Adventist Health
White Memorial

2019

Malcolm Baldrige
National Quality Award Application

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National Quality Award
2019 Award Recipient

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Responses Addressing All Criteria

Glossary of Terms & Abbreviations

ABFM - American Board of Family Medicine

ACC - American College of Cardiology

ACGME - Accreditation Council for Graduate Medical Education

ACR - American College of Radiology

ADA - Americans with Disabilities Act

ADN - Associate Degree in Nursing

ADT - Admission, Discharge, Transfer alerts

AH - Adventist Health

AHWM - Adventist Health White Memorial

AIDET - Acknowledge, Introduce, Duration, Explanation, Thank You - Framework for staff to communicate with patients/families

ALOS - Average Length of Stay

AMB - Ambulatory/Outpatient

AMI - Acute Myocardial Infarction

AOB - Adjusted Occupied Bed

AOS - Available on Site

BOD - Board of Directors

BSN - Bachelor of Science in Nursing

CAP - College of American Pathologists

CAPE - California Award for Performance Excellence

CAUTI - Catheter-associated Urinary Tract Infection

CC - Core Competency

CDC - Centers for Disease Control

CDPH - California Department of Public Health

CEO - Chief Executive Officer

CEU - Continuing Education Units

CHNA - Community Health Needs Assessment

CIC - Community Information Center

CMQCC - California Maternal Quality Care Collaborative

CMS - Centers for Medicare and Medicaid Services

COPE - Community Outreach Prevention Education

CP - Competitor's Patient

CT - Computerized Tomography

CTQ - Critical to Quality

DMAIC - Define/Measure/Analyze/Improve/ Control

ECRI - Emergency Care Research Institute

EBIDA - Earnings Before Interest, Depreciation, Amortization

ED - Emergency Department

EDCAHPS - Emergency Department Consumer Awareness of Healthcare Providers and Systems

EDGE - Every Day Giving Excellence Course

EDIE - Emergency Department Information Exchange

EMR - Electronic Medical Record

EOC - Environment of Care

EICS - Emergency Incident Command System

FMEA - Failure Mode and Effects Analysis

FP - Former Patient

FTE - Full-time Equivalent

FQHC - Federally Qualified Health Center

GPO - Group Purchasing Organization

HASC - Healthcare Association of Southern California

HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems

HELP - Healthy Eating Lifestyle Program

HHS - Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act

HR - Human Resources

HRSA - Health Resources and Service Administration

ICR - Interdisciplinary Care Rounds

ICU - Intensive Care Unit

IHI - Institute for Healthcare Improvement

IMC - Information Management Council

IM&T - Information Management & Technology

IOM - Institute of Medicine

IP - Inpatient

IS - Information Security Department

IT - Information Technology

JLL - Jones Lang LaSalle

LA - Los Angeles

LADWP - Los Angeles Department of Water and Power

LAPD - Los Angeles Police Department

LEM - Leadership Evaluation Manager

LOS - Length of Stay

LOVED - Living Our Values Every Day (award)

MEC - Medical Executive Committee

MAOF - Mexican American Opportunity Foundation

MOF - Monthly Operating Forecast

MSN - Master of Science in Nursing

MVVG - Mission, Vision, Values, Guiding Principles

NAO - New Associate Orientation

NICU - Neonatal Intensive Care Unit

NPO - New Physician Orientation

NRC - National Research Council

OAS CAHPS - Outpatient Ambulatory Surgery Consumer Awareness of Healthcare Providers and Systems

OB - Obstetrics

OC - Organizational Chart

OIG - Office of Inspector General

OP - Outpatient

OPC - Organizational Performance Council

OSHA - Occupational Safety and Health Administration

OSHPD - Office of Statewide Health Planning and Development

P - Patient

PACS - Picture Archiving and Communication System

PASS - Pull, Aim, Squeeze, Sweep Fire Extinguisher Protocol

PCEC - Patient/Customer Experience Council

PCI - Percutaneous Coronary Intervention

PDSA - Plan-Do-Study-Act

PI - Process Improvement

PIC - Project IntelliCare

PP - Potential Patient

PRC - Professional Research Consultants (vendor)

PSA - Primary Service Area

QFD - Quality Function Deployment

RADAR - Automated Incident Reporting System

RCA - Root Cause Analysis

RN - Registered Nurse

S&P - Standard and Poor's Financial Index

SA - Strategic Advantage

SANS Top 20 - Cyber Security Control Process

SBAR - Situation Background Assessment Recommendation

SC - Strategic Challenge

SCN - Southern California Network

SCPC - Society of Cardiovascular Patient Care

SCR - Southern California Region

SIPOC - Supplier, Input, Process, Output, Customer; a tool used in process management.

SIR - Standardized Infection Rate

SPP - Strategic Planning Process

STAT - AHWM's Employee Newsletter

STEMI - ST-Elevation Myocardial Infarction

SWOT - Strengths, Weaknesses, Opportunities, and Threats

TAT - Turnaround Time

TB - Tuberculosis

TELACU - The East Los Angeles Community Union

Title 22 - California Code of Regulations

TJC - The Joint Commission

UCLA - University of California Los Angeles

USC - University of Southern California

Vital Signs - Organizational and Council Metrics

VOC - Voice of the Customer

W@W - Wellness@White

WELCOA - Wellness Councils of America

WMCHC - White Memorial Community Health Center

Organizational Profile

P.1 Organizational Description

In 1913, Adventist Health White Memorial (AHWM) opened its doors as a neighborhood clinic to serve the impoverished, inner-city Los Angeles community of Boyle Heights. Today, AHWM is the only acute care private nonprofit "safety-net" hospital serving residents living in the community of East Los Angeles – a densely populated enclave characterized by poor immigrant families, first-generation American households, gang members and homeless encampments. More than 2 million people live within a five-mile radius of the 353-bed hospital, and the population is 89% Hispanic, making it California's largest Hispanic population. With a per capita income less than $17,000 and most residents living below the Federal Poverty Level, it is a federally designated Medically Underserved Area. One-third of the Primary Service Areas residents have less than a ninth-grade education, and the payor mix is 97% Medicaid and Medicare.

The area surrounding the hospital is also challenged by high crime rates including active gang violence. In a recent study, Boyle Heights had an annual count of 4,483 acts of violence for every 100,000 per capita, as compared to the same per capita counts for the nation at 2,837 and California 2,998. The Hollenbeck Police Department reports that within Boyle Heights alone, there are 35 gangs. One gang, the "Primera Flats," covers three-quarters of the hospital's surrounding area.

And yet, despite the combination of crime, poverty and heavy reliance on government funding, AHWM achieves national top decile clinical outcomes and remarkable financial performance.

P.1a Organizational Environment

P.1a(1) AHWM has six key service lines, presented in **Figure P.1-1** in order by revenue. The primary delivery mechanism is serving patients on-site, directly through AHWM's workforce.

P.1a(2) AHWM's Mission, Vision and Values are presented in **Figure P.1-2**. The Values are translated into characteristics of culture through corresponding "I Will" Guiding Principles behavioral statements. Guiding Principles represent actual behaviors that are desired as part of the AHWM culture. These Guiding Principles, combined with a dedication to the Mission and Vision, create a specific culture within AHWM that is first introduced in workforce interviews and orientation.

AHWM's Core Competencies and Mission are complementary to one another. AHWM is deeply dedicated to the East LA community as seen in processes described in **1.2c**. Living God's Love is the core of the AH Mission and is behind the spirit of serving the underserved in the East LA community. The core competency of data-driven pursuit of excellence is also embedded in the Mission as AHWM is committed to providing services to the East LA community in an environment of performance excellence. As described in **P.2(c)**, there is a strong organizational culture based on creating high-performance and value for stakeholders that is fact-based and systematic.

Figure P.1-1: Key Service Lines Ranked By Net Importance to Sustaining Patient-Centered Care

Service Lines in Order of Priority	Annual Revenue
General Medicine	$130,014,000
Cardiovascular	$51,104,000
Surgical	$38,401,000
Orthopedic	$35,620,000
Women's Services	$20,193,000
Emergency	$19,402,000

Figure P.1-2: Mission, Vision & Values

Mission

Living God's love by inspiring health, wholeness and hope

Vision

We will transform the health experience of our communities by improving health, enhancing interactions and making care more accessible

Values

Compassion, Excellence, Integrity and Respect

Guiding Principles

I will:

- Take personal responsibility to ensure safety of patients, co-workers, and all others I come in contact with while at work
- Reach for the highest standards in my work
- Be honest in all things
- Provide services that my customers say are excellent
- Use all resources responsibly and efficiently
- Treat others with the same compassion and respect I would want my family to experience

Core Competencies

1. Mission-driven partnership with the East LA community
2. Caring for the underserved
3. Data-driven pursuit of excellence

P.1a(3) AHWM segments its workforce as seen in **Figure P.1-3**. It is important to note that California is one of only a handful of states that prohibits hospitals from directly employing physicians, so AHWM physicians are not employed by AHWM, but have privileges to practice at AHWM as a member of the medical staff. Physicians are involved as equal and highly-valued members of the Organizational Performance Council (OPC) structure as well as the medical staff committee and department structure. Included in the physician segment are medical residents. In 1913, AHWM's roots were that of a teaching medical facility for Adventist Health. Today, while that tradition of teaching continues, the key work accomplished in the hospital is aimed at delivery of patient-centered care for inpatients, ambulatory and emergency patients.

Figure P.1-3: Key Workforce Groups

Workforce Group	Numbers	Key Engagement Drivers	Results
Associates	**2,038**	Personal growth Recognition Trust Sense of mission Spirituality	7.3-9
Clinical	1,620		
Non-Clinical	418		
Physicians	**459**	Leader alignment with MVV High-quality care Teamwork Confidence in future success High patient satisfaction	7.3-10
Volunteers	**170**	Positive experience Appreciation Job satisfaction	7.3-11

Key changes to the workforce have been minimal. Centralized corporate services include consolidated financing, cash and financial management, budgeting and reimbursement, legal, marketing and communication, information technology, internal auditing, supply and materials management, human resources, and trust management. This centralized approach enhances the ability for delivery of consistent support processes across the growing AH healthcare network. This change has been accomplished over time and has had minimal impact on workflow since the associates who formerly held the AHWM positions now hold the AH positions.

Education requirements in health care vary by job description. All patient-care staff must complete a level of education specific to their fields of work and retain appropriate licensing and/or certification required by the state of California. In addition to job specific state and federally mandated education requirements, AHWM also requires all patient-care staff to complete additional training such as CPR and Advanced Cardiac Life Support, depending on level of care. Non-patient care staff may also have specific education/licensing/certification requirements as identified by each job description. Key drivers that motivate AHWM's workforce are presented in **Figure P.1-3**.

AHWM has no bargaining units. Traditional key health and safety requirements include mandatory annual participation in all safety in-service offerings (such as fire safety), as well as completion of the Los Angeles City Fire Department Fire and Life Safety Training which occurs every four years. Inner-city issues increase safety concerns for the workforce. To address this concern, AHWM deploys a Security Management Plan that includes increased security, such as proximity security access, increased security presence, and annual training, depending on job type.

P.1a(4) See **P.1-4** for key technology and equipment utilized on AHWM's East LA campus. AHWM does not have significant intellectual property.

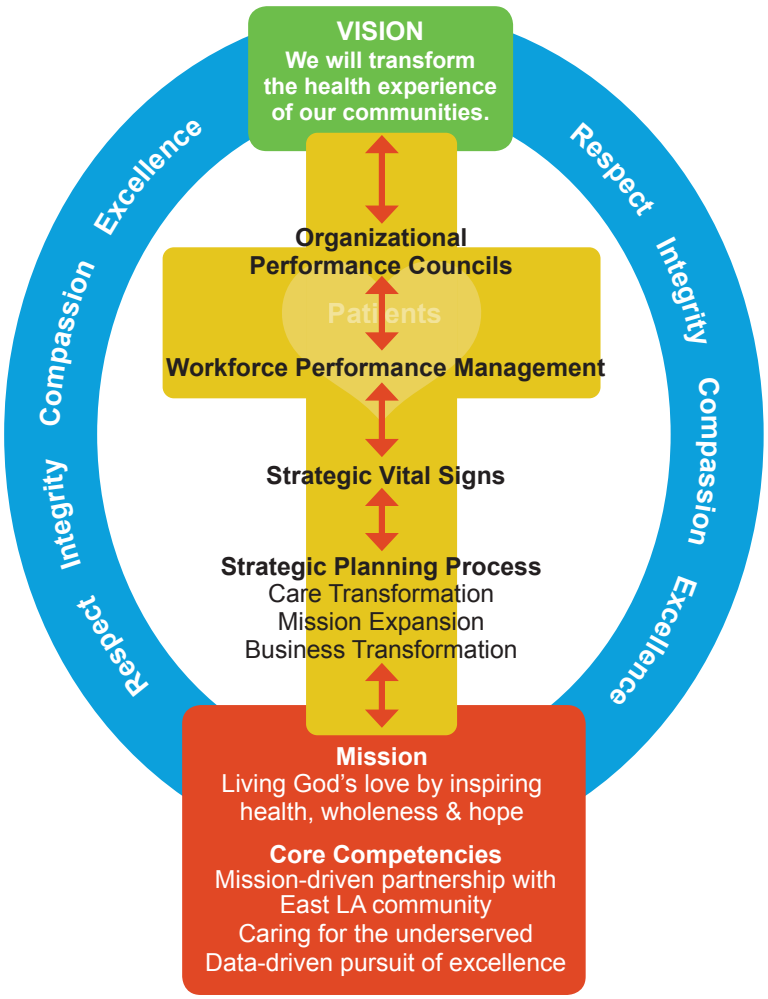
Figure P.1-4: Technology & Equipment

Advanced Technology	Equipment
• Bar Code Medication Administration for improving safety • Blood Bridge for barcoding technology • BMDI Connectivity for enabling wireless connectivity for clinical equipment • Care View Equipment for enabling bed sitter capability • IEM Equipment for enabling call light alerts to phones • NIC View for enabling real time 24-7 views of babies in critical care units to be seen by parents and family members • Omnicell Equipment which is an integrated medication/supply management system • Simulation Lab for student training • Tap-N-Go Technology for enabling quick access for clinical staff/physicians to view labs and other patient test results • Teletracking for enabling tracking of patient flow • KATE™ • MEWs	• Cardiac catheterization lab • EP Lab Equipment (Robot) • HERO Bed for tracking the very sick NICU babies • HIGI for monitoring blood pressure for the public • Microblog MD, a HIPAA-compliant digital messaging communication platform • Micro Turbines for producing energy • PACS System for archiving of imaging • Project Intellicare for enabling Electronic Medical Records (EMR) • Surgical Robot (DaVinci) • Xenex Robot enabling environmental disinfection • Surgical Robot (Mako)

Figure P.1-5: Regulatory Agencies

Baldrige Question	Area	Agency
Health and Safety	State	CDPH, CAL OSHA
Accreditation	Voluntary	TJC, ACGME, ACR
Certification	Voluntary	TJC, SCPC, STEMI, PEDs
Industry Standard	Federal, State	CMS, Cal OSHA, OIG
Environmental	Federal, State, Local	CDPH, CMS, OSHPD, Air Quality Management District
Financial	Local	Corporate and External Audits
Health Care Service Delivery	Federal, State	CMS,CDPH (Title 22), Board of Pharmacy, HHS (HIPAA)

Figure P.1-6: Leadership System



P.1a(5) Key regulatory agencies are presented in **P.1-5**.

P.1b Organizational Relationships

P.1.b(1) AHWM is one of 20 hospitals that comprise Adventist Health. Founded on Seventh-Day Adventist heritage and values, the AH hospitals span the states of California, Hawaii, Oregon and Washington and remain deeply dedicated to providing compassionate, community-based health care, focused on the whole person. AHWM is part of AH's Southern California Network (SCN).

All powers and duties with respect to governance of AHWM are vested in the AH Corporate Board of Directors. The Corporate Board delegates certain authority to a local AHWM Governing Board including planning, operations, quality of care, and medical staff functions. SCN President, Andrew Jahn, is the chair of AHWM's Governing Board, comprised of 20 members who represent the AHWM community and patient population and serve staggered two-year terms. The President and the Governing Board exercise their delegated powers under ultimate direction of the Corporate Board. AHWM's President, John Raffoul, reports to Andrew Jahn, and all other senior leaders report to the President **(OC-1)**. Collectively, the senior leaders comprise the executive team.

The AHWM leadership system **(Figure P.1-6)** positions the patient as the heart and center of all processes (Category 3). The foundation of the leadership system is based on the Core Competencies and Mission while the Values

Figure P.1-7: Key Customers & Stakeholders

KEY CUSTOMERS	KEY REQUIREMENTS	RESULTS
Patients • Inpatients (IP) • Ambulatory/ outpatients (AMB) • Emergency patients (ED)	Safe	7.1a
	Effective	7.1a
	Patient-centered	7.2
	Timely	7.1b(1)
	Efficient	7.1b(1)
	Equitable	7.4a(5)
	Access to care	7.4a(5)
KEY STAKEHOLDERS	**KEY REQUIREMENTS**	**RESULTS**
Community	Access to care	7.4a(5)
	Sustainability	7.5a(1)
	Ethical business practices	7.4a(4)
	High-quality outcomes	7.1a
	Community-oriented	7.4a(5)
Charitable Contributors	Sustainability	7.5a(1)
	Ethical business practices	7.4a(4)
	High-quality outcomes	7.1a
	Low cost	7.5-4-6
	Community-oriented	7.4a(5)
Payors	High-quality outcomes	7.1-15
	Low cost	7.5-6

Figure P.1-8: Suppliers, Partners & Collaborators

Suppliers	Partners	Collaborators
Cardinal: Pharmacy and medical supplies *(On-time delivery and fill rate,* **Figure 7.1-40***)*	**JLL:** Facilities Management Ticket resolution time **(Figure 7.1-41)**	**AH sister facilities:** Comparisons and learning
Premier: Purchasing/ Quality platform *(Cost savings,* **Figure 7.1-38,39***)*	**FQHC-WMCHC:** Access for low income outpatient care **(Figure 7.4-14)**	**East LA Community College:** Workforce Source
GE: Clinical Engineering *(Preventive maintenance, AOS)* NEW in 2019	**Cerner:** EMR services and revenue cycle *(EMR downtime and revenue cycle results)* **(Figure 7.1-42)**	**Dolores Mission:** Joint community outreach
		Hollenbeck Police Station/Local LAPD: Workforce and patient safety **(Figure 7.1-36)**

Figure P.2-1: Comparative Data Sources (sample)

Comparisons Within Health Care	
American College of Cardiology	Premier/Quest
California Hospital Compare	CMQCC
Centers for Disease Control	The Joint Commission
CMS	Adventist Health
HASC	Press Ganey
Comparisons Outside of Health Care	
Gallup	NRC
S&P Financial	

provide the surrounding framework in which all processes are accomplished. Inside the cross and stemming from the Mission and Core Competencies is the Strategic Planning Process (Category 2), which is followed by the associated Strategic Vital Signs (Category 4). The Workforce Performance Management (Category 5) process, which focuses on the accomplishment of Vital Signs, indicates the work that is accomplished by associates, physicians and, volunteers. This process intentionally overlays the heart as the workforce is the heart and soul of the patient-centered leadership system. Next is the Organizational Performance Council and supporting councils and sub-councils (Category 1), which are positioned to support the accomplishment of the AHWM Vision: *We will transform the health experience of our communities by improving health, enhancing interactions, and making care more accessible*. Two-way arrows indicate information flowing between all processes (Category 6), as well as an interdisciplinary and integrated culture, which ultimately results in high performance (Category 7).

P.1b(2) Key customers and stakeholders are presented in **Figure P.1-7**. Key market segments are the same as the service lines presented in **Figure P.1-1**. The Institute of Medicine (IOM) released To Err is Human, Building a Better Health System, an alarming report that brought tremendous public attention to the crisis of public safety in healthcare environments. As a result, six "Aims for Improvement" were identified. AHWM embraces these six aims as the primary patient requirements across patient segments and service lines. Based on the Community Health Needs Assessment (CHNA), AHWM also embraces access to care as a seventh patient requirement.

P.1b(3) Key suppliers, partners and collaborators are presented in **Figure P.1-8**, along with the role they play in delivery of healthcare services and AHWM's key requirements for them. Suppliers and partners are selected partially based on their ability to offer innovation in the area of their expertise. JLL and Cerner have associates on site full-time at AHWM; they function the same as AHWM associates.

P.2 Organizational Situation

P.2a Competitive Environment

P.2a(1) AHWM operates in a highly competitive marketplace. AHWM has 10 other hospitals within its primary service area, with three identified as its key competitors, due to the potential for patient and/or physician migration.

Figure P.2-2: AHWM Advantages & Challenges

Strategic Advantages	Strategic Challenges
1. Strong brand image with presence in East LA since 1913 and #1 hospital market share in Primary and Secondary service areas.	1. Highly populated service area with many healthcare options for customers.
2. Strong community partner as evidenced by more than 90 partnerships and a cumulative economic impact to East LA of $1.3 billion.	2. Increasing access to care.
3. Mission driven workforce with less than 18% living in the PSA, and the remaining 82% choosing to commute to work, passing other hospitals as they do.	3. Competition for physicians.
4. Excellent clinical outcomes, including many results in the national top decile and quartile.	4. Dependent on government programs for 97% of reimbursement.
5. Strong financial viability, including zero debt.	5. Increasing operating costs and capital demands.

P.2a(2) Key competitiveness changes include new employment models for physicians, movement toward managed care and full-risk contracts, uncertainty of healthcare reform, and expense management.

P.2a(3) Key sources of comparative and competitive data are presented in **Figure P.2-1**. Data limitations include reporting lags, gaps in reporting for some clinical services, and limited comparative or competitive data in some areas. Also, though Premier provides risk-adjusted comparative data, this data does not allow comparison of performance to other hospitals that share AHWM's unique inner-city demographic or its poor payor mix.

P.2b AHWM presents its strategic challenges and advantages in **Figure P.2-2**.

P.2c The AHWM leadership system **[P.1b(1), Figure P.1-6]** provides the framework for performance improvement at all levels of the organization:

Organizational Level: AHWM has established a system of Organizational Performance councils and sub-councils, which report to the Governing Board and interface with the Medical Staff committee structure, to provide oversight and accountability for performance improvement **(OC-2)**. All senior leaders sit on the overarching Organizational Performance Council (OPC), which oversees all the councils and supporting sub-councils. The councils and sub-councils are multi-disciplinary but focus on specific aspects of the business. Formal charters identify specific responsibilities, goals, Vital Signs **[4.1a(1)]** and membership. **OC-2** presents

the specific councils and sub-councils, which participate in a regular organizational rhythm to drive performance improvement **(Figure P.2-3)**.

Department Level: Each department has Vital Sign measures aligned with the overall Strategic Vital Signs. These measures populate each leader's Leadership Evaluation Manager (LEM) tool **[5.2a(4)]** to create accountability for leaders and departments. Directors review these measures during one-on-one meetings held every 90 days with their senior leader.

Figure P.2-3: Organizational Rhythm

Individual Level: Each associate is also involved in organizational improvement through goals that are part of the annual associate performance system, Healthstream Performance Center.

Tools: To enable organizational improvement, AHWM deploys the following tools:

- DMAIC **(Figure P.2-4)**
- PDSA
- Lean and Six Sigma

Process improvement is accomplished through multidisciplinary stakeholder teams that may include physicians, patients, partners, and suppliers, as appropriate. Process Improvement (PI) is system-wide, and trained PI Facilitators are available to lead efforts as described in 6.1b(4).

To assure that AHWM is getting outside and unbiased opinions of processes and outcomes, AHWM utilizes the Baldrige framework to obtain feedback reports. In 1998, one of AHWM's executive-level leaders became a national Baldrige Examiner and volunteered for many years. AHWM is a Baldrige-based organization and has participated in the state Baldrige program, the California Awards for Performance Excellence (CAPE), to obtain critical feedback reports to further the journey toward best practice. AHWM is honored to have received CAPE's highest award in 2017.

Figure P.2-4: DMAIC Model for Performance Improvement

D Define	M Measure	A Analyze	I Improve	C Control
• Define the issue • Translate Voice of the Customer into Critical to Quality (CTQ) expectations • Construct a SIPOC and flowchart of the existing process • Utilize Quality Function Deployment tool for prioritization	• Validate expectations of the SIPOC (including input and output expectations) • Determine and collect the needed data • Utilize Value Stream Maps to understand the efficiencies of the process	• Analyze collected data utilizing specification limits and control limits • Identify probable causes of breakdown utilizing failure mode effects and critical analysis and/or root cause analysis	• Identify opportunities to Lean your process: defects, waste, non-value-added steps, or rework loops • Determine what charges need to be made, plan (mistake proofing, planning for failure), and implement (action plan)	• Ensure that the process grows and matures into permanent change that benefits customers, staff, and others • Standardize new process in organizational or departmental policies and procedures • Reexamine measures in VItal Signs against process specifications, utilizing statistical process control techniques

Category 1

1.1 Senior Leadership

1.1a Vision, Values & Mission

1.1a(1) AHWM's passion and commitment to living God's love (mission) and transforming the community's health experience (vision) begin with the organization's visionary leaders and their ability to engage a talented and driven workforce in this very important work. AHWM's executive team, comprised of its most senior leaders, sets and annually reviews the Mission, Vision, and Values through the SPP in alignment with AH. Prior to the annual kick-off of AHWM's SPP, John Raffoul, AHWM's President, attends an annual strategic planning event with other CEOs and senior leaders of Adventist Hospitals. The outcome of this event provides alignment for Mission and Values across the entire AH organization and serves as a key input into the AHWM SPP **[2.1a(1)]**. The latest Mission, Vision, Values, and Guiding Principles (MVVG) are presented in **Figure P.1-2**.

It is during Step Two **[2.1a(1)]** of the annual SPP that the MVVG are discussed through a formal visioning exercise focusing on AHWM's future. In attendance are the Strategic Planning Department, executive team and the 20 Strategic Cabinet members including governing BOD members, medical staff leaders, physicians and directors. Any changes are approved with deployment plans developed to ensure alignment across the organization. John personally introduces the new MVVG to AHWM associates, physicians, and volunteers so that every workforce member understands first-hand the reasoning for any change and the opportunities the change brings.

The AHWM leadership system **(Figure P.1-6)** supports deployment of the MVVG. Deployment begins even prior to onboarding, as the workforce interview process aims to select candidates who can fully embrace the MVVG, and it continues through onboarding for each associate, physician, and volunteer, as well as for key suppliers and partners. The Mission and Vision drive development of the strategic plan **[2.1a(1)]** and the Vital Signs measurement system **[4.1a(1)]**, framing strategic and operational decisions and work at all levels of the organization. Workforce performance management further reinforces the MVVG. Leaders, departments and associates set annual goals to support the mission-driven strategy, and they are evaluated relative to the Values and Guiding Principles. Aligned measures are embedded in contracts for medical directors and key suppliers and partners, and performance relative to the Values and Guiding Principles is a factor in medical staff re-credentialing. Numerous communication mechanisms highlighted in **Figure 1.1-1** ensure consistent messaging and provide regular reminders of the importance of the MVVG.

Senior Leaders' personal actions reflect AHWM's values in several ways. First, senior leaders are selected partially based on their ability to be role models of the Values and Guiding Principles. Once selected, leaders are evaluated based on these same values and principles through the HealthStream Performance Center. Second, senior leaders are dedicated to deployment of the Values and Guiding Principles through a series of organizational processes including the following examples:

- Creation of the Soul Work Council as part of the OPC structure to preserve the work of the Mission.
- Participation in week-long mission work with recent trips made to Mexico and Africa.
- Providing sponsorship and volunteering to the Dolores Mission, where senior leaders and other AHWM workforce members donate time cooking, serving food and other activities.
- Taking bus trips to local bridges sheltering the homeless and to pass out clothing and toys for children.
- Providing sponsorship and donating clothing for job search assistance at House of Ruth, a local charity that is aimed at assisting battered women.
- Attending multiple health fairs and cooking and/or serving food.

Figure 1.1-1: Deployment of MVVG

	Website	New Associate Orientation	Daily Huddles	Performance Evaluations	E-Newsletter	Staff Meetings	Annual All Staff Assembly	Leadership Meetings including I-Lead	One-on-One Meetings	External Focus Groups	Pictures on the Wall	Admitting Brochures	News App	Intranet
Patients	◆								◆	◆	◆	◆		
Associates	◆	◆	◆	◆	◆	◆	◆	◆			◆		◆	◆
Leaders	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆		◆	◆
Volunteers	◆	◆	◆	◆	◆		◆				◆			◆
Physicians	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆			◆
Community	◆									◆	◆			
Charitable Contributors	◆				◆					◆	◆			
Suppliers	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆		◆	◆
Partners	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆		◆	◆
Collaborators	◆								◆	◆	◆			

Third, role modeling is observed through senior leaders' spontaneous and less formal approaches, including their own individual behaviors and actions in their daily work. For example, John was recently seen in the parking lot during the holidays when the guest exit line was excessively long using his associate card to allow visitors to exit the parking area using the associate lane as that lane was shorter. This is an example of his "treating others with the same *compassion* and *respect* I would want my family to experience." Senior leader's commitment to *Integrity* is presented in **1.1(a)2**. *Excellence* is embodied into the Council and Committee structure as this process embodies the core competency of data driven pursuit of excellence.

1.1a(2) Senior leader's personal actions demonstrate their commitment to legal and ethical behavior. First and foremost, they implemented and oversee the organization's key legal and ethical processes, described in **1.2b**, as well as processes to deploy and reinforce the AHWM value of Integrity and the Guiding Principle, "I will be in honest in all things" **[1.1a(1)]**.

Senior leaders also:

- Serve on the cross-functional Bioethics Committee, which is on call to help patients, families and workforce members address difficult situations.
- Annually complete compliance education and sign conflict of interest statements.
- Established a just culture and provide just culture training to all leaders.
- Review hotline calls and any compliance audit findings, taking action, as appropriate.
- Review legal and compliance issues with the Board Compliance Committee on a quarterly basis.
- Oversee development of ethics education for New Associate Orientation (NAO) and New Physician Orientation (NPO).
- Established and review the AHWM Code of Ethics, which was adopted by AH and deployed across the entire system.

Senior leaders participate in an annual review of legal and ethical processes to keep them timely and responsive to AHWM's changing environment.

1.1b Communication AHWM has an on-site Communications Department that partners with the SCN regional communication team to deploy various communication methods. These methods are assessed by surveys to stakeholders to determine value, usage, preference, as well as potential gaps. Recent enhancements are the development of an E-Newsletter that replaced a paper newsletter and an internal news "app." Key decisions are communicated through formal communication plans developed by the regional and local communication associates and based on stakeholder needs. Please see **Figure 1.1-2** for the current Communication Matrix representing all stakeholders and indicating two-way communication mechanisms. Key decisions are communicated to the organization through several processes:

- Formal emails from John communicate larger changes within AHWM.
- Marketing developed a standardized key messaging document for distribution at iLead.
- Daily Huddles are scripted by Human Resources and Marketing to verify communication is consistently deployed across the network.
- FAQ documents are scripted and provided for all supervisory positions to support consistent communication and messaging.

Figure 1.1-2: Communication Matrix

	◄► New Associate Orientation	Meetings	E- Newsletters (STAT)	◄► Daily Huddles	◄► Strategic Planning Events	◄► Board Presentations	◄► Organizational Performance Council	◄► Physician Administrative Council	◄► Performance Evaluation	◄► All Hands Meeting (Revive)	Community Calendar	Community Newsletter	Vive Bien Newsletter	John's Blog	◄► Social Media (Facebook/Twitter)	Share a Vision Newsletter (Website)	Intranet	CEO's Email Update	Govt Relations
Patients		◆	◆				◆				◆	◆	◆	◆	◆	◆			
Associates	◆	◆	◆	◆			◆		◆	◆	◆			◆	◆	◆	◆	◆	
Leaders	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆			◆	◆	◆	◆	◆	
Volunteers	◆	◆	◆	◆			◆		◆	◆	◆	◆		◆	◆	◆	◆	◆	
Physicians	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆			◆	◆	◆		◆	
Community		◆	◆		◆	◆	◆				◆	◆	◆	◆	◆	◆			
Charitable Contributors		◆	◆		◆	◆					◆				◆	◆			
Key Suppliers & Partners	◆	◆	◆	◆	◆		◆		◆	◆	◆			◆	◆	◆	◆	◆	
Community Leaders		◆	◆		◆	◆					◆	◆	◆	◆	◆	◆		◆	
Payors		◆			◆														◆

◄► Two-way Communication

Senior leaders play a direct role in driving workforce engagement and motivating the workforce toward high performance through a systematic process designed for organizational alignment to achieve high organizational performance. This process begins with the alignment of the MVVG to the strategic plan and by managing the work and monitoring its results through the council and sub-council structure **(P.2c)**. AHWM's recognition system is also aligned to the MVVG elements, and senior leaders participate in various recognition events, including the Daisy, Heroes, Bee, STAR PERFORMANCE, Hospital and Nursing Excellence award presentations. Senior leaders also select the annual AHWM Hall of Fame award winners from the recipients of those awards. The Hall of Fame awards honor those that best exemplify the six Guiding Principles. Associate recognition is a standing agenda item during iLead meetings and during monthly department director meetings, with senior leaders taking 30 minutes or longer to recognize leaders and other workforce members. The opportunity for physicians, volunteers and associates to participate in interdisciplinary process improvement opportunities as well as shared governance work is also meaningful to AHWM's workforce since the number one driver of engagement as determined by Gallup is the "sense of Mission." Associates typically drive by other hospitals to work at AHWM indicating their dedication to work and practice medicine to LA's underserved.

As a cycle of improvement, AHWM now customizes workforce rewards and recognitions based on associate input. Self-selected, front-line staff formed a recognition group that developed and launched the Associate Ovation Program.

1.1c Mission & Organizational Performance

1.1c(1) Senior leaders have created a systematic process for creating an environment for success now and into the future through the Leadership System **(Figure P.1-6)** and specifically the council and sub-council structure **(OC-2, P.2c)**. This process aligns the work of the organization to an accountable measurement system **[4.1a(1)]** with results reviewed and monitored through a systematic monthly process and organizational rhythm **(Figures P.2-3, 4.1-2)**.

Each of the councils referred to in **OC-2** is made up of an interdisciplinary membership and championed by at least one senior leader who oversees the work and results related to various sub-councils and taskforces throughout AHWM. AHWM physicians are equally committed to performance improvement as are nursing and leader associate populations and participate shoulder to shoulder within the council structure. Leaders from key suppliers and partners participate as well. Each council and sub-council has a formal charter that includes oversight responsibility for specific organizational performance measures named Vital Signs **[4.1a(1)]**.

AHWM utilizes the talents of two departments (Decision Support and Organizational Performance) that provide all councils and leadership with the required and analyzed data to support organizational performance reviews **(4.1b)**. Decision Support provides financial support, while the Organizational Performance Department provides support for all other measures. During week two of the organizational rhythm, these two departments meet to analyze the data and review performance outcomes of the Vital Signs. During week three of the organizational rhythm, the chairs of each sub-council, share Vital Sign results with their respective council. It is through these councils that decisions are made to address AHWM's opportunities for improvement. This is also where decisions are made for assigning mid-term actions such as special taskforces or Lean Teams to address improvement, or perhaps altogether exiting a strategy. Week four of the organizational rhythm is when the OPC (the oversight body of all councils) meets and makes key decisions that are communicated during the same week through the iLead meeting which all leaders, beginning at the supervisory level, attend. iLead is a major communication and alignment mechanism, as results and action plans are shared vertically and horizontally across the organization, including key suppliers and partners, using a standardized key messaging document.

The aligned and multidisciplinary structure of the councils ensures organizational alignment with a constant focus on the Mission and the strategic plan. This same structure also ensures that AHWM is agile, as changes of direction based on data and facts occur on an as-needed basis, further supporting efforts for organizational sustainability. Senior leaders analyze this process annually to assess organizational contribution and to consider opportunities for improvement. This is accomplished as a part of preparing for the SPP.

While workforce engagement is addressed in **1.1b**, AHWM leaders provide an environment that fosters patient engagement and a culture for patient safety through specific processes, beginning with the Mission, Vision, Guiding Principles and the second Core Competency of "caring for the underserved." These are aligned with the following systems:

- A strategic area of focus for improving customer engagement as described in **Categories 2 and 3**
- One of the eight OPC councils, the Patient/Customer Experience Council, dedicated to analyzing and improving the patient's experience
- A Patient and Family Advisory Council that includes a rotation of IP, ED and AMB members to capture real-life comments and input for improving processes
- Numerous sub-councils focused on patient safety, engagement, and health care outcomes supported in alignment with the core competency of data-driven pursuit of excellence

Safety is a key focus within AHWM. It is demonstrated as the first "I will" statement: I will take personal responsibility to ensure safety of patients, co-workers, and all others I come in contact with while at work. While many processes are discussed within this application to support a safe patient and workforce culture, senior leaders best model this focus when conducting Leadership Safety Rounds. These are accomplished by partnering a senior leader champion with a physician champion who work as a team to meet with unit or department champions to speak to front-line staff about safety issues and concerns. The rounding team discusses actions

for improvement and assigns responsibility for resolution and improvement. An update is provided during the next Leadership Safety Round so the process is full circle with all issues ultimately resolved.

To cultivate organizational agility, accountability, organizational and individual learning, innovation and intelligent risk taking, the following processes are deployed:

Agility: The OPC structure enables agility since the cadence is ongoing and the intent of the structure is to constantly review key areas of strategic and operational performance. Additionally, the senior leaders meet weekly addressing any key and urgent matters. And, of course, any of the senior leaders are constantly available for access, as needed. One senior leader actually lives on the hospital campus for quick access, if needed.

Accountability: The OPC structure is largely the process used by AHWM to assure accountability. The LEM process is also a direct tool that aligns the directors and leaders to the OPC Strategic and Operational Vital Signs. Each leader is responsible for cascading their areas of focus for results into their units and departments. My Rounding is another process where accountability is encouraged as well as audited.

Organizational & individual learning: The OPC structure provides a systematic process to identify organizational learning and for taking action. Learning was the underlying reason for deploying this process across AHWM as it allows for integration of strategic focus, daily operations and assessment of the current environment with a system built in for taking action including corrective action, as needed. Trends from the council and sub-council meetings serve as major opportunity for learning and input for driving educational decisions. Educational decisions are also reviewed as part of the SPP in Step Three (SWOT). Funds are allocated annually to every department to educate leaders and staff **(5.2b)**. Additionally, funds are available for attending best practice conferences such as CAPE and Quest for Excellence as well as other conferences highlighting best practices.

Opportunities for innovation and for taking intelligent risks: Innovation is accomplished in four ways through: strategic planning **[2.1a(2)]**; the council, sub-council and taskforce meetings; in departments by associates and leaders; and through a formal AH program.

- The strategic planning process includes a specific visioning exercise that is led by a trained facilitator.
- The council, sub-council and taskforce meeting process promotes brainstorming opportunities for innovation. The entire focus of these meetings is based on organizational improvement, so conversations about change, process improvement, best practices, and innovation are inherent in this structure.
- Each department is responsible for searching for best practices for its respective operating areas. Examples include focus groups, research through organizations such as Institute for Healthcare Improvement (IHI), the Baldrige community, Premier's Quest collaborative, Kaiser Institute, The Advisory Board, etc. AH provides formal sharing venues that provide for the entire system to compare processes in search of best practices.
- AH sponsors an organization-wide effort to spur innovative ideas. AHWM associates are encouraged to submit innovation proposals to AH, which offers a financial reward of $25,000-$50,000 for ideas to be further developed. An example is that AHWM won a $50,000 "Innovation Grant" from AH to establish the AHWM Faculty Institute of Research Education (FIRE). The goal is to improve patient outcomes, advance medical knowledge, decrease care costs, generate additional revenue, attract practitioners, and provide additional treatment options for the community.

As an example of an intelligent risk to improve safety, AHWM partnered with the Hollenbeck Police Station and hired a reformed and broadly respected gang member, Mike Garcia, to work in the ED. Due to his presence, AHWM is now informed whenever major gang events are expected to occur. For example, recently two major gangs were planning an attack on another gang's leaders. Because of advanced notice through Mike, AHWM was prepared, so that the emergency room remained safe for all. This hire has not only improved ED safety, but has long-reaching impact earning AHWM a reputation as a true community partner, even by gang members, and the campus stands out in the neighborhood with no graffiti. The Hollenbeck Police Department share heat maps of local crime and the areas surrounding the hospital are remarkably lower than other local areas, thus creating a protected haven of safety for patients, visitors and the workforce. Overall, risk-taking such as this has made a tremendous contribution to the ability to successfully operate in the inner-city East LA environment.

Succession planning: Senior leaders participate in succession planning and development through the Engagement Council. This Council developed a career-ladder progression matrix, called the Roadmap to Leadership that systematically develops potential leaders **[5.2c(4)]**. This process also identifies opportunities to fill positions internally. One of the key benefits of this process is that it integrates the opportunities for potential leaders to work beside current leaders across all councils and peer groups. It is through the annual evaluation for improving this process that discussions are held identifying potential leader successors. As the latest cycle of learning, the Executive Team has begun formalizing identification of short- and long-term successors for development of specific leadership competencies. Physician leader succession planning happens through the medical staff structure, whereby the medical staff elects a Chief of Staff, Vice Chief of Staff and medical staff department chairs and vice-chairs, with the intention that they will progress into next-level medical staff leadership positions. AHWM sends emerging physician leaders to leadership development opportunities to prepare them for their future roles.

1.1c(2) AHWM senior leaders create a focus on action that will achieve the mission through leadership system **(Figure P.1-6)**, which links the council and sub-council structure, the strategic plan, and Vital Sign measures. The OPC is

responsible for identifying strategies and action plans that lead to AHWM achieving its short- and long-term objectives. Accountability is built in through the organizational rhythm reviews, the LEM, and associate evaluations through HealthStream Performance Center. This entire process is reconsidered each year during Step 3 of the SPP for improvement.

Senior leaders consider the balance of meeting all stakeholder needs through Steps Four and Six of the SPP. All stakeholder needs are considered during strategic planning through multiple sources including in-person attendance, as appropriate, in strategic planning meetings, surveys, CHNA, BOD feedback, etc. To demonstrate personal accountability for AHWM's actions, each senior leader serves as a champion for at least one, if not multiple, councils and sub-councils and collectively serves as primary members of the OPC and the Strategic Cabinet, discussed in **Category 2**. These are key learning and decision-making bodies that serve as the core of AHWM's entire organizational pursuit of performance excellence.

1.2 Governance & Societal Contributions

1.2a Organizational Governance

1.2a(1) AHWM assures organizational governance through many processes beginning with the structure of the organization and its governing and corporate BODs. The corporate AH BOD delegates certain authorities to the local governing BOD and to AHWM's president for oversight of planning, daily operations, quality of care, medical staff, administration and community involvement. AHWM's president is responsible to the regional AH president, who is in turn responsible to the corporate BOD. The governing BOD is comprised of 20 members who serve staggered two-year terms. AHWM senior leaders are accountable for the strategic plan, which is reviewed and approved by the regional President and the governing BOD. AH sets financial targets on an annual basis, which become AHWM's annual operating and capital budget. These efforts are sustained through corporate internal, mid-year and year-end audits. An external auditing organization, Ernst and Young, provides further oversight and support through annual audits, which include a management report that is submitted to senior leaders and to the governing BOD. Governing BOD members are selected based on skill sets, influence, knowledge of the communities served as well as representation of the ethnic diversity of the communities served by AHWM. For example, the Chief of Police of the Hollenbeck Police Station serves on AHWM's Community Well-Being Council. Additional board committee members represent local business leaders and school officials, including not-for-profit organizations, like the YMCA and the Archdiocese. Annually, BOD members receive an orientation and conduct a self-assessment, analyzing the effectiveness of the BOD. All BOD members sign an annual conflict of interest form listing all potential interests. Creating balance for stakeholders is achieved through the makeup of the BOD, the SPP and through the monthly reviews of council and sub-council outcomes as part of the organizational rhythm. Succession planning is addressed in **1.1c(1)**.

1.2a(2) Performance evaluation of the senior leaders and governing BOD is accomplished through five processes as follows:

1. AH corporate completes a quarterly review of executive team performance on strategic objectives.
2. AH regional president conducts mid-year and year-end reviews for AHWM's president, and AHWM's president conducts mid-year and year-end reviews for his direct reports. These reviews use the standard HealthStream Performance Center tools and processes **[5.2c(1)]** to evaluate behaviors relative to the values.
3. The LEM **[5.2c(1)]** facilitates ongoing review of leader performance relative to strategic goals and the Strategic Vital Signs. Executive bonuses are tied to achievement of Vital Sign goals.
4. The CEO conducts an annual review of the entire executive team performance in the format of strengths and weaknesses.
5. Surveys of satisfaction with the senior leaders by management, associates, and medical staff.

Medical staff leadership review is conducted every two years by the Department Chair review process.

The governing BOD conducts an annual self-assessment to rate the entire board and individual performance on oversight responsibilities for planning, quality, finance, and management. Opportunities for improvement are identified and drive development of an action plan.

1.2b Legal & Ethical Behavior

1.2b(1) AHWM anticipates legal, regulatory, and community concerns through several processes.

Figure 1.2-1: Regulatory, Legal, Accreditation & Risks

Process	Measure	Goal	Result
Compliance screens	% completion	100%	7.4-8
Code of Conduct training	% completion	100%	7.4-8
Regulatory reporting	% timely reporting	100%	7.4-8
State health department	Licensure	Full	7.4-7
The Joint Commission	Accreditation	Full	7.4-7
CMS	Licensure	Full	7.4-7

Figure 1.2-2: Key Measures of Ethical Behavior (Figure 7.4-8)

Ethical Indicator	Goal
Annual Conflicts of Interest Statement by Governing BOD and Senior Leaders	100%
Annual Vendor/Supplier Contracts Compliance Rate	100%
Annual Associate Participation Rate with Compliance Training	100%
Annual Documented Receipt of Signed Code of Conduct from all workforce members	100%

Legal: Instituted by AH in 1996, the Compliance Program provides a standard for ethical behavior and a reporting system for notifying management of potential ethical breaches. The organization's legal board adopted the formalized compliance program, which consists of written policies, procedures and a code of conduct. These are designed to prevent, detect and correct violations of applicable laws, regulations, policies, and procedures. The Corporate Compliance Officer and Local Compliance Officers are responsible for managing the program. All workforce members, suppliers and partners are screened against OIG, GSA and other federal databases prior to hiring, credentialing or contract completion and each month thereafter. AHWM supports and encourages each associate to maintain individual responsibility for monitoring and reporting any associate activity that appears to violate any applicable laws, rules, regulations or the Compliance Program. AH's self-monitoring compliance program provides a confidential reporting system with the following options available for handling Compliance Program concerns:

- Department Supervisor
- Local Compliance Officer
- Facility Privacy Officer
- Compliance Report Form
- Corporate Compliance Officer (877-336-3566)
- Hotline (888-366-3833), publicly displayed and available to patients, workforce, suppliers, partners, and collaborators

All workforce members, as well as the onsite associates of key suppliers and partners, complete annual compliance training and sign a commitment to abide by the Code of Conduct. Acknowledgement of the Code of Conduct is also a mandatory element of supplier qualifications in the vendor management system **(6.1c)**.

Regulatory: The Director for Regulatory and Accreditation is dedicated to the oversight of regulatory compliance. Additionally, the interdisciplinary Regulatory Compliance, Patient Safety, and Compliance Committees—part of the Medical Staff structure—are dedicated to oversight of accreditation and regulatory compliance. Membership in all committees includes the executive team members, key partners/suppliers, and various clinical and non-clinical leaders. These meetings provide opportunities to learn and to integrate key outcomes, increasing knowledge across the organization. To further strengthen the regulatory processes and to avoid blind spots, AHWM has an additional process of hiring an outside expert to perform mock surveys. This helps AHWM provide a sound, unbiased, and fact-based method of supporting a culture that is proactive in its approach to responsibly managing regulatory matters.

A key component of regulatory compliance relates to AHWM's key stakeholder group of payors. To optimize reimbursement from the Centers for Medicaid and Medicare Services (CMS), AHWM has established a robust and pro-active reporting process to submit results for mandatory measures, including those tied to performance-based reimbursement. AHWM systematically monitors potential and actual CMS changes to position the organization for future success under evolving federal healthcare reform, including an active government relations program **(Figure 1.2-3)**.

Community Concerns: AHWM is deeply dedicated to responsibly serving the East LA primary service area and deploys several processes to assure a sound approach:

- **Foundation Board:** The board of directors for AHWM's philanthropic 501c(3) is comprised of influential community members charged with making sure AHWM fulfills its societal responsibilities.
- **Community Well-being Council:** This council is dedicated to keeping a close and formal relationship with other city leaders so that there is a joint and aligned approach for serving the East LA area and its residents with public services. The dynamics of successfully operating in an inner-city environment result in the need for close collaboration and sharing between the various organizations also serving these same residents. Membership includes AHWM executives, governing BOD members, and local non-profit professionals, government officials, community agencies, business owners, and leaders. One of the responsibilities of this council is to serve as the primary source for identifying and addressing public concerns and the impact of AHWM operations today and into the future for the local community.
- **Patient/Customer Experience Council:** One of the responsibilities of this council is to serve as the primary source for identifying and addressing public concerns and impacts of AHWM healthcare services. The Quality Improvement Committee, part of the medical staff structure, plays a key role in this effort.

These councils identify and monitor community needs and potential or actual concerns through extensive Voice of the Customer listening methods **(Figure 3.1-1)**. The councils provide key inputs into the SPP **[2.1a(1)]** and may escalate more urgent concerns to OPC throughout the year. Additionally, during the SPP, when senior leaders are considering new service offerings, a formal proforma process facilitates identification of potential risks associated with a proposed service **[3.1b(2)]**.

Figure 1.2-1 indicates AHWM's key measures for monitoring legal, regulatory and accreditation requirements, as well as potential risks.

1.2b(2) AHWM promotes an ethical organization primarily through a formal Code of Ethics. This is a comprehensive plan and defines how AHWM does business and establishes professional conduct expectations. It addresses confidentiality, quality of patient care, patient's rights, billing practices, health education, marketing and advertising, vendor relationships, human resources, medical education, and identifies conflicts of interest. The Code of Ethics is reviewed on a regular basis by the senior leaders. The version that was adopted by the AH Corporation was written by AHWM senior leaders. The following processes are used to successfully deploy the Code of Ethics across the AHWM stakeholders to accomplish a sound approach for creating an ethical organization:

- **Onboarding:** The Code of Ethics is introduced during orientation for new associates, physicians, volunteers, BOD

members, partners and suppliers. All workforce members, key suppliers, and partners receive initial training for AHWM's expectations for creating an ethical workplace and place for patients to receive care.

- **Annual Training:** AHWM's BOD and all workforce members receive an annual update for ethics training.
- **AH Corporate Ethics Hotline:** All reports are sent to the AHWM Corporate Compliance Officer who initiates an investigation, if warranted. This position reports directly to AHWM's President. Results are discussed during the Compliance Meeting attended by senior leaders and reported to the AH corporate office to ensure external oversight.
- **AH General Complaint Hotline:** AHWM also offers a general complaint process which may receive ethical concerns or inquiries. Anyone can access this complaint hotline including patients, the community, suppliers and partners. All reports are sent to the AHWM Corporate Compliance Officer and are also sent to the AH corporate office.
- **Bioethics Committee:** A multidisciplinary committee is available 24/7 for questions and concerns related to ethical aspects of patient care. Two senior leaders including the President and Chief Patient Executive are standing members of this committee.
- Per the Code of Ethics and supporting policies, breaches of ethical behavior are investigated and can result in disciplinary

Figure 1.2-3: Supporting & Strengthening the East LA Community

Area of Focus	Strategic Initiatives	Community Support
Promote Community Well-being & Mission Integration	Chronic disease management	**Diabetes Healthy Eating Lifestyle Program (HELP) Partnership** with elementary schools focuses on children at-risk for diabetes, helping them and their families adopt healthier eating while increasing their physical activity emphasizing long-term lifestyle changes.
	Health literacy	**Welcome Baby Program Partnership** with First5LA and community organizations, provides interventions for pregnant and postpartum women, working with families to maximize health, safety and security for the developing parent-child relationship. One of the major goals of this program is to teach the benefits of breastfeeding, which has been a cultural gap as many Hispanics believe that affluent populations feed infants store-bought formula.
	Economic environment	**Nursing Health Careers Partnership** with TELACU Educational Foundation and colleges supports students completing their education as RNs. Local bilingual/bicultural Hispanic nursing students receive financial and supportive services and resources to complete their degree and attain a RN license. The need for bilingual, culturally sensitive nurses in California continues to escalate. Latinos account for more than half of California's population, and yet currently less than one in 10 nurses is Latino.
		Health Careers Pathway Partnerships with local high schools and colleges provide students interested in pursuing health careers mentorship opportunities in the healthcare field through hands-on activities, leadership development programs and community service projects.
		Community Childcare Partnership with the Mexican American Opportunity Foundation and community organizations to bring quality affordable childcare for children of local families.
	Hispanic Health (Center for Hispanic Health)	40% of AHWM's patient population has a diagnosis of diabetes. Yet, when trying to teach patients better diets, the national diabetes norms do not consider a traditional Hispanic diet. The norm may say "half of a slice of bread," but that does not easily translate for the Hispanic community who commonly eat tortillas instead of bread. To address this issue, AHWM is working with national organizations such as the American Diabetes Association to influence processes and outcomes for the Hispanic population, one of the fastest growing populations across America. Additionally, staff also educate in Washington D.C. so that Hispanic needs are considered as policy makers make health-related decisions.
		Within the Hispanic culture, mental health is viewed as a secret subject, even in the safe environment of family. To address this observed need, AHWM applied for and received a grant to launch a program in the AHWM OBGYN clinic to identify depression and offer in-house counseling and education through a dedicated social worker.
		Near AHWM is Loma Linda, California, the only "blue zone" (where the average life span is at least 100 years) within the U.S. Loma Linda's residents are predominantly of Adventist faith and follow a vegetarian diet. AHWM is partnering with Loma Linda Hospital and UCLA researchers to develop a plant-based diet for the Hispanic community. This research is the first in the nation.
Improve Access	Access optimization	**FQHC:** AHWM resourced and continues to be a formal partner in managing a primary-care clinic to serve low-income residents on the AHWM campus. The clinic continues to expand its services to meet community needs.
	Government relations	The philanthropy executive is responsible to ensure senior leaders intentionally interact with individual state and national legislators and participate in organizations that work to influence state and national policy related to government healthcare funding. In particular, John Raffoul is a founding member, past president, and the AH representative to Private Essential-Access Community Hospitals (PEACH). The group, comprised of 77 hospitals from across the state, formed 25 years ago to represent safety-net hospitals and protect government healthcare funding. The group helps member organizations both anticipate and influence state and national funding changes.

action, including termination or removal of hospital privileges.

Key indicators of Ethical Behavior are found in **Figure 1.2-2**. Information from these processes is analyzed, trended, included as an input to the SPP, and used to improve ethics processes and training each year.

1.2c Societal Contributions

1.2c(1) To live God's love (mission) and transform the health experience of the communities it serves (vision), AHWM has intentionally selected its core strategies and areas of focus to embed societal well-being and benefit into its strategy and daily operations **(Figure 2.2-1)**. Mission Expansion is one of the three core strategies in the five-year plan, with corresponding focus areas of Promoting Community Well-being and Improving Access. Supporting initiatives, action plans and Vital Signs for each area of focus create alignment and accountability to engage the workforce, suppliers and partners in the privileged work of serving the East LA community. Specific initiatives prioritized through the SPP [2.1a(1)] address community health (social) needs related to physician recruitment, primary care access, chronic disease management, health literacy, healthy living, and Hispanic health.

Additional strategic initiatives are aimed at improving the economic health of AHWM's impoverished, largely uneducated service area. These initiatives focus on workforce development for area residents, community childcare, transportation services, and government relations. As an input to the SPP, AHWM completes an annual Economic Impact Study. Most recently, AHWM, the largest employer in the area, along with its workforce and capital improvements, generated $1.3 billion in economic activity and supported 8,430 jobs.

To address environmental stewardship, AHWM deploys a Green Team that has identified the following strategies:

- Diverting waste, including electronics, batteries, green waste, wood, metal, construction debris, medical waste, and food
- Water conservation, including water restrictors and new faucets
- Energy production through micro turbines that generate the maximum allowed by the city of LA – 1 megawatt of electricity

To support implementation of community support initiatives described here and in **1.2c(2)**, AHWM established a 501c(3) Foundation responsible for raising funds to meet the needs of the East LA community.

For more specifics on how the strategic initiatives support and strengthen the East LA community, see **1.2c(2)**.

1.2c(2) AHWM leverages its core competencies of caring for the underserved and mission-driven partnership with the East LA community to execute its Mission Expansion core strategy and support and strengthen the community it has been privileged to serve since 1913. AHWM determines specifically how it will support this community through the SPP as described in **1.2c(1)** and **2.1a(1)**. Key participants in this prioritization include:

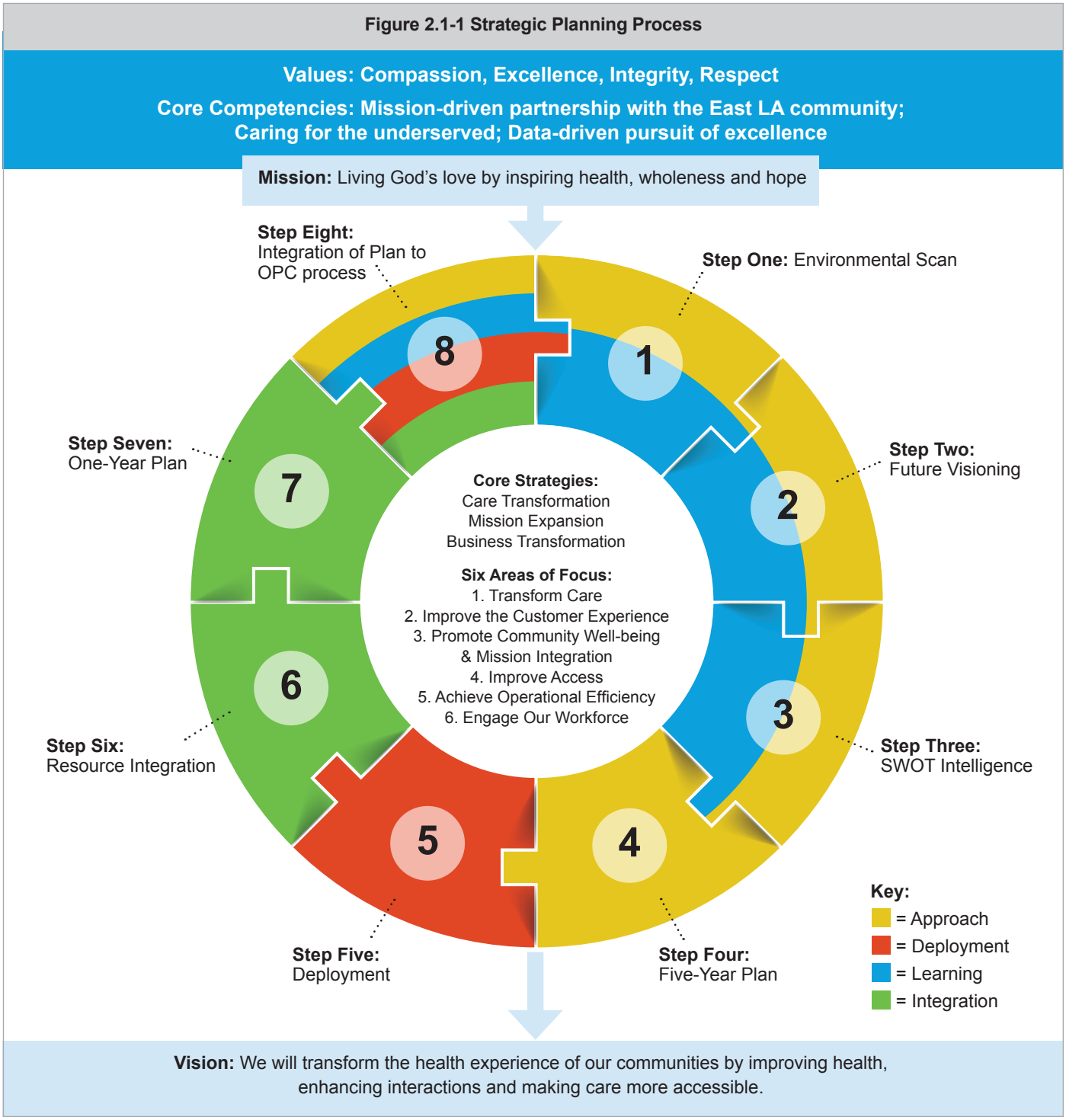
- **Community Well-Being Council:** Established in 2017, this council is dedicated to the health, well-being, and quality of life throughout Boyle Heights and its surrounding community, providing leadership and direction in supporting active and meaningful participation and benefit. It is co-chaired by two members of the Governing Board to provide oversight and an external view to make sure AHWM is addressing the needs of the community. This committee is responsible for the relational connectivity efforts with various other organizations that share AHWM's values and priorities. AHWM has more than 90 partnering community groups, proudly supporting services, volunteerism, and sponsorships to benefit the residents of East LA. This committee also supports development of a Community Benefits Plan, which aligns with AHWM strategic initiatives to support and strengthen the East LA community.
- **LA Partnership:** This county-wide collaboration, comprised of all local hospitals, focuses on wellness. An AHWM senior leader serves on the Steering Committee.
- **Foundation [1.2c(1)]**

Figure 1.2-3 highlights community support programs associated with strategic initiatives in the five-year plan.

Senior leaders are actively involved in supporting and improving AHWM's community. While the majority of community support is aimed to benefit East LA, John Raffoul also encourages world-wide thinking towards health and community benefit. AHWM participates in frequent healthcare mission trips and partners with other regional AH hospitals on others; an AHWM executive goes on each trip, all executives have been on one or more trips, and John is the mission leader for all of SCN.

Workforce members offer support to the local community through local health fairs, wellness education, and free healthcare services. They also support holiday drives for clothing, food, and toys in addition to partnering with local organizations such as the Chamber of Commerce, local businesses, schools, and government agencies to provide low-cost childcare programs, gang abatement efforts, and homeless-outreach initiatives. Volunteers serve at sites on Los Angeles' Skid Row, the Dolores Mission and House of Ruth, and also engage homeless persons under bridges and in encampments. AHWM also sponsors events like Bridge to Health, one of several free community health, wellness and safety fairs, as well as engaging in local agencies' community-sponsored events. AHWM also works with the community to address gang violence and to help young people leave the gangs. With its visible commitment to living God's love, AHWM serves as a beacon of community pride in these underserved neighborhoods.

Figure 2.1-1 Strategic Planning Process



Category 2

2.1 Strategy Development

2.1a Strategy Development Process

2.1a(1) AHWM conducts its strategic planning through an annual strategic planning process (SPP) with key steps represented in **Figure 2.1-1**. AHWM is a Baldrige-based organization and recently incorporated a cycle of improvement by aligning all of the steps for strategic planning with ADLI. The strategic plan includes a short-term plan of one year and a long-term rolling plan of five years. The five-year, rolling plan is developed first, as it drives the one-year plan.

The development of the five-year rolling plan helps to align AHWM's strategic plan to the overall AH plan driving alignment across the AH organization. The one-year plan, called the Annual Refresh, is guided by the OPC and is approved by the governing BOD and is primarily deployed through LEM, HealthStream **[5.2c(1)]** and the Vital Signs measurement system **[4.1a(1)]**. Each step is further defined below in AHWM's eight-step annual process including key participants:

Step One: This first step is an environmental scan, gathering data and information that may contribute to learning from the past and making decisions for the future **[2.1a(3)]**.

Types of data typically collected are key trends and drivers, demographics, community needs, market position, customer, competitive, and stakeholder survey data. Examples of data sources are the CHNA and the Community Awareness Survey. Participants include the Strategy Planning Department, which is largely responsible for gathering the data and preparing for the annual SPP. Other participants include the executive team and Strategic Cabinet members. The Strategic Cabinet is responsible for overseeing and guiding the five-year plan. Membership includes approximately 20 people including the executive team, governing BOD members, medical staff leaders, physicians and directors. During the entire eight-step strategic plan development process, this cabinet oversees and ensures alignment of the Mission with the strategies and helps to vet and prioritize initiatives.

Step Two: "What do we want AHWM to look like in the future?" Innovative thinking is stimulated by intense, rigorous visioning exercises guided by the executive team and guest speakers who lead the Strategic Planning Department, the Strategic Cabinet, and other participants to evaluate best practices and AHWM's competitive position. Often these visioning exercises are held as retreats, to give the intellectual space needed to reflect and challenge the thinking of strategy team members. The intellectual space is needed to question the familiar, remove barriers, embrace curiosity, state the unusual and the unknown, and describe strategic opportunities to serve the underserved, while at the same time remembering to monitor performance metrics and assess financial resources. During the most recent meeting, the following Strategy Statement was developed:

White Memorial Health is made up of an exceptional team of physicians, community partners and workforce who are changing the way our community experiences the lifelong commitment to healthy living.

Figure 2.1-2: Environmental Assessment

	Sample Data/Information
Overall AHWM	Vital Sign performance, performance projections, AH target walk for AHWM, Organizational Performance dash-boards, CAPE OFIs
Transform Care	DRG prioritization matrix, QUEST per-formance (affordability, effective care & coordination, patient safety, mortality, focused populations), Premier pay for performance calculations, Medicare spending per beneficiary, length of stay dashboard, utilization management dashboard
Improve Customer Experience	VOC data, satisfaction, dissatisfaction, social media
Promote Community Well-being	CHNA priority needs, focused interven-tion areas & partners
Improve Access	Market share, payor mix, consumer preferences & perception, physician needs
Achieve Operational Efficiency	Profitability by service line (market), supply costs per AOB, premium pay
Engage Our Workforce	Workforce engagement survey results, Culture of Safety, well-being, injuries

Our understanding of the culturally diverse communities we serve, our rich heritage of promoting health and wellness, and our reputation, size, and scope of service will make us a magnet for attracting any significant network wishing to serve the Los Angeles metro market.

We will be the health provider of choice in our market by:

- *Creating more places and ways in which people can connect with our health care experts and services*
- *Ensuring at least top quartile performance in quality, safety, satisfaction and efficiency*

In addition to the Strategy Statement, aspirational values are exclusively identified to support the SPP and made into statements. The aspirational values are intended to create a leveling of mindset amongst leaders during the SPP to align perspectives and attitudes. For example, one of the aspirational values stemming from a recent retreat is pertaining to innovation:

Innovation: *AHWM will think differently and apply innovation and creativity in everything done to advance the Mission. AHWM will question the familiar, embrace curiosity, and explore the unusual or unknown.*

Initiative Teams composed of executive champions and initiative owners are responsible for describing strategic opportunities, issues, and problems, removing barriers, securing resources, encouraging innovative ideas, and monitoring performance metrics.

There are multiple aspirational values agreed to during this phase of the SPP. Others are available on site.

Step Three: Step Three focuses on a SWOT analysis that assesses the strategic advantages and challenges. The Strategic Planning Department conducts interviews with key stakeholders, reviews internal operations, including associate capacity and capability needs, and compares actual performance to the most recent plan to prepare an Environmental Assessment Reference Guide **(Figure 2.1-2)**. During the SWOT, innovation is discussed during the Opportunities phase. Participants include the executive team, Strategic Cabinet, Strategic Planning Department, councils/ sub-councils, and Decision Support.

Step Four: Step Four is developing the five-year rolling plan. The five-year plan sets the three long-term core strategies. Development considerations are based on what is necessary to achieve the Mission and Vision. The primary participants for developing the five-year, rolling plan are members of the Strategic Cabinet and the regional Director of Strategic Planning. AHWM's executive team and Strategic Planning Department are utilized as subject matter resources during the development phase. It is during this phase that AHWM identifies its core strategies for addressing transformational change and the strategic six areas of focus for the next five years. The current three core strategies were identified as key to driving organizational sustainability:

- **Mission Expansion:** This strategy involves increasing the number of people served by moving care further into the

community through clinics, physician offices, and urgent care.

- **Care Transformation:** This strategy focuses on bringing an innovative approach to the way care is delivered. AHWM is transforming from a volume-based care model to a value-based care model, providing the right care, in the right place, by the right people, for every patient, every time.
- **Business Transformation:** This strategy aims to create an authentic workforce experience and ensure financial stability through innovative and collaborative resource solutions.

It is also at this point that potentially competing initiatives may become apparent and need resolution by the participants. AHWM deploys a systematic process to prioritize the competing strategies. Each strategy "swim lane owner" completes a process form that forces alignment and questions "why this project?" Strategy owners then present their initiative to attendees and recommends their top three projects based on criticality (upstream, urgency, required organizational energy) and alignment with the six areas of focus. Each senior leader is then given five votes, and the executive team votes to select the top projects.

Step Five: Senior leadership and the Strategic Cabinet communicate new strategies to the stakeholders, as appropriate, through several communication channels (President's Blog, daily huddles, iLead, departmental meetings, etc.) and through special events like QI and Strategy Day, which is the venue where key community members, suppliers and partners learn of the plan. The communication emphasizes AHWM's commitment to excellence, reminding the organization that change is inevitable along a journey that requires an innovative mindset to achieve fullest potential, fulfill the mission and serve the underserved.

Step Six: Step Six is the point where AHWM integrates the human and financial needs of the plan with resources identified to support the plan and its core strategies. This step includes an analysis of staffing needs and educational programs that are required to support the strategic plan. Dashboards are defined to support monitoring the plan, including projections, as appropriate. Key participants are the governing BOD, executive team, councils, and sub-councils.

Step Seven: Step Seven positions the five-year plan to be realized for near-term development and deployment, and the one-year Annual Refresh plan is formed. The one-year plan includes initiatives and action plans that align with the core strategies, and areas of focus. Action plans are then developed at the unit/department level. LEM is also updated to integrate the action plans and corresponding metrics for assuring accountability. Dashboards are created specific to units/departments and service lines.

Step Eight: The Dashboards correlate data that are reviewed as Strategic and Operational Vital Signs during the organizational rhythm process and through the various councils and sub-councils, with the OPC ultimately holding full accountability for the success of the accomplishment of the strategic plan. The OPC is responsible to the governing BOD for communicating updates on the entire SPP. The OPC is largely accountable for keeping the organization agile and flexible through monitoring of the progress of the plan against the current environment through the organizational rhythm. It is through the monthly council and sub-council organizational rhythm that needed changes are introduced, and if a change is more urgent, it occurs at the executive level and/or through the OPC.

2.1a(2) The SPP formally encourages innovation in Steps Two through Four as identified in **Figure 2.1-1** and described above in the specific steps. Please see Step Two for the innovation aspirational value that was agreed to by strategic planning participants. This is further deployed as part of the communication to the entire organization when introducing the strategic plan (Step Five). Processes to embed innovation are described in **1.1c(1)**. Central to AHWM's approach is the council and sub-council structure which provides a continuous platform to embrace innovation and create an environment for ideation sharing and risk-taking throughout the year. Also described is the formal AH Innovation program. AH Innovation is further supported by AHWM's very own librarian, Myrna. Myrna is literally famous throughout AHWM for her incredible research skills. She was nominated by AHWM Residents and won a Heroes Award for her highly-valued talents.

AHWM developed a process in 2015 to ensure that the organization has a process for taking intelligent risks. It was decided that the filters for assessing risk would be at the council level. As an opportunity is identified, the relevant council analyzes its risk by weighing the potential benefit to the risk and by using the strategic plan as a guide to make sure the risk is in alignment with the current organizational direction. All recommendations for risk-taking require OPC approval.

The SPP Steps Three and Four, as described above, are integral to the identification of strategic opportunities. Strategic opportunities in AHWM's terms are named core strategies and are identified in Step Four of the SPP as Mission Expansion, Care Transformation, and Business Transformation.

2.1a(3) AHWM collects and analyzes extensive data and information during the SPP to support consideration of strategic challenges and advantages, potential changes in the regulatory and business environment, potential blind spots, and execution of the strategic plan. As an input into Step One and Step Three of the SPP **[2.1a(1)]**, the Strategic Planning Department prepares an Environmental Assessment Reference Guide aligned with the six strategic areas of focus and including data and information highlighted in **Figure 2.1-2**. Additional inputs include stakeholder interviews, demographics, competitor analysis, and review of workforce capacity and capability needs.

This extensive data and information inform the SWOT analysis, which is performed during Step Three of the SPP and facilitates validation or identification of strategic challenges and advantages. Specific inputs related to payors, demographics, market performance, and competitor activity help AHWM anticipate potential changes in the regulatory and

Figure 2.2-1: Strategic Plan Alignment

Core Strategies *5 year*	Areas of Focus* *5 year*	Sample Strategic Initiatives *1 year*	Sample Action Plans *1 year*	Sample Strategic Vital Signs
Care Transformation	**Transform Care** CC-2,3; SA-3,4; SC-1,3-5; P,C,Pa	Continuum of care redesign	Cardiovascular	Mortality rate (7.1-2) CAUTI (7.1-13) Length of stay (7.1-17)
		High-reliability care	Hospital acquired conditions	
		Clinical value	Appropriate hospital use	
	Improve the Customer Experience CC-2,3; SA-3,4; SC 1-5; P,C,Pa	Inpatient experience	Hourly rounding	HCAHPS (7.2-2) Patient rounding (7.2-14)
		Outpatient experience	Leader rounding on patients	
Mission Expansion	**Promote Community Well-being & Mission Integration** CC-1,2; SA-1-3; SC-2; P,C,ChC	Chronic disease management	Diabetes management	Philanthropy dollars raised (7.4-12)
		Health literacy	Disease-specific interventions	
		Economic environment	TELACU	
		Hispanic Health	Center for Hispanic Health	
	Improve Access CC-1,2; SA-1-4; SC-1-3,5; P,C,Pa	Provider network	Physician recruitment	Outpatient visits (7.5-16)
		Access optimization	FQHC	
		Revenue diversification	Alternative payment models	
		Government relations	Government funding optimization	
Business Transformation	**Achieve Operational Efficiency** CC-3; SA-5; SC-1,4,5; P,C,ChC,Pa	Labor management	Productivity optimization	FTEs per adjusted occupied bed (7.3-3) Net revenue (7.5-3) Days cash on hand (7.5-9)
		Facilities performance	Bed configuration	
		Supply chain performance	Value analysis savings	
		Revenue cycle performance	Cash collections growth	
	Engage our Workforce CC-1-3; SA-103; SC-3; P,C	Leadership development	Succession planning	Associate retention (7.3-1)
		Associate engagement	Leader rounding	

*CC: Core Competencies 1-3 (Figure P.1-2); SA: Strategic Advantages 1-5 (Figure P.2-2); SC: Strategic Challenges 1-5 (Figure P.2-2); Stakeholders: Patients (P), Community (C), Charitable Contributors (ChC), Payors (Pa)

business environments both during the SPP and throughout the year. The Compliance Officer and Operations Executive are responsible for regulatory changes, while changes to the business environment are the responsibility of the Business Strategy Council. The comprehensive nature of the SPP's environmental assessment, coupled with frequent performance reviews throughout the year **(4.1b)**, helps AHWM avoid potential blind spots.

Ensuring execution of the SP begins during the environmental assessment, with analysis of the organization's current and projected financial performance and workforce capabilities and capacities. Step Six identifies the human, educational, and capital resources necessary to execute the plan, while Step Seven integrates the plan into AHWM's operations through department and individual contributions, as well as dashboard systems that drive accountability for plan execution. Step Eight is the process by which the plan is deployed into the Vital Sign dashboards **[4.1a(1)]** and council structure and becomes part of the monthly organizational rhythm. The LEM for leaders and HealthStream Performance Center for associates further reinforce execution of the plan **[5.2c(1)]**.

2.1a(4) Across AH, all major outsourcing decisions have been centralized to AH corporate to leverage economies of scale and enhance standardization. AHWM has the opportunity to provide input into these decisions but only has limited authority over small, local outsourcing decisions. The executive team owns these local decisions and makes them primarily based on alignment with the organization's core competencies: caring for the underserved, mission-driven partnership with East LA community, and data-driven pursuit of excellence. As a result, the executive team has made the strategic decisions not to outsource care delivery and to seek local partners when possible.

Work system decisions that facilitate the accomplishment of the strategic plan are considered in Steps Two, Three and Six of the SPP. Step Two of the SPP enables visioning for AHWM's future, which leads to consideration of future core competencies and work systems. Step Three facilitates a SWOT analysis to identify opportunities for consideration. Step Six includes a focus on resourcing the plan.

2.1b(1) **Figure 2.2-1** presents AHWM's strategic objectives, which the organization refers to as "areas of focus." Each of the six areas of focus is defined in the strategic plan with an assigned Executive Champion and supporting initiatives and projects. They frame the organization's five-year plan. Strategic Vital Signs establish the most important goals for each area of focus.

A key change occurring now and into the near future is the movement toward a value-based care model from a volume-based care model. Strategic initiatives for Transform Care, Promote Community Well-being, Improve Access, and Achieve Operational Efficiency address this change **(Figure 2.2-1)**.

2.1b(2) AHWM's areas of focus address its strategic challenges and leverage its core competencies, strategic advantages and strategic opportunities (core strategies) as shown in **Figure 2.2-1**. The core strategies and areas of focus have a five-year timeline, while initiatives and projects are one-year. Through Step Four of the SPP, the areas of focus are intentionally selected to balance the needs of all key stakeholders, as indicated in **Figure 2.2-1**.

2.2 Strategy Implementation

2.2a Action Plan Development & Deployment

2.2a(1) AHWM's one-year initiatives and action plans (referred to as projects), which support the five-year core strategies and areas of focus (strategic objectives), are presented in **Figure 2.2-1**. Action plans occur at the council, sub-council, taskforce, unit, and department levels. The OPC leads the implementation effort for deploying action plans and verifies that all action plans are in alignment with the six areas of focus and the corresponding initiatives. Action plans are developed in Step Seven as described in **2.1a(1)**.

2.2a(2) Leadership communicates action plans to associates and physicians through several meetings designed to deploy the strategic plan down as well as across AHWM. Directors, managers and supervisors hold meetings and discuss their respective unit or department initiatives with their associates. Action plans are developed per unit or department, and in some cases, even per associate. Action plans may include community members, suppliers, partners, and patients as appropriate, and onsite leaders with key suppliers and partners develop and deploy their own action plans. Councils and sub-councils also develop action plans to align with initiatives and projects. Deploying action plans *down* to the unit or department ensures associates are aware and engaged. Deploying action plans *across* the councils and sub-councils provides for interdisciplinary engagement. This bi-directional deployment ensures a well aligned, systematic and robust SPP process.

The ability to sustain the plan is accomplished through the 90-day LEM reviews. Also, councils and sub-councils meet monthly to review Strategic Vital Signs, as well as Operational Vital Signs, which are previous Strategic Vital Signs in sustainment mode. The Organizational Performance and Decision Support departments provide data to support the entire review process.

2.2a(3) AHWM has a systematic approach to integrating the SPP, budgeting and capital allocation to ensure that financial and other resources are available to support achievement of the strategic plan while meeting current obligations. Despite AHWM's 97% government payor mix, years of strong financial stewardship have resulted in virtually no debt and almost 400 days cash on hand **(Figures 7.5-8, 9)**. To maintain this financial performance, the organization uses a rigorous annual budgeting process that integrates AH financial goals, projected patient volumes, department operational needs, and resource requirements associated with strategic initiatives and projects. A local capital committee, with representatives from across the organization, uses a standard form to review capital proposals and prioritizes them for approval by the executive team, Governing Board and approval, as appropriate. Daily, weekly and monthly financial reviews throughout the year at all levels of the organization create accountability for performance to budget and quickly identify any areas that need attention.

2.2a(4) Step Six of the SPP identifies and addresses workforce capability and capacity needs to support the strategic plan and daily operations as described in **5.1a(1)**. Specific key workforce plans to support the five-year plan and annual refresh are reflected in strategic initiatives and supporting projects aligned with the areas of focus, Improve Access and Engage Our Workforce **(Figure 2.2-1)**. Initiatives to Improve Access address physician capability and capacity needs associated with serving the East LA community and preparing for transition to a value-based care model. Engage Our Workforce initiatives focus on leadership development needs and engaging associates in the challenging work of caring for the underserved.

2.2a(5) AHWM selects its Strategic Vital Signs to track achievement and effectiveness of action plans as described in **[4.1a(1)]**. Sample Strategic Vital Signs are presented in **Figure 2.2-1**, in alignment with the six areas of focus. The cascading Vital Signs system **[4.1a(1)]** uses LEMs and council and department dashboards to reinforce alignment from executive to front-line associate and across the OPC council and sub-council structure.

2.2a(6) Performance projections for the Strategic Vital Signs are presented with their corresponding results in **Category 7**, as indicated in **Figure 2.2-1**. Strategic Vital Signs are intentionally selected because they are key measures in need of improvement relative to national benchmarks, so specific initiatives and projects in the annual refresh are designed to close these gaps. AHWM originally projected 2020 performance in 2015, as part of the five-year plan **[4.1c(1)]**. However, the organization has already surpassed those projections in many areas so projections were revised to continue the focus on data-driven excellence.

2.2b Frequent, scheduled review of Strategic Vital Sign performance through the OPC structure and rhythm, as well as other venues highlighted in **Figure 4.1-2**, alert the executive team and other leaders if circumstances require a shift in action plans. Any areas not performing to plan are critically analyzed and presented to the OPC for developing action plans to improve progress. Action plan modifications are then shared with all leaders using a standardized key message document at monthly iLead meetings, creating a systematic way of keeping everyone informed as to the progress of the strategic plan. OPC monitors performance moving forward to make sure the action plan is effective.

Category 3

3.1 Customer Expectations

3.1a Listening to Patients & Other Customers

3.1a(1) AHWM engages numerous formal and informal Voice of the Customer (VOC) approaches to listen to, interact with, and observe patients and other stakeholders to obtain actionable information. The approaches vary by patient group and relationship stage, as highlighted in **Figure 3.1-1**, but are consistently deployed across markets (service lines).

The Patient/Customer Experience Council (PCEC, **OC-2**) – a key part of the OPC council/sub-council infrastructure and rhythm – reviews the VOC mechanisms to make sure they stay current with organizational and patient needs. For example, PCEC established the Patient and Family Advisory

Council in 2015 to engage former patients in the OPC structure and obtain their input on both overall strategy and specific services. PCEC aggregates and reviews VOC data and information to identify improvement opportunities and inform strategic and operational decisions **(3.2c)**.

The Marketing Department systematically gathers customer information through social media. The Facebook page is checked daily for customer comments, while Yelp is monitored to gather patient reviews of the medical center's performance. Through a cycle of improvement, AHWM partnered with Broadly in 2016 to scan social media for feedback and comments. If Broadly detects a dissatisfied customer, it reaches out real-time to the patient or family member to ask if that individual would like to be contacted by AHWM. That interaction feeds into the complaint management process **[3.2a(3)]**.

AHWM obtains immediate and actionable feedback through rounding, bedside shift report, What Matters to Me **[3.2a(1)]**, discharge phone calls, social media, and the complaint management process. Free-form comments from the NRC surveys may also trigger a real-time alert **[3.2b(1)]**.

3.1a(2) AHWM listens to former, competitors' and other potential patients and other customers through mechanisms highlighted in **Figure 3.1-1**. In particular, AHWM completes the CHNA, including interviews with community leaders, patient focus groups, community partners, and a robust community outreach program to better understand the health status and needs of potential patients. The CHNA provides data on key health indicators, morbidity, mortality, and social determinants of health, including population demographics, income, poverty, education levels, unemployment statistics, housing needs, violence outcomes, health status, chronic diseases, health behaviors, hospitalizations, and the physical environment. All of this information is aggregated, analyzed and used as an input to the SPP and to improve healthcare services, patient support, and transactions. Patient satisfaction surveys **[3.2b(1)]** also provide insights into former and competitors' patients and their perceptions of services, support, and safety. In addition to PCEC **[3.1a(1)]**, the Community Well-being Council **[1.2c(2)]** plays a key role in analyzing this data and prioritizing opportunities to improve health and wellness within the underserved East LA community.

3.1b Patient & Other Customer Segmentation & Service Offerings

3.1b(1) AHWM's approach to determine patient and other customer groups and market segments is embedded in the SPP. As an input into the SPP Step One **[2.1a(1)]**, the Business Strategy Council uses extensive VOC data and information **(Figure 3.1-1)** to assess the healthcare needs of the community, as well as changes in the regulatory and competitive environments. AHWM determines which patient groups and markets to emphasize based on this analysis. AHWM involves key stakeholders including physicians, staff, patients, and community leaders, as well as inputs from payors, in identifying the types of healthcare services that will differentiate AHWM while providing value to the community.

Figure 3.1-1: Obtaining Voice of the Customer

Approach	Customer/ Stakeholder*	Stage**
LISTENING		
Patient satisfaction surveys (NRC, HCAHPS, OASCAHPS, EDCAHPS) **3.2b(1)**	IP, AMB, ED	3
Brand monitoring survey	C	1,3
CHNA	C	1,3
Complaint management process **3.2a(3)**	All	1-3
Demographic & utilization data	All	1,3
Social media	All	1,3
Philanthropic activity	CC	n/a
CMS/legislative updates	P	n/a
INTERACTING WITH & OBSERVING		
Patient & Family Advisory Council	IP, AMB, ED	3
AIDET **3.2a(1)**	IP, AMB, ED	2
Leader rounding on patients	IP, AMB, ED	2
Nurse hourly rounding	IP, AMB, ED	2
Bedside shift report	IP, ED	2
What Matters to Me **3.2a(1)**	IP	2
Pre-operative classes	IP, AMB	1,2
Discharge phone calls	IP, AMB, ED	3
Spiritual care	IP	2
Health education classes	IP, AMB, ED, C	1-3
Outreach health fairs	IP, AMB, ED, C	1-3
Governing Board	C, CC	n/a
Foundation Board	C, CC	n/a
PEACH **Figure 1.2-3**	P	n/a
Legislative visits	P	n/a

*Inpatient (IP); Ambulatory/Outpatient (AMB); Emergency (ED); Community, including potential & competitors' patients (C); Charitable Contributors (CC); Payors (P)

**(1) Before admission/service; (2) During admission/service; (3) After admission/service

These stakeholders provide input through surveys and focus groups on how a service is currently being delivered, either by AHWM or others. The Business Strategy Council then considers community needs, demographics, utilization, payor reimbursement, costs, risks and other factors in making a determination. For example, Women's Services was added as a service line based on a need identified through the CHNA survey. The current market segments **(Figure P.1-1)** represent the service lines that are most critical to both meeting the needs of the community and sustaining AHWM's revenue.

3.1b(2) AHWM systematically determines key requirements for each of its patient and stakeholder groups. AHWM initially identified key patient requirements based on a groundbreaking Institute of Medicine (IOM) report that brought tremendous public attention to the crisis of public safety in healthcare environments. AHWM adopted the report's six "Aims for

Improvement" as the primary requirements across patient groups and service lines. Based on the CHNA, AHWM added access to care as a seventh patient requirement. These requirements **(Figure P.1-7)** are verified as part of the SPP.

Key requirements for the stakeholder groups of community and charitable contributors come from analysis of VOC data and information, such as CHNA and focus groups. Payor requirements align with performance-based reimbursement programs established by CMS.

The SPP is also the context for identifying new service offerings. The Business Strategy Council reviews extensive VOC data and information **(Figure 3.1-1)** as well as other key inputs **(Figure 2.1-2)** to identify potential new service offerings. After initial vetting, a formal proforma process, supported by standard templates, facilitates evaluation of proposed services relative to community need, resource requirements, risks, return on investment, and other key strategic and operational considerations. To support the vision of improving health and making care more accessible, community need may outweigh return on investment in the evaluation process. AHWM may leverage its strong financial viability (SA5) and make decisions based on community need, not solely return on investment. Examples of this include the limb preservation and cleft palate clinics. If approved by OPC, the new service becomes part of the five-year strategy and is resourced through the budget and capital processes, as appropriate **[2.2a(3,4)]**.

Once a new service offering is approved, AHWM uses its service/process design methodology **(Figure 6.1-2)** to design and adopt service offerings to meet patient and other customer requirements, exceed their expectations, enter new markets, attract new patients, and expand relationships with current patients.

3.2 Customer Engagement

3.2a Patient & Other Customer Relationships & Support

3.2a(1) At AHWM, building and managing patient and other customer relationships is key to living God's love.

AHWM's approach to acquire patients, build market share, and enhance brand image begins with an annual marketing plan developed to support the strategic plan. The plan includes advertising, promotional materials and social media to promote specific services as well as the overall brand of AHWM. The organization recently launched a major brand awareness campaign including highly visible billboards and bus stop displays, as well as a series of YouTube videos.

PCEC has oversight for AHWM's approach to retain customers, meet their requirements, and exceed their expectations. Based on review of extensive VOC data and information **(Figure 3.1-1)**, the council identifies key initiatives and projects, which are integrated into the SPP to support the Improve the Customer Experience focus area **(Figure 2.2-1)**. Key projects included in the 2019 strategic plan include:

- Hourly rounding, an evidence-based nursing practice that engages staff nurses to pro-actively round on their patients each hour using specific behaviors and language to promote patient safety and a positive patient experience
- Bedside shift report, another evidence-based nursing practice that engages patients in hand-off communications between nurses at shift change
- Leader rounding on patients in inpatient and outpatient settings, which further deploys an effective relationship-building mechanism in use on inpatient nursing units

These 2019 projects are part of a three-year Studer Group engagement focused on building relationships with patients. Tools already deployed across the organization include the AIDET communication tool and in-room white boards to document rounding times, daily care plans, provider names, pain scale and other patient preferences. AIDET is an acronym for: (1) Acknowledge patients and family members by greeting them with a smile and using their names; (2) Introduce yourself and say how you are going to help them; (3) Duration of the procedure or the expected wait times; (4) Explain what you are doing; and (5) Thank them for the opportunity to serve them. Every staff member involved in patient care is audited for their use of AIDET by managers and charge nurses, and results are reported to OPC.

Another relationship-building tool AHWM uses is *What Matters to Me* – a best practice learned from a Scotland hospital. AHWM earned an AH Corporate Innovation grant to adapt *What Matters to Me* for its patient population, creating a conversation tool to identify individual patient likes and interests and communicate them to the rest of the care team. Care givers can then initiate meaningful conversations with patients and their family members to help patients feel more comfortable. This tool is in place in four units and is being deployed further across the organization.

Additional programs and processes in place to ensure that AHWM exceeds patient expectations include:

- Caring for the underserved of the East LA community is a privilege for those who work at AHWM. Part of the hiring process **[5.1a(2)]** focuses on cultural fit to identify candidates who will engaged in the Mission of Living God's love by inspiring health, wholeness, and hope and who can live the Guiding Principles.
- To specifically engage associates outside of nursing, AHWM uses a program called No Pass Zone so that anyone passing a patient room with an active call light is trained to stop and respond to the patient's need, as appropriate.
- Chaplains are available to patients of all faiths, and a Catholic priest visits daily to provide communion for the predominantly Catholic patient population.
- New facilities, such as the new patient tower, and remodels incorporate the Disney concept of onstage/offstage to keep patient-care areas quieter and less busy and to protect patient dignity by minimizing interactions with the public.
- Outpatient settings now have cell phone charging stations.

To maintain patient relationships after discharge, AHWM completes discharge phone calls to check in on patients

Figure 3.2-1: Sample Support Mechanisms

Support Mechanism	Info	Services
My Adventist Health patient portal	X	X
Website	X	X
Social media	X	
Email/phone call	X	
Support groups	X	X
Community Information Center	X	X
Pre-operative classes	X	X
Discharge plans	X	X
Discharge phone calls	X	
Care transition Nurse	X	X
Rounding	X	X
Translation services	X	X
Outreach health fairs	X	X
Free health screenings		X
FQHC		X
Tu Mondo Hoy/Your World Today	X	
Patient information packets	X	
White boards	X	
Bedside shift reports	X	X
Van service, taxi vouchers		X
Diabetes school program (HELP)		X
Welcome Baby		X
Center for Hispanic Health	X	X
Focused SMS texting	X	X

and address any questions or concerns they may have, and a patient portal allows patients to see provider notes, send secure messages to providers, and view/pay bills. In a recent cycle of learning, AHWM hired a care transition nurse to work with patients and families of patients at risk for readmission to help them develop and implement an effective discharge plan. Community support programs, such as the Community Information Center [3.2a(2)], provide ongoing population-specific support.

3.2a(2) To address its key patient requirement of Access to Care, AHWM has established many mechanisms to make it easy for its unique patient population to seek information and support **(Figure 3.2-1)**. The PCEC determines patient support requirements and mechanisms across patient groups and service lines based on its ongoing review VOC data and information from a myriad of communication tools **(Figure 3.1-1)**. Specifically, the Community Perception and CHNA surveys ask questions about how potential and existing customers would like to receive information and access services. The Council uses this data to determine key contact requirements. Changes in key requirements are communicated to key process owners and built into processes through process design/redesign **(Figure 6.1-2)**. They also are an input into the SPP **[2.1a(2)]**.

Sample support mechanisms include:

- AHWM utilizes web-based MyAdventistHealth to assure patients have access to their health information when and where they need it. MyAdventistHealth offers patients personalized and secure online access to portions of their medical records. Patients have a direct link to their electronic health record, which is available 24/7 and includes test results, immunizations, medications, allergies, and recent clinic visits. To further enhance the patient experience, in 2016, Open Notes (admission, discharge instructions, and clinical summaries written by the provider) was added to the online feature to allow even more information so patients can manage their health online.
- AHWM opened a Federally Qualified Health Center (FQHC) on its campus.
- The Community Information Center (CIC) provides free bilingual assistance with health insurance enrollment, senior wellness services, and a variety of invaluable health and wellness educational programs, materials, and workshops.
- AHWM launched *¡Tu Mundo Hoy!* on MundoFox/Channel 22. *¡Tu Mundo Hoy!* is a daily, award winning Spanish-language TV program addressing issues of health, finance and other issues that impact the Hispanic community. The show was so successful that AHWM has launched *Your World Today!* an English version of the show twice a month. Both shows provide viewers information on a variety of health issues and feature AHWM doctors, nurses and staff. Topics of discussion include diabetes, heart disease, obesity and other chronic illnesses with special segments specifically addressing issues related to overall health and well-being. These two shows help AHWM's community make informed choices that encourage wellness in the community which is in line with the Mission, *"Living God's love by inspiring health, wholeness and hope."* Over 100 shows have aired and are available to the community through the AHWM digital library.

Other support mechanisms, such as the HELP school diabetes program and the Center for Hispanic Health, are highlighted in **Figure 1.2-3**.

3.2a(3) AHWM uses its Complaint Management System **(Figure 3.2-2)** to resolve complaints, recover confidence, and avoid similar complaints in the future. Patients and other customers may make informal and formal complaints through multiple mechanisms, including workforce members, the patient safety officer, and a complaint hotline. These mechanisms are communicated to patients and other customers through admissions materials, the website, and patient rights posters displayed in all facilities. AHWM also pro-actively anticipates and captures complaints through structured patient interactions, such as rounding, bedside shift reports and *What Matters to Me*. Complaints are registered into the RADAR database to ensure follow-up and resolution. Informal complaints, which are typically verbal and minor, are usually resolved within 24 hours. Formal complaints may be verbal or written and are addressed through a formal grievance structure. If a formal complaint does not require multidisciplinary consultations, policy changes, or significant investigation, it is typically resolved within seven days. Grievances occur when a patient is not satisfied with the

proposed resolution of his/her complaint. They are also usually resolved within seven days.

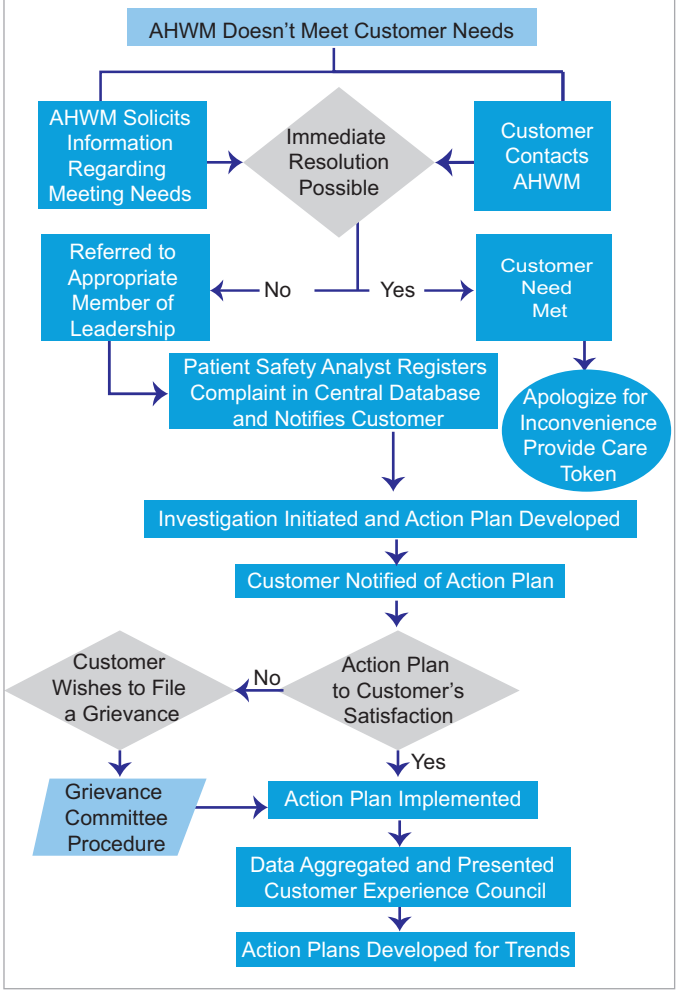
Workforce members receive training on complaint management during onboarding and are empowered to resolve an informal complaint by:

- Listening to and acknowledging the patient's concerns
- Taking steps to promptly address and reasonably resolve the issue
- Apologizing for an inconvenience and using Care Tokens, such as flowers and meal vouchers.

If a complaint cannot be resolved in the timeframes noted above, patients are advised when resolution will occur and kept informed of progress until resolution. PCEC aggregates and analyzes complaint data on a monthly basis to identify opportunities for improvement and avoid similar complaints in the future. The PCEC and OPC monitor these improvement initiatives as a part of the operational rhythm. Aggregated complaints are also an input into the SPP. PCEC evaluates the complaint management process and continues to refine it through cycles of learning.

3.2b Determination of Patient & Other Customer Satisfaction & Engagement

Figure 3.2-2: Complaint Management System



3.2b(1) To determine patient satisfaction and engagement, AHWM contracts with national survey vendor NRC to administer surveys to patients who received care within the organization. Surveys customized by patient group – IP, AMB, ED – provide quantitative and qualitative data on each patient's experience and allow analysis by location and service line. Patients score AHWM on various aspects of their care experience and have the option to add free-form comments. Survey results are web-based and real-time and are available for immediate action by leaders, associates and medical staff.

NRC also administers the CMS-mandated CAHPS surveys on behalf of AHWM. These nationally standardized surveys are customized by patient group – IP (HCAHPS), AMB (OASCAHPS) and ED (EDCAHPS) – to help AHWM understand patient satisfaction and engagement. HCAHPS performance is also a factor in Medicare and Medicaid reimbursement through the CMS Value-Based Purchasing (VBP) program.

AHWM determines patient dissatisfaction through the NRC survey, Broadly social media reports, and the complaint management process **[3.2a(3)]**. When a telephone surveyor encounters a dissatisfied patient or family member, NRC immediately emails an action alert to the AHWM Patient Safety Analyst, who then places the complaint into the complaint management process to resolve the issue **(Figure 3.2-2)**.

Patient satisfaction, dissatisfaction and engagement data are used as described in **3.2c**. PCEC annually evaluates the survey tools and complaint management process to ensure they are still meeting organizational needs.

3.2b(2) AHWM obtains information on patient satisfaction relative to other organizations, including competitors, primarily through NRC and the CMS publicly reported database. As described in **3.2b(1)**, NRC administers a survey to AHWM patients – including IP, AMB and ED – and compares performance to its national database so AHWM is able to evaluate its performance relative to the national top quartile and top decile. Also, the CMS website contains publicly available, facility-based patient satisfaction data for all hospitals based on nationally standardized patient satisfaction surveys. Specific surveys address each of AHWM's patient groups – IP (HCAHPS), AMB (OASCAHPS) and ED (EDCAHPS) – and allow comparison to the national database or to individual competitor hospitals.

In addition, AHWM conducts market research through outside organizations such as Broadly for trends in social media and NRC for brand monitoring to understand patient and community perceptions of AHWM and its key competitors. AHWM also has conducted focus groups with patients who have sought care at competitor hospitals or at hospitals outside its service areas to get information about their satisfaction with other organizations.

3.2c Use of VOC & Market Data

The PCEC is charged with selecting VOC data **(Figure 3.1-1)** to build a more patient-focused culture and support fact-based decision making. The council, with support from

Organizational Performance, aggregates, trends and reviews VOC results throughout the year to identify opportunities for improvement and annually to make sure the VOC data is still meeting organizational needs. Specifically, the review considers whether the VOC data covers major service lines and customer segments and whether it is meaningful and actionable. For instance, AHWM has not historically surveyed patients from the cardiac catheterization lab. However, the cath lab is becoming increasingly important to the cardiovascular service line, so those patients began receiving surveys this year. Also, as social media has become so prevalent, PCEC identified the need to detect and capture AHWM-related posts. Now, AHWM contracts with Broadly to collect real-time information for integration into the complaint management system **[3.2a(2)]**.

Based on VOC data and information, PCEC prioritizes annual organization-wide initiatives, which feed into the strategic plan in support of the focus area, Improve the Customer Experience **(Figure 2.2-1)**. AHWM also intentionally integrates VOC data into its performance measurement **[4.1a(1)]** and performance management **[5.2c(1)]** systems. Both Strategic and Operational Vital Signs incorporate VOC data, which cascades to LEMs and department dashboards across the organization. The Shared Governance structure **(5.2b)** engages front-line associates in reviewing VOC data and driving improvement work at the unit level. VOC data also is embedded in the medical staff credentialing process and in medical director contracts, and is an input into process/service design **(Figure 6.1-2)** and supply-chain management **(6.1c)**.

Category 4

4.1 Measurement, Analysis & Improvement of Organizational Performance

4.1a Performance Measurement

4.1a(1) AHWM selects, collects, aligns, and integrates data to track daily operations and overall organizational performance through a systematic approach based on the following types of measures:

1. **Strategic Vital Signs:** These are selected during step six of the SPP and are measures selected to track overall organizational performance and progress on strategic initiatives aligned with each of the six areas of focus. The Strategic Vital Signs are intentionally selected as critical to monitor performance as part of the OPC process.
2. **Operational Vital Signs:** Once Strategic Vital Signs from previous years that have reached their goal and are being monitored for sustainability purposes. These are also a part of the OPC process. Targets for both Strategic and Operations Vital Signs are established as described in **4.1a(2)** to support AHWM's one-year and five-year plans and goals.
3. **Process Measures:** These are key process measures including daily operational and department-based measures with samples provided in **Figure 6.1-1**. Some may also be Strategic or Operational Vital Signs for targeting or sustaining improvement.
4. **Monthly Operating Forecast (MOF):** These are a standardized set of measures that all AH hospitals are held accountable to, and are reviewed each month with the corporate office. These may include Strategic and Operational Vital Signs or process measures.

Figure 4.1-1: Learning

Year	Improvements to Vital Sign System
2018	Enhanced timeliness and accuracy of patient safety data
2017	Cascaded Strategic Vital Signs to shared governance structure
2016	Piloted care redesign composite measures
2015	Developed four-quadrant map to summarize Strategic Vital Sign results for each core strategy section
2014	Simplified iLead format used to present Strategic Vital Sign results
2013	Revised iLead format to summarize on-track, progressing to goal, and need correction

To engage and align the workforce, the Organizational Performance Department works with the executive champion for each of the six areas of focus to identify a slate of measures aligned with the Vital Signs for consideration by leaders during LEM development **[5.2c(1)]**. A combination of mandatory LEM measures and area-specific LEM measures aligned with the Vital Signs drive development of department dashboards, which include process measures. In parallel, the OPC councils identify leading indicators to support achievement/sustainment of the Vital Signs and develop council dashboards. Medical staff departments also develop dashboards.

Monthly results for Strategic and Operational Vital Signs and council dashboards are populated automatically or centrally by Organizational Performance and Decision Support in dashboards displayed on the intranet. Departments manually populate their dashboards from standardized reports or self-service data sites.

AHWM uses a stoplight approach to color-code results, with green indicating performance to target, yellow indicating performance within 10% of target, and red indicating more than 10% from target. Red indicators require an action plan, with progress monitored by the appropriate council and escalation to OPC.

In 2018, AHWM identified 43 Strategic Vital Signs and 95 Operational Vital Signs. A sample of the Strategic Vital Signs, including key short-term and long-term financial measures, are presented in **Figure 2.2-1**, and both Strategic and Operational Vital Signs are indicated throughout **Category 7**. The remaining measures are available on site.

The Vital Sign system has undergone multiple cycles of learning, as highlighted in **Figure 4.1-1**.

4.1a(2) Selection of comparative data and information to support fact-based decision is embedded in the annual

Figure 4.1-2: Key Performance Reviews

Venue	Participants	Measures	Frequency
Governing Board	Governing Board	SVS	**Quarterly**
Clinical Committee	Governing Board members	Quality & safety measures, patient experience, associate engagement	**Monthly**
Mission Integration Committee	Governing Board, Exec Team	CHNA, population health measures, community support measures	**Quarterly**
Executive Committee	President, direct reports	SVS, OVS	**Weekly**
OPCs	Leaders, associates, physicians, partners, suppliers	SVS, OVS, Council & Subcouncil dashboards	**Monthly**
PAC	Exec Team, MEC	SVS, patient safety measures	**Twice monthly**
MEC	Med Staff leaders	SVS, quality & patient safety measures, HCAHPS	**Monthly**
Quality Improvement Committee	Senior leaders, medical staff, select directors	SVS	**Monthly**
Patient Safety Committee	Physicians, senior leaders, select directors	Patient safety measures	**Monthly**
Med Staff department meetings	Department chair, physicians	Med Staff dashboards	**Monthly/ quarterly**
iLead	Senior leaders, directors, managers	SVS, OVS	**Monthly**
Department/unit meetings	Department/ unit leader, associates	Department/unit dashboards	**Monthly**
Daily huddles	All associates	Census, patient satisfaction, safety	**Daily**

Strategic Vital Signs (SVS); Operational Vital Signs (OVS)

process to identify and cascade Strategic and Operational Vital Signs **[4.1a(1)]**. During the SPP, senior leaders evaluate and refine an overarching comparative data strategy, which currently focuses the organization on achieving at least national top quartile and ultimately top decile performance for clinical, customer and workforce measures and top quartile performance for financial measures. While AHWM has achieved and sustained excellent performance for many of its financial measures despite its poor payor mix, this approach demonstrates and supports the organization's commitment to serving its community and at times prioritizing community needs over financial return.

When setting targets for Vital Signs, executive champions and Organizational Performance evaluate the current result and trajectory for each measure. If a result is below average, the target for the year ahead represents 50 percent improvement. For performance approaching top quartile, the target may represent top quartile or performance midway to top quartile, depending on current performance. The same approach applies to performance between top quartile and top decile. The targets cascade with each measure to the appropriate LEMs and council/department dashboards. To reinforce use of comparative data to support fact-based decision making throughout the organization, the template used for monthly Vital Sign review **(4.1b)** reminds participants of the benchmark used as the basis for target-setting.

4.1a(3) AHWM ensures that its performance measurement system can respond to rapid or unexpected changes through the SPP and frequent review of Vital Signs and other key results **(4.1b)** throughout the year. Regularly scheduled performance reviews alert leaders across the organization to changes impacting performance so they can take immediate corrective action. If the action requires a change in a measure or the addition of a new measure, the responsible leader goes to OPC for approval and works with Organizational Performance and Decision Support to implement a dashboard change. Senior leaders review the performance measurement system during the SPP and identify needed changes. For example, in 2016, AHWM added staffing dashboards to push real-time data to leader phones.

AHWM's approach to providing timely data is described in **4.2a(2)**.

4.1b Performance Analysis & Review

AHWM reviews the organization's performance and capabilities through its cascading Vital Signs system **[4.1a(1)]**, its fully deployed OPC structure **(OC-2)**, and its organizational rhythm **(Figure P.2-3)**, with key performance reviews highlighted in **Figure 4.1-2**. The Vital Signs and supporting dashboard measures, including process measures, are intentionally selected as indicators of organizational success, financial health, and strategic progress **[4.1a(1)]**.

OPC – the overarching council that guides the organization in measurement analysis and knowledge management – meets monthly to review Strategic and Operational Vital Signs and hear scheduled reports from supporting councils and sub-councils. Each of the supporting councils and sub-councils also meets monthly to review their respective dashboards and identify performance variances that require action plans **[4.1a(1)]**. Through the scheduled council reports, OPC is able to remove barriers, shift resources, and assess the capability of the organization to achieve year-end targets.

Physicians participate in the OPC structure, as well as a separate Medical Staff committee structure, which reviews overall organizational performance and physician-influenced quality and patient safety measures. The Governing Board, with its focused sub-committees, also reviews Strategic Vital Signs and supporting measures. The Organizational Performance and Decision Support Departments provide data

and analyses to support meaningful performance reviews and ensure valid conclusions at all levels. Depending on the data set, analyses may include statistical process control, regression analysis, variance tracking, comparative and competitive studies, or drill-downs related to patient demographics, payor or individual physicians.

The frequency and rhythm of performance reviews enable the organization to respond rapidly to changing organizational needs and challenges. If performance drops unexpectedly or fails to reach target, the appropriate council or leader takes corrective action.

4.1c Performance Improvement

4.1c(1) AHWM projects its future performance in the rolling five-year strategic plan based on current and historical performance, national benchmarks, anticipated changes in the organizational and external environment, and the regulatory and competitive landscape. AHWM translates the five-year plan into a one-year plan with incremental targets. In 2015, with the current five-year plan, AHWM projected 2020 performance to be national top quartile for most Strategic Vital Signs. However, in the first year, performance surpassed top quartile in many areas, so senior leaders revised the projections **[2.2a(6)]**. AHWM's executive team participates in a Monthly Operating Forecast (MOF) meeting with the AH regional President and Finance Officer to review local performance and reconcile any differences between corporate goals, AHWM's annual projections, and the expected results of AHWM's initiatives and action plans.

4.1c(2) AHWM uses performance review findings to develop priorities for continuous improvement and opportunities for innovation during the SPP, with reinforcement throughout the year. During the SPP Step Three **[2.1a(1)]**, senior leaders and the Strategic Cabinet, with support from Organizational Performance, Decision Support and Strategic Planning, complete a SWOT analysis, including review of organizational performance relative to plan. A key output from this step is identification of strategic priorities for improvement and innovation, which drive development of core strategies, areas of focus, strategic initiatives and Strategic and Operational Vital Signs **[4.1a(1)]**, as well as a list of the top strategic PI initiatives **[6.1b(4)]**. The cascading Vital Signs system then provides the framework for scheduled performance reviews throughout the year by the Governing Board, OPC, workforce (all levels), partners and suppliers **(4.1b)**, with development of action plans and accountability through the OPC structure to drive improvement of under-performing measures. Physicians and key suppliers and partners participate in the OPC structure and are part of performance reviews and action planning. Additional suppliers may be invited to participate to address specific issues or provide needed expertise.

4.2 Information & Knowledge Management

4.2a Data & Information

4.2a(1) AHWM implements, monitors and improves multiple administrative, physical, and technical safeguards to ensure the highest level of data and information accuracy, validity, integrity, reliability, and currency. To support the core competency of Data-Driven Pursuit of Excellence, AHWM's Information Management Council (IMC) participates in the AH Information Management and Technology (IM&T) strategic planning process to assess technology and data needs for the organization. Major initiatives identified through this process are included in the overall strategic planning process. Data quality control mechanisms include:

Accuracy & validity: Quality assurance testing; extensive user testing and acceptance sign-off; end-user training; strict change-manage process; error reporting; audits; use of algorithms and drop-down menus.

Integrity & reliability: Redundant solutions for critical systems, such as the electronic medical record; computer system protocols; service desk support; tested business continuity and disaster recovery processes.

Currency: Real-time enterprise system updates, remote user access, and use of intranet/shared drives.

Additional levels of quality control are in place for high-risk, high-volume, or problem-prone data and information.

IMC evaluates the effectiveness of these mechanisms, as well as emerging technology and solutions, during the IM&T strategic planning process to drive cycles of learning.

4.2a(2) The AH IM&T strategic planning process assesses and addresses data and information availability for key stakeholders. Locally, AHWM also conducts an annual information management needs assessment. Results of the survey, coupled with corporate and local strategic initiatives, are inputs into the AHWM strategic plan.

Stakeholder-specific systems and applications make appropriate data and information available in real-time through a secure, redundant network that supports wired and wireless computing, as well as remote access for authorized users:

- **Workforce:** The Cerner electronic medical record, known as Project IntelliCare (PIC), captures and displays patient care data and information from clinicians involved in each patient's care. The RADAR system tracks complaints and safety incidents. MicroBlogMD provides a HIPAA-compliant platform for nursing, physicians and residents to text about patients, view an electronic on-call board, and request patient status alerts. Vital Signs and other operational dashboards, such as real-time ED, Labor & Delivery, and OR dashboards, are available on the intranet, and a teletracking system with real-time status of all patients is accessible on any computer, remotely, and on displays in each unit. The intranet and shared drives provide links to policies and procedures, HR information, standardized forms and templates, and many other resources.
- **Patients:** The secure Patient Portal allows patients to access their medical history, view test results and make inquiries from computers, tablets and even phones. AHWM has portal terminals available on-site for public use. The public website also provides general information for patients and the community.

- **Payors:** The Organizational Performance Department submits data to CMS at least monthly through Premier. CMS also pulls data directly from billing files.
- **Suppliers, Partners:** Onsite associates of key partners and suppliers have access to the same data and information sources as the AHWM workforce, and key suppliers are set up with electronic data interchanges.

A current AH priority related to data and information availability is the design of systems to transition additional data transfers from manual to electronic processes. Also, in a recent cycle of improvement, AHWM transitioned to an upgraded Cerner application that allows system updates without any downtime or interruptions.

The AH IM&T strategic planning process also assesses hardware and software needs, types of data, current performance, and key user requirements to ensure reliability of information systems. The IM&T plan identifies potential gaps for reliability and targets these gaps for improvement.

To ensure hardware reliability, AHWM deploys a rolling four-year equipment refresh matrix. The matrix ensures that each piece of equipment is replaced within a three-year timeframe for clinical and five-year for business support based on the age of existing equipment, criticality of reliability for the unit/department, strategic initiatives requiring increased information technology capabilities, changes in user preferences, and replacement stock in-house for emergency system failures.

To ensure user-friendliness, prior to the purchase of new systems, key users are interviewed to understand their requirements. When appropriate, an interdisciplinary group is formed to interview vendors, conduct site visits and recommend purchases. The dimensions of user-friendliness and reliability are reviewed during this process and are key determinants of purchase preference. Once a vendor/product is chosen, an implementation plan is developed that includes pilot testing and workforce training. Ongoing reliability is measured by tracking planned and unplanned system downtime.

4.2b Organizational Knowledge

4.2b(1) AHWM manages organizational knowledge as follows:

- AHWM collects and transfers workforce knowledge through mechanisms including orientation, shared drives, intranet, policies/procedures, council and committee structure, Daily Huddles, Leader Rounding, SBAR communication tool, and various other communication mechanisms highlighted in **Figure 1.1-1**. Also, use of the PreManage communication tool with high-risk patients ensures immediate transfer of critical information between caregivers. EDIE aggregates a patient's medical history from multiple ED visits, across multiple facilities, to support clinicians in delivering the most appropriate care, and ED Results Callback tracks patients requiring follow-up. Additional mechanisms for collection and transfer of workforce knowledge are described in **4.2a(2)**.
- Scheduled reviews of Vital Signs dashboards that integrate data from different sources are the primary tools AHWM uses to blend and correlate data.
- In addition to the electronic medical record and secure Patient Portal **[4.2a(2)]**, AHWM transfers relevant knowledge from and to patients through its VOC processes **(Figure 3.1-1)** and support mechanisms **(Figure 3.2-1)**. Knowledge transfer with suppliers, partners and

Figure 4.2-1: Pursuit of Excellence

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6
2013	Code of Conduct	Revisions to SPP timeline	Distinguished Guest services	Shared Value Analysis between hospitals	Associate file automation, executive rounding, Wellness@ White	SIPOC methodology, interdisciplinary care rounds
2014	Revive (all-staff assembly)	One-page strategy map	Pet therapy program	Electronic recall system	Recruitment site, competency process criteria, formal preceptor training, Roadmap to Leadership, associate access to Living Well	Quality Day, revenue cycle implementation
2015	John's blog	Pilot for regional/ market strategy alignment process	OB focus group, in-home Med/Surg patient interviews	ECRI for product benchmarking, digital boards for communication	COPE Health Scholars, enhanced focus on healthy habits	Revisions to process for rapid cycle of improvement
2016	Revisions to core competencies, new CHNA process	Revisions to template for project plans	New Patient & Family Advisory council	Upgrades to Omnicell for expired supplies	Engagement Coordinator position, alignment of titles & job codes	Director of Nursing operations position, revisions to process mapping
2017	Corporate-wide MVV, new visioning process	Enhancement to physician feedback process, key decision-making guidelines	SONIFI patient entertainment & education system, hourly rounding	Wavemark (Cath Lab)	Nurse transition program, Wellness Fair/ Farmers Market, stress management program, HIGI machines	Redesign of emergency management process
2018	Formalized senior leader rounding	Refined prioritization process	Nurse manager rounding on patients	Artificial intelligence in ED	Formalized associate engagement debriefing process	Structured/formalized vendor tray management

collaborators occurs through orientation, contracts, regularly scheduled meetings, business reviews, and electronic data interchanges. Also, onsite associates of key suppliers and partners participate in all the workforce knowledge transfer mechanisms described above. Transfer of data and information to payors is described in **4.2a(2)**. CMS publishes regulatory updates to keep AHWM abreast of changes to reporting requirements and reimbursement. Also, AHWM leaders have established formal communication mechanisms with state and national legislators to anticipate and influence healthcare policy decisions that may impact AHWM and its underserved community **(See Government Relations, Figure 1.2-3)**.

- Knowledge relevant to AHWM's innovation and strategic planning processes is assembled and transferred through the SPP Step 1, as described in **2.1a(1)** and **2.1a(3)**.

4.2b(2) AHWM uses the OPC council and sub-council structure to identify internal best practices for sharing. Monthly reviews of organizational performance **(4.1b)** reveal departments that are consistently high-performing. The appropriate council then reaches out to the department to understand and consider the logistics of broadly deploying its successful tactics. For processes that extend beyond the scope of a single council, the OPC identifies best practices that can benefit the entire organization.

AHWM also devotes significant resources to identifying best practices from outside the organization. The organization invests in benchmarking opportunities **[4.2b(3), Figure P.2-1]** and contracts with external subject matter experts to guide specific initiatives. Also, leaders, associates and physicians attend conferences and visit high-performing organizations. External best practices are shared with the appropriate council for adoption consideration.

To hardwire an identified best practice, an assigned task force develops policies, procedures, algorithms, training curriculum, competency checklists and monitoring tools. Audits and/or observation in the early stages of implementation ensure compliance and effectiveness. Recent examples of hardwired best practices include fall prevention in the ED and early ambulation of joint replacement patients.

In a recent local cycle of learning, AHWM introduced playbooks to enhance deployment of best practices across the organization. Also, AHWM began participating in an AH regional leadership triad to maximize best practice sharing across SCN.

4.2b(3) AHWM uses its knowledge and resources to embed key aspects of the Baldrige definition for organizational learning in its operations as follows:

- Based on the Baldrige framework, AHWM builds evaluation cycles into its key approaches. For instance, OPC reviews and verifies key work and support processes annually during the SPP Step 2 **[2.1a(1)]**, and the PCEC annually reviews VOC mechanisms to make sure they continue to address organizational needs **(3.2c)**. Each council also annually reviews its charter and membership to make sure it continues to address organizational needs and stays current with organizational or environmental changes. The result is continuing Baldrige-driven progress toward performance excellence **(Figure 4.2-1)**.
- The councils and sub-councils, including unit-based councils, create a framework and rhythm for reviewing performance and obtaining ideas from the workforce, as well as key partners and suppliers.
- Best practice sharing occurs as described in **4.2b(2)**.
- AHWM has a systematic approach for benchmarking key performance measures **[4.1a(2)]** and invests in key comparative data sources. The organization also resources benchmarking opportunities such as Premier comparative database; engagements with Studer Group, Gallup and IHI; conference participation; the AHWM library; and site visits to high-performing organizations.

Category 5

5.1 Workforce Environment

5.1a Workforce Capability & Capacity

5.1a(1) Workforce capability and capacity decisions are led by a variety of leaders including the executive team, OPC, and the Engagement Council. Capability needs are addressed annually during Step Six of the SPP **[2.1a(1)]**, as well as weekly as described below in **5.1a(3)**. Capacity needs are reviewed annually, weekly, and every four hours. Annually, they are reviewed during Step Six of the SPP. Additionally, because staffing needs are constantly changing, department leaders are monitoring productivity and capacity every four hours of every day to verify staffing levels are responsibly meeting the needs of the ever-changing patient volume. Monitoring staffing levels is addressed in more detail in **5.1a(3)**.

During Step Six of the SPP, the Strategic Cabinet also reviews staffing capacity and capability. It is then that both the capability of the workforce, as well as staffing levels, are analyzed to support the current operations and plans for future operations that stem from new strategic initiatives and action plans. Also, as part of the SPP, the OPC evaluates skills, competencies, certifications, and staffing levels of both associates and the medical staff to assure that they align with the strategic initiatives and operational needs. Specifically, the following data are analyzed during the SPP for determining workforce capability and capacity needs:

- Key environmental factors including regulatory changes that may impact nursing levels, etc.
- Vital Sign results
- Leadership, nursing, non-nursing, and medical staff competencies
- LEM and staff performance evaluations
- Sentinel event root cause analyses
- Complaint data
- User error data

- Department/unit retention data
- Associate injury events and trends
- Productivity standards for staffing levels by unit and department
- Medical staff composition and activity

Business Development owns a medical staff development plan based on a three-year comprehensive assessment with annual refreshes to determine physician capability and capacity needs associated with healthcare disparities, service leakage, service line development, and planned retirements. The plan, in addition, to strategic initiatives and action plans, drives physician recruitment in collaboration with other area physicians.

To address volunteer capability and capacity, directors submit requests to address specific needs in their departments.

5.1a(2) The Talent Acquisition Department is responsible for recruitment processes for new associates. For recruitment, job fairs, affiliations with various community resources, such as local trade schools or universities, are utilized for clinical and non-clinical positions. Search firms and recruiters are utilized, as appropriate. Job posting and application processes are accomplished online for both internal and external candidates. A standardized interview tool is utilized to ensure consistent interviewing processes that assess each candidate's ability to uphold AHWM's non-negotiable Guiding Principles.

All new associates, volunteers, and physicians participate in onboarding specific to their role, with all members of the workforce receiving orientation on MVVG and the Code of Ethics. Each department is then responsible for further acclimating its workforce members to cultural and operational expectations. To support ongoing retention, the Engagement Council monitors associate retention data through the OPC rhythm and shares best practices from high-performing departments with departments working to improve their performance.

Diversity is a critical consideration at AHWM due to the highly diverse patient population served. Each year, AHWM produces a thorough Diversity Report that indicates diversity outcomes for the Governing BOD, Foundation BOD, residency programs, chaplaincy, physicians, volunteers, workforce segments, Medical Executive Committee, as well as for patients. AHWM is dedicated to hiring locally, whenever possible, to support the local East LA community; a partnership with TELACU financially supports local residents who want to pursue a career in nursing **(Figure 1.2-3)**.

5.1a(3) AHWM uses its FTE sub-council to address changing workforce capability and capacity needs. The sub-council – comprised of representatives from AHWM's executive team, nursing, ancillary services, and support departments – oversees the approval of all new and replacement, clinical and non-clinical positions throughout AHWM. The exception is leadership positions or new positions associated with a strategic initiative, which are overseen and guided by the executive team.

The FTE sub-council meets weekly to evaluate staffing requests (approve, deny, or delay), and to ensure that productivity, budget, and recruitment are aligned. The sub-council identifies and monitors the top 10 departments with the highest productivity variances to monitor trends and responsibly avoid layoffs, if the need arose in the future.

In addition to the weekly FTE process, AHWM also deploys a daily process to balance census count for patient volumes against clinical staff levels every four hours. AHWM uses a flexing program and cross-training to make staffing adjustments on a day-to-day basis. This critical information is aligned with other organizational needs through the council and sub-council structure, Vital Signs, monthly OPC meetings, weekly executive team meetings, and Daily Huddles (attended by all workforce) so that leaders as well as associates know the current status of staffing needs. These combined weekly and daily processes provide AHWM a robust process for avoiding staffing changes such as layoffs, while also meeting growth demands.

5.1a(4) Work is accomplished through a traditional healthcare structure of departments and units. All workforce members are assigned to a specific unit or department. Each department includes one or more managers reporting to a director, depending on size. Each director is responsible to a vice president or senior leader. Directors participate in the council and sub-council structure. Additionally, all leaders participate in LEM, which is further discussed in **5.2c(1)**. Departments are organized to support at least six Vital Signs. The alignment of Vital Signs to each department integrates the strategic plan into daily work. Further, all managers and associates within a department also have goals set in their LEM or performance evaluations that support the overall strategic initiatives and/or action plans. Core competencies are naturally embedded into daily work since each workforce member is screened for hire based on the desire to care for the underserved and a commitment to work in East LA. Further, AHWM screens for workforce members that care about performance excellence to align with the core competency of data-driven pursuit of excellence. The OPC and the council structure, in partnership with Quality Improvement, Patient Safety and other MEC-associated committees, together drive AHWM's patient-centered. The OPC leads this effort and relies on the Quality Improvement and Patient Safety Committees to analyze trends that impact patients and healthcare outcomes. Both the MEC and councils are interdisciplinary in membership between administration and the medical staff so all are involved in PI activities to support the core competencies, Mission and Vision of the organization. Performance is reviewed at least monthly through the organizational rhythm **(4.1b)**. The various councils and sub-councils share oversight of Vital Signs and assign action items for any areas not performing to plan. The reward and recognition system **(Figure 5.2-1)** is purposely aligned to the MVVG.

5.1b Workforce Climate

5.1b(1) AHWM's Environment of Care (EOC) committee oversees accountability for ensuring workplace health,

security, and accessibility. Wellness@White is a program aimed to improve and sustain associate health and each associate's spouse and/or dependents may participate. The EOC and AHWM's Safety Office are responsible for processes such as safety rounds, proactive workplace risk assessments, and emergency preparedness drills. Volunteers and physicians also participate in these programs. AHWM deploys the following processes to assure workplace health, security, and accessibility:

Health: Wellness@White (W@W) is AHWM's Associate Wellness Program which has been in place since 2012. It was developed to support the AH associate Engaged benefits plan **[5.1b(2)]**. Each year, the Associate Wellness Coordinator and the Wellness Taskforce, which reports to the Engagement Council, conduct a needs assessment to inform future decisions on workplace wellness. This is also shared as an input into Step One of the SPP. This process includes analysis based on local aggregated Associate wellness data received from AH. W@W uses Precede/Proceed logic model for programming. This model has three phases; planning, implementation and evaluation. In the planning phase, a needs assessment is conducted to identify health priorities and indicators and decide what programming is needed to improve these priorities. In the implementation phase, a Gantt chart is used to schedule program planning throughout the year. W@W partners with the Marketing Department to develop materials and to communicate health education and program offerings. Since program origination, some successful programs include having an on-site, weekly Farmers' Market, opening a no cost 24/7 associate fitness center, Fitbit discount and subsidy program, advocating and getting Weight Watchers added to the AH benefits plan, installing two Higi Health Kiosks on campus and annual participation in the American Heart Association's Heart Walk. To evaluate the success of the various programs, data is collected, analyzed, aggregated and provided annually to the Wellness Taskforce and the Engagement Council. To glean an outside perspective, W@W utilizes a scoring system for worksite safety based on the Centers for Disease Control (CDC) Worksite Health Score **(Figures 5.1-1** and **7.3-7)**. Applications are submitted annually for a minimum of one National Associate Wellness Award where experts provide feedback on program improvement. To date, AHWM has received five awards – four from the American Heart Association and one from the Wellness Councils of America (WELCOA).

Figure 5.1-1: Key Measures & Goals

Measure	Goal	Results
Biometric Risk Index	31.68%	7.3-7
CDC Worksite Health Score	227	7.3-7
Wellness Exchanges	24,347	7.3-7
Annual TB Test Compliance	100%	7.1-35
Staff Knowledge of Fire Life Safety Systems/ Protocols	100%	7.1-35
Environment of Care Round Compliance	100%	7.1-35
Staff Knowledge of Biohazard/Chemical Spill Code	100%	7.1-35

Safety: Safety is a key focus at AHWM as evidenced in the Guiding Principle of "I will take personal responsibility to ensure the safety of patients, coworkers, and all others I come in contact with while at work." Safety education begins with eight hours of training as a part of New Associate Orientation and further deployment through an additional six hours of annual and as-needed training, which varies per job description. Positive safety practices are reinforced through associate recognition. The Joint Commission-recommended environmental strategies are used to measure and decrease clinical staff fatigue, a common occurrence in health care. AHWM also follows California and OSHA standards established in the Hospital Patient and Health Care Worker Injury Protection Act to address environmental factors such as injuries from patient lifts, while measuring competencies and training completion for proper patient lift procedures. Associate Health and Education and Training oversee this process.

Security: Security needs are elevated at AHWM due to the hospital's location in Boyle Heights. The following processes are deployed to ensure a safe and secure workplace environment:

- Security officers on campus
- Classes on how to deal with violent behaviors
- A concierge to assist patients and staff
- Phones placed in select places
- Cameras in select places

Figure 5.1-2: Key Workforce Benefits

Benefit	Associates	Physicians	Volunteers
Health Insurance	◆		
403B Option	◆		
Daycare	◆	◆	◆
Associate Assistance Program	◆		
Flu and Other Vaccines	◆	◆	◆
Dental	◆		
Tuition Reimbursement	◆		
Life Insurance	◆		
Ride Share Subsidies	◆		
Flexible Spending	◆		
Vision	◆		
Certification Reimbursement	◆		
Notary	◆	◆	◆
Paid Leave	◆		
Sick Leave	◆		
Special Events: Hospital Week, Holiday Brunch, Workforce Picnic, Service Awards	◆	◆	◆
Voluntary Insurances: Homeowner, Pet, Auto, Critical Illness, Pre-paid Legal	◆		
Living Well Center (gym)	◆	◆	◆

- Publicly announced codes that identify situations that may need reinforcement
- Presence of former gang member in the ED
- Staff training through annual house-wide competency, STAT, Daily Huddle, staff meetings

Accessibility: AHWM is fully ADA compliant and Baby Friendly, including baby changing stations in men's bathrooms.

Figure 5.1-1 indicates AHWM's measures and goals for workplace environment factors.

Since AHWM is primarily one facility, there are no significant differences in workplace requirements for health, security, and accessibility for its workforce. However, there are heightened security sensitive areas where dual security systems such as restricted badge access processes and NICU patient band alarms are utilized.

5.1b(2) AHWM's key benefits are shown in **Figure 5.1-2**. These many programs are offered as choices for associates and can be tailored to meet the highly their diverse needs. AH annually revisits benefits and conducts a market comparison to determine needs and potential benefit gaps.

AHWM offers associates a choice of two-tiered benefit levels, a Base or Engaged plan. The Engaged plan costs associates less and provides participation benefits such as nutrition counseling and no cost generic maintenance medications. Participation is based on meeting four considerations:

- Biometric testing
- Online wellness assessment
- Wellness program participation
- Care management, if needed

The Base plan is more traditional in scope and benefit level. Each year, associates may select and enroll into the plan that best meets their current needs.

Physicians and volunteers also benefit from daycare, vaccines, notary services and participation in special events such as service awards and annual picnic **(Figure 5.1-2)**.

5.2 Workforce Engagement

5.2a Assessment of Workforce Engagement

AHWM utilizes the expertise of the Gallup organization to determine key associate drivers and to assess associate engagement. Basic drivers of engagement are captured through the Gallup Q12 (12 questions that have become an industry standard and best practice), to which associates rank their agreement based on a five-point scale. While the Gallup Q12 are indeed known as an industry best practice for measuring engagement, associate feedback strongly indicated that a key engagement factor for AHWM associates is the mission. As a cycle of improvement, AH partnered with Gallup and added tailor questions to address this engagement factor.

Gallup has conducted the annual associate engagement survey since 2014. It is deployed to all AHWM associates including part-time. Results are segmented by clinical and non-clinical work groups, leaders, and front-line staff and by department or unit. Department leaders together with their managers develop an IMPACT Plan to address and improve opportunities specific to their departments. Daily manager checklists are also identified. The intent of the daily checklists combined with the IMPACT Plans is to improve associate engagement over time by embedding daily processes that will drive higher performance. Each IMPACT Plan is accomplished by department or unit and identifies two questions from the survey to improve over the next cycle to promote an entire organizational approach for improvement that is systematic. Additionally, senior leaders include one of the Gallup questions during their monthly rounding to conduct "pulse checks." Results are captured in the My Rounding tool to synthesize trends and monitor corrective action throughout the year.

Physicians and volunteers participate in annual engagement surveys, and respective volunteer and physician leaders own accountability for addressing improvement strategies, as appropriate. As a cycle of learning, AHWM transition from NRC to Press Ganey as the physician survey vendor in 2017. Similar to the Gallup associate survey, it supports identification of key physician engagement drivers.

Retention is also used as a means to measure associate engagement by appropriate segments. **(Figure 7.3-1)**. Workforce engagement results are an input into the SPP.

5.2b Organizational Culture

AHWM sets the tone for culture and high performance through the identification of Engage Our Workforce as one of the six areas of focus and Business Transformation as a core strategy through the SPP **[2.1a(1)]**. The fully deployed MVVG **[1.1a(1)]** and core competencies **(Figure P.1-2)** also contribute to the formulation of culture. For example, one of the core competencies "Data driven pursuit of excellence" sets the tone and expectation for delivering high-quality performance. This is further noted as an expected behavior in the Guiding Principles, "I will reach for the highest standards in my work" and "I will provide services that my customers say are excellent." The Guiding Principles reinforce culture as they exemplify behaviors that are in concert with the values. Associates are held accountable to these Guiding Principles through the annual performance evaluation process **[5.2c(1)]**. The six areas of focus and the MVVG are all deployed through transparent communication processes including the SPP, councils, and Vital Signs, with reinforcement through Daily Huddles, rounding, department and leadership meetings, recognition programs, newsletters and electronic media. Annually, during the SPP, culture is studied for improvement as part of Step Two **[2.1a(1)]**, including fact-based analysis of associate, physician, and volunteer feedback about culture and communication. The annual Diversity Report **[5.1a(2)]** assures that decisions include considerations for accomplishing a culture that is rich in diversity.

Associates are empowered at AHWM through shared governance. In 2013, AHWM began a journey toward shared governance that started in the nursing units and today

is almost deployed house-wide. Shared governance is an evidence-based practice in health care that leads to higher associate empowerment, engagement, and even higher quality outcomes. Shared governance promotes joint accountability and responsibility for making decisions that affect work processes including patient outcomes. When frontline staff members are empowered to make decisions, they're more likely to take ownership of their practice, both at and away from the bedside. A front-line associate serves as the Shared Governance Coordinator for AHWM and leads the Shared Governance Council, which is part of the OPC council structure and responsible for activities including the following:

- Provide oversight and manage the implementation of ongoing shared governance processes
- Address and resolve any conflicts and provide direction that is cohesive and productive
- Set goals and objectives for the year
- Integrate the strategic plan into shared governance
- Serve as a decision-making body

A full description of shared governance is available on site through the Connect page as part of AHWM's intranet as well as through the annual Shared Governance Report.

Figure 5.2-1: Reward & Recognition Programs

Recognition/ Reward Name	Nomination Source	Who is Eligible	Award
High-Five	Peer to Peer	All associates	Recognition and appreciation
Living our Values Every Day (LOVED)	Patients and family members	All associates	Recognition and appreciation
Raising The Bar Together	Associates, suppliers/partners or physicians	Any team such as a council, department, or a group	Celebration and story communicated in STAT newsletter
Hall of Fame or the Standing Ovation Award	This is voted on by all councils	Any individual or team (council, department, or a group)	Flowers, award, $250.00 and a portrait displayed on wall
BEE Award	Associates, physicians, patient, family member, volunteer, or visitor	Non-nursing staff	Bee pin, honey jar, honey buns, department banner
DAISY	Patients, families, visitors, physicians, associates, volunteers	Nurses	Daisy gift bag, certificate, DAISY pin, Healer's Touch sculpture, two boxes of Cinnabons and a banner hung in unit or department
Professional Practice Model (PPM) Award	Anyone	Nurses	Trophy, PPM pin, featured story in STAT newsletter
Physician of the Year	Nominations are from anyone, and the entire organization votes	Any physician that has contributed to the overall focus on performance excellence and patient-centered care	This recipient becomes AHWM's nominee to be considered for the AH Physician of the Year award
Angel	Foundation	Any person that has made a donation in honor of an associate, physician or volunteer	Certificate
Volunteer Recognition Luncheon	Foundation invitation to all volunteers	Volunteers	Lunch
Thank-you Notes	Leaders	Any associate, physician, partner/ supplier with the primary target being front-line staff	Thank-you notes sent to homes
Specialty Certificates	By accomplishment of certification	Any staff/volunteer that has obtained specialty certificate in their discipline	Recognition plaque in department or unit
Quarter Century Club	Human Resources issues upon service date of 25 years	Any 25 year employee	Name added to recognition wall in the Specialty Care Tower, 1st floor corridor
Service Awards	Human Resources	All associates celebrating service times at five year increments	Service awards banquet event plus one, trophies, gift, pin

5.2c Performance Management & Development

5.2c(1) AHWM has a systematic, fully deployed, and aligned approach to manage workforce performance to support high performance, a patient focus and strategy achievement. For associates, AHWM utilizes the HealthStream Performance Center to evaluate cultural performance relative to the values and Guiding Principles, as well as achievement of goals aligned with strategic action plans and the Vital Signs. This process occurs annually through a formal written review and is further supported by in-person meetings held with each associate every 90 days. The process also includes a discussion about personal development and career goals. HealthStream Performance Center includes a Writing Assistant and Coaching Advisor to help each manager understand how to prepare a successful performance review and conduct positive and meaningful conversations about performance and career progression. Leader performance management also happens through the LEM, which aligns leader goals to the Vital Signs **[4.1a(1)]** and strategic initiatives **[2.2a(2)]**.

To further support high performance, AHWM deploys a systematic recognition system that is

robust and aimed at rewarding positive behavior aligned with the values and Guiding Principles. The reward programs are presented in **Figure 5.2-1**. As a mission-driven organization, AHWM is committed to maintaining fair and competitive compensation. Benchmarking is conducted locally as well as through AH to determine appropriate compensation levels.

Physician performance management happens through the medical staff Ongoing Professional Practice Evaluation (OPPE) and re-credentialing processes. Individual physician performance is evaluated on an ongoing basis relative to department-specific quality measures aligned with the Vital Signs, as well as cultural indicators such as patient complaints. Every two years, physicians must be re-credentialed by the Governing Board to maintain privileges. Medical directors have additional performance evaluation relative to metrics specified in their contracts, which are reviewed at least every three years.

Volunteer performance is evaluated after each work assignment by the work supervisor. Feedback goes to the volunteer manager.

5.2c(2) To support organizational needs and the personal development of workforce members, AHWM conducts an annual fact-based assessment that includes an education and training survey and analysis of the following inputs:

- Gallup engagement survey data
- Associate performance evaluation trends from HealthStream Performance Center
- LEM trends (for leaders)
- Leadership interviews
- Course evaluations
- Associate and physician forums
- Incident reports
- Clinical outcome trends

To ensure that the data is analyzed to address all of AHWM's various types of employment categories, the assessment is segmented by job classification. An added benefit of the assessment is that it includes a gap analysis of workforce capabilities to inform staffing decisions. Conclusions are developed from the assessment, and then curriculum decisions are made to close any gaps for learning and training needs. This process enables AHWM to understand the desires of the workforce and leaders for educational choices. The CME Committee is responsible for identifying physician development needs.

To assure that organizational needs are met, AHWM's robust SPP impacts educational and training decisions. AHWM's core competencies and strategic challenges are addressed in Step One of the SPP, which shapes decisions that lead to educational offerings later described in Step Six of the SPP. Achievement of short- and long-term initiatives and action plans, performance improvement, organizational change and innovation are all incorporated into the analysis conducted as parts of Steps One and Six of the SPP. Additionally, courses are selected to complement the core competencies. For example, EDGE (Every Day Giving Excellence) supports the Core Competency of "data driven pursuit of excellence" and the Guiding Principle of "providing services that my customers say are excellent."

Ethical education decisions are made based on compliance requirements, and annual mandatory training is conducted, as appropriate to the associate's job description requirements. Each job description includes competencies that support the six strategic areas of focus and the accompanying strategic initiatives and projects. Organizational changes stemming from the SPP may require changes to these job-related competencies, which are identified during Step Six as described in **2.1a(1)**.

A strong focus on patients is accomplished through the third area of focus of the SPP, "Improving the customer experience." Specific training such as AIDET, has a direct correlation to support this area of focus as well as other programs such as *What Matters to Me* and rounding.

AHWM utilizes HealthStream Learning Center for accomplishing elective, as well as required learning opportunities. AHWM also uses FlexEd, a Los Angeles based collaborative that offers educational onsite learning opportunities in and around LA, helping associates complete educational needs outside the hospital's campus. Each associate's performance evaluation includes an annual assessment of learning opportunities. Leader opportunities are identified as part of the LEM process.

5.2c(3) AHWM evaluates the effectiveness of its learning and development offerings through the robust assessment process described in **5.2c(2)** and through the data-driven analysis of Vital Signs performance, including trends in quality and patient outcomes, combined with correlated trends of associate performance evaluations and engagement survey results.

5.2c(4) Career development and succession planning are accomplished through a formal process owned by the Engagement Council and utilizing the HealthStream Performance Center. The process – called the Roadmap to Leadership [also described in **1.1c(1)**] – is based on the concept of a mapped career progression path. This is a matrixed process describing technical and soft-skill development for a successful transition toward clinical or nonclinical leadership roles. The matrix includes these components per job title: required years of experience, degree, responsibilities, suggested courses and memberships, and sources for learning and professional development. Examples of sources for learning are participation in the Simulation Lab, local college classes, HealthStream, certification programs and shared governance participation, as appropriate. This tool provides recommendations for networking opportunities that can further career development and professional growth. As the latest cycle of learning, the Executive Team has begun identification of successors and the leadership competencies they need to develop before moving into an executive role.

Figure 6.1-1: Key Work Processes

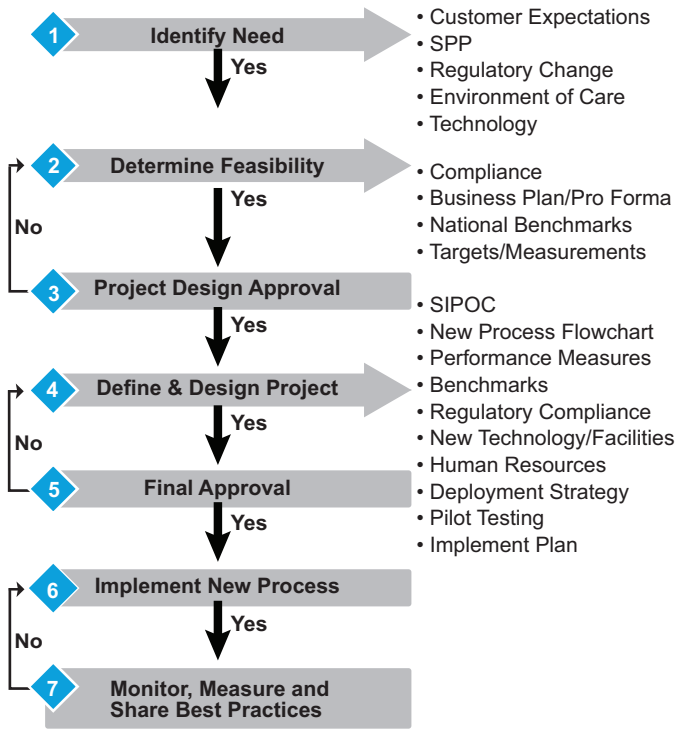
KEY WORK PROCESS	KEY REQUIREMENTS	SAMPLE PROCESS MEASURES	FIGURES	SAMPLE OUTCOMES
Provide Inpatient Care	Timely diagnosis & care, safe & effective care, value	Hand hygiene	7.1-23	• Mortality *7.1-2* • Patient satisfaction *7.2a(1,2)* • Physician engagement *(7.3-10)* • Operating Margin *(7.5-2)*
		Antenatal steroids	7.1-11	
		Barcode medication administration	7.1-25	
Provide Ambulatory/ Outpatient Care	Experience, safe, effective	Colonoscopy care	7.1-20	
		On-time case starts	7.1-28	
		Returns to ED post-ambulatory surgery	7.1-19	
Provide Emergency Care	Experience, access, safe, timely, appropriate	PCI in 90 minutes	7.1-33	
		ED care for chest pain	7.1-18	

Physician's development plans are reviewed annually on an individual level so that CEUs are appropriately earned to maintain required Board and other Certifications. The CME Committee oversees the process. An annual assessment is also conducted as a part of the SPP for the entirety of the medical staff to determine any gaps between current skill sets and competencies against organizational future needs.

Support is provided with the availability of continuing educational funds and tuition reimbursement. AHWM also deploys formal mentoring programs to support career growth and succession planning:

- Preceptorship programs for nursing
- Faculty mentors for residents
- Leadership buddy program

Figure 6.1-2: Healthcare Services Design Process



Category 6

6.1 Work Processes

6.1a Service & Process Design

AHWM uses a formal healthcare services design process **(Figure 6.1-2)** to determine key healthcare service and work process requirements and to design services and processes to meet those requirements. New healthcare services are identified during Steps 1-3 of the healthcare services design process. The executive team initially identified the key work processes **(Figure 6.1-1)** through a facilitated workshop in 1998. The processes have been mapped and assigned to process owners.

Figure 6.1-3: SIPOC

Suppliers	Inputs	Process	Outputs	Customers	Requirements
Who are the key suppliers and stakeholders in your sub-process?	What do each need to bring into process?	What are the sub process steps?	What outputs are produced?	Who are your key customers?	What are their most important requirements?

Once the executive team decides to move forward with a new healthcare service or work process, determination of key service/process requirements happens during Step 4 of the healthcare services design process. A team of appropriate stakeholders uses SIPOC **(Figure 6.1-3)**, direct engagement with internal process customers, and external listening and learning methods **(Figure 3.1-1)** to determine key healthcare and work process requirements. Key work process requirements are highlighted in **Figure 6.1-1**.

During the feasibility/proforma process (Step 2), the team quantifies the need for a service or process and considers potential risks, patient safety implications, regulatory and accreditation requirements, financial and other resource requirements, and return on investment. In Step 4, the team researches best practices, benchmarks, evidence-based medicine, and new technology. If the process or service incorporates new technology or supplies, actual users participate in the selection process, and process/service

Figure 6.1-4: Process Mapping

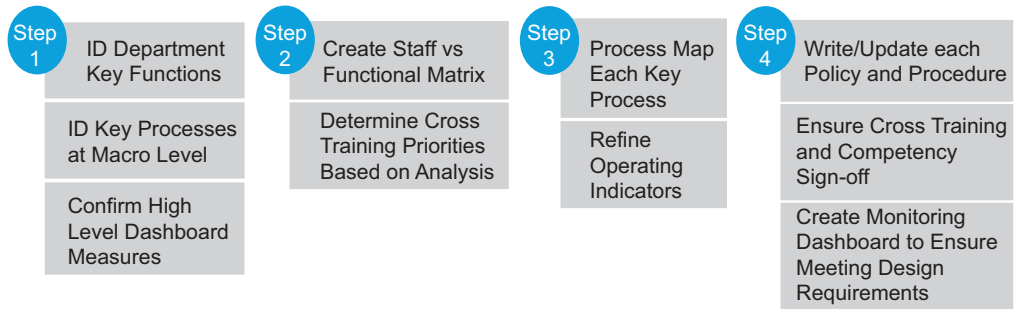
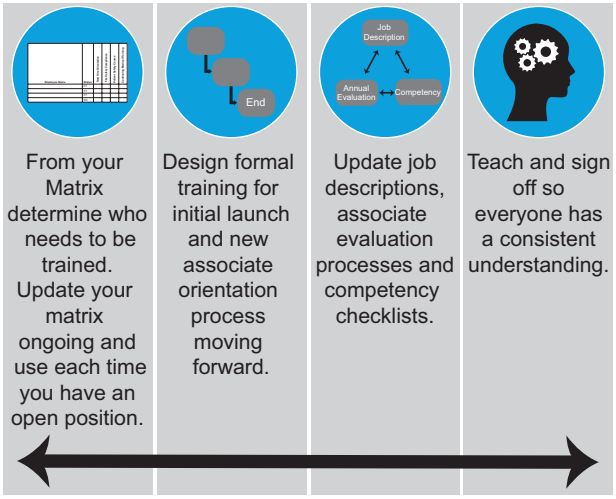


Figure 6.1-5: Training Competency Sign-Off



requirements are a key element of selection. Step 4 also incorporates formal process mapping and identification of effectiveness and efficiency measures to ensure key process requirements are met. As part of an implementation plan, these measures are assigned to the process owner for monitoring and placed on a dashboard for management through the OPC council structure. Workforce champions may be engaged to support implementation. The final task in the design process is compiling a list of lessons learned for sharing across AHWM and the region.

The OPC reviews and verifies the key work processes annually during SPP Step Three **[2.1a(1)]**, and the processes have gone through multiple cycles of improvement. Most recently, leaders completed department-level process mapping **(Figure 6.1-4)** to align department processes and sub-processes and ensure consistent implementation across the organization. To support process implementation and sustainment, leaders systematically identified and addressed training and competency needs as highlighted in **Figure 6.1-5**.

6.1b Process Management & Improvement

6.1b(1) Process implementation begins in Step 4 of the healthcare services design process **(6.1a, Figure 6.1-2)**, when the multidisciplinary design team develops an implementation plan, including financial, technology, and training/competency requirements. With final approval from the executive team, the assigned process owner coordinates implementation of the plan and manages day-to-day operations using key performance measures and in-process measures, such as those highlighted in **Figure 6.1-1**. Additional process management support comes from Organizational Performance and Decision Support, the council structure's monthly organizational rhythm **(Figure P.2-3)**, and multiple real-time tools. For example, the ED and Labor & Delivery have real-time electronic dashboards to visibly update associates and physicians on the number and status of current patients, and an electronic staffing system updates staffing needs every four hours based on patient volumes and acuity. Also, the Teletracking system displays real-time information about facility-wide patient flow on large flat panel units, and through a 2016 cycle of learning, ADT (admission, discharge, transfer) alerts go out to leader phones based on defined patient flow parameters. If processes are not performing to requirements, process owners take immediate corrective action and develop and implement action plans to drive improvement.

6.1b(2) AHWM's Values and Guiding Principles **(Figure P.1-2)** focus the organization on considering and addressing each patient's expectations and preferences. Understanding and setting patient expectations begins with the initial consent and assessment process, which captures and documents information on patient preferences for care, spiritual needs, language, diet and more. Admission packets reinforce expectations, and some patients attend pre-admission classes. Caregivers work with patients and families to develop a personalized plan of care and update it throughout a patient's stay/visit. White boards in patient rooms post care goals, and rounding by physicians, managers, and other caregivers provide frequent opportunities to address expectations and preferences. Throughout a patient's stay/visit, caregivers use AIDET **[3.1a(1)]** to explain health care service delivery processes and likely outcomes to patients and families, and they use the *What Matters to Me* tool **[3.1a(1)]** to personalize the care. Bilingual members of the workforce and video-based translation services help deliver information in the patient's preferred language.

To support the Mission of living God's love, chaplains round daily and visit new inpatients to assess and address their spiritual care preferences. An ED case manager and social workers on site 16 hours every day further engage patients across care settings to address their individual needs.

AHWM has a multi-faceted approach for addressing the expectations, preferences and needs of its large underserved population. A case manager visits homeless inpatients during the first 24 hours of their admission, and per a formal policy, homeless patients across care settings meet with a social worker, who assesses their needs and assists with discharge, including temporary housing for some patients. Financial

Figure 6.1-6: Key Support Processes

KEY SUPPORT PROCESS	KEY REQUIREMENTS	SAMPLE PROCESS MEASURES	FIGURES
Manage People	Timely, accurate, engaged	Retention	7.3-1
		Physician recruitment	7.3-4
Manage Education	Experience, appropriate, effective	Certification exam performance	7.3-15
		RN scholarships for service area residents	7.4-13
Obtain & Manage Supplies & Equipment	Access, timely, value	Fill rate	7.1-40
		Supply expense	7.1-38
Continuously Improve Performance	Strategic alignment, value	Timely reporting of events	7.4-8
		Value realization	7.1-34
Plan for the Future	Clear path, clear vision	Strategy achievement	7.5-17

counselors work with patients to help them qualify for assistance programs.

Service lines review and improve area-specific mechanisms for considering and addressing patient expectations. For instance, in a recent cycle of improvement focused on improving outcomes for joint replacement patients, the PI team redesigned the preoperative clearance process, implemented pre-admission classes in English and Spanish, and began offering a video for patients who cannot attend onsite classes.

6.1b(3) Senior leaders initially determined the key support processes necessary to perform the key work processes during the same 1998 facilitated process management workshop described in **6.1a**. **Figure 6.1-6** highlights key support processes, which are designed, implemented, managed and annually reviewed as described for key work processes **(6.1a)**. To determine key support process requirements, process owners survey a sample of process customers to understand their needs. Key support process requirements are highlighted in **Figure 6.1-6**.

6.1b(4) Leveraging the core competency of Data-Driven Pursuit of Excellence, AHWM's approach to improve work processes begins during SPP, when senior leaders identify and prioritize improvement needs. A color-coded DRG prioritization matrix compares AHWM discharge information to national top quartile and top decile benchmarks to identify performance gaps. The analysis also reviews progress on PI initiatives from the prior year to determine if they need to remain on the list of priorities. The top strategic PI priorities go to OPC for review and approval and are documented in an annual Performance Improvement Plan. The PI initiatives are assigned to multidisciplinary stakeholder teams, including physicians, residents and partners, as appropriate, and the teams come together for a day-long Quality Day to kick off their work. Each team receives a trained PI facilitator to provide data and to guide selection and use of DMAIC **(Figure P.2-4)** and Lean Six Sigma tools aimed at understanding root cause and reducing variation. Standard toolkits deploy and hardwire improvements across the organization.

For example, as a result of a PI initiative, an interdisciplinary readmission team now meets weekly to review patients identified as high risk for readmission. Additionally, AHWM hired a Care Transition nurse who is responsible for the discharge needs assessment, discharge teaching, communication of discharge plans with patients and families, and post hospital follow-up assistance.

Also, to address respiratory illnesses prevalent in the East LA community, AHWM has worked to reduce related readmissions. Through a collaboration with respiratory therapy, pharmacy, and case management, high-risk patients with pulmonary conditions are counseled individually and in group settings, with post-discharge follow-up to ensure patients are adhering to regimens and increasing their personal capabilities.

Improvement needs that arise outside the SPP go to OPC for review, scoring and approval. Leaders, who all receive PI training, manage improvement work within their departments. PI tools and templates are available for broad use.

Process improvement teams report their progress to their respective council or sub-council, which provides alignment and accountability and facilitates sharing of lessons learned across process owners. Teams that make dramatic improvements are invited to present at leadership meetings and are featured in the employee newsletter, STAT.

Each year the Director of Organizational Performance with the Operations Executive evaluates key work and support processes by comparing actual performance to target or best practice. The results go to OPC and become an input to Step One of the SPP.

6.1c Supply Network Management

To leverage economies of scale, overall management of key suppliers has been centralized to AH with processes for AHWM to provide input and manage local suppliers. AH SCR has Value Analysis Groups that collaborate with AH corporate contracting and care delivery departments to evaluate and select suppliers for the region's hospitals. AHWM has a core team of members who serve in the groups, which engage subject matter experts to analyze service levels with a focus on quality, safety, performance improvement, contractual expectations, costs and other factors, such as new technology. The teams bring together users who have clinical, financial, and purchasing expertise to make best-value product and service decisions.

AH has a formal Vendor Management System, which reinforces the organization's Mission, Values and ethical

code. Performance metrics are embedded in key supplier contracts. AHWM and the AH Value Analysis Group review individualized dashboards with key suppliers, such as Cardinal and group purchasing organization (GPO) Premier, during regularly scheduled meetings. Other suppliers are assigned to leaders, who meet with them monthly to review performance. If a supplier is not performing to expectations, internal committees and/or the value analysis group work with the supplier to resolve the issue and improve performance. If a successful resolution cannot be identified or agreed upon, AHWM will find another supplier.

Some key suppliers, such as GE, and key partners, such as JLL and Cerner, have full-time associates on site at AHWM. These associates complete the same orientation and annual learning as AHWM associates. They also participate in OPC councils/sub-councils, iLead, PI teams and other approaches that align and engage key stakeholders in driving organizational excellence.

6.1d Innovation Management

AHWM manages for large-scale innovation through a corporate Innovation Council and SPP **[2.1a(2)]**. The proforma process AHWM uses to evaluate strategic opportunities assesses factors such as risk, return on investment, strategic alignment, community need, and financial implications, including resource requirements. Approved intelligent risks are resourced through SPP and the supporting labor, operating and capital budgets. Investments exceeding $500K are presented to AH for approval. If a strategic opportunity is presented outside the usual SPP cycle, OPC and Executive Committee evaluate the opportunity using the same proforma process and allocate appropriate resources. In both cases, the approval process requires identification of measures and targets to monitor progress and performance relative to the proforma.

Approved intelligent risks are assigned to the relevant council and/or medical staff committee for ongoing, scheduled monitoring. For example, the Quality Improvement Committee reviews key measures for a new surgical procedure, Transcatheter Aortic Valve Replacement (TAVR, **Figure 7.5-18**). Initiatives not performing to target escalate to OPC, which works with the design team to eliminate barriers or get the initiative back on track. If the initiative continues to miss targets, OPC re-evaluates the proforma and may decide to discontinue pursuing the opportunity.

6.2 Operational Effectiveness

6.2a Process Efficiency & Effectiveness

AHWM uses multiple approaches to control operational costs, prevent rework and errors, and minimize the costs of inspections and audits:

- During the annual budget process, department directors are responsible for development of departmental budgets with approval and oversight from their respective VPs.
- AHWM manages labor costs on an annual, weekly and hourly basis. During the annual budget process, departments use productivity benchmarks to establish and budget for anticipated staffing needs, and VPs and department directors review performance relative to plan in regularly scheduled meetings throughout the year. The FTE Sub-Council meets weekly to evaluate staffing requests and provide position control. An electronic staffing system provides updates every four hours on staffing needs based on current and anticipated volume and acuity.
- By carefully managing its supply chain and leveraging AH supplier relationships **(6.1c)**, AHWM achieves more than $2 million in savings each year.
- Process design and improvement teams pro-actively identify ways to prevent rework and errors and minimize inspections. Use of Lean Six Sigma by PI teams **[6.1b(4)]** addresses root-cause analysis of errors. AHWM uses evidence-based, standardized protocols and technology-enhanced, force controls to provide real-time quality control. For instance, the electronic medical record incorporates hard stops, reminds caregivers of critical tasks, and issues alerts for potential adverse drug reactions and deteriorating patient vital signs.
- PI facilitators from the Clinical Quality Department are assigned to specific service lines to track fallouts and incident reports and coordinate RCAs and FMEAs. The facilitators look for trends and share learnings across service lines.
- Key processes have measures of cycle time and productivity; the few key processes without such measures do not have timeliness as a key performance requirement. Process owners review these measures daily, weekly or biweekly depending on the process and take corrective action if needed.
- Automation and training front-line staff to perform inspections in real-time and at the point-of-service when possible, minimize inspection and audit costs. Safety rounds, regulatory tracers, and observation audits for National Patient Safety Goals, such as hand hygiene, help to minimize costs as well.

The AHWM Values and the core competency of Caring for the Underserved guide the organization in balancing the need for cost control with the needs of patients and the community. The strategic plan and Vital Signs focus action plans and measures not only on Achieving Operational Efficiency, but also on Transforming Care, Improving Access, and Promoting Well-being and Mission Integration. Proformas for new healthcare services **[3.2a(1)]** consider and address risks.

6.2b Security & Cybersecurity

AH has a systems approach to ensure the security and cybersecurity of sensitive and privileged data and information, including compliance with all HIPAA requirements. The AH Data Quality Control System focuses on integrity and security of information systems and the data within them, with processes including user passwords, role-based access linked to standardized job descriptions, automatic sign-offs during inactivity, and daily/weekly rounding by IT and clinical informatics staff.

AH maintains a risk-based enterprise information security program, led by the centralized Information Security (IS) Department. The annual IS program pro-actively addresses potential threats identified through the following: 1) the Verizon Data Base Incident Report, which provides an

ongoing awareness of emerging security and cybersecurity threats, including incidents identified within healthcare; 2) the SANS Top 20; 3) results of the AH annual penetration testing, which allows identification and prioritization of IT systems to secure from cybersecurity attacks; and 4) Meaningful Use Assessments.

AH has built its IT infrastructure so that all external access to AH data and assets is routed through corporate, and thus, corporate is responsible to detect potential and actual security and cybersecurity events. If a breach or intrusion is detected within AHWM, corporate engages IT associates onsite at AHWM to complete a local investigation and take appropriate follow-up action. To prevent cybersecurity events and comply with strict HIPAA regulations, AHWM also requires all associates, physicians, volunteers, suppliers and partners to complete training before being granted access to AH systems. Individuals in all of these groups also annually agree to abide by strict AH and AHWM policies.

6.2c Safety & Emergency Preparedness

6.2c(1) In keeping with the first Guiding Principle – Take personal responsibility to ensure the safety of patients, coworkers, and all others I come in contact with while at work – the Environment of Care (EOC) Committee oversees AHWM's approach for providing a safe operating environment. The multidisciplinary committee, including the safety officer and employee health manager, develops and annually updates the EOC Plan and monitors key indicators of workplace safety. The committee also performs proactive risk assessments and safety rounds, using quantitative criteria to score areas throughout the hospital **(Figure 7.1-35)**. The risk assessments, safety rounds, and performance reviews are inputs into the EOC Plan and drive correction action plans, as appropriate. Daily Huddles and quarterly unit safety audits also address workplace safety.

All safety incidents are entered into RADAR, AHWM's automated incident reporting system. RADAR routes the incident to the appropriate departments based on the nature of the incident. Sentinel events trigger a response team to immediately fix the problem and prevent recurrence.

The Patient Safety Committee has unit-based safety champions in each clinical area to identify safety improvement opportunities. AHWM brings the safety champions together quarterly to provide education, identify resource needs, discuss trends, and facilitate inter-departmental collaboration.

Safety education is provided through orientation, mandatory annual safety training, monthly safety articles in the STAT newsletter, and department-specific safety in-services. AHWM uses recognition to reinforce positive safety practices. An annual Culture of Safety Survey identifies units that have the lowest safety and resilience scores. These units are assigned an executive champion and a physician champion to round on the unit monthly and help them build internal capabilities to manage and improve performance.

AHWM conducts FMEAs to address the highest risks to patient and workforce safety. For example, a recent FMEA addressed clinical alarm fatigue. The team identified and reviewed the number of alarms by unit and category. The team eliminated the unnecessary alarms, provided education, and recommended a system upgrade, which was approved and implemented through SPP.

6.2c(2) AHWM operates an Emergency Incident Command System (EICS) with multiple predetermined emergency response plans to ensure business continuity in the event of planned and unplanned emergencies. An Incident Commander directs four chiefs of logistics, planning, operations, and finance, as well as supporting staff; and clearly defined roles and checklists delineate areas of responsibility. Administrative team members, directors, managers, and coordinators are trained based on a national curriculum. The organization holds two drills each year and reviews performance to identify opportunities for improvement.

To ensure coordination with external agencies, AHWM's EICS parallels that of the local health, police, and fire departments. AHWM participates in the county-wide Emergency Preparedness Committee to ensure external coordination.

The EOC annually evaluates AHWM's emergency readiness including management plans, business continuity plans, and evacuation plans. The EOC identifies key failure points along with action plans for correction, improvement, and prevention. The evaluation becomes the basis for the next year's emergency preparedness goals, which are communicated to suppliers and partners with a role in the hospital's daily operations. Partner JLL actually manages emergency preparedness for AHWM and, thus, is an integral part of all planning and implementation. Key suppliers and partners also participate in drills. AHWM has agreements in place with key suppliers to ensure availability of critical supplies during an emergency.

AHWM's policies for the offsite storage of data, redundant hardware and software systems, and a downtime analysis and improvement system are coupled with the Hospital Emergency Incident Command System to ensure availability of systems and information in the event of an emergency. AHWM also provides downtime computers (724) on each unit with a current (up to the time of outage) database of patient transactions and records for use by physicians and nurses. These computers have their own power systems to ensure they do not fail in the event of a power outage. AHWM ensures that hardware and software systems and data and information continue to be secure and available in the event of an emergency through planned downtime policies, procedures, and drills; redundancy for services, core network and telephone switches, infrastructure and utilities; offsite data storage; and daily, weekly, and monthly data backup procedures. Critiques of each downtime incident are analyzed by the IMC to identify improvements in technology, processes, and/or utilities that can prevent or mitigate additional downtime and ensure future reliability.

Category 7

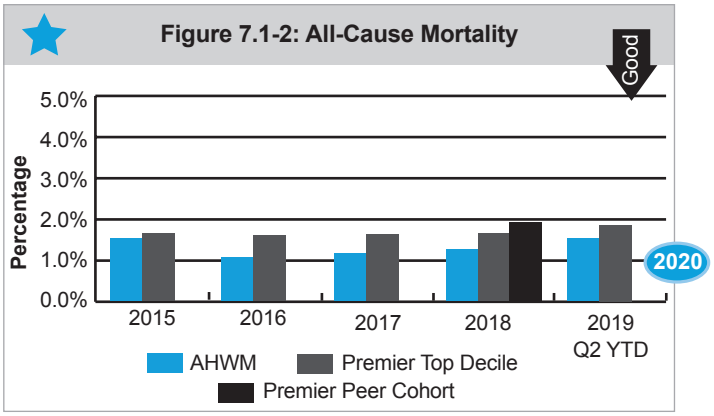
On its continuing journey to excellence, AHWM participates in national databases to understand and challenge its performance relative to other high-performing organizations. However, AHWM is not like most other organizations. It serves inner-city East LA, with all of its poverty, gangs, and homelessness, and in fact, out of Premier's extensive national database, which encompasses nearly half of all U.S. hospital discharges, only six other similar-size hospitals face a government payor mix similar to AHWM's (referred to as Premier Peer Cohort in **7.1** and **7.2**). And yet, despite these truly unique challenges, AHWM is able to achieve national top decile and top quartile performance and deliver value that is nearly unprecedented in today's healthcare industry **[7.5a(1)]**. These results, presented throughout Category 7, demonstrate the organization's commitment to *Living God's love* and *transforming the health experience* of the community it is privileged to serve.

Results for AHWM Strategic Vital Signs (★) and Operational Vital Signs (★) are indicated, with Strategic Vital Sign 2020 performance projections as available (2020).

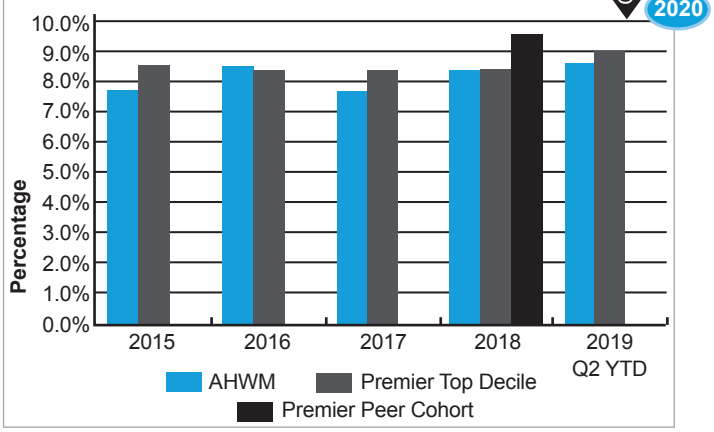
Figure 7.1-1: Integration & Alignment

Key Factor		Healthcare Results
Service Offering/ Market Segment	General Medicine	7.1-5
	Cardiovascular	7.1-6, 18, 33
	Surgical	7.1-7, 12, 19, 28
	Orthopedic	7.1-8
	Women's Services	7.1-10, 11, 12
	Emergency	7.1-18, 26, 30-33
Patient Group	IP	7.1-2-17, 24, 27
	AMB	7.1-19-22, 24, 28, 29
	ED	7.1-18, 26, 30-33

★ **Figure 7.1-2: All-Cause Mortality**



★ **Figure 7.1-3: All-Cause Readmissions**



7.1 Health Care & Process Results

To ensure delivery of care that meets the key patient requirements of safe, effective, timely, and efficient, AHWM measures and reviews outcomes and process measures across its main service offerings (markets) and patient groups **(Figure 7.1-1)**. With each measure, AHWM uses the best-available, relevant comparative data to support its core competency of data-driven excellence. AHWM has invested in quality improvement data analytics from Premier, which uses proven algorithms to risk-adjust clinical results from hospitals and health systems across the country and provide meaningful and timely comparative data for many outcome measures. In targeted areas, Premier offers voluntary Quest collaboratives for high-performing organizations. To support meaningful analysis and drive improvement, AHWM has extensive capabilities to segment its key results. With limited space in the application, AHWM will show samples of this segmentation throughout **Category 7**, with additional segmented results available on site.

7.1a Health Care & Customer-Focused Results

INPATIENT

Mortality is broadly considered a universal indicator of a hospital's overall quality of care. For all-cause mortality **(Figure 7.1-2)** – a Strategic Vital Signs measure – AHWM has **sustained performance better than the Premier top decile** each year since 2015 and outperforms the Premier peer cohort of other hospitals heavily reliant on government payors. Disease-specific mortality results are available on site.

Unplanned readmissions within 30 days of a hospital discharge are another indicator of overall quality of care, especially related to discharge and post-acute care coordination. Readmissions are also a key component of CMS reimbursement and impact hospital payments through the Readmissions Reduction Program. Again, AHWM has been able to **sustain performance at or better than the national top decile** each year since 2015 and outperforms its peer cohort group **(Figure 7.1-3)**. Disease-specific readmission results are available on site.

Figure 7.1-4: All-Cause Complications

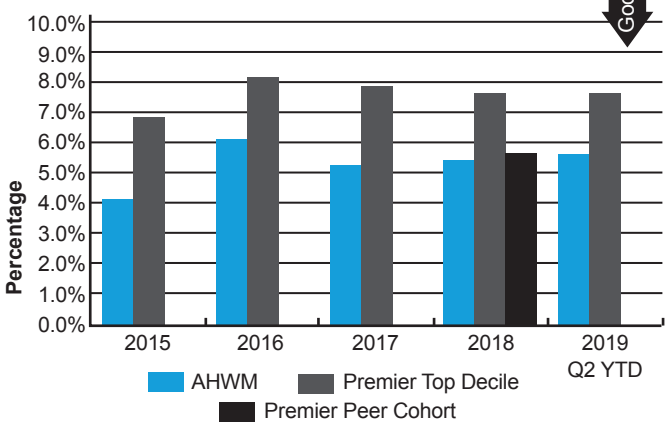


Figure 7.1-5: General Medicine Complications

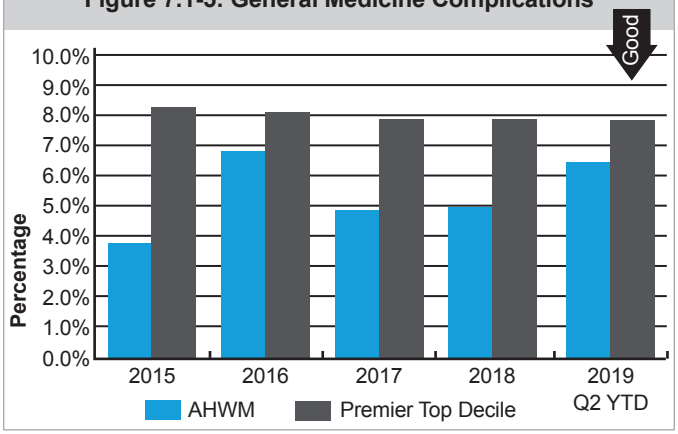
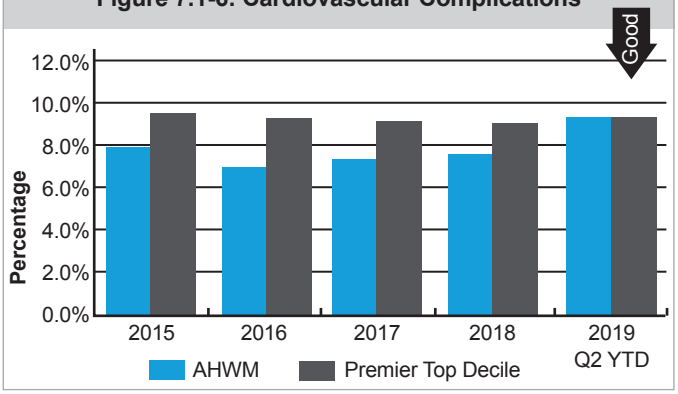


Figure 7.1-6: Cardiovascular Complications



Complication rates provide additional information about the reliability of care provided by AHWM. For all-cause complications **(Figure 7.1-4)**, AHWM has sustained excellent performance since 2015, with levels **better than the national top decile** each year. AHWM demonstrates similar results for its service offerings of General Medicine, Cardiovascular and Surgical Services **(Figures 7.1-5-7)**, and Orthopedics complications have improved to **outperform the national top decile** in 2017 and 2018 **(Figure 7.1-8)**.

AHWM also monitors complications for patients with sepsis – the top contributor to patient mortality across the country. Again, results **outperform the national top decile**

Figure 7.1-7: Surgical Services Complications

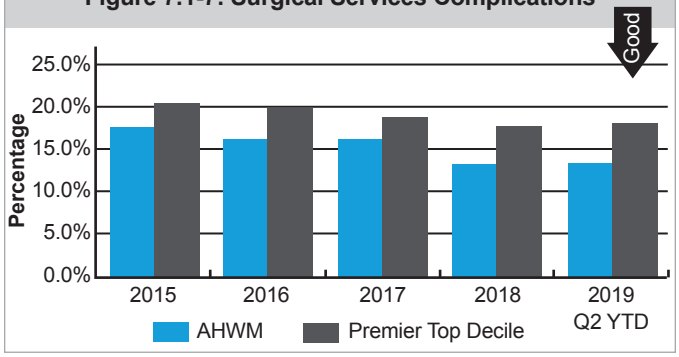


Figure 7.1-8: Orthopedics Complications

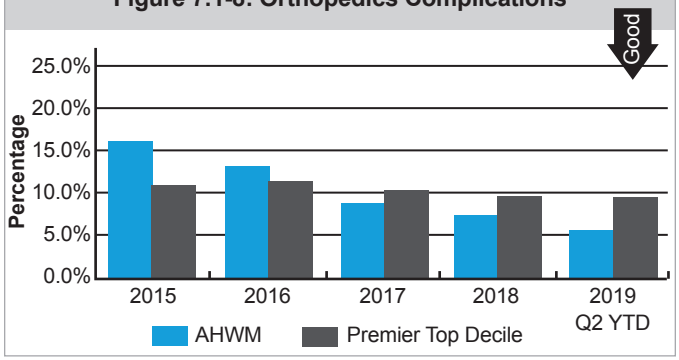


Figure 7.1-9: Sepsis Complications

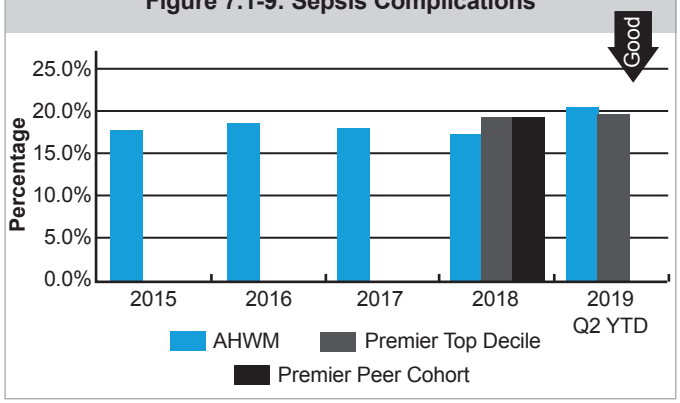


Figure 7.1-10: Perinatal Elective Deliveries

Good

	2014	2015	2016	2017	2018	2019 Q2 YTD
AHWM	1	1	0	0	0	1
Top Decile - Quest			0	0	0	0

and peer cohort **(Figure 7.1-9)**, due to focused PI efforts that developed an early identification and intervention algorithm including triage criteria and a sepsis alert.

For the main service offering of Women's Services, national evidence-based practice establishes a different set of key performance measures. AHWM's performance on perinatal elective deliveries **(Figure 7.1-10)** places it in the **top decile** for Premier's high-performer QUEST collaborative. The number of elective deliveries performed prior to 39 weeks gestation without medical necessity is a publicly reported core measure, a component of CMS value-based purchasing

Figure 7.1-11: Antenatal Steroids

Good

	2014	2015	2016	2017	2018	2019 Q2 YTD
AHWM	100%	100%	100%	100%	100%	100%
CMQCC			≥ 85%	≥ 85%	≥ 85%	≥ 85%
TJC Top Decile				100%	100%	100%

Figure 7.1-12: Abdominal Hysterectomy SSIs

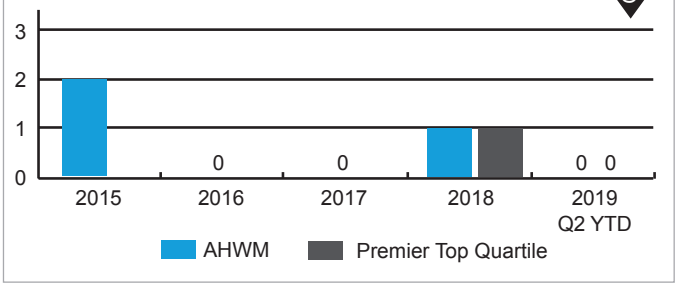
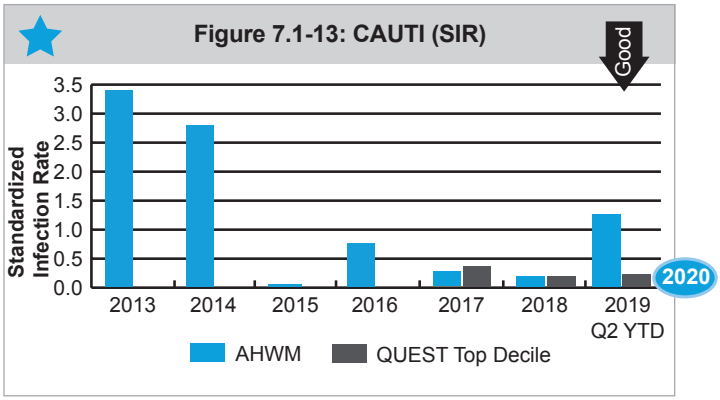


Figure 7.1-13: CAUTI (SIR)



and an indicator of safe, effective care.

AHWM is also is in the **national top decile** for use of antenatal steroids, an evidence-based practice that reduces complications in newborns **(Figures 7.1-11)**.

Surgical site infections for abdominal hysterectomies is another key indicator for Women's Services, as well as Surgical Services. AHWM has achieved national top quartile performance for this measure, with only three infections over the past four years combined **(Figure 7.1-12)**.

AHWM also closely monitors other hospital acquired infections as an indicator of the key patient requirement of safe care and a key component of the CMS Hospital Acquired Conditions (HAC) program. AHWM has developed and implemented evidence-based guidelines to dramatically reduce catheter-associated urinary tract infections since 2013 **(Figure 7.1-13)**. Results for this Strategic Vital Sign measure are now in the **top decile** of QUEST, Premier's high-performer collaborative.

AHWM has also achieved significant improvement in Clostridium difficile (C. diff) infections—a Strategic Vital Sign—to near national top quartile in 2018 **(Figure 7.1-14)**.

CMS calculates an overall Value-Based Purchasing

Figure 7.1-14: C diff infections

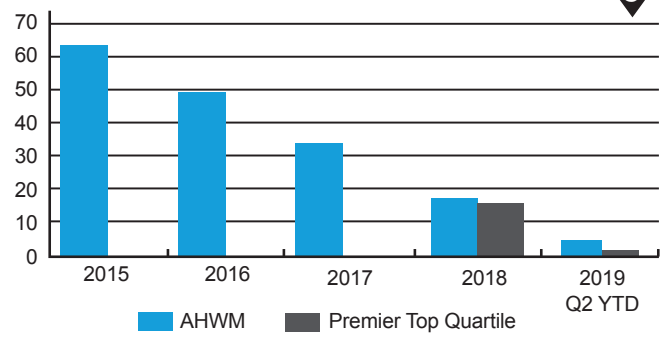


Figure 7.1-15: Value-Based Purchasing Performance

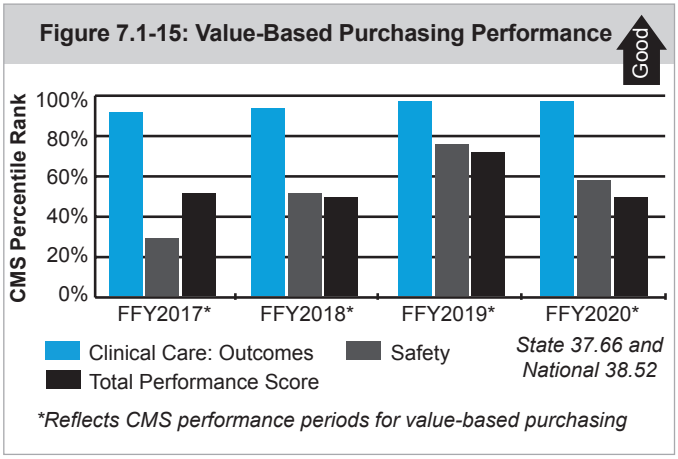
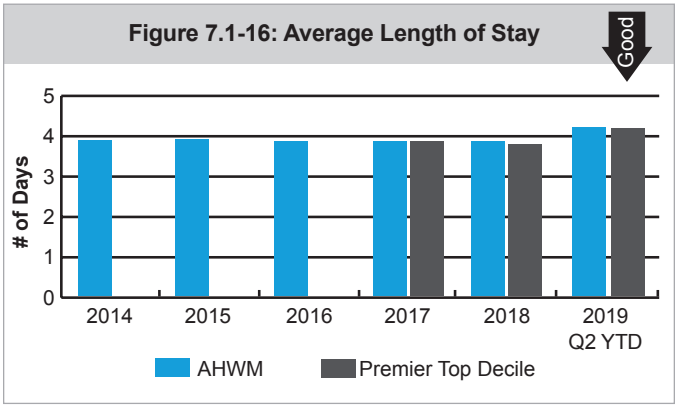


Figure 7.1-16: Average Length of Stay



Score based on performance for clinical outcomes, safety measures, and patient experience. For the three most recent federal fiscal years, AHWM has achieved **national top decile** for its clinical care score, and both its safety and total performance scores have sustained a beneficial trend to reach national top quartile **(Figure 7.1-15)** supporting the payor requirement of high-quality outcomes.

Average length of stay (ALOS) is a universally accepted measure of hospital efficiency and value and has a significant impact on overall cost of care. AHWM is very near **national top decile performance** for this measure, sustaining excellent performance since 2014 **(Figure 7.1-16)**. With its payor mix, AHWM specifically monitors the Medicare Length of Stay Index **(Figure 7.1-17)** as a Strategic Vital Sign. Results for this measure, which reflects actual LOS relative to nationally calculated, risk-adjusted expectations, have improved each year since 2014 to reach

Figure 7.1-17: Medicare Length of Stay Index

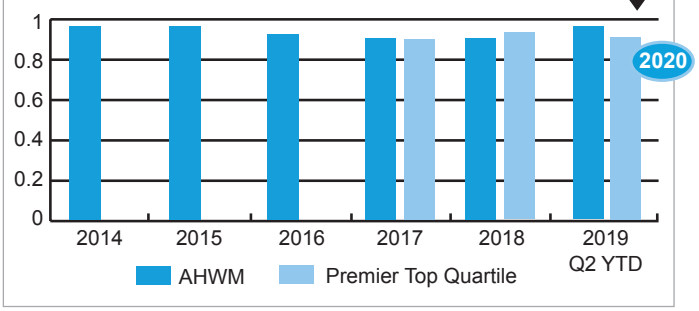


Figure 7.1-18: ED Care for Chest Pain

	2014	2015	2016	2017	2018
Aspirin at Arrival (% compliance)	100%	96%	94%	95%	100%
CMS Top Decile	99.9%	99.9%	99.9%	99.9%	99.9%

Good

Figure 7.1-19: Returns to ED Post Ambulatory Surgery

Good

	2015	2016	2017	2018	2019 Q2 YTD
% ED cases	0	0	0	0	0

national top quartile. This performance supports timely, effective care.

EMERGENCY (ED)

To understand performance for both the Cardiovascular and Emergency service offerings, as well as the ED patient group, AHWM monitors compliance with the evidence-based practice of giving chest pain patients aspirin at arrival. AHWM has achieved **national top decile performance** for this publicly reported measure **(Figure 7.1-18)**. Several additional ED health care measures are presented in **7.1b(1)**.

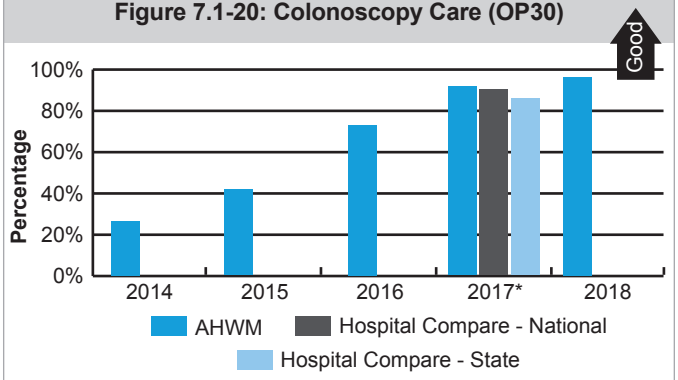
OUTPATIENT/AMBULATORY (AMB)

Nationwide, the healthcare industry is working to identify meaningful measures for services provided in non-hospital settings, and AHWM is no exception. One measure AHWM monitors for the outpatient portion of Surgical Services is returns to the ED after ambulatory surgery. The organization has had zero ED returns since 2014, which places it in the **national top decile (Figure 7.1-19)**.

Another outpatient procedure provided through Surgical Services is colonoscopy. AHWM has improved compliance with evidence-based care for colonoscopies each year since 2014 and in 2017 and 2018 outperformed both California and the nation for this publicly reported CMS core measure **(Figure 7.1-20)**.

To support the community's large Hispanic diabetes population, AHWM offers a unique specialty limb preservation clinic, which manages and supports complex patients to increase their limb function and survival. The

Figure 7.1-20: Colonoscopy Care (OP30)



*Latest-available comparative data

Figure 7.1-21: Lower Leg Amputation Rate

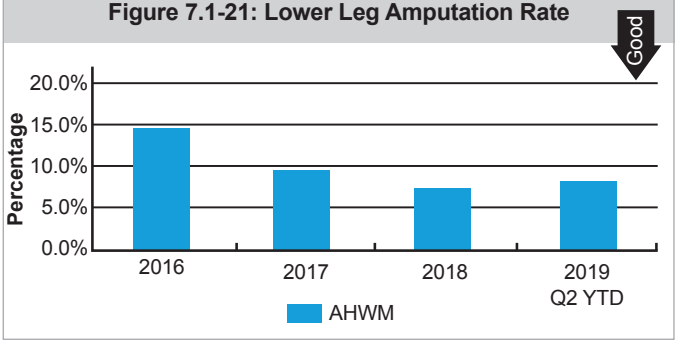
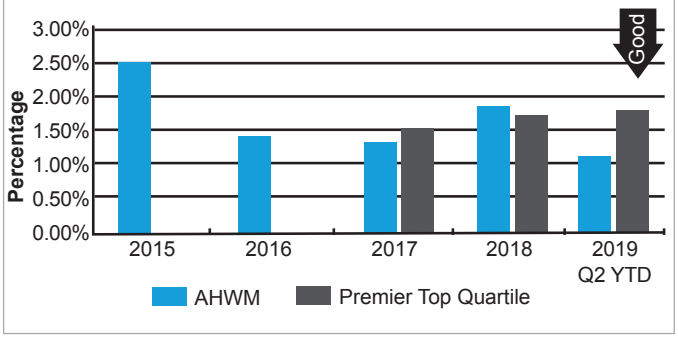


Figure 7.1-22: Mortality Rate for Lower Limb Amputation



clinic continues to successfully reduce the lower leg amputation rate for these patients **(Figure 7.1-21)**. Also, by managing the care of patients recovering from a lower limb amputation, the clinic has improved the mortality rate among these patients to achieve near top-quartile performance **(Figure 7.1-22)**.

7.1b Work Process Effectiveness Results

7.1b(1) Results for indicators of AHWM's key work and support processes are presented here and throughout **Category 7** as indicated in **Figures 6.1-1** and **6.1-6**. Results for additional process measures are available on site.

Provide Inpatient Care. AHWM has seen significant improvement in compliance with hand hygiene, which is the #1 way to reduce the spread of infections and support delivery of safe care. Compliance almost doubled from 2014 to 2018 to surpass the CDC national benchmark **(Figure 7.1-23)**.

Figure 7.1-23: Hand Hygiene

	2014	2015	2016	2017	2018	2019 Q2 YTD
AHWM	53%	91%	97%	98%	97%	96.29%
Recent Baldrige Recipient					89%	89%

Figure 7.1-24: Timely History & Physical Documentation

	2014	2015	2016	2017	2018	2019 Q2 YTD
IP	97%	97%	93%	96%	97%	98%
OP/AMB	98%	98%	97%	98%	98%	99%

Figure 7.1-25: Barcode Medication Administration

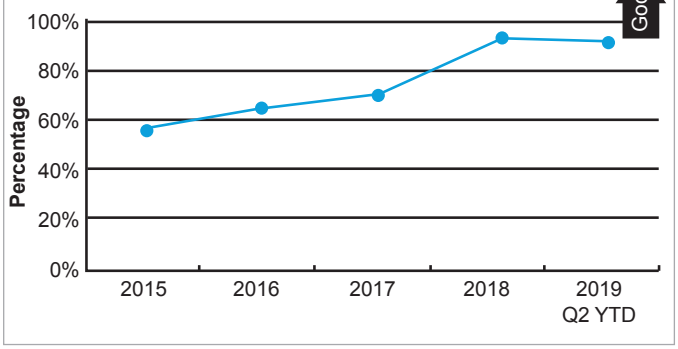
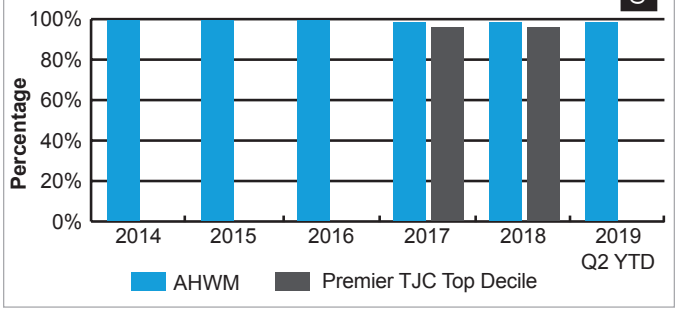


Figure 7.1-26: Stroke Core Measures



To ensure timely availability of patient information to support appropriate care, AHWM monitors turnaround of history and physical information **(Figure 7.1-24)**. No benchmark is available, but AHWM has sustained near-perfect performance in both inpatient and outpatient/ambulatory settings.

To ensure safe, timely administration of medication, AHWM uses barcode scanning to match patients with their prescribed medications. Use of barcode medication administration has increased each year since 2015 to near-perfect performance **(Figure 7.1-25)**. No benchmark is available.

The publicly reported stroke core measures indicate compliance with processes that support effective, evidence-based stroke care. AHWM has sustained perfect or near-perfect performance since 2014 **(Figure 7.1-26)**.

To improve patient outcomes, AHWM adopted national

Figure 7.1-27: Code Blues & Rapid Response Team

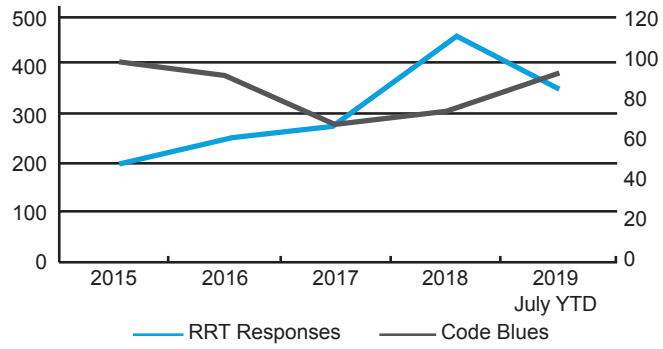


Figure 7.1-28: OR Process Measures

	2017	2018	2019 Q2 YTD	Novia Top Quartile
OR On-Time Start Times*	72.5%	74%	66.10%	72%
OR Cancellations	1.35%	1.0%	1.60%	<5%

**2020 projection = 88.3%*

Figure 7.1-29: Cleft Palate Clinic

	2016	2017	2018	2019 Q2 YTD
Documentation of abuse, neglect screening	100%	100%	100%	100%
Medication reconciliation	100%	100%	100%	100%

best practice and implemented a rapid response team. The specialized team is on call to support caregivers across the hospital when a patient's condition begins to deteriorate, with the goal of preventing code blues, or cardiopulmonary arrests. As the number of team responses has increased, the number of code blues has decreased, demonstrating timely, effective care **(Figure 7.1-27)**.

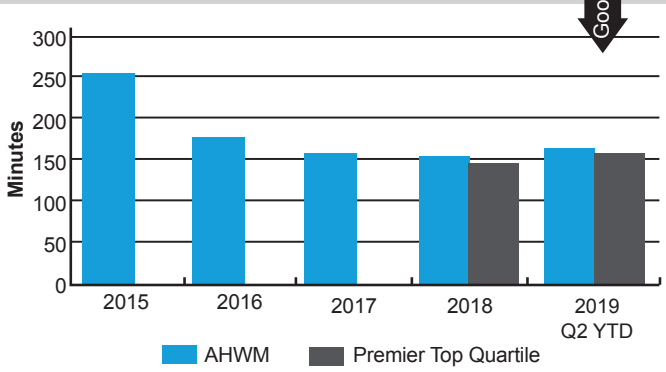
Provide Ambulatory/Outpatient Care. This key work process focuses primarily on ambulatory surgery, so indicators of operating room (OR) efficiency and productivity are important to ensuring timely, effective use of resources. AHWM outperforms the national top quartile for OR on-time start times and cancellations **(Figure 7.1-28)**.

AHWM established a cleft palate clinic to meet community needs. Since its inception, the clinic has achieved 100% compliance with required documentation and medication reconciliation **(Figure 7.1-29)**.

Additionally, AHWM has sustained near-perfect timely documentation of history and physical information to support appropriate outpatient care **(Figure 7.1-24)**.

Provide Emergency Care. AHWM has devoted significant resources to reducing its ED length of stay **(Figure 7.1-30)**. Performance has improved each year since 2015 to near national top quartile performance. Use of a real-time

Figure 7.1-30: ED Door to Departure



electronic dashboard to monitor each phase of a patient's stay in the ED supports caregivers in delivering timely, patient-centered care.

Demonstrating innovation, AHWM is piloting an artificial intelligence application, known as KATE™, to improve triage accuracy in the ED. KATE™ uses data and information in the patient record to predict patient acuity, with the ultimate goal of ensuring the most appropriate level of care for each patient in a timely fashion. As a baseline, AHWM traditional ED triage processes are 65% accurate (better than national average). Triage accuracy increases to 84% with KATE™ and even higher – 94% – for patients with critical presentations **(Figure 7.1-31)**.

Figure 7.1-31: KATE™ Triage Accuracy

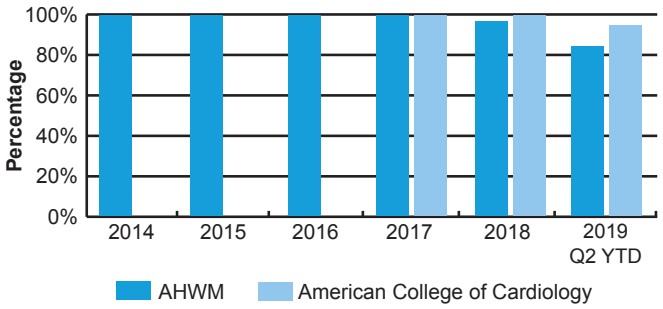
	ED Triage Accuracy
Traditional triage	65%
KATE™ overall	84%
KATE™ for critical presentations	94%
Measurement period = Dec 2018 - Mar 2019	

Figure 7.1-32: Imaging Turnaround Times (minutes)

	2015	2016	2017	2018	2019 Q2 YTD
ED CT TAT	157	115	114	74	73
Advisory Board			135	135	87.3

Good

Figure 7.1-33: PCI within 90 minutes



Imaging turnaround times significantly impact an ED patient's length of stay. Turnaround times for CT have improved each year and compare favorably to benchmarks from the national best practice organization The Advisory Board **(Figure 7.1-32)**.

Figure 7.1-34: Value Realization

	2014	2015	2016	2017	2018	2019 Q2 YTD
Level of Care	$255,304	$426,994	$988,907	$1,162,722	$1,274,240	$700,961
Length of Stay	$5,127,300	$3,692,260	$5,408,320	$3,050,640	$2,723,680	$378,441

For the Cardiovascular service offering, delivery of evidence-based care means achieving door-to-balloon times of less than 90 minutes (or PCI within 90 minutes) for heart-attack patients. AHWM has sustained perfect or near-perfect performance since 2013 **(Figure 7.1-33)**.

The excellent clinical and process performance presented here is the result of AHWM's focused PI efforts. In addition to improving the quality of care for patients, these efforts also save money and avoid costs for both patients and the organization. From just two initiatives alone – one focused on getting patients into the most appropriate level of care and one addressing length of stay – AHWM has realized almost $28 million in value since 2014 **(Figure 7.1-34)**.

7.1b(2) AHWM monitors multiple measures as indicators of the organization's safety and emergency preparedness systems **(Figure 7.1-35)**. With the prevalence of gangs around AHWM's East LA location, security is a particular concern. The organization's strong partnership with the community continues to reduce the number of crimes

Figure 7.1-35: Safety & Emergency Preparedness

Good

	2014	2015	2016	2017	2018	2019 Q2 YTD
EOC round compliance	94%	95%	97%	97%	97%	95%
Average EOC department score				97%	97%	95%
Staff knowledge of Fire Life Safety Systems/Protocol	100%	100%	100%	100%	100%	95%
Staff knowledge of PASS	81%	94%	100%	100%	100%	95%
Staff knowledge of SAFE	75%	92%	100%	100%	100%	93%
Staff knowledge of disaster procedures	100%	92%	98%	100%	100%	88%
Completion of required drills	100%	100%	100%	100%	100%	98%
TB Test compliance	96%	97%	97%	97%	96%	97%

Figure 7.1-36: Security

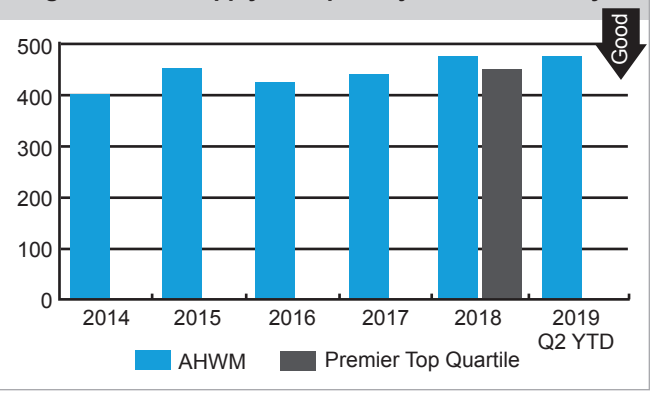
Good

	2014	2015	2016	2017	2018	2019 Q2 YTD
Crimes reported to LAPD	n/a	56	82	47	46	32

Figure 7.1-37

Chart removed due to proprietary content.

Figure 7.1-38: Supply Cost per Adjusted Patient Day



reported to the LAPD **(Figure 7.1-36)**.

With a focus on workforce safety, Workers Compensation costs have decreased each year since 2015, with a marked improvement from 2017 to 2018 **(Figure 7.1-37)**.

7.1c Supply-Network Management Results

With competitive changes and strategic challenges related to healthcare reform and payor mix, AHWM closely monitors costs as a key requirement of its supply chain and as an indicator of how effectively Premier's GPO is helping the organization manage costs. Despite exponentially increasing healthcare costs across the country, AHWM's supply cost per adjusted patient day has increased only slightly since 2014 and is right at the national top quartile **(Figure 7.1-38)**. With specific initiatives focused on supply costs each year, AHWM has saved more than $12 million on supplies over the past five year **(Figure 7.1-39)**.

AHWM also monitors the ability of key supplier Cardinal Health – AHWM's primary distributor – to deliver needed supplies **(Figure 7.1-40)**. Cardinal Health has surpassed contract requirements and sustained near-perfect performance since 2014.

Some of AHWM's key partners deliver key services to the organization so AHWM monitors their performance relative to established metrics. JLL, which manages AHWM facilities, consistently completes almost 100%

Figure 7.1-39: Supply Cost Savings

	2014	2015	2016	2017	2018	2019 Q2 YTD
AHWM	$2,453,557	$2,516,529	$3,710,101	$2,360,078	$1,181,396	$518,010

Figure 7.1-40: Cardinal Health Fill Rates

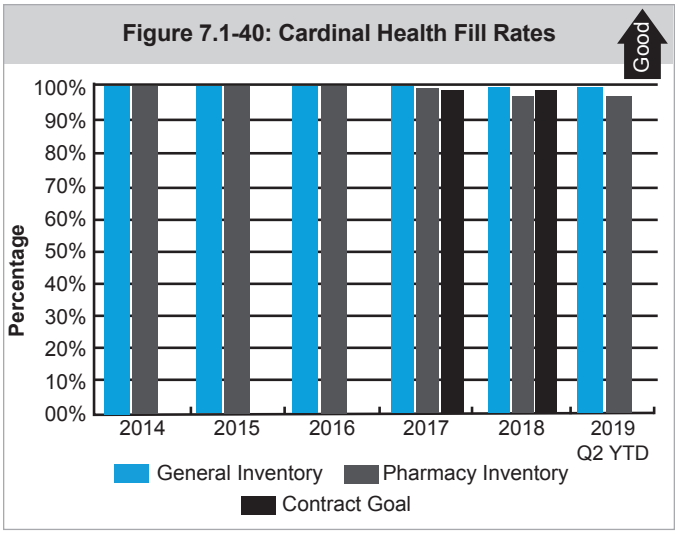


Figure 7.1-41: JLL Performance

	2014	2015	2016	2017	2018	2019 Q2 YTD
Work Order Completion	99.11%	99.09%	99.24%	99.28%	99.80%	99.97%

Figure 7.1-42: Cerner Performance

	2014	2015	2016	2017	2018	2019 Q2 YTD
Medical Record Delinquency	2%	3%	3%	2%	2%	1%
EHR Uptime	100%	100%	100%	100%	100%	100%

of work orders on time **(Figure 7.1-41)**. Cerner maintains 100% EHR uptime and meets its requirements for minimal medical record delinquency **(Figure 7.1-42)**. Results for GE, which began its contract in 2019, are available onsite.

7.2 Customer Results

Results presented throughout **7.2** are key to how AHWM measures its effectiveness in addressing the key patient requirement of patient-centeredness and patient perceptions related to the other key patient requirements of safe, effective, timely, and efficient care. The results address each patient group, service offering, and market as indicated in **Figure 7.2-1**. Key patient requirements and other stakeholders are addressed as indicated in **Figure P.1-7**.

The primary tool AHWM uses to measure inpatient satisfaction and engagement is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, with its separate HCAHPS (inpatient), ED CAHPS (ED), and OAS CAHPS (AMB) tools to address AHWM's three key patient groups. The organization changed vendors in 2015, as indicated on each relevant graph throughout **Category 7**. However, with the new vendor, the survey questions – nationally standardized by CMS – and the survey administration process remained the same.

7.2a Patient-Focused Results

7.2a(1) AHWM looks to the HCAHPS Overall Hospital Rating as a key indicator of inpatient satisfaction. Performance for this measure has shown an overall beneficial trend since 2014 to reach levels that are better than the **national top quartile**, its key competitors, its peer cohort of hospitals with heavy reliance on government payors, and two recent Baldrige recipients **(Figure 7.2-2)**. AHWM also monitors performance for each key service offering in market for use in improving performance closest to the patient **(Figure 7.2-3)**. Comparative data is not available for these measures, as each organization defines them differently.

As additional indicators of inpatient satisfaction, AHWM closely monitors results for dimensions of the HCAHPS survey, especially those that correlate with key patient requirements. These results are publicly reported and impact value-based reimbursement from CMS. Performance for the HCAHPS dimensions of Medication Explanation, Responsiveness, and Communication with Doctors and Nurses have shown an overall favorable trend since 2015 **(Figure 7.2-4)**. Two of the dimensions outperform the national top quartile, and two are approaching it.

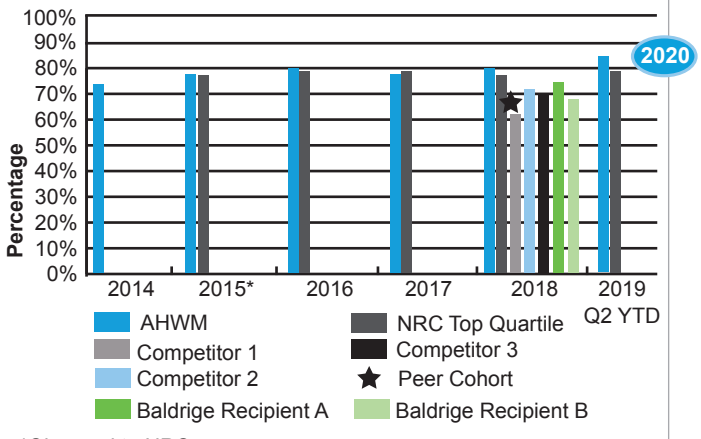
The OAS CAHPS survey is a newer tool that uses nationally standardized questions to measure satisfaction with ambulatory surgery. AHWM implemented the survey in 2016 and has achieved performance almost at the very competitive national top quartile **(Figure 7.2-5)**.

The nationally standardized ED CAHPS survey began in 2015. Since then, AHWM has improved each year and remains very near top quartile **(Figure 7.2-6)**.

Figure 7.2-1: Alignment & Integration

Key Factor		Satisfaction	Engagement
Patient Group	IP	7.2-2-4	7.2-9-10
	AMB	7.2-5	7.2-11
	ED	7.2-6	7.2-12
Service Offering/ Market	General Medicine	7.2-3	7.2-10
	Cardiovascular	7.2-3	7.2-10
	Surgical	7.2-3	7.2-10
	Orthopedic	7.2-3	7.2-10
	Women's Services	7.2-3	7.2-10
	Emergency	7.2-6	7.2-12

Figure 7.2-2: HCAHPS: Overall Hospital Rating



*Changed to NRC

Figure 7.2-3: HCAHPS Overall Rating, Segmentation

Good

	2015	2016	2017	2018	2019 Q2 YTD	Benchmark Q2 YTD
General Medicine	76.5	79.8	79.0	77.4	82.0	79.5
Surgical Services	80.1	77.6	79.2	82.3	85.6	79.5
Women's Services	80.3	82.3	79.5	79.2	83.3	79.5
Cardiovascular Services	74.3	78.3	79.7	82.8	82.4	79.5
Orthopedic Services	80.7	79.4	77.9	71.6	85.1	79.5

Figure 7.2-4: HCAHPS Dimensions

Good

Key Patient Requirement	HCAHPS Dimension	2015	2016	2017	2018	2019 Q2 YTD	NRC % Rank
Patient-Centered	Medication Explanation	75	71	70	74	71.6	83rd
	Communication with Doctors	86	85	87	87	84.5	71st
	Communication with Nurses	78	82	83	84	82.2	64th
Timely	Responsiveness	67	69	70	72	70.2	64th

Figure 7.2-5: OAS CAHPS Overall Rating

Good

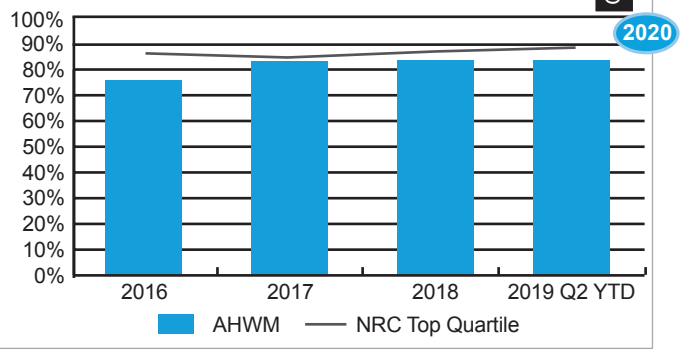
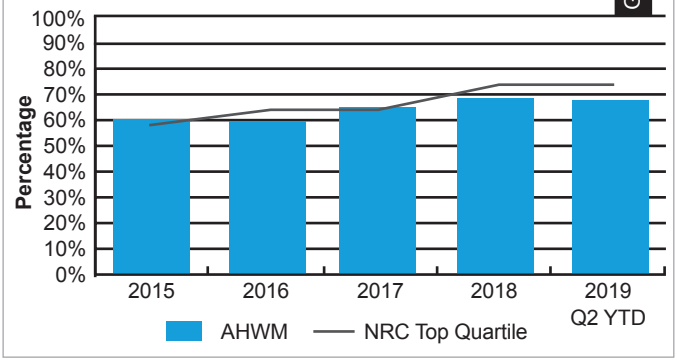


Figure 7.2-6: ED CAHPS Overall Rating

Good



AdventistHealth White Memorial

Figure 7.2-7:Complaints & Grievances

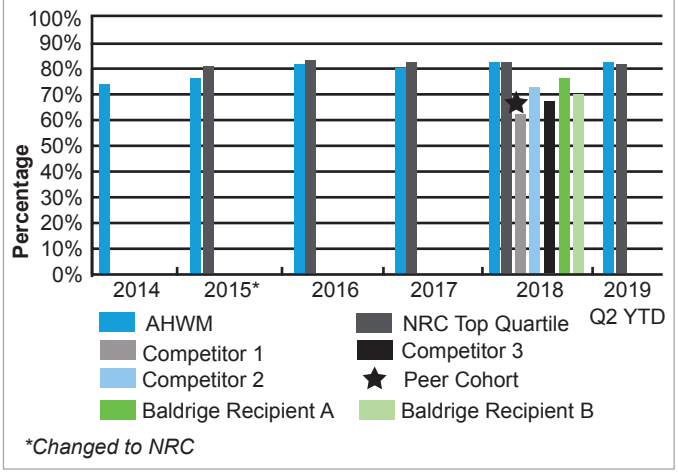
	2013	2014	2015	2016	2017	2018	2019 Q2 YTD
Complaints	40	28	28	42	48	52	50
Grievances	8	7	14	9	18	13	16
Total Complaints	48	35	42	51	66	65	66

Figure 7.2-8: Social Media Perceptions

Good

	2017	2018
Would not recommend AHWM	4.77%	3.58%

Figure 7.2-9: HCAHPS Would Recommend



*Changed to NRC

AHWM monitors complaints and grievances as indicators of patient dissatisfaction. The organization has worked to increase the number of reported complaints to better understand patient needs and expectations **(Figure 7.2-7)**.

To obtain additional information on dissatisfaction, AHWM contracted with Broadly in 2017 to capture feedback and comments from social media. The percentage of comments indicating dissatisfaction decreased from 2017 to 2018 **(Figure 7.2-8)**.

7.2a(2) AHWM uses the likelihood to recommend questions from the nationally standardized CAHPS surveys to measure satisfaction across its key patient segments. For inpatients, HCAHPS results have shown a favorable trend since 2014, have achieved **national top quartile**, and outperform key competitors, the government-payor peer cohort, and two recent Baldrige recipients **(Figure 7.2-9)**.

Figure 7.2-11: OAS CAHPS Likelihood to Recommend

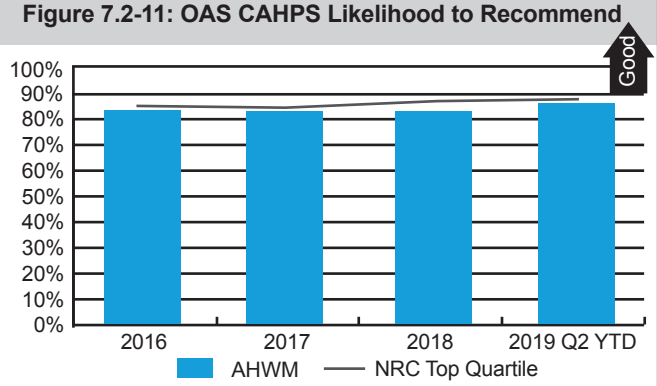


Figure 7.2-12: ED CAHPS Likelihood to Recommend

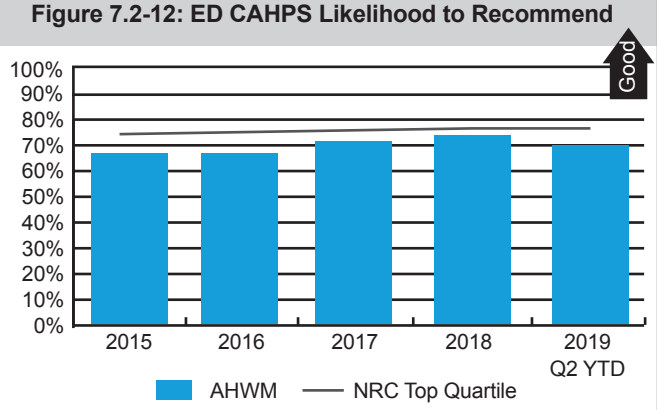
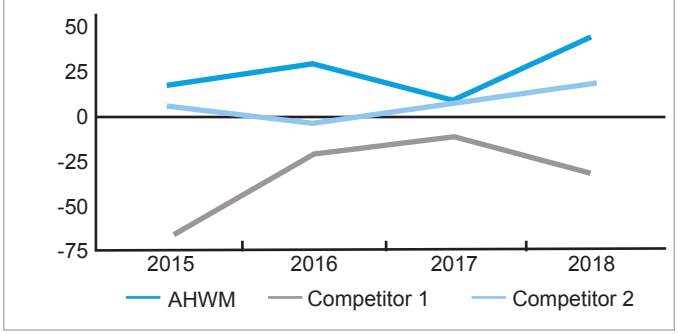


Figure 7.2-13: Net Promoter Score



AHWM segments these results to understand engagement across its service offerings and markets **(Figure 7.2-10)**. Three of the five service offerings with inpatient services are at the overall top quartile level, with the remaining two not far away.

As a measure of engagement for the ambulatory/outpatient patient group, AHWM has sustained performance on the "likelihood to recommend" question near the top quartile since the survey launched in 2016 **(Figure 7.2-11)**.

ED CAHPS "likelihood to recommend" performance has improved each year since 2015 to approach top quartile **(Figure 7.2-12)**.

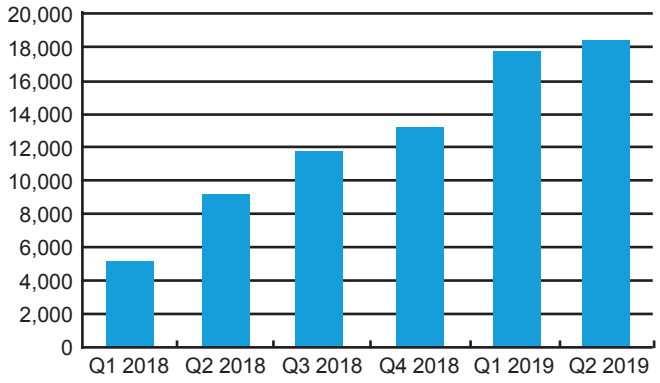
AHWM uses NRC's consumer awareness survey to monitor

Figure 7.2-10: HCAHPS Would Recommend, Segmentation

Good

	2015	2016	2017	2018	2019 Q2 YTD	Benchmark Q2 YTD
General Medicine	75.2	79.8	79.6	77.6	82.9	81.5
Surgical Services	80.1	77.6	79.2	82	79.6	81.5
Women's Services	79.1	81.3	79.4	80.6	85.7	81.5
Cardiovascular Services	90	77.6	77.6	81.8	79.9	81.5
Orthopedic Services	78.9	79.9	76.9	76.2	86.1	81.5

Figure 7.2-14: Nurse Rounding



engagement for its community stakeholder, including potential patients. Results for net promoter score show a significant increase from 2015 to 2018, outperforming its key competitors each year **(Figure 7.2-13)**.

Nurse leader rounding is a key mechanism AHWM uses to build relationships with patients. Results show increased rounding each quarter since AHWM began deployment in 2018 **(Figure 7.2-14)**.

The Community Information Center is another key mechanism AHWM uses to build relationships with both potential and former patients, as well as the community. The center engages seniors with free services such as translation, Medicare planning, transportation services, nutrition counseling, wellness, and family caregiver tools. It continues to see significant growth each year **(Figure 7.4-13)**.

Additional measures for approaches AHWM uses to build relationships with the community and potential customers are presented in **7.4a(5)**.

7.3 Workforce Results

7.3a Workforce-Focused Results

7.3a(1) AHWM monitors two key measures of associate capability and capacity as Strategic Vital Signs – overall associate retention and clinical associate retention **(Figure 7.3-1)**. AHWM has sustained voluntary retention rates well above regional rates since 2014. Results showed a slight dip in 2017 due to an unusually large number of expected retirements. Additional segmentation is available on site.

To both address capability and capacity needs and support the surrounding community, AHWM works to build the capability of residents in its impoverished service area. Almost half the nursing scholarships AHWM awarded in 2016, 2017 and 2018 went to service area residents, and the organization specifically tries to recruit service area residents to fill open positions **(Figure 7.4-13)**.

To manage labor costs, AHWM monitors productivity measures, such as overtime, which continues to show a beneficial trend **(Figure 7.3-2)**. In 2017, AHWM established

Figure 7.3-1: Associate Retention

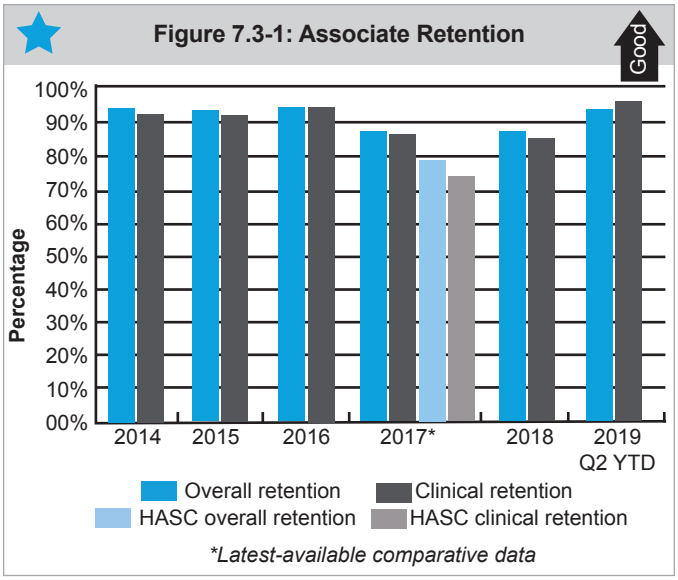


Figure 7.3-2: Associate Capability & Capacity

	2015	2016	2017	2018	2019 Q2 YTD
Overtime (Good)	10.51%	8.08%	8.3%	6.4%	6.2%
RNs who can float (Good)	n/a	n/a	100%	100%	100%

Figure 7.3-3: FTEs per Adjusted Occupied Bed

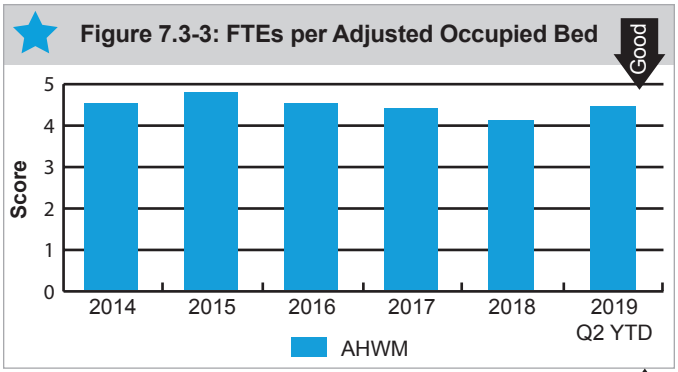


Figure 7.3-4: Physician Capability & Capacity (Good)

	2014	2015	2016	2017	2018	2019 Q2 YTD
# Practitioners with Admitting Privileges	328	362	412	459	539	597
# New Practitioners	34	50	47	67	74	23
Resident Retention	n/a	6%	6%	24%	28%	41%

Figure 7.3-5: Volunteers (Good)

	2014	2015	2016	2017	2018	2019 Q2 YTD
# of Volunteers	199	138	115	144	190	129

a cross-training matrix so that nurses can float between units as needed to address changing capability and capacity needs: 100% of nurses were trained per the matrix in 2017 and 2018 **(Figure 7.3-2)**.

Figure 7.3-6: Associate Survey: Recognition

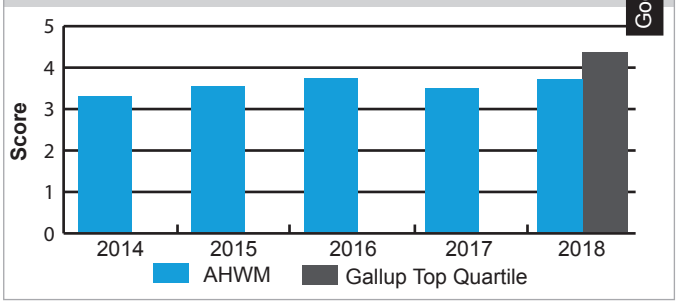
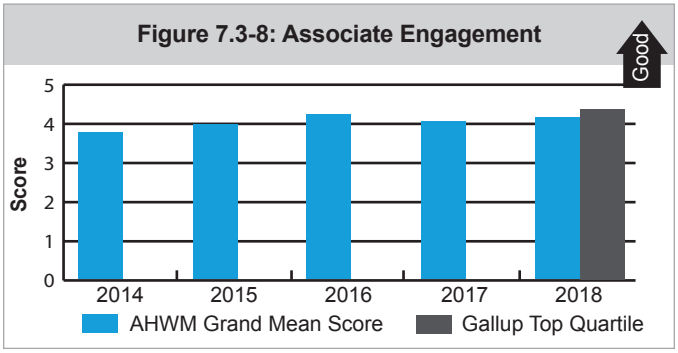


Figure 7.3-7: Workforce Wellness

	2014	2015	2016	2017	2018
CDC Worksite Health Scorecard (Good ↑)	n/a	181	226	233	235
CDC Benchmark					194
AHWM Biometric Risk Index (Good ↓)	32	32	31	30	31
AHWM Wellness Exchanges (Good ↑)	19,323	24,367	28,790	32,916	n/a
AHWM BMI Risk (Good ↓)	64	66	66	67	65

Figure 7.3-8: Associate Engagement



Another key productivity measure AHWM monitors is FTEs per adjusted occupied bed. Results for this Strategic Vital Sign have shown a favorable trend each year since 2015 **(Figure 7.3-3)**. No comparative data is available for this metric.

Additionally, results for salaries and benefits as a percent of net patient revenue are reported in **Figure 7.5-5**.

To address physician capability and capacity needs, AHWM continues to grow its medical staff and has met or exceeded physician recruitment goals **(Figure 7.3-4)**. AHWM has a systematic and effective approach to retaining residents after graduation to help address physician recruitment.

AHWM also monitors the number of volunteers **(Figure 7.3-5)**.

7.3a(2) AHWM monitors various aspects of its workforce climate. Associate satisfaction with recognition shows an overall beneficial trend since 2014 and is approaching national top quartile **(Figure 7.3-6)**.

AHWM performance on key measures of worksite health continue to show a beneficial trend and outperform the national benchmark from the U.S. Centers for Disease

Figure 7.3-9: Associate Engagement Drivers

Engagement Driver	Result
Personal Growth	7.3-12-14
Recognition	7.3-6
Trust	7.4-9
Sense of Mission	7.4-3
Spirituality	7.4-3

Figure 7.3-10: Physician Engagement

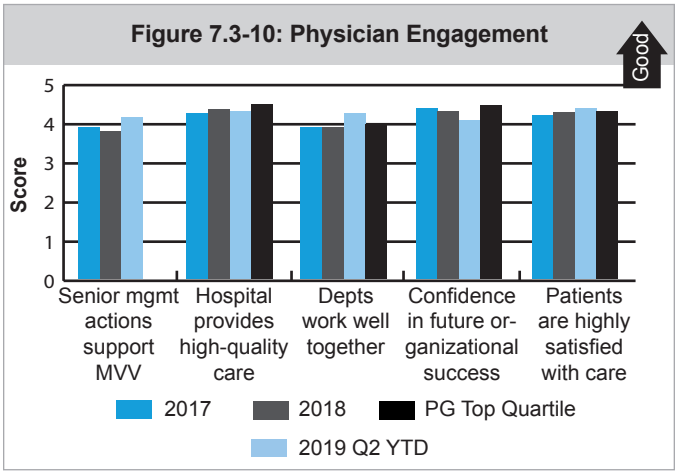
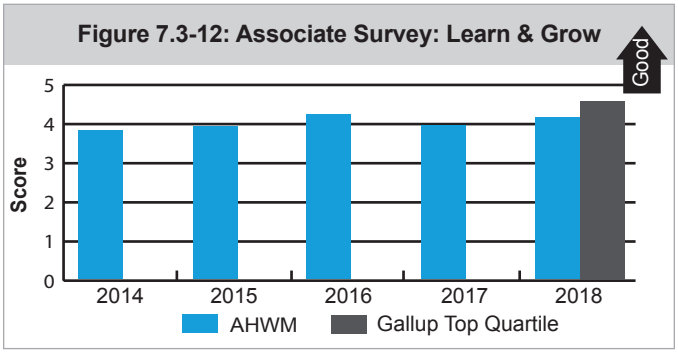


Figure 7.3-11: Volunteer Satisfaction

	2013	2014	2015	2016	2017	2018
Overall: Extremely/ Very Satisfied	100%	94%	82%	86%	93%	98%
Positive Experience	100%	100%	100%	100%	100%	100%
Proper Amount of Training	100%	100%	100%	100%	100%	100%
Appreciation*					94%	98%

**New question in 2017*

Figure 7.3-12: Associate Survey: Learn & Grow



Control and Prevention **(Figure 7.3-7)**. Additionally, the biometric risk index for AHWM associates, as well as wellness exchanges for associates, physicians and volunteers continue to improve **(Figure 7.3-7)**.

Results for workforce safety, security and workers compensation are presented in **Figures 7.1-35-37**.

7.3a(3) AHWM uses annual engagement surveys to gain insight into associate, physician and volunteer engagement.

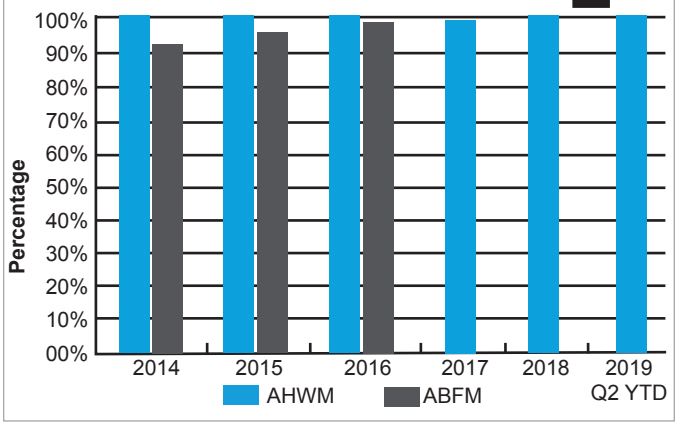
Figure 7.3-13: Professional Development (Good)

	2014	2015	2016	2017	2018
Tuition Reimbursement (# associates)	69	62	54	54	61
Tuition Reimbursement (total $)	$146,526	$164,715	$126,554	$130,362	$144,264
Educational Assistance for Certifications (# associates)	9	6	7	12	16
Educational Assistance for Certifications (total $)	$2,700	$2,064	$2,156	$4,614	$7,243
Advanced Certification Bonuses (# associates)	65	131	140	124	141
Advanced Certification Bonuses (total $)	$41,194	$75,504	$93,439	$78,653	$89,519

Figure 7.3-14: HealthStream Learning Assignments (Good)

	2014	2015	2016	2017	2018	2019 Q2 YTD
# of assigned courses	60	68	87	136	170	196

Figure 7.3-15: ABFM Certification Exam (Good)



For associates, the grand mean score on the Gallup survey has shown overall favorable trend since 2014 and is very near the national top quartile **(Figure 7.3-8)**. Segmented results are available on site. Results for each of the key associate engagement drivers are shown as indicated in **Figure 7.3-9**. AHWM has sustained or improved results for survey questions mapped to each engagement factor, and results for the non-custom survey questions are nearing national top quartile.

Results for the new Press Ganey physician engagement survey, which launched in 2017, show performance at or very near top quartile for each of the physician engagement factors with available comparative data **(Figure 7.3-10)**.

The volunteers are consistently extremely satisfied or very satisfied, and the survey continues to show improving results **(Figure 7.3-11)**. Results for key volunteer engagement factors show similar performance.

7.3a(4) To make sure the organization is addressing the key associate engagement driver of personal growth, AHWM monitors results for the engagement survey question about opportunities to learn and grow. Performance has shown a favorable trend since 2014 **(Figure 7.3-12).**

AHWM supports professional development in many ways, devoting more than $1.1 million over the past five years **(Figure 7.3-13)**, with particular investment in supporting advanced certifications through education assistance and bonuses.

To increase learning and development opportunities and make them more broadly accessible, AHWM has been working to increase the number of courses pushed out through its learning management system. The number of

Figure 7.4-1: Associate Survey: Communication (Good)

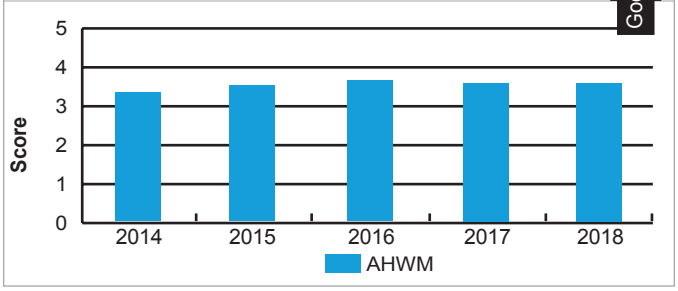


Figure 7.4-2a: Physician Survey: Communication (Good)

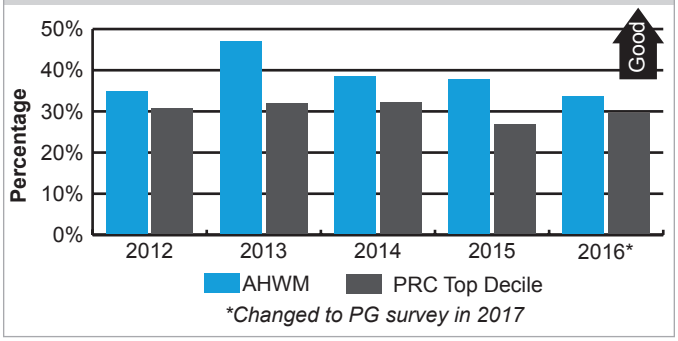


Figure 7.4-2b: Physician Survey: Communication (Good)

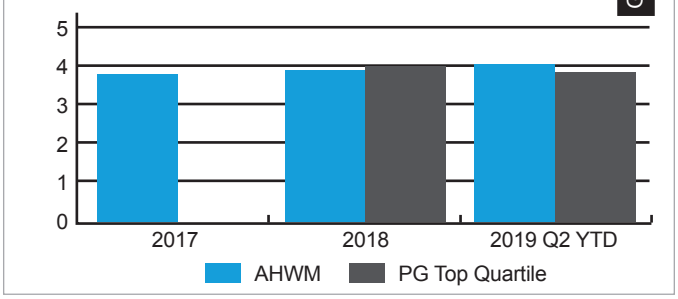


Figure 7.4-3: Associates: Mission & Spirituality

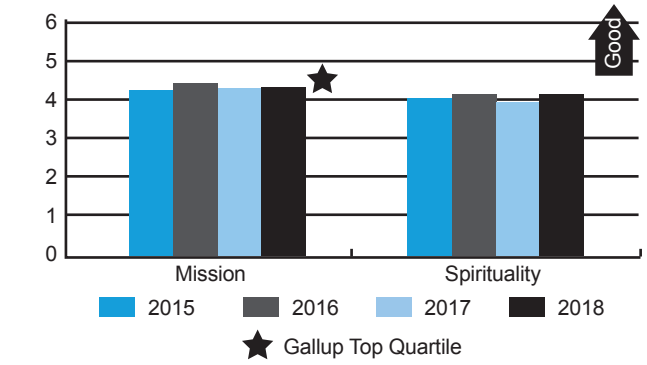


Figure 7.4-4: Patients: Spiritual Care

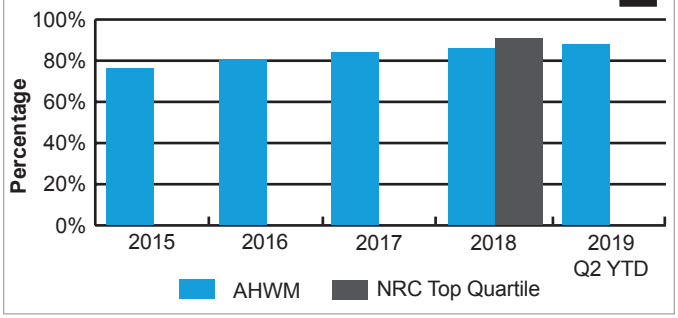


Figure 7.4-5: Board Assessment

	2015	2016	2017*	2018
Planning	100%	100%	88%	89%
Quality	100%	100%	100%	100%
Mission Impact	n/a	n/a	88%	100%

**New questions, began externally administering*

Figure 7.4-6: Board Participation in Giving

	2014	2015	2016	2017*	2018
Foundation Board	100%	96%	100%	71%	95%
Governing Board	95%	95%	95%	80%	80%

** Incomplete data due to change in finance platform.*

courses assigned through HealthStream has nearly tripled since 2014 **(Figure 7.3-14)**.

An indicator of physician development is how well resident physicians do on certification exams. AHWM has sustained perfect performance for the percentage of family medicine residents who pass the ABFM certification exam on the first try since 2014, surpassing the latest-available national benchmark **(Figure 7.3-15)**.

Volunteers are consistently satisfied with the amount of training they receive to do their job **(Figure 7.3-11)**.

7.4 Leadership & Governance Results

7.4a Leadership, Governance & Societal Contribution Results

Figure 7.4-7: Compliance, Accreditation & Risk

Process	2014	2015	2016	2017	2018	2019 Q2 YTD
ACCREDITATION/LICENSURE						
TJC/CMS Accreditation	Full	Full	Full	Full	Full	Full
CDPH/Board of Pharmacy Licensure	X	X	X	X	X	X
CAP/CLIA/COC/ACR Accreditation/Licensure	X	X	X	X	X	X
TJC/ACGME/ACC Accreditation	X	X	X	X	X	X
TJC/SCPC/STEMI/PEDs Certification	X	X	X	X	X	X
REGULATORY/LEGAL COMPLIANCE						
Federal sanctions (including CMS, CDPH, OSHA, HHS, OSHPD)	0	0	0	0	0	0 Good
Internal audits: % of work plan audits completed	100%	100%	100%	100%	100%	100% Good
External audit findings (including Ernst & Young)	0	0	0	0	0	0 Good
Contracts reviewed	100%	100%	100%	100%	100%	100% Good

X = Achieved

7.4a(1) As an indicator of leadership performance, AHWM measures the effectiveness of communication across the organization and key workforce groups. AHWM has sustained associate satisfaction with communication since 2014, per this custom question **(Figure 7.4-1)**. Physician satisfaction with communication outperformed the national top decile each year from 2012 to 2016, based on the PRC survey tool **(Figure 7.4-2a)** and demonstrates top quartile performance after AHWM transitioned to the more competitive Press Ganey database in 2017 **(Figure 7.4-2b)**.

AHWM uses results from the associate engagement survey to monitor the effectiveness of senior leader efforts to deploy the mission. The organization has sustained performance at the national top quartile **(Figure 7.4-3)**. Also, associate satisfaction with spirituality – which is foundational to the AHWM mission – remains high **(Figure 7.4-3)**. A Gallup benchmark is not available for this custom survey question.

Patient satisfaction with spiritual care has increased each year since this survey question was added and is nearing national top quartile **(Figure 7.4-4)**.

7.4a(2) AHWM measures its governance effectiveness using an annual Board assessment survey. Most results for Board oversight of strategic planning and quality are consistently at 100% **(Figure 7.4-5)**. With the organization's strong commitment to the mission, Board

Figure 7.4-8: Ethics Processes

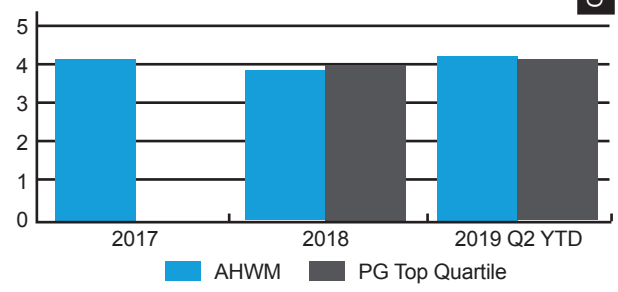
	2014	2015	2016	2017	2018	2019 Q2 YTD
Annual conflict of Interest forms signed	100%	100%	100%	100%	100%	100%
Ethics annual training for workforce and BOD	100%	100%	100%	100%	100%	100%
Monthly workforce/ supplier screenings	100%	100%	100%	100%	100%	100%
HIPAA fines and sanctions	0	0	0	0	0	0
OIG sanctions	0	0	0	0	0	0
Timely reporting of unusual and adverse events	100%	100%	100%	100%	100%	100%

Figure 7.4-9: Associate Trust: Culture of Safety Survey

2018*	AHWM	Top Decile
I can report patient safety mistakes without fear of punishment.	4.32	4.36
In my work unit, we discuss ways to prevent errors from happening again. In my work unit, we discuss ways to prevent errors from happening again.	4.38	4.38

**New survey tool*

7.4-10: Physician Trust



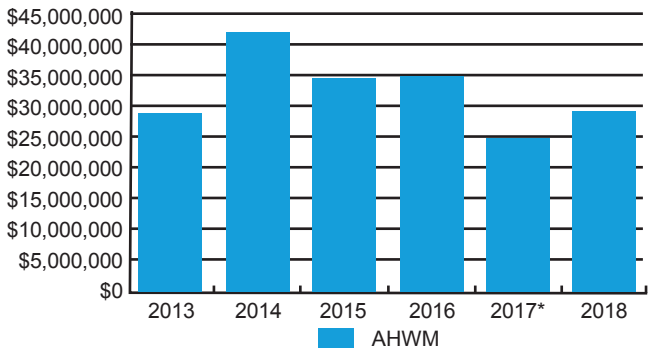
members also assess how consistently they include mission impact as a key consideration in decision-making.

Board participation in giving – another indication of Board engagement – remains high, especially for the Foundation Board **(Figure 7.4-6)**. Transition to a new finance platform in 2017 caused a dip in performance, but it rebounded in 2018.

Internal and external audits aimed at ensuring financial accountability continue to yield no findings **(Figure 7.4-7)**.

7.4a(3) AHWM has a strong focus on meeting and exceeding all legal, regulatory and accreditation requirements. The result is full accreditation and licensure, as well as additional voluntary certifications, with no sanctions or audit findings **(Figure 7.4-7)**.

Figure 7.4-11: Community Benefits



**Latest-available data; change in state calculations*

7.4a(4) AHWM is in full compliance with its key processes for promoting and ensuring ethical behavior **(Figure 7.4-8)**. Completion of annual conflict of interest forms and annual workforce and Board training on Code of Ethics is consistently at 100%. Also, the organization meets regulatory reporting requirements for unusual and adverse events and continues working to encourage reporting of potential and actual ethical concerns into the RADAR system.

Additionally, Culture of Safety survey results for the organization's just culture have achieved top decile or near top decile performance for this indicator of associate trust in leaders **(Figure 7.4-9)**. Physician trust in the administration remains at national top quartile **(Figure 7.4-10)**.

7.4a(5) AHWM remains deeply committed to the East LA community and to addressing the key patient and community requirements of improving access to care and being community-oriented. In 2018 alone, the organization's formally reported community benefits totaled approximately $25 million **(Figure 7.4-11)**. The number dropped from 2016 to 2017, according to the latest-available data; however, that is due to a change in state reporting methodology, not a change in AHWM's commitment to community benefit. Also, over the past five years, AHWM has raised more than $27 million through its charitable foundation and almost $1 million through its annual employee giving campaign **(Figure 7.4-12)** to support community health programs.

AHWM monitors various metrics to understand and improve the effectiveness of its many community support

Figure 7.4-12: Community Health Investments

	2014	2015	2016	2017	2018	5 Year - Total
Charitable Foundation	$5,858,855	$5,779,222	$4,846,662	$5,898,125	$4,751,350	$27,134,214
Associate Giving Campaign	$165,622	$164,083	$165,476	$164,022	$141,939	$801,142
Welcome Baby Program	$1,029,346	$1,693,493	$1,545,260	$1,611,311	$1,516,224	$7,395,634

Figure 7.4-13: Community Impact	2014	2015	2016	2017	2018
Chronic Disease Management					
HELP: Children who maintained or reduced BMI		74%	72%	82%	76%
Health Literacy					
Welcome Baby: Moms who initiate breastfeeding in the hospital	67%	n/a	92%	93%	92%
Economic Environment					
TELACU: RN scholarships for service area residents			49%	49%	40%
Associates who live within service area			39%	40%	40%
Community Childcare Partnership: Children served	85	85	85	85	85
	(maximum capacity of program)				
Hispanic Health					
Community Information Center: Event sign-ins		5,968	13,253	22,541	24,602

Figure 7.4-14: FQHC Patients & Encounters	2017	2018	2019 Q2 YTD
Patients Served	11,082	14,927	10,951
Patient Visits	25,451	44,127	25,047

Figure 7.4-15: Protecting the Environment	2016	2017	2018	2019 Q2 YTD
Energy generated in-house	5,710,694 kilowatt hours	6,279,650 kilowatt hours	5,441,072 kilowatt hours	3,673,642 kilowatt hours
Waste diversion	48%	45%	44%	46%

programs **(Figures 1.2-3, 7.4-13)**:

- The HELP partnership with local schools shown an overall beneficial trend for its efforts with children at risk for diabetes.
- Despite prevalent Hispanic cultural beliefs that have historically kept many of AHWM's new moms from breastfeeding, the Welcome Baby program has increased breastfeeding among new moms by almost 30 percentile points over the past five years.
- To support the local economy, AHWM continues to award almost half its nursing scholarships to area residents and remains committed to hiring area residents when possible.
- Hispanic community members reached through Community Information Center have increased four-fold over the past four years. The center's free services include translation, Medicare planning, transportation services, nutrition counseling, wellness, and family caregiver tools.

To address the key patient and community requirement of access to care, AHWM leveraged its core competency of mission-driven partnerships with the East LA community to open a federally qualified health center (FQHC) on its campus in 2017. Volumes continue to grow **(Figure 7.4-14)**, and plans are already underway to expand the services.

To minimize its carbon footprint and support its commitment to community well-being, AHWM began generating some of its own electricity in 2016 and continues to generate as much as the city will allow **(Figure 7.4-15)**. AHWM also maintains a robust waste-diversion program that outperforms the national average of 38%. AHWM received 3rd place in the 2017 Sustainability Award for Water Management Greenest Customers through the LA Department of Water and Power.

7.5 Financial, Market & Strategy Results

7.5a Financial & Market Results

7.5a(1) Despite AHWM's challenging patient demographics and almost complete dependence on government reimbursement, the organization has achieved consistently strong financial performance while delivering world-class clinical results.

For EBIDA margin, AHWM has achieved 8% or better each year since 2014, surpassing 17% in 2018 **(Figure 7.5-1)**. This performance far exceeds its key competitors and its national peers (inside and outside of health care) with A bond rating from Standard and Poor (S&P). In fact, it even **outperforms the S&P highest performers** (AA+ rating).

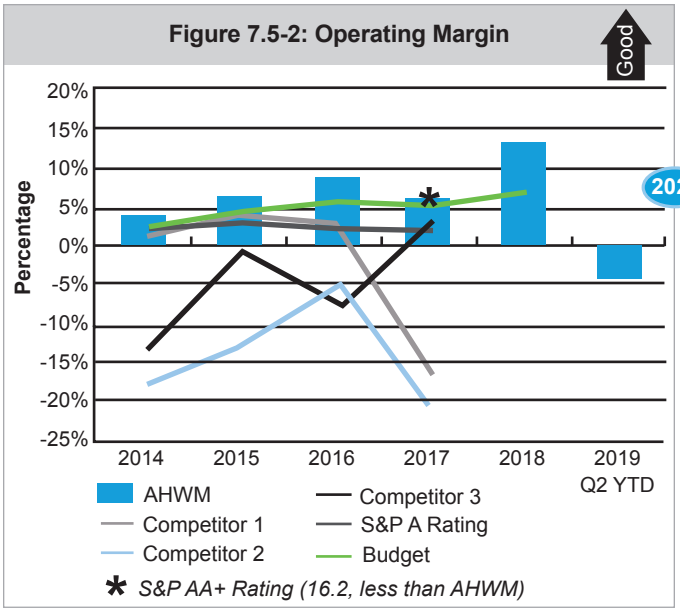
Operating margin has also shown marked improvement since 2014 and consistently outperforms key competitors, its A-rated S&P peers, as well as AA+ S&P organizations **(Figure 7.5-2)**. Its key competitors are actually losing money.

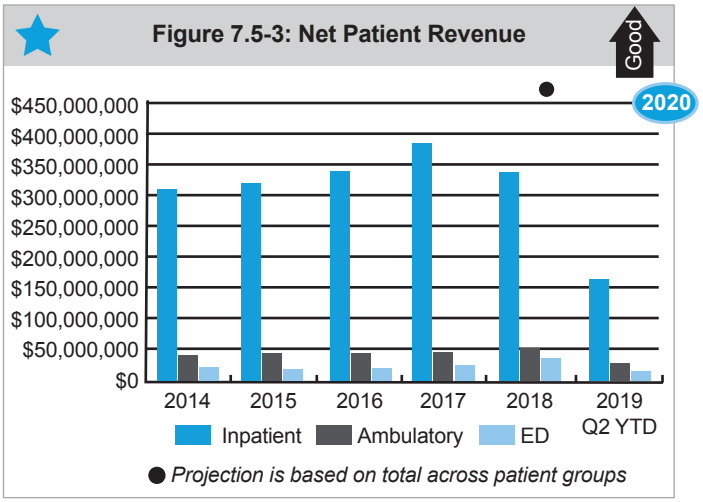
Both EBIDA and operating margin – indicators of financial return – show sustained, strong performance relative to budget **(Figures 7.5-1,2)**.

As in other items within **Category 7**, AHWM segments data, as appropriate, to support meaningful analysis and organizational improvement. With financial results, AHWM does not segment overall financial return and viability measures, which are intended to provide a organization-level perspective of financial performance. However,

Figure 7.5-1

Chart removed due to proprietary content.

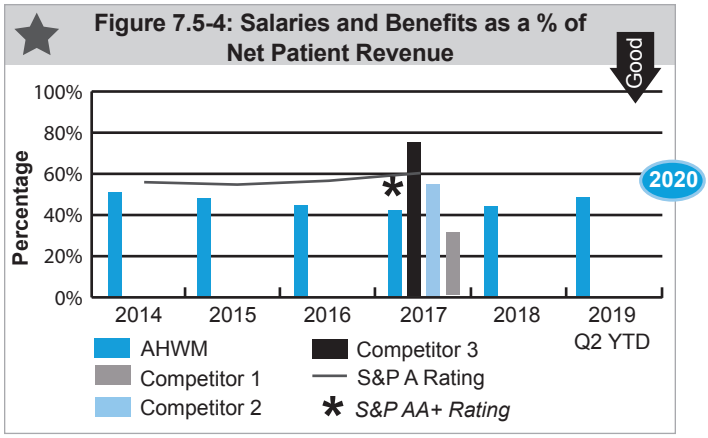


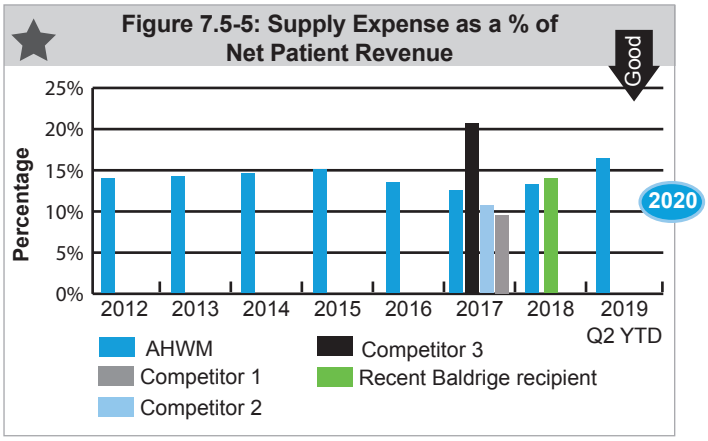


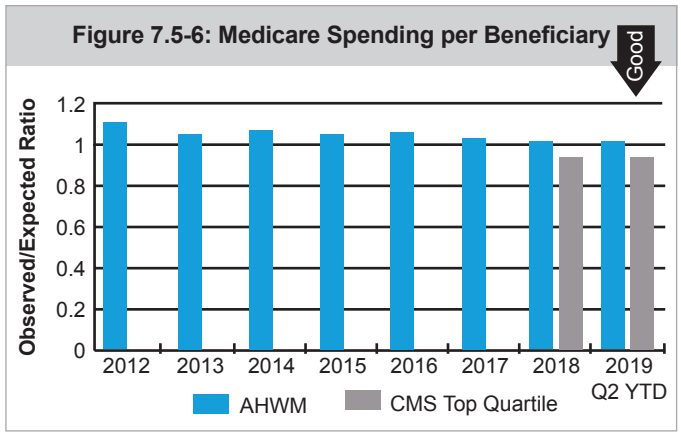
AHWM does segment net patient revenue – a Strategic Vital Sign – to understand performance across its key patient groups. Since 2014, AHWM has seen overall growth in net patient revenue with the beginning of an anticipated shift in revenues from inpatient to ambulatory and emergency services **(Figure 7.5-3)**.

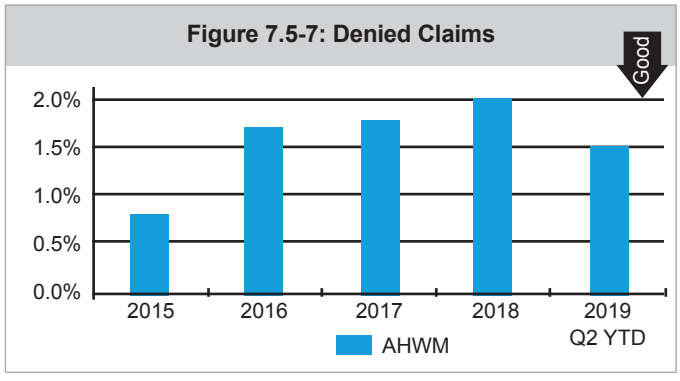
To prepare for healthcare reform and other anticipated reimbursement changes, AHWM carefully and pro-actively manages its costs. For the past five years, AHWM has demonstrated an overall favorable trend and consistently spends less than its competitors and its A-rated peer institutions across the country on salaries and benefits as a percent of net patient revenue **(Figure 7.5-4)**. AHWM also outperforms AA+-rated institutions for this measure, which is the single largest contributor to overall costs.

Likewise, for the past five years, AHWM has spent less than competitors on supplies as a percent of net patient revenue and has sustained this performance despite exponential increases in healthcare costs across the country **(Figure 7.5-5)**. S&P does not report comparative data for this metric so a recent Baldrige recipient is shown here.









The federal government calculates and reports each organization's Medicare spending per beneficiary to ensure value and stewardship of federal healthcare dollars. AHWM has sustained a beneficial trend since 2012 to approach the national top quartile **(Figure 7.5-6)**. An O/E

Figure 7.5-8: Long Term Debt to Capitalization Ratio

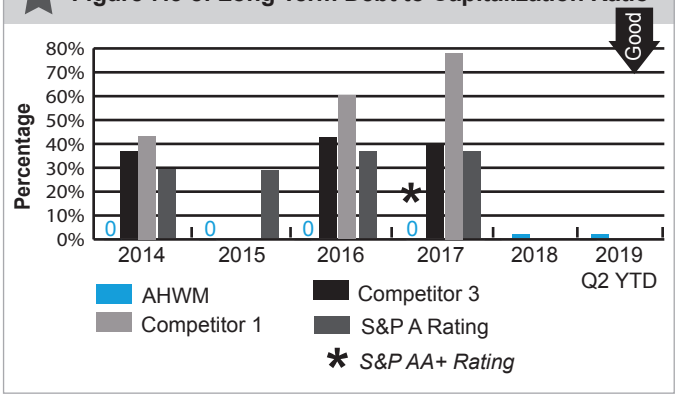


Figure 7.5-9: Days Cash on Hand

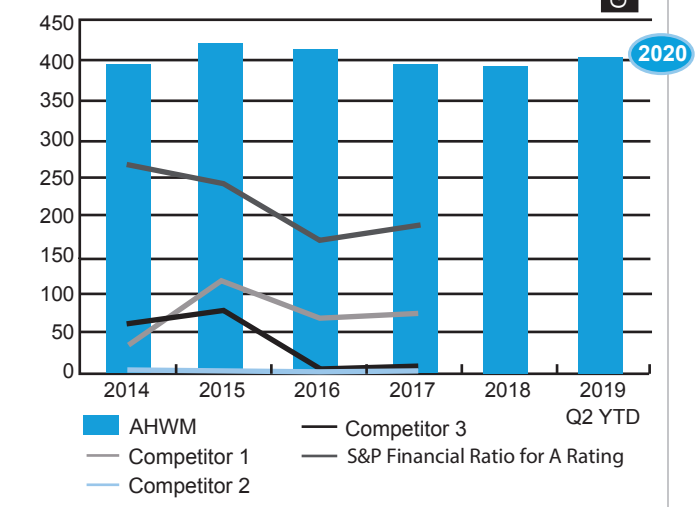
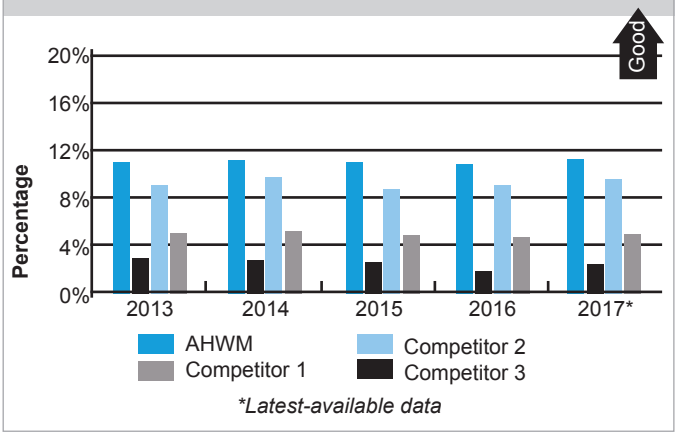


Figure 7.5-10: Total Market Share



of 1 indicates AHWM's spending is right where CMS would expect. These results indicate AHWM is meeting the key payor requirement for low cost, despite the unique challenges of its patient population. In particular, this calculation includes costs incurred by the patient during the 30 days after hospital discharge, and in many cases, it is not safe for AHWM to send discharged patients to their home.

Another indicator of how well AHWM is meeting payor needs is its claim denial rate, which has shown significant improvement over the past few years **(Figure 7.5-7)**.

Figure 7.5-11: General Medicine Market Share

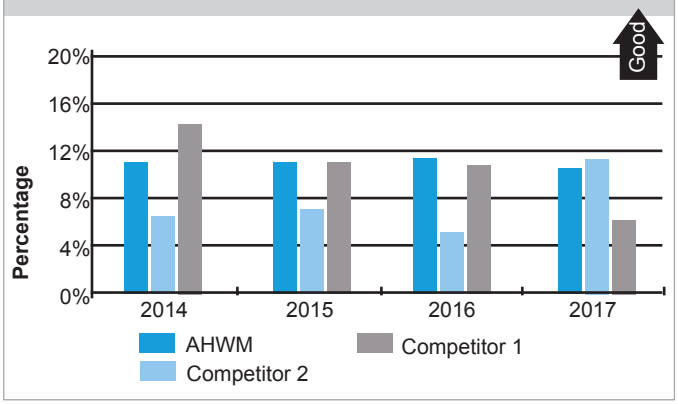
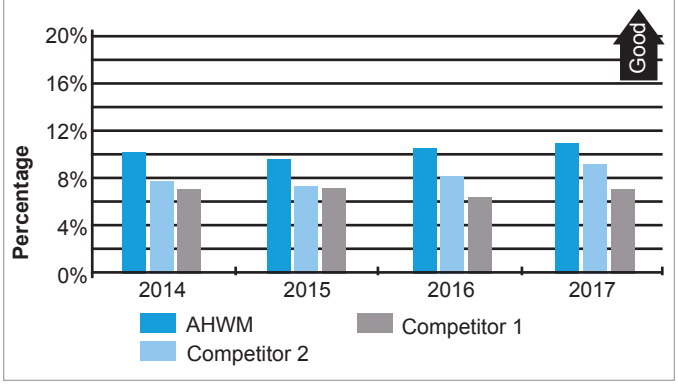


Figure 7.5-12: Cardiovascular Market Share



With years of strong, prudent financial management, AHWM's results for financial viability support organizational sustainability well into the future. Despite an impoverished service area and dependency on government reimbursement, **AHWM has virtually no debt and almost 400 days cash on hand (Figures 7.5-8, 9)**. For both of these measures, AHWM far exceeds its key competitors and the A-rating benchmark.

For long-term debt to capitalization, AHWM also far outperforms the top-rated S&P organizations (AA+). Results for Competitor 2 are not reported on the graph because they are so low (-135% for 2017, latest-available data).

For days cash on hand – a Strategic Vital Sign – AHWM exceeds performance for AA-rated organizations and is approaching AA+ levels.

With performance that is far superior to its key competitors and to peer institutions across the country, AHWM has a strategic advantage in the marketplace and is positioned well to address strategic challenges related to the uncertainty of healthcare reform, especially with its reliance on government payors.

7.5a(2) Marketplace performance is highly competitive across LA. The city has more than 100 hospitals, and 30 of them are located within 10 minutes of AHWM. AHWM has the largest market share of any hospital in the city, with the

Figure 7.5-13: Orthopedic Market Share

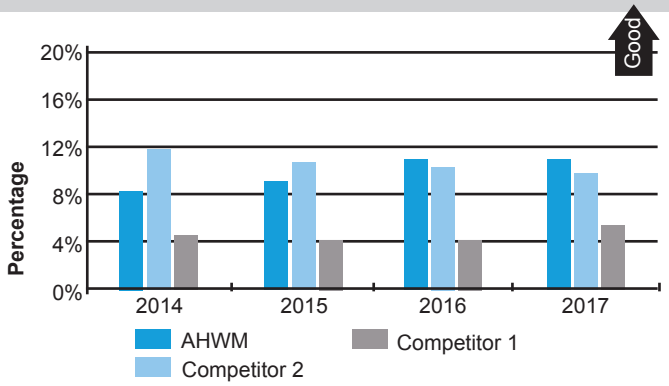
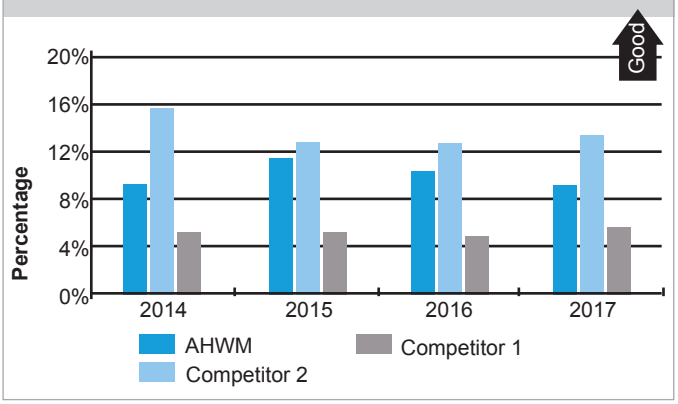


Figure 7.5-14: Surgical Services Market Share



top 10 largest hospitals reporting single-digit market shares. AHWM has maintained a double-digit market share since 2013 and consistently outperforms its key competitors **(Figure 7.5-10)**. Market share has a significant lag time and, thus, is only reported here through 2017.

AHWM also monitors market share for its main service offerings and markets. Market share for Cardiovascular **(Figure 7.5-12)**, Orthopedics **(Figure 7.5-13)** and OB **(Figure 7.5-15)** continue to show steady growth, key competitors reporting losses in Orthopedics and OB. AHWM has sustained market share for General Medicine despite an increase in market share by Competitor 2 **(Figure 7.5-11)**. Both AHWM and Competitor 2 have seen a slight decrease in Surgical Services market share over the past two years, but AHWM remains above its 2014 performance **(Figure 7.5-14)**. With service line-specific data, Competitor 3's numbers are too low to report.

Market share data is not available for ambulatory and ED services, so AHWM monitors volumes as an indicator of marketplace performance for these patient groups. Despite emerging competitors, AHWM has increased ED volumes each year since 2013 and achieved an overall favorable trend for ambulatory surgery volumes **(Figure 7.5-16)**.

As an indicator of market performance in new markets entered as well as a key patient and community requirement of access to care, patient volumes at the FQHC continue to grow **(Figure 7.4-14)**.

Figure 7.5-15: OB Market Share

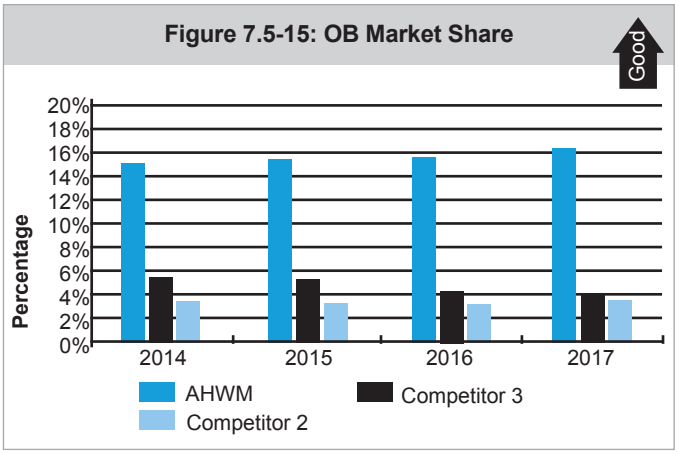


Figure 7.5-16: Patient Volumes

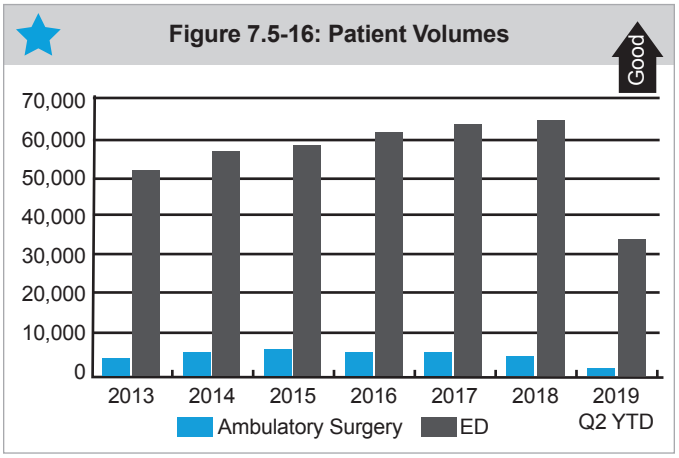


Figure 7.5-17: Strategy Accomplishment

	2014	2015	2016	2017	2018
% Strategic Vital Signs Achieved	28%	35%	22%	37%	32%

Figure 7.5-18: Intelligent Risk

		Q3 2018
Transcatheter Aortic Valve Replacement (TAVR)	Mortality	0
	Significant Cardiac Event	0
	Bleeding	0
	Vascular Complication	0

7.5b Strategy Implementation Results

AHWM's results for achievement of strategy are presented as indicated in **Figure 2.2-1**, and marked with the ★ throughout **Category 7**. The fact that AHWM has already reached 2020 performance projections in many areas indicates the organization's effectiveness in achieving its strategy and action plans. **Figure 7.5-17** shows year-over-year achievement of Strategic Vital Sign targets, which are intentionally set to continuously stretch the organization toward excellence.

Figure 7.5-18 presents preliminary results for an intelligent risk AHWM launched in 2018. This innovative Cardiovascular procedure – known as transcatheter aortic valve replacement (TAVR) – caused no adverse events during Q3 2018, according to the only results available at the time of this application.