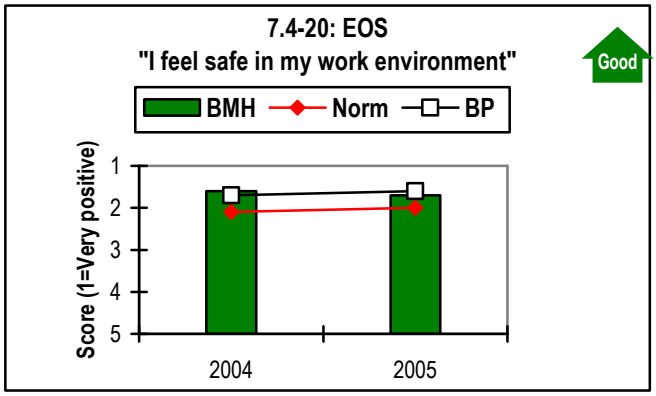




Employees are BMH's most valuable resource. EOS data analysis indicates that job mobility is an important factor for career progression and employee satisfaction (Figure 7.4-17).



Promotional opportunities, as well as flexibility to support work/life balance, are important factors in retaining a high performing workforce. The percent of promotions from within was slightly lower in 2004 due to the limited availability of opportunities for promotion as a result of low vacancy and turnover (Figure 7.4-18).



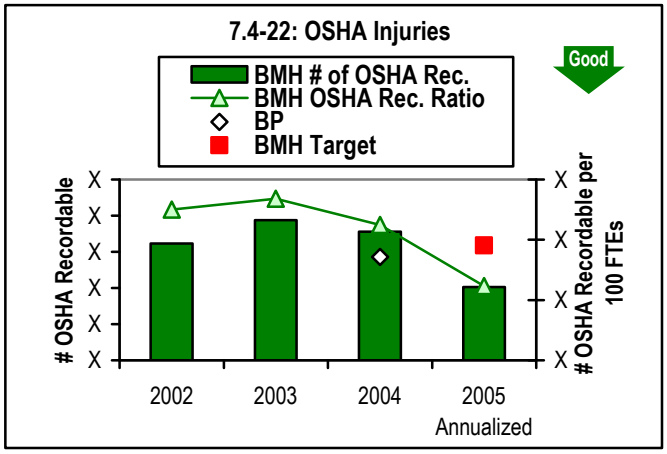
Satisfaction and morale are further enhanced through the promotion of a safe work environment. A new question on the EOS in 2004 asked employees if they feel safe in the work environment (Figure 7.4-20).

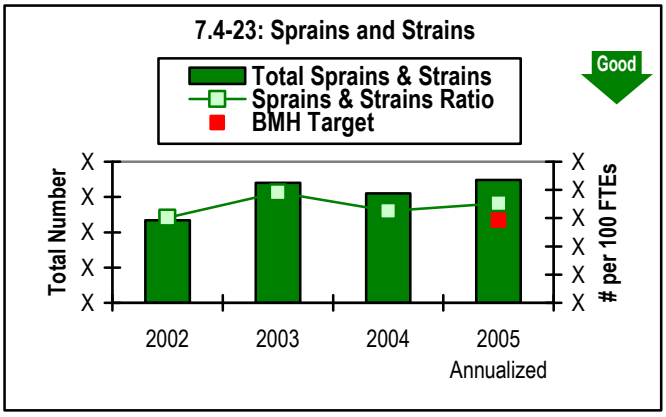
Figures 7.4-21 through 7.4-24 are results related to the key measures of work environment performance. This data is reviewed quarterly by the patient safety committee, CE SOT, ET, and the performance improvement committee of the BOD.

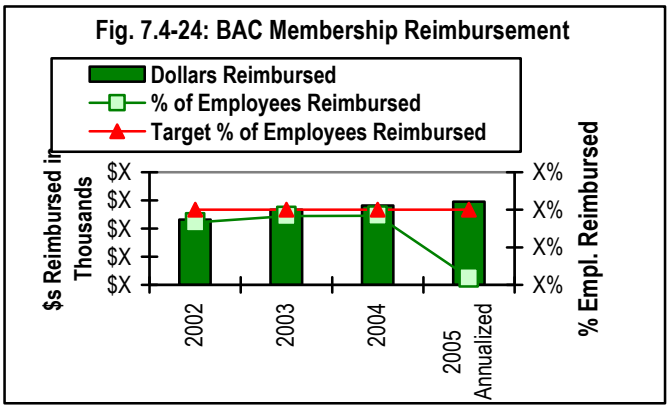
7.4-21 Work Environment Factors, Measures & Results

Factor	Measure	Target	Results
Health	Annual TB test compliance	100%	100%
Safety	Annual employee MWR	100%	100%
	Safety drill completion	100%	100%
Security	Infant abduction drills	100%	100%
Ergonomics	Dept. health & safety reviews	100%	100%

OSHA recordable injuries (Figure 7.4-22) declined slightly in 2004 due to increased awareness and education related to employee safety and injury prevention. Sprains and strains are the leading type of work injury for BMH (Figure 7.4-23). Back safety education is an annual MWR for all staff. Worksite ergonomic assessments represent another proactive approach to preventing sprains and strains as well as other types of injury. BMH also analyzes injury data by job class to determine if new requirements for training need to be added to specific job performance standards.



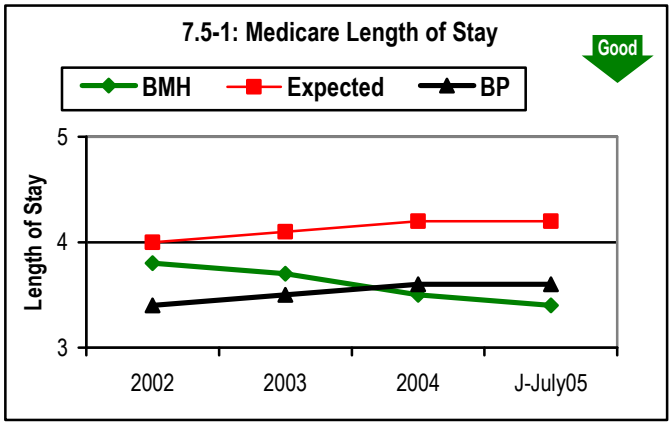




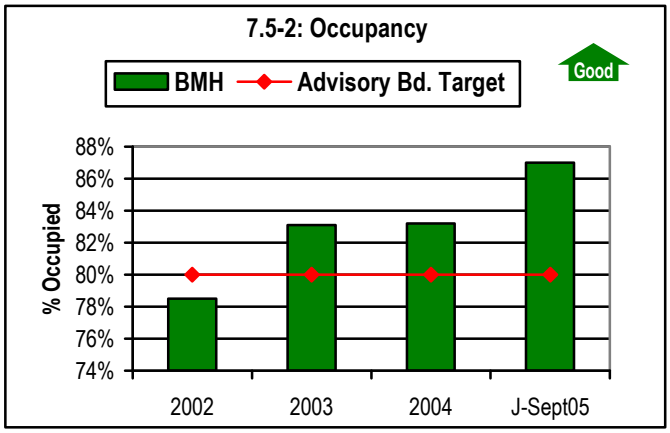
To promote employee health and wellness through regular exercise, BMH developed an innovative athletic club benefit (Figure 7.4-24). All employees are eligible for half-off the initiation fee at the Bronson Athletic Club (BAC). Primary BAC members who visit the club at least eight times per month are reimbursed for monthly dues. To assess the effectiveness of this benefit, BMH is administering a multi-year research study to determine if regular exercise and personal knowledge of key health factors will impact not only individual health status but organizational benefit costs.

7.5 Organizational Effectiveness Results

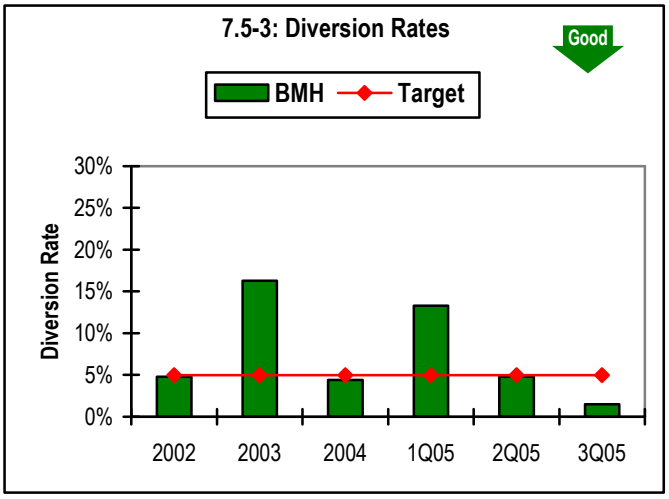
7.5a(1) Healthcare process performance: A strategic challenge for BMH is meeting the needs of the growing number of patients with increasingly complex healthcare conditions. LOS, a measure of ability to effectively manage care during the inpatient stay, can be significantly impacted by this challenge (Figure 7.5-1). The implementation of new hospitalist and intensivist services in late 2003 has allowed for more efficient movement of patients through the system. Without the competing outpatient practice, the physicians are better able to manage the acute needs of these patients, thereby reducing the amount of time in the hospital.



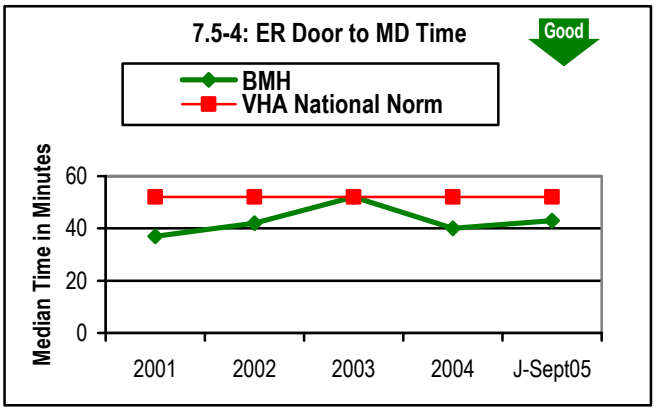
High quality patient outcomes, excellent customer service, and community perception as the best hospital have resulted in increased use of BMH services, evidenced by occupancy data (Figure 7.5-2). Patient throughput and efficient patient care delivery is an organizational focus for BMH.



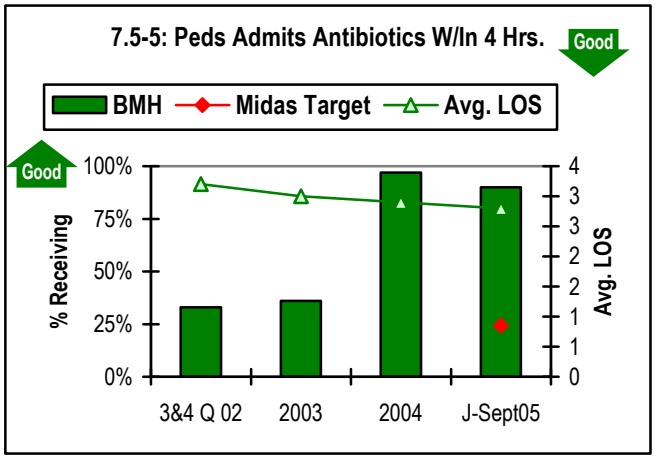
Growth in BMH services has led to inpatient bed status often at capacity, causing the ER to go on diversion (Figure 7.5-3). To address this issue the hospital has looked at facility expansion and process issues using the PDCA model. In 2003, a new bed coordinator position that assigns all beds to patients within the organization was developed. To enhance this role, an automated bed tracking system allows for electronic viewing of current bed status. Case managers in the ER assist in screening patients for placement in the community with appropriate resources rather than hospital admission. Over the past three years, BMH has opened an additional 35 beds, the most recent in 2005, to alleviate capacity issues. In addition, BMH partnered with a 25-bed LT acute care hospital to continue the care for chronically acute patients. A nine-bed post procedure unit was added for short stay patients. Historically, during the first quarter, BMH experiences a higher occupancy and diversion rate, due to seasonality. However, a team has been chartered to complete a FMEA on patient throughput as part of the next PDCA cycle. Hospitalist and intensivist efficient management of patients will also reduce the length of stay, thereby opening beds for other patients.

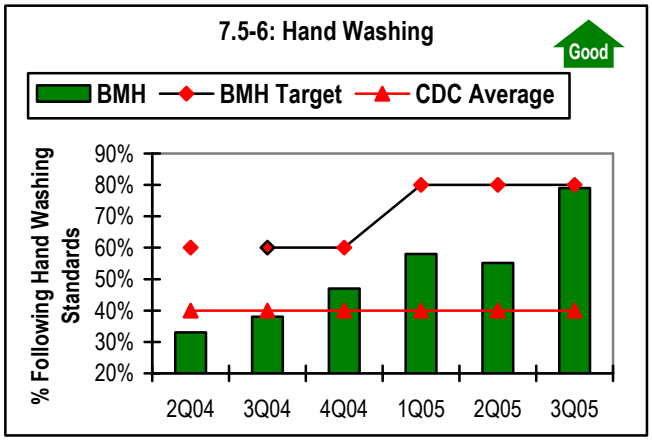


ER door to MD time (Figure 7.5-4), measures the amount of time from when a patient arrives at the door of the ER, to the time the physician first sees them. This is an in-process efficiency measure for the ER. Enhancements to the triage process, such as having a single level triage for Express Care and Emergency Services, and creation of evidence-based triage protocols, have had a positive impact on this measure.

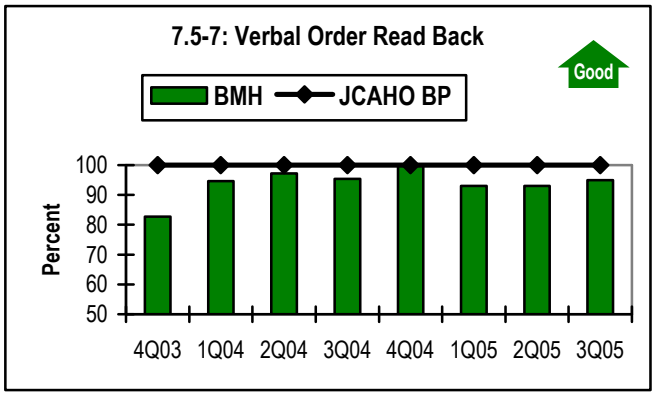


Unlike the evidence-based research for adult patients (Figure 7.1-7), medical literature does not suggest that administration of antibiotics within four hours in pediatric patients reduces overall mortality or morbidity. The practice, does however, impact the LOS for pediatric patients with pneumonia. BMH instituted this in-process indicator (Figure 7.5-5) as a measure of efficiency of the care provided to pediatric patients. In collaboration with pharmacy and physicians, BMH developed protocols to standardize the care provided to pediatric patients which are available online for easy access. Restructure of the timing of resident and nursing shift change produced an overall reduced cycle time.





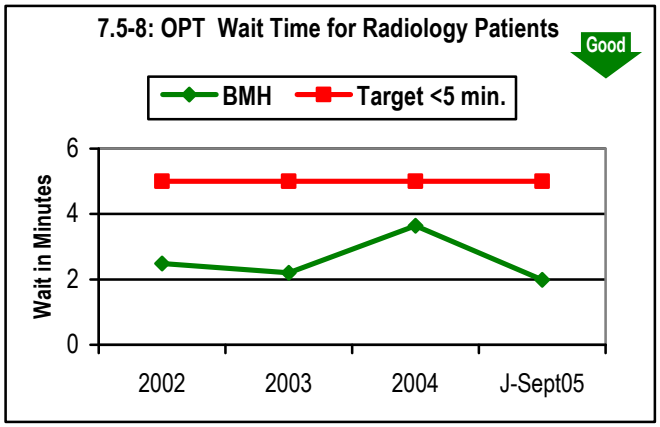
Hand washing compliance is recommended by the CDC, NNIS ad is a national patient safety goal for JCAHO. Hand washing is the primary means to reduce the spread of infections. In 2005, BMH has placed added emphasis on compliance with this measure (Figure 7.5-6). Education, convenient access to alcohol-based washing solution, and posting of audit results has impacted first quarter performance.



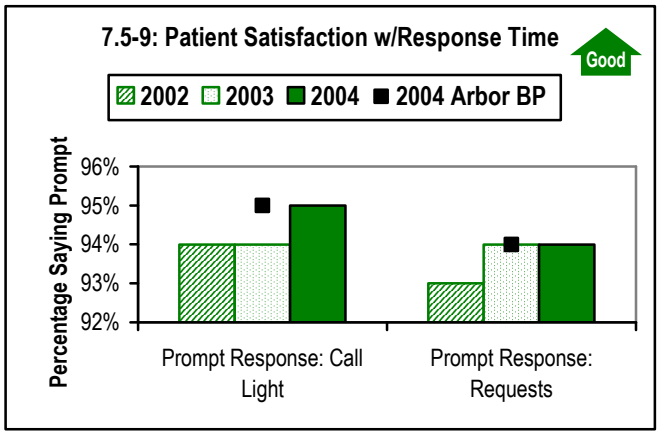
Verbal orders is a national patient safety for the JCAHO. Since a physician is not at the bedside throughout the day, it may be necessary for a RN to accept a verbal order. To prevent errors from occurring in these situations, the RN writes the order down in the chart, and reads it back to the physician to verify the correct order was received. Figure 7.5-7 is an in-process measure that supports patient safety. Communication issues have been identified as the number one root cause in sentinel events. Effective communication,

which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error. BMH continues to focus on this important measure and raise awareness of performance through feedback and education.

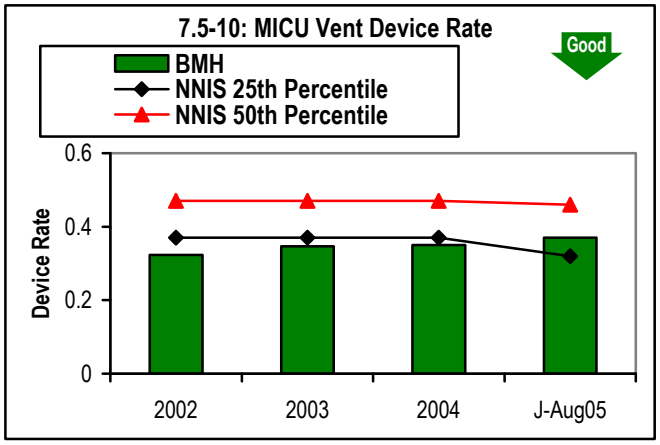
Wait times are a measure of efficiency, a key requirement of BMH patients (Figure 7.5-8). Once a patient has completed the registration process, they wait in the centralized Outpatient Testing waiting area to be greeted by a radiology staff member. To ensure that the wait meets the <5 minute target, staff used the PDCA model, installed an electronic staff notification process and a patient pager system.



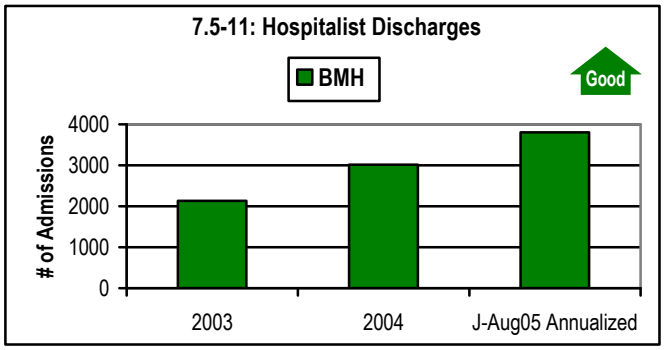
The patient requirement of responsiveness is measured by specific questions on the Arbor patient satisfaction survey (Figure 7.5-9). Call light response has seen an increase in 2004 due to high patient census levels. To increase the focus on this important measure, the percent of call lights answered within three minutes is on all nursing unit scorecards. For some units, it is a department gainshare target.

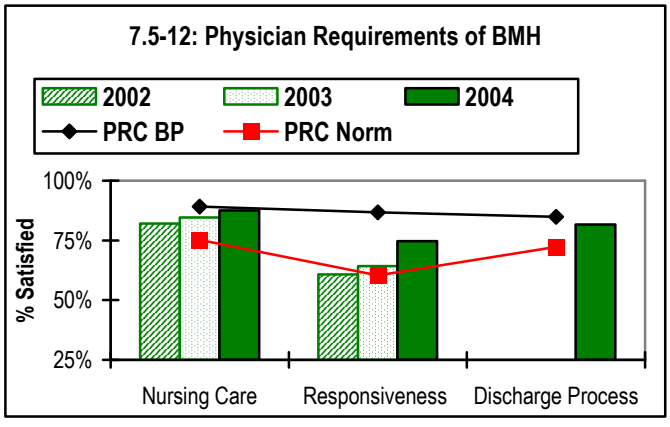


BMH understands the relationship between effective healthcare processes and clinical outcomes, and how hospital/physician partnering can achieve both. By partnering with physicians, BMH improved in-process performance and overall clinical outcomes for patients in the medical intensive care unit (MICU). In 2003, BMH hired intensivist physicians to manage the care of MICU patients. In coordination with the MHA and Johns Hopkins University, BMH is participating in the Keystone ICU Project, a collaborative of 108 Michigan ICUs. The goal of this statewide effort is to improve critical care and safety in ICUs. Keystone is a two-year endeavor that focuses on reporting and reducing adverse events, intensivist staffing, improving the culture of safety, and communication among caregivers. Figure 7.5-10 reflects an in-process measure of the number of vent days in the MICU. Reduction vent days impacts the likelihood of VAP. We expect the 2005 rate to normalize and there were no VAPs in 2005.



To assist in addressing the strategic challenge related to management of patients with increasingly complex diagnoses, in December 2003, BMH contracted with a new hospitalist group to provide care of adult hospitalized patients (Figure 7.5-11). Without competing priorities of a physician office practice, hospitalists were able to see 887 more patients in 2004 and decrease LOS from 5.3 days to 4.16 days. The decrease in LOS is consistent with other hospitalist programs and is largely due to physician availability to respond to consultants and test results.





BMH uses PRC to administer an annual physician satisfaction survey. BMH's ability to meet the physician requirements of BMH (Figure P.1-5) measured by PRC questions. In Figure 7.5-12, the quality of nursing care relates to the requirement of competency. Efficiency relates to the discharge process, which was a new survey question in 2004. Figure 7.5-13, are measures that relate directly to the physician requirement of access through scheduling of healthcare services as well as computer access to patient care information.

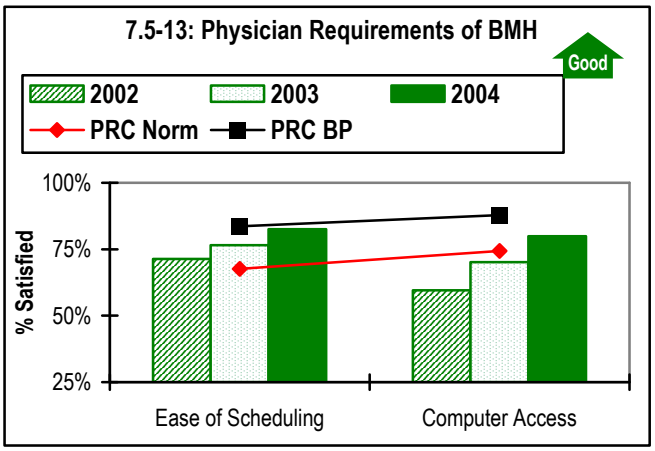
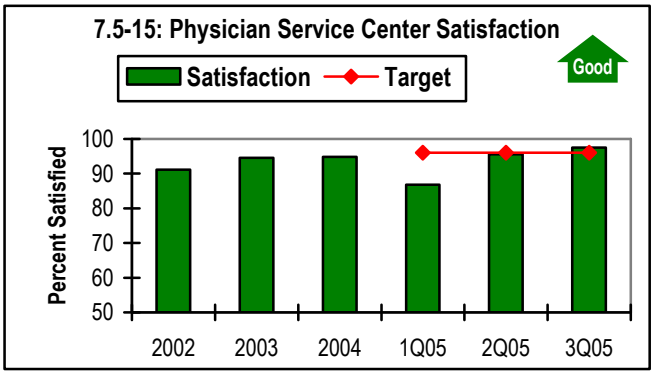


Figure 7.5-14 lists the awards BMH received from PRC for 2005.

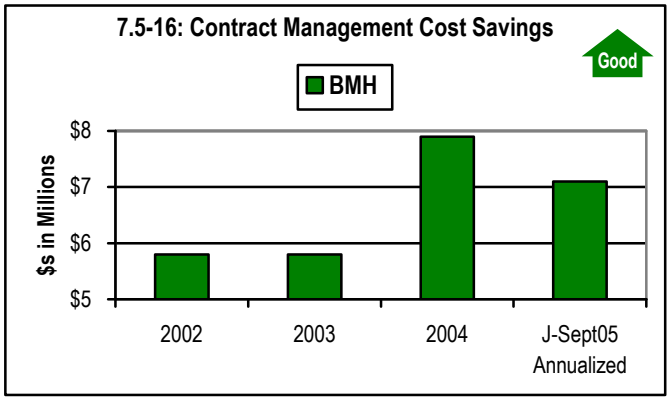
7.5-14 2005 PRC Awards

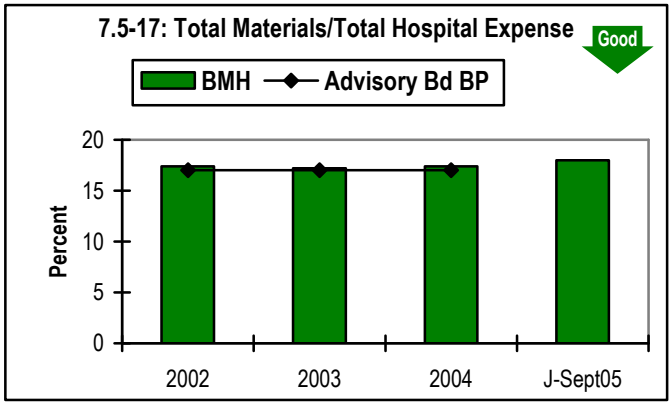
Designation	Scores	Awards
5 Stars ★★★★★	At or above 90th percentile	• A place to practice medicine • Quality of nursing care • Radiology services • Laboratory services • Anesthesia services
4 Stars ★★★★	75th to 89.9th percentile	• Overall quality of patient care • Pathology services

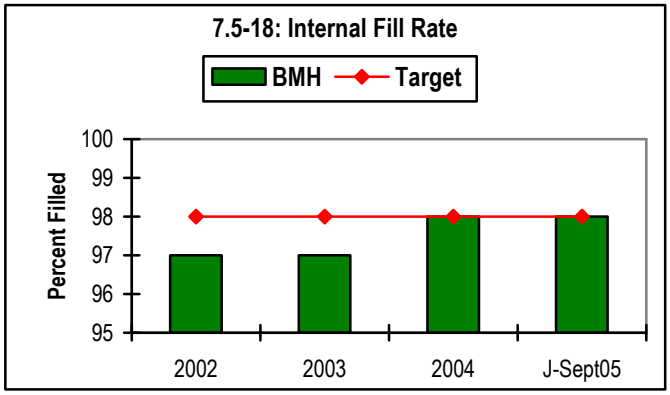
The BMH Physician Service Center is an important strategy for building loyalty with physicians and their staff members. The center provides information, support, physician recruitment, orientation, and education. Satisfaction with the center is measured through a quarterly internal survey of customers (Figure 7.5-15). First quarter scores are slightly lower than expected and the center is collecting direct feedback from the physician office staff to determine areas for improvement.



7.5a(2) Support process performance: BMH performance requirements for suppliers are quality, cost and timely delivery. To maintain strong financial performance and support LT sustainability, the BMH purchasing and materials management staff measures annual cost savings attributable to contract development, negotiations and product consolidation (Figure 7.5-16). Lead by a multidisciplinary team focused on cardiac service line profitability, for example, contracts were renegotiated in 2004 with the three cardiovascular supply vendors, resulting in a $1.2 million reduction in cardiac device expenses. Overall effectiveness of materials management is further illustrated in Figure 7.5-17.

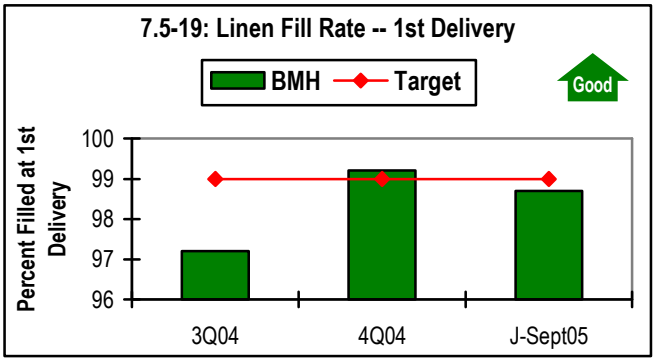




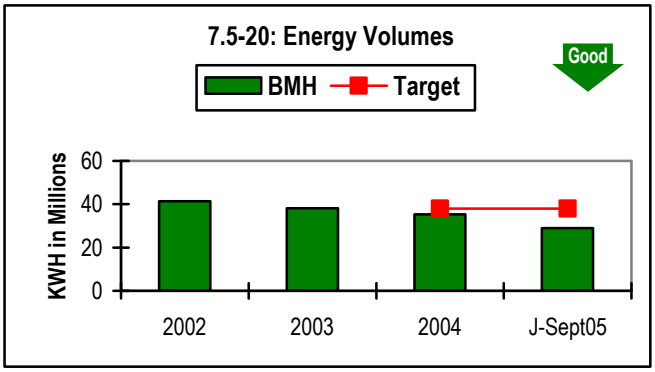


Having necessary supplies and materials available when needed is a key requirement of the materials distribution support process. BMH monitors the internal fill rate, the fill rate for items supplied by the BMH distribution center, to all internal customers (Figure 7.5-18). The automated materials system, along with vendor management strategies, assists in achieving the fill rate target. In 2004, nursing satisfaction with the quality and availability of linen products was very

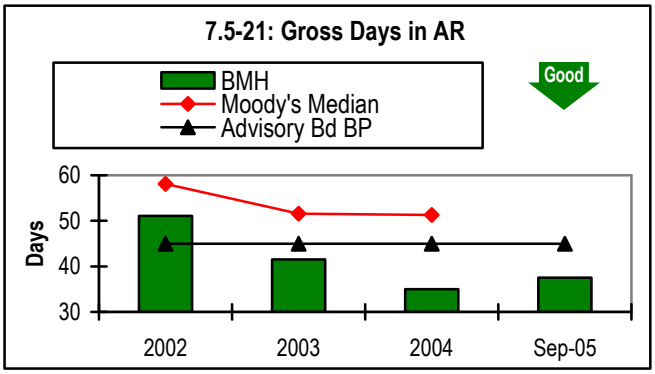
low. To improve performance, BMH implemented a new supplier report card after benchmarking with Baldrige recipient St. Luke's Hospital. Figure 7.5-19 shows just one of the measures on the linen supplier scorecard that improved as a result of this new supplier communication and performance monitoring tool.



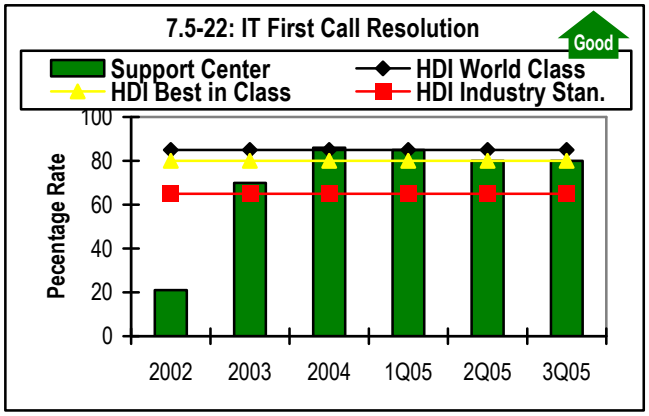
Energy conservation, part of the environmental management support process, benefits the hospital financially but also serves to position BMH as an environmentally friendly organization (Figure 7.5-20). In support of this effort, the IT department converted PC monitors from 15" CRTs (75 watts) to LCD 17" flat screens (40 watts), saving $21,850 in energy cost per year. To ensure staff is well informed, they must complete annual CBL education related to pollution prevention and waste minimization.



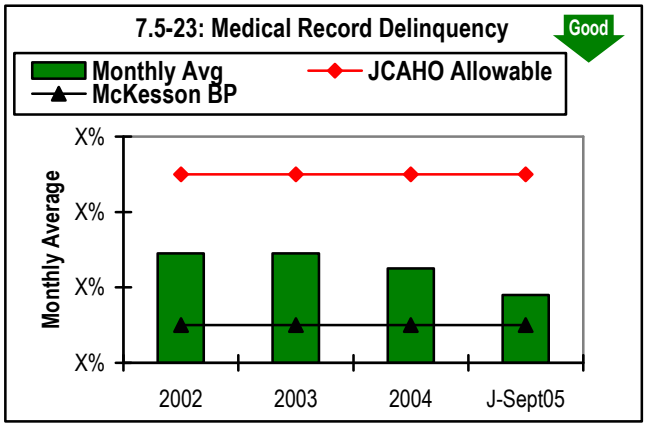
Days in accounts receivable (AR) is a leading indicator of the revenue cycle, measuring BMH's cycle time to collect on a patient bill (Figure 7.5-21). Through continuous cycles of improvement, which included use of an electronic contracting system to monitor correct payment, a unique team approach for collections, claims and follow up requests, and rigid monitoring of performance by the patient accounting staff, BMH gross days in AR has decreased to 35 days as of year-end 2004.



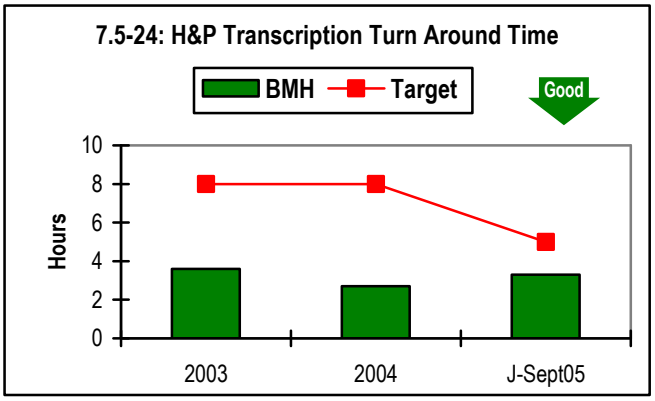
Employees and physicians rely on technology systems as a source of timely, accurate information. The IT department serves internal customers through the help desk (Figure 7.5-22) providing timely and courteous assistance and problem resolution. By implementing best practices from the Help Desk Institute, BMH has improved first call resolution. Since all employees at BMH have access to email, IT surveyed staff regarding the appropriateness of the email communication they were receiving. When over 70% responded that they received too much "junk" email and that much of the communication did not apply to them, policies related to email distribution groupings and using email were revised. When surveyed again in 2005, there was a 36% improvement in employee perception of email appropriateness. BMH is the first healthcare IT support center, and one of only 17 centers across all industries, to earn the Help Desk Institute's (HDI) site certification for IT customer service.

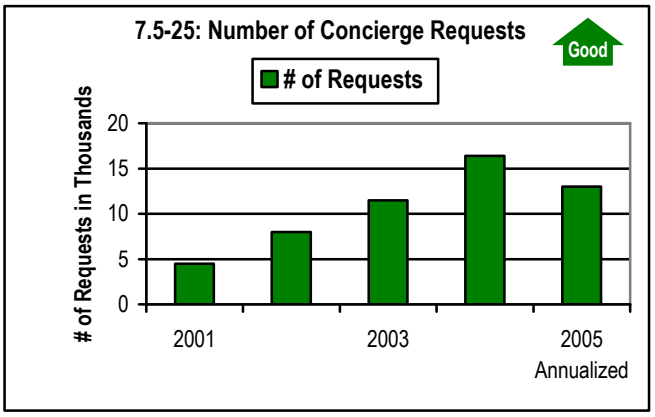


To meet patient care needs as well as JCAHO requirements, BMH monitors medical record delinquency (Figure 7.5-23). By using an electronic signature system, physicians are able to complete records from remote locations via the clinical portal. According to McKesson, the best practice for hospitals using electronic medical record systems is 10%.

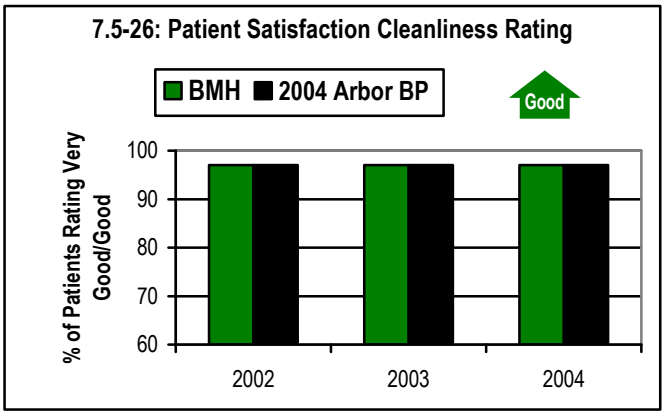


The history and physical (H&P) provides critical information for a patient medical record. The transcription turnaround time (TAT) is an in-process measure that ensures critical patient information is available to the care team (Figure 7.5-24). The health information management (HIM) department utilizes appropriate staffing and technology to exceed the five-hour target.

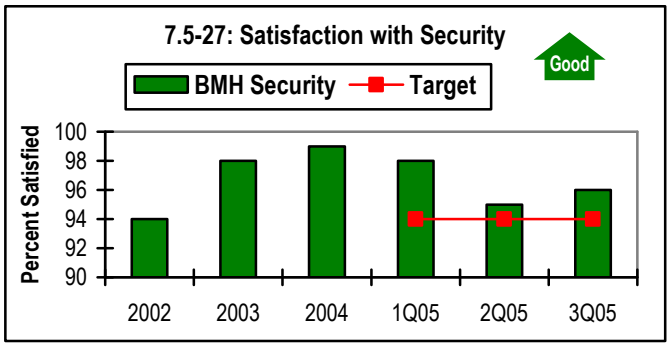




Concierge services is a key loyalty-building strategy with employees, physicians and patients at BMH. Since the service began in 2001, there has been a steady increase in its popularity and demand for services (Figure 7.5-25). In 2004, 74% of the BMH workforce utilized the service. National research confirms that employees who use concierge services save an average of two hours for every request made with the concierge. Fifty percent of those employees are putting that energy back into work, and 25 percent are spending more time with families. This results in less stress and a higher quality of life, important components of employee satisfaction. 99% of BMH users indicated that the service helps them to balance work and personal responsibilities.



The Environmental services department measures productivity and efficiency outcomes with Arbor patient satisfaction cleanliness ratings (Figure 7.5-26). The BMH security department measures responsiveness and ability to meet internal customer needs with a quarterly satisfaction survey (Figure 7.5-27). Customer service is a department-specific gainshare measure and a priority for all security officers.



7.6 Leadership and Social Responsibility Results

7.6a(1) Organizational strategy: Following a quarterly review schedule, the BOD uses the BMH scorecard (Figure 7.6-1 removed for competitive reasons) along with the long-term goals (Figure 7.6-2 removed for competitive reasons) to manage progress toward achievement of strategic objectives and to ensure organizational sustainability. The BOD, working with the ET, monitors performance to ensure the balance between ST objectives and LT goals. The scorecard is a macro view of performance and includes a roll-up of numerous indicators that are reflected in the red (risk), yellow (moderate), and green (meets) format. This format provides the ability to drill down to other levels and indicators, if desired. The 2010 LT goals are measures of success related to BMH organizational sustainability. Green indicates that the goals have already been accomplished with action plans in place to maintain performance. All other goals are yellow, indicating progress has been made and BMH is positioned to achieve these targets by 2010.

To assess community perception, BMH measures its image and perceived value in the community with an annual community attitude survey administered by Arbor. To expand upon Figure 7.2-13, the best overall hospital rating, Figure 7.6-3 lists BMH as highest in all areas and also improved in all scores, widening the gap between BMH and the local competition. This preference is indicative of growth and increasing demand for BMH services.

7.6-3 Community Survey-1st Place Rankings

Attribute	2003	2004
Best overall hospital	✓	✓
Attracts/retains highest quality staff	✓	✓
Attractive and clean environment	✓	✓
Courteous employees	✓	✓
Highly skilled nurses	✓	✓
Highly skilled physicians	✓	✓
Success in treating difficult cases	✓	✓
Most up-to-date technology	✓	✓
Leader in healthcare	✓	✓
Caring and compassionate to patients	✓	✓
Innovative in approach to healthcare	✓	✓
Hospital you can trust	NA	✓

7.6a(2-4) Ethical behavior and trust: Figure 7.6-4 shows BMH's results for leadership and social responsibility measures. BMH has received full accreditation from every appropriate accrediting body, trained all staff on compliance and ethics requirements, and used the corporate compliance plan to ensure ethical governance processes.

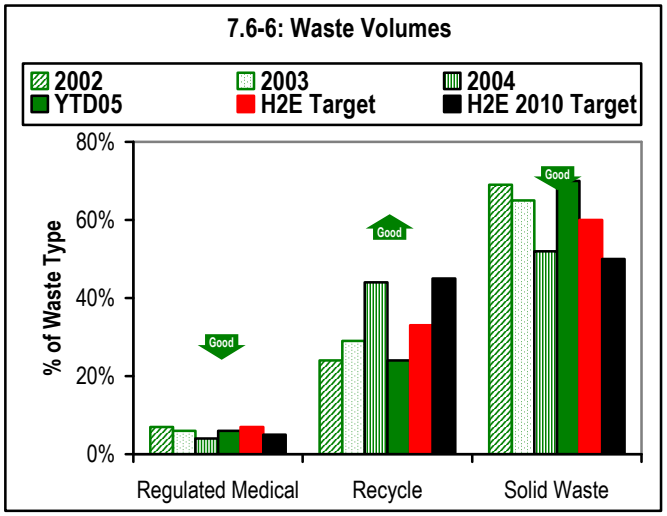
7.6-4 Leadership and Social Responsibility

Measures	Results
Employees trained on corp. compliance	100%
Employees trained on code of conduct	100%
Employees trained on HIPAA	100%
JCAHO survey	Full accreditation
CAP survey	Full accreditation
ACS survey	Full accreditation
ACR	Full accreditation
CMS conditions of participation	Full participation
ICAVL survey	Full accreditation
ICAEL survey	Full accreditation
AACVPR survey	Full accreditation
Certification results	Full accreditation
Staff licensure	100%
Independent board members	100%
Independent auditor results	0 irregularities
Physician contract compliance	100%

In 2004, BMH achieved a superior JCAHO survey accreditation rating with no recommendations for improvement.

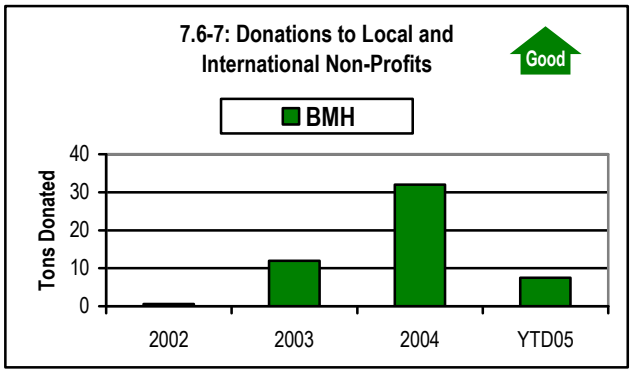
BMH's fiscal accountability and processes are audited each year by the firm of Ernst & Young. The clean audit findings reflect strong fiduciary processes.

For three years in a row, BMH has been a recipient of the *Environmental Leadership Award* presented by Hospitals for a Healthy Environment (H2E). In 2005, BMH is one of only eight facilities across the country to win this premier national recognition. Award recipients are distinguished by their pioneering efforts to reduce the environmental impact of the healthcare industry by implementing innovative programs that set industry standards for waste reduction and pollution prevention. The BOD and ET committed to using the H2E Sustainable Environmental Leadership criteria as guidelines for pollution prevention and energy conservation.



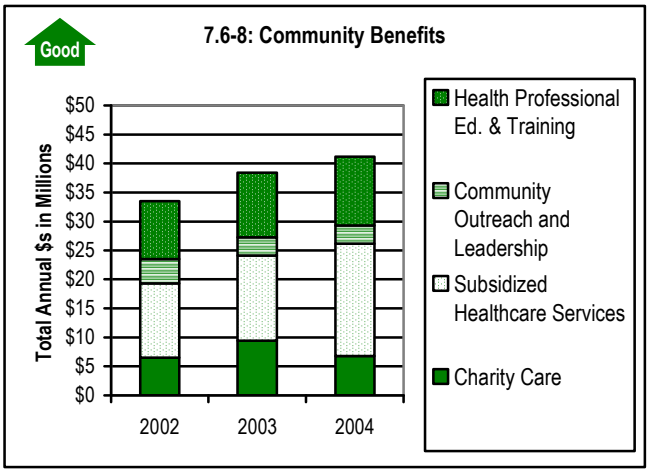
As a result, the hospital has a waste management plan that includes waste reduction and pollution prevention policies. The goals of the program are to reduce regulated medical and solid waste while increasing recycled waste. BMH surpassed the 25% minimum requirement of H2E, recycling 44% of the total waste stream in 2004 (Figure 7.6-6). The H2E 2010 targets have been set and BMH is already surpassing this target for regulated medical waste reduction. Innovative strategies implemented by BMH as part of the waste management plan include:

- Changing to a new vendor for treatment of regulated medical waste. The vendor uses a combination of steam sterilization and microwave technology to grind the waste, thus reducing the volume sent to landfills by 85%. The system is environmentally friendly, having no water effluents or air emissions. The vendor change resulted in a financial savings to BMH of $11,564 in 2004.
- Switching to micro-fiber mops, eliminating 480,000 gallons of water and 13,000 gallons of chemicals used.
- Donating a total of 32 tons of equipment and supplies in 2004 to local and international agencies, community programs, and schools (Figure 7.6-7). The BMH commitment to responsible environmental management practices complements our commitment to serving the community through our waste management program.



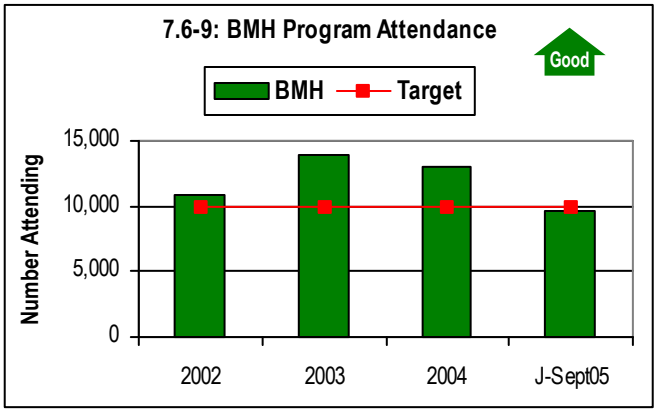
7.6a(5) Organizational citizenship and health of the community: The community is defined as a stakeholder, thus, it is important for BMH to consider how the organization's services, actions, and success affect the community. Key requirements of the community

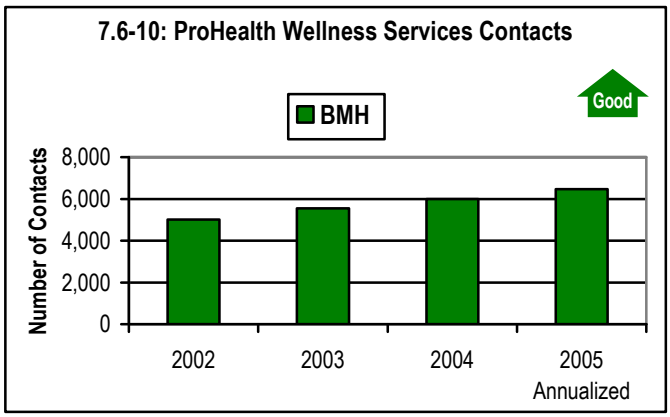
include: leadership and support, access to healthcare services, health information, and quality outcomes.



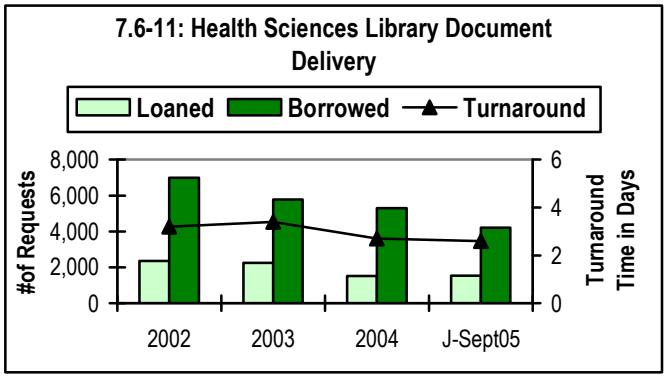
The BHG system conducts an annual, organization-wide inventory to monitor involvement in community health activities (defined as community benefit) and contributions. Figure 7.6-8 lists the unaudited 2004 community benefits results, of which BMH is the key contributor as the flagship organization in the system. The hospital's societal responsibility to the community is a direct result of strategic leadership and the dedicated efforts of leaders and staff. In the most recent community benefit report, in excess of 50,000 staff hours impacted 200,000 community members with a net value of $41.2 million reinvested in community health activities.

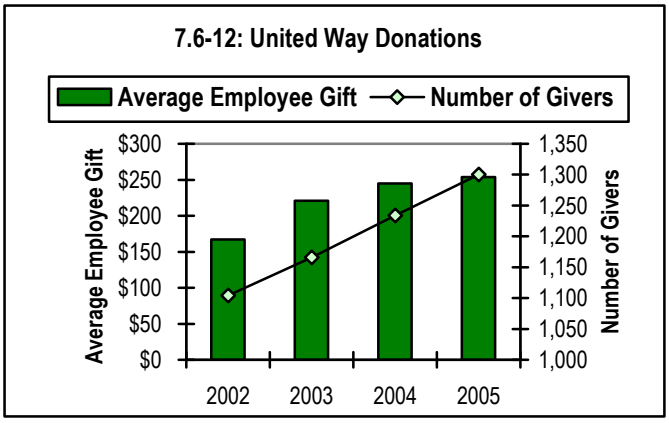
To meet the community need for health information, BMH has a comprehensive array of community health programs (Figure 7.6-9) that include unique offerings targeted at seniors, women's health, and also parents and families. BMH ProHealth Wellness Services works closely with area employers to deliver innovative programs to promote safe and healthy lifestyles for residents. Figure 7.6-10, reflects the positive reception in the community of the worksite health screenings, community presentations and events. During a worksite health screening for a large employer with more than 2000 employees, two employees were identified as having critical health risks and were referred to their personal physician within 24 hours of the screening. Identified through an irregular pulse, one participant was immediately put on medication by his physician. The worksite screening played a key role in preventing a possible stroke. Sixty people were referred to their primary physician within three days of the screening due to blood sugar and blood pressure findings.





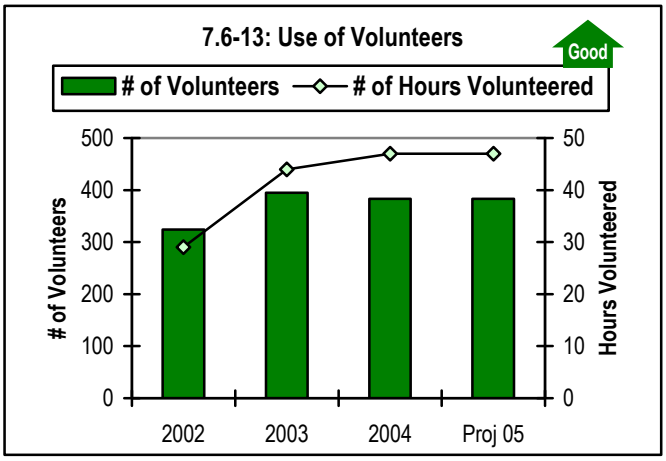
Another mechanism for providing health information is the BMH Health Sciences Library, providing information access to physicians and other medical professionals to support patient care. Document delivery (Figure 7.6-11) refers to the borrowing of articles and books from other libraries. Approximately 57% of the customers utilizing document delivery are physicians. Library staff use e-delivery to electronically transfer information via the web or email whenever possible to deliver the vital information to the clinician faster. BMH continues to meet the three-day turnaround time target for document delivery.





For the fourth year in a row, BMH has been a pacesetter company in the annual Greater Kalamazoo United Way campaign. Pacesetters run an earlier campaign, serve as a role model, set aggressive targets, and use best practices to communicate the campaign to employees. BMH's commitment to the community is evidenced by the increasing strong performance in Figure 7.6-12.

Figure 7.6-13, use of volunteers, reflects the hospital's connection with the community through the generosity of service hours. BMH provides a supportive environment for community members to contribute to the hospital, including an enhanced program for teens. The VolunTeen program is an integral part of the WDP focused on increasing youth opportunities in healthcare.



The BMH vision to *be a national leader* challenges the hospital to provide the very highest level of healthcare quality to patients in southwestern Michigan. Through the commitment to excellence, BMH staff brings the mission and values to life with every interaction.