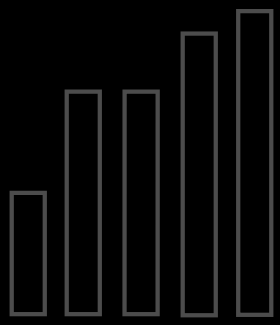
BALDRIGE
Performance Excellence Program



Copansburg Regional Health System

health care

2022

#Baldrige
www.nist.gov/baldrige

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2022 ELIGIBILITY CERTIFICATION FORM

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1. Your Organization

Official name	Copansburg Regional Health System
Other name	
Prior name	*(if changed within the past 5 years)*

Headquarters address: 1000 Copansburg Boulevard
Lexington, KY 40517

2. Highest-Ranking Official

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Keith Turley
Job title	President and CEO
Email	Keith.Turley@crhs.org
Telephone	502-555-1234
Fax	502-555-5678

Address: ☒ Same as above

3. Eligibility Contact Point

Designate a person who can answer inquiries about your organization. Questions from your organization and requests from the Baldrige Program will be limited to this person and the alternate identified below.

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Cody St. Ours
Job title	VP, Performance Improvement
Email	Cody.StOurs@crhs.org
Telephone (office and cell, if possible)	Office: 502-555-1357 Cell: 502-555-2468
Fax	502-555-5678

Address: ☒ Same as above

Overnight mailing address: ☒ Same as above *(Do not use a P.O. box number.)*

4. Alternate Eligibility Contact Point

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Devon Koonce	Telephone	502-555-9753
E-mail	Devon.Koonce@crhs.org	Fax	502-555-5678

5. Application History

a. Has your organization previously submitted an eligibility certification package?

☒ Yes. *Indicate the year(s). Also indicate the organization's name at that time, if different.*

Year(s)	2020, 2021
Name(s)	

☐ No

☐ Don't know

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b. Has your organization ever received the Malcolm Baldrige National Quality Award®?

☐ Yes.

Did your organization receive the award in 2015 (the year you submitted award-winning application) or earlier?

☐ Yes. *Your organization is eligible to apply for the award.*

☐ No. *If your organization received an award between 2016 and 2020, it is eligible to apply for feedback only. Contact the Baldrige Program at (877) 237-9064, option 3, if you have questions.*

☒ No

c. Has your organization participated in a regional/state/local or sector-specific Baldrige-based award process?

☒ Yes. Years: 2016, 2017, 2018, 2019

☐ No

d. Is your organization submitting additional materials (i.e., a completed Organizational Profile and two results measures for each of the five Criteria results items [option 8 in section 6k]) as a means of establishing eligibility?

☒ No. *Proceed to question 6.*

☐ Yes. *In the box below, briefly explain the reason your organization chose this eligibility option. (This information will be shared with the Alliance leadership, without revealing your organization's identity.)*

6. Eligibility Determination

See also Is Your Organization Eligible? (https://www.nist.gov/baldrige/baldrige-award/your-organization-eligible/).

a. Is your organization a distinct organization or business unit headquartered in the United States?

☒ Yes ☐ No. *Briefly explain.*

b. Has your organization officially or legally existed for at least one year, or since April 1, 2021?

☒ Yes ☐ No

c. Can your organization respond to all seven Baldrige Criteria categories? Specifically, does your organization have processes and related results for its unique operations, products, and/or services? For example, does it have an independent leadership system to set and deploy its vision, values, strategy, and action plans? Does it have approaches for engaging customers and the workforce, as well as for tracking and using data on the effectiveness of these approaches?

☒ Yes ☐ No

d. If some of your organization's activities are performed outside the United States or its territories and your organization receives a site visit, will you make available sufficient personnel, documentation, and facilities in the United States or its territories to allow a full examination of your worldwide organization?

☐ Yes ☐ No ☒ Not applicable

e. If your organization receives an award, can it make sufficient personnel and documentation available to share its practices at the Quest for Excellence® Conference and at your organization's U.S. facilities?

☒ Yes ☐ No

If you checked "No" for 6a, 6b, 6c, 6d, or 6e, call the Baldrige Program at (877) 237-9064, option 3.

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Questions for Subunits Only

f. If your organization is a subunit in education or health care, does your subunit provide direct teaching and instructional service to students or direct health care services to people?

☐ Yes. (https://www.nist.gov/baldrige/baldrige-award/your-organization-eligible). ***Then proceed to item 6k.***

☐ No. *Continue with 6g.*

g. Does your subunit function independently and as a discrete entity, with substantial authority to make key administrative and operational decisions? (It may receive policy direction and oversight from the parent organization.)

☐ Yes. *Continue with 6h.*

☐ No. *Your subunit probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

h. Does your subunit have a clear definition of "organization" reflected in its literature? Does it function as a business or operational entity, not as activities assembled to write an award application?

☐ Yes. *Continue with 6i.*

☐ No. *Your subunit probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

i. Is your subunit in manufacturing or service?

☐ Yes. *Does it have 500 or fewer employees? Is it separately incorporated and distinct from the parent organization's other subunits? Or was it independent before being acquired by the parent, and does it continue to operate independently under its own identity?*

☐ Yes. *Your subunit is eligible in the small business category. Attach relevant portions of a supporting official document (e.g., articles of incorporation) to this form.*

If your subunit has 500 or less employees, you may apply under Manufacturing or Service if it is more appropriate than Small Business.* ***Proceed to item 6k.*

☐ No. *Continue with 6j.*

j. Is your subunit self-sufficient enough to be examined in all seven categories of the Criteria?

- Does it have its own senior leaders?
- Does it plan and implement its own strategy?
- Does it serve identifiable customers either inside or outside the organization?
- Is it responsible for measuring its performance and managing knowledge and information?
- Does it manage its own workforce?
- Does it manage its own work processes and other aspects of its operations?
- Can it report results related to these areas?

☐ Yes. *Proceed to 6k (table on next page).*

☐ No. *Your organization probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

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k. Does your organization meet one of the following conditions?

1. My organization has won the Baldrige Award (prior to 2017).	**Yes** ☐	Your organization is eligible.	**No**	Continue with statement 2.
2. Between 2017 and 2021, my organization applied for the national Baldrige Award, and the total of the process and results band numbers assigned in the feedback report was 8 or higher.	**Yes** ☒	Your organization is eligible. Year: 2020 Total of band scores: 9	**No**	Continue with statement 3.
3. Between 2017 and 2021, my organization applied for the national Baldrige Award and received a site visit.	**Yes** ☒	Your organization is eligible. Year of site visit: 2021	**No**	Continue with statement 4.
4. Between 2016 and 2021, my organization received the top award from an award program that is a member of the Alliance for Performance Excellence.	**Yes** ☒	Your organization is eligible. Award program: State Center for Performance Excellence (SCPE) Year of top award: 2019	**No**	Continue with statement 5.
5. More than 25% of my organization's workforce is located outside the organization's home state.	**Yes** ☐	Your organization is eligible.	**No**	Continue with statement 6.
6. There is no Alliance for Performance Excellence award program available for my organization.	**Yes** ☐	Your organization is eligible.	**No**	Continue with statement 7.
7. Between 2017 and 2021, my organization applied for the national Baldrige Award through the alternate method (option 8 below) and the total of the process and results bands assigned in the feedback report was 6 or higher.	**Yes** ☐	Your organization is eligible. Year:	No, my organization did not apply using this method. ☐ My organization applied using this method, but did NOT receive a total of 6 or higher.	Continue with statement 8. Your organization is not eligible. Call 877-237-9064, option 3, if you have questions.
8. My organization will submit additional eligibility screening materials (i.e., a complete Organizational Profile and two results measures for each of the five Criteria results items). The Baldrige Program will use the materials to determine if my organization is eligible to apply for the award this year (as described in the fact sheet at Eligibility FAQs).	**Yes** ☐	The Baldrige Program will review the materials and contact your ECP after determining your eligibility.	**No**	Call 877-237-9064, option 3, if you have questions.

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7. Award Category

a. Award category *(Check one.)*

Your education or health care organization may use the Business/Nonprofit Criteria and apply in the service, small business, or nonprofit category. However, you probably will find the sector-specific (Education or Health Care) Criteria more appropriate.

For-Profit	Nonprofit
☐ Manufacturing	☐ Nonprofit
☐ Service	☐ Education
☐ Small business (≤ 500 employees)	☒ Health Care
☐ Education	
☐ Health Care	

b. Industrial classifications. In table below, list up to three of the most descriptive NAICS codes for your organization (see NAICS list included at the end of this document). *These are used to identify your organizational functions and to assign applications to examiners.*

622	6214	6211

8. Organizational Structure

a. For the preceding fiscal year, the organization had in

☐ up to $1 million	☐ $1.1 million–$10 million	→	☐ sales
☐ $10.1 million–$100 million	☐ $100.1 million–$500 million		☒ revenue
☐ $500.1 million–$1 billion	☒ more than $1 billion		☐ budget

b. Attach a line-and-box organization chart that includes divisions or unit levels. In each box, include the name of the unit or division and the name of its leader. Do not use shading or color in the boxes.

☒ The chart is attached.

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c. The organization is _____ a larger parent or system. *(Check all that apply.)*

☒ not a subunit of (*See item 6 above.)*

☐ a subsidiary of ☐ controlled by ☐ administered by ☐ owned by

☐ a division of ☐ a unit of ☐ a school of ☐ other _____

Parent organization		Address	
Total number of paid employees*			
Highest-ranking official		Job title	
Telephone			

Paid employees include permanent, part-time, temporary, and telecommuting employees, as well as contract employees **supervised by the organization. Include employees of subunits but not of joint ventures.*

Attach a line-and-box organization chart(s) showing your organization's relationship to the parent's highest management level, including all intervening levels. In each box, include the name of the unit or division and its leader. Do not use shading or color in the boxes.

☒ The chart is attached.

d. Considering the organization chart, briefly describe below how your organization relates to the parent and its other subunits in terms of products, services, and management structure.

e. Provide the title and date of an official document (e.g., an annual report, organizational literature, a press release) that clearly defines your organization as a discrete entity.

Title _____ Date _____

Attach a copy of relevant portions of the document. If you name a website as documentation, print and attach the relevant pages, providing the name only (not the URL) of the website.

☐ Relevant portions of the document are attached.

f. Briefly describe the major functions your parent or its other subunits provide to your organization, if appropriate. *Examples are strategic planning, business acquisition, research and development, facilities management, data gathering and analysis, human resource services, legal services, finance or accounting, sales/marketing, supply chain management, global expansion, information and knowledge management, education/training programs, information systems and technology services, curriculum and instruction, and academic program coordination/development.*

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9. Site Listing

You may attach or continue your site listing on a separate page as long as you include all the information requested here. You may group sites by function or location (city, state), as appropriate. Please include the total for **each column** (sites, employees/faculty/staff, volunteers, and products/services). If different sites are located on the same campus (e.g., medical building and acute care hospital), please indicate that in the "Sites" column. See the ABC HealthCare example below. If your organization has any joint ventures, please list and describe those in the second table below.

Please include a detailed listing showing all *your sites. If your organization receives a site visit, an examiner team will use this information for planning and conducting its visit. Although site visits are not conducted at facilities outside the United States or its territories, these facilities may be contacted by teleconference or videoconference.*

Example (ABC HealthCare)					
		Workforce* *List the numbers at each site.*		*List the % at each site, or use "N/A" (not applicable).*	
	Sites (U.S. and Foreign) *List the city and the state or country.*	*Check one or more.* ☒ **Employees** ☐ **Faculty** ☐ **Staff**	**Volunteers (no. or N/A)**	*Check one.* **% of** ☐ **Sales** ☒ **Revenue** ☐ **Budget**	**Relevant Products, Services, and/or Technologies**
	ABC Medical Center, Anytown, NY	1,232	147	77%	Admin. offices, inpatient care, ED, imaging services, lab
	ABC Hospital West, West Anytown, NY	255	78	14%	Inpatient services, ED, lab
	ABC Medical Group, Anytown, NY Located on same campus as ABC Medical Center	236	N/A	6%	Primary & specialty physician care
	ABC Imaging Center, West Anytown, NY	11	N/A	1%	Imaging services
	ABC Hospice Services, West Anytown, NY Different location than ABC Hospital West and ABC Imaging Center	94	89	1%	On- and off-site hospice services
	ABC Urgent Care, West Anytown, NY	8	N/A	1%	Outpatient emergency and urgent care services
Total	**6**	**1,836**	**314**	**100%**	

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Your Organization					
	Sites (U.S. and Foreign) *List the city and the state or country.*	**Workforce*** *List the numbers at each site.* *Check one or more.* ☒ **Employees** ☐ **Faculty** ☐ **Staff**	**Volunteers (no. or N/A)**	*List the % at each site, or use "N/A" (not applicable).* *Check one.* **% of** ☐ **Sales** ☒ **Revenue** ☐ **Budget**	**Relevant Products, Services, and/or Technologies**
	Copansburg Medical Center—Lexington; Lexington, KY	4,500	315	44.5%	600-bed academic medical center, inpatient care, ED, imaging services, lab
	Copansburg Hospital—Berea; Barea, KY	1,500	85	15.3%	150-bed community hospital, inpatient care, ED, imaging services, lab
	Copansburg Hospital—Frankfort; Frankfort, KY	1,000	65	9.8%	50-bed community hospital, inpatient care, ED, imaging services, lab
	Copansburg Rehab Hospital, Richmond, KY	500	25	6.7%	50-bed rehabilitation hospital, post-acute care, therapy services
	Copansburg Hospital—Stanton; Stanton, KY	300	10	3.3%	25-bed critical-access hospital, inpatient care, imaging services, lab (no surgery or OB services)
	Copansburg Medical Offices—Lexington	200	0	1.7%	Primary and specialty physician care, imaging, lab, home health/DME
	Copansburg Medical Offices—Berea	150	0	.6%	Primary and specialty physician care, lab
	Copansburg Medical Offices—Frankfort	150	0	.5%	Primary and specialty physician care, lab
	Copansburg Medical Offices—Richmond	150	0	.5%	Primary and specialty physician care, imaging, lab
	Copansburg Surgery Center—Lexington	60	0	.9%	
	Copansburg Surgery Center—Georgetown	60	0	.9%	
	Copansburg Surgery Center—Richmond	60	0	1.5%	
	Copansburg Advanced Imaging Centers—Lexington, Georgetown, Richmond, Winchester, Frankfort, Paris	120	0	3.3%	
	Copansburg Urgent Care—Lexington	20	0	.05%	Urgent care services

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	Copansburg Urgent Care—Nicholasville	20	0	.03%	Urgent care services
	Copansburg Urgent Care—Winchester	20	0	.03%	Urgent care services
	Copansburg Urgent Care—Shelbyville	20	0	.03%	Urgent care services
	Copansburg Urgent Care—Mount Sterling	20	0	.02%	Urgent care services
	Copansburg Physical Therapy and Rehabilitation Services—Lexington	20	0	.03%	Physical therapy, occupational therapy, speech pathology
	Copansburg Physical Therapy and Rehabilitation Services—Georgetown	20	0	.02%	Physical therapy, occupational therapy, speech pathology
	Copansburg Physical Therapy and Rehabilitation Services—Winchester	50	0	.02%	Physical therapy, occupational therapy, speech pathology
	Copansburg Corporate Service Center	890	0	10.27%	Corporate services supporting health care, ACO and health plan operations
Total	**26**	**9,830**	**500**	**100%**	

**The term* workforce *refers to all people actively involved in accomplishing the work of an organization. The workforce includes paid employees (e.g., permanent, part-time, temporary, telecommuting, and contract employees supervised by the organization) and volunteers, as appropriate; it also includes team leaders, supervisors, and managers at all levels.*

Joint Ventures				
	Partner Organization	**# of applicant employees included in joint venture**	**% Owned by the Applicant**	**Describe extent/level of operational and managerial responsibility your organization has for the joint venture.**
	Copansburg Surgery Center—Lexington	60	**51%**	CRHS has 100% operational and managerial responsibility for joint venture
	Copansburg Surgery Center—Georgetown	60	**51%**	CRHS has 100% operational and managerial responsibility for joint venture
	Copansburg Surgery Center—Richmond	60	**51%**	CRHS has 100% operational and managerial responsibility for joint venture
	Copansburg Advanced Imaging Centers—Lexington, Georgetown, Richmond, Winchester, Frankfort, Paris	120	**60%**	CRHS has 100% operational and managerial responsibility for joint venture
Total	**4**	**300**		

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10. Key Business/Organization Factors

List or briefly describe where necessary the following key business/organization factors (we recommend using bullets). Please be concise, but be as specific as possible. Provide full names of organizations (i.e., do not use acronyms). *The Baldrige Program uses this information to avoid conflicts of interest when assigning examiners to your application. Examiners also use this information in their evaluations.*

a. Main products and/or services and major markets served (local, regional, national, and international)

Copansburg Regional Health System is a not-for-profit integrated delivery health care provider serving the greater Lexington, KY region of more than 1 million residents, encompassing both urban communities in Lexington and rural areas of Kentucky. Services across the continuum of care include inpatient care, emergency care, physical medicine and rehabilitation care, and outpatient services, including physician office care, imaging services, and rehabilitation therapy.

b. Key competitors (those that constitute 5 percent or more of your competitors)

Hospital competitors (with bed sizes) include academic medical centers at University of Churchill Downs (400) and Rivertown University (450); a National Hospital Corporation hospital (250); and independent hospitals such as St. Paul's Hospital (200) and Edwardia Hospital (150). Competition in the outpatient setting includes those same hospitals and some for-profit entities, such as Mount Washington, LaGrange, Rivers Imaging Centers, Trulent Surgery Centers, Movement Physical Therapy, and PatientNow Urgent Care. Competition in the health insurance space comes from national health insurers, such as Ryland, Xyrus, Norwood, Haferty, and Briars.

c. Key customers/users (those that constitute 5 percent or more of your customers/users)

Patients and people they define as family within the CRHS service area

d. Key suppliers/partners (those that constitute 5 percent or more of your suppliers/partners)

Suppliers include Bluebird and Hilltop (medical supplies, equipment, and pharmaceuticals); Sarmac (imaging equipment); Ingleton, Marcus, J & M (surgical supplies and equipment); Apex (electronic medical record); Wellmed (emergency and anesthesia physician services), and Amwell GPO.

Partners include independent surgeons in surgery center joint venture; Radiology Physicians of Kentucky in imaging centers joint venture; University of Lexington School of Medicine (medical students and residents); Excel Ambulance (ambulance and transport services); University of Churchill Downs (nursing, mid-level providers [MLPs], technologists, and pharmacy personnel); Nicholasville Community College (nursing personnel); and Communities of Excellence partners.

e. Financial auditor

Financial auditor	Fiscal year (e.g., October 1–September 30)
Pinnacle Audit Services	January 1–December 31

f. Parent organization (if your organization is a subunit).

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11. Nomination to the Board of Examiners

If your organization is eligible to apply for the Baldrige Award in 2022, you may nominate one senior member from your organization to the 2022 Board of Examiners.

Nominees are appointed for one year only. Nominees

- **must not have served previously on the Board of Examiners** and
- must be citizens of the United States, be located in the United States or its territories, and be employees of the applicant organization.

The program limits the number of examiners from any one organization. If your organization already has representatives on the board, nominating an additional person may affect their reappointment.

Board appointments provide a significant opportunity for your organization to learn about the Criteria and the evaluation process. The time commitment is also substantial: examiners commit to a minimum of 200 hours from April to August, including approximately 40–60 hours in April/May to complete self-study, four days in May to attend Examiner Preparation, and 95–130 hours from June through August to complete an Independent and Consensus Review. If requested by the program, examiners also participate in a Site Visit Review of approximately nine days. The nominee or the organization must cover travel and housing expenses incurred for Examiner Preparation.

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Devon Koonce	from our organization will serve on the 2022 Board of Examiners.
Devon.Koonce@crhs.org	Email address

☒ I understand that the nominee or the organization will cover travel and hotel costs associated with participation in Examiner Preparation. I also understand that if my organization is determined to be ineligible to apply for the Baldrige Award in 2022, this examiner nomination will not be considered for the 2022 Board of Examiners.

12. Self-Certification and Signature

I state and attest the following:

(1) I have reviewed the information provided in this eligibility certification package.

(2) To the best of my knowledge,
- this package includes no untrue statement of a material fact, and
- no material fact has been omitted.

(3) Based on the information herein and the current eligibility requirements for the Malcolm Baldrige National Quality Award®, organization is eligible to apply.

(4) I understand that if the information is found not to support eligibility at any time during the 2022 award process, my organization will no longer receive consideration for the award and will receive only a feedback report.

Signature of highest-ranking official	Printed name	Date
Keith Turley	Keith Turley	2/12/2022

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13. Submission

To be considered for the 2022 award, your complete eligibility certification package *must be submitted electronically no later than* February 16, 2022.

To submit your Eligibility Certification package, request a link to NIST's secure file transfer system by emailing asqbaldrige@asq.org. Do not email your eligibility package directly to ASQ.

Do you authorize ASQ to return copies of your date-stamped eligibility forms (required to be included in your application package) via email? *If you check "no" below, the copies will be returned to you via the secure file transfer system.*

☒ Yes ☐ No

14. Fee

Indicate your method of payment for the $400 eligibility certification fee.

☒ **Check** ☐ **Money order**

Official Name of Organization:

Copansburg Regional Health System

Mailing Address:

1000 Copansburg Boulevard

Lexington, KY 40517

To pay by check or money order, please make payable to the **Malcolm Baldrige National Quality Award®** and include the name of the organization applying on the memo line. Include one printed copy of this page with your payment.

☐ **ACH payment** ☐ **Wire transfer**

Checking ABA routing number: 041000124 Checking account number: 4245714835

Before sending an ACH payment or wire transfer, please notify the American Society for Quality (ASQ; [414] 765-7205, or asqbaldrige@asq.org). Reference the Baldrige Award with your payment.

☐ Visa ☐ MasterCard ☐ American Express

Card number		Authorized signature	
Expiration date		Printed name	
Card billing address		Today's date	

W-9 Request: If you require an IRS Form W-9 (Request for Taxpayer Identification Number and Certification), contact ASQ at (414) 765-7205.

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2022 Eligibility Certification Form

Malcolm Baldrige National Quality Award®

OMB Control No. 0693-0006
Expiration Date: 07/31/2023

1. Eligibility Certification Form*

☒ I have answered all questions completely.

☒ I have included a line-and-box organization chart showing all components of the organization and the name of each unit or division and its leader.

☒ The highest-ranking official has signed the form.

For Organizations Submitting Additional Eligibility Screening Materials (to meet the alternative eligibility condition no. 8 for question 6k; see the table on page E-4)

☐ I have enclosed a complete Organizational Profile.

☐ I have enclosed data for two results measures for each of the five Criteria results items.

For Subunits Only

☐ I have included a line-and-box organization chart(s) showing the subunit's relationship to the parent's highest management level, including all intervening levels.

☐ I have enclosed copies of relevant portions of an official document clearly defining the subunit as a discrete entity.

**Please do not staple the pages of this form.*

2. Fee

☒ I have indicated my method of payment for the nonrefundable $400 eligibility certification fee.

☒ If paying by check or money order, I have made it payable to the **Malcolm Baldrige National Quality Award®** and included it in the eligibility certification package.

3. Submission and Baldrige Examiner Nomination

☒ I am nominating a senior member of my organization to the 2022 Board of Examiners.

☐ I am not nominating a senior member of my organization to the 2022 Board of Examiners.

☒ I am emailing asqbaldrige@asq.org to request a link to NIST's secure file transfer system to upload my eligibility certification package.

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ORGANIZATION CHARTS

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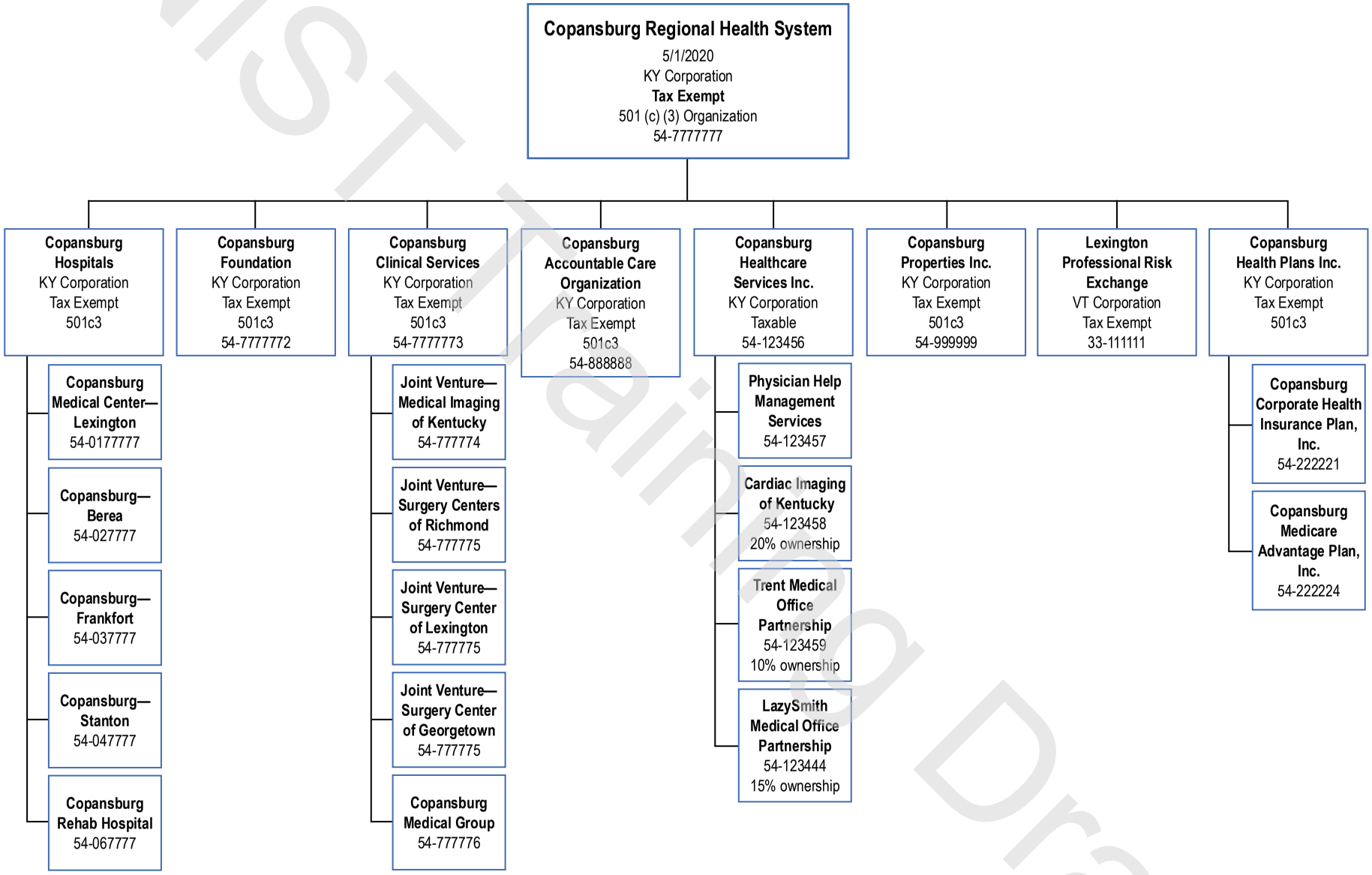
Copansburg Regional Health System Corporate Organization Chart



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Copansburg Regional Health System Organization Chart

Designates Executive Leadership Team Member

Copansburg Regional Health System Board of Trustees

Copansburg Hospital Advisory Boards

Risk Management & Compliance Officer **Tom Blalock**

Medical Staff President **Blain Joe, MD**

President and CEO Keith Turley

Copansburg Foundation Board of Trustees

Chief Medical Officer **Beverly Tai, MD**

- VP, Medical Group **John Moss, MD**
- VP, Practice Operations **Mike Johnson**
- VP, Physician Services **Carla Robinson**
- VP, Medical Informatics **Carl Szlyk, MD**
- VP, Graduate Medical Education **John Jett, MD**

Chief Information Officer **Tom Wick**

- VP, Technology **Maria Thomasino**
- VP, Nursing Informatics **Monica Lee, RN**
- VP, Analytics **Johnathan Leslie**
- VP, Cybersecurity **Geoff Wylie**

Chief Nursing Officer **Eileen Kay, DNP**

- VP, Inpatient Nursing Practice **Jen Freed, RN**
- VP, Ambulatory Nursing Practice **Eric Thomas, RN**
- VP, Clinical Education **Sara Mikel, DNP**

Chief Operating Officer **Tejas Lopez**

- Hospital Leaders **Becky Anders, Michelle Pastorius, Jackie Santonio, Michael Watson, Nancy Yablonski**
- VP, Performance Improvement **Cody St. Ours**
- VP, Ambulatory Operations **Marie Anafere**
- Service Line VPs Cardiac— **Marie Hager** Oncology— **Mike Brown** Women's— **Missy Reese** Orthopedics— **Tammy Matthis** Neurology— **Vacant**

Chief Financial Officer **Sean O'Casey**

- VP, Supply Chain **Alan Tillon**
- VP, Revenue Cycle **Sarah Barden**
- VP, Managed Care **Luis Bandera**
- VP, Facility Management **Curt Brody**
- VP, Biomed & Engineering **Joe Tracy**

Chief Strategy Officer **Marcus Wright**

- VP, Business Development **Tina Brooks**
- VP, Marketing & Communications **Lisa Flaherty**
- VP, Government Relations **Chris Ryan**
- VP, Corporate Strategy **Phillip Dermott**
- VP, ACO and Population Health **Vy Turner**
- VP, Health Plans **Lavert Magrino-Smith**

Chief Human Resources Officer **Jerome Thomas**

- VP, Associate Relations **Kathy Cruz**
- VP, Recruitment **Alwad Chaudhari**
- VP, Benefits & Compensation **Anna Chijka**
- VP, Learning & Development **Devon Koonce**
- VP, Patient Experience **Takiya Rey**
- VP, Volunteer Services **Annie Riddick**
- VP, Diversity and Inclusion **Sandy Gomez**

Foundation President **Xavier Mulkie**

- VP, Major Gifts **Alexandria Wolinski**
- VP, Fundraising Events **Chris Wall**

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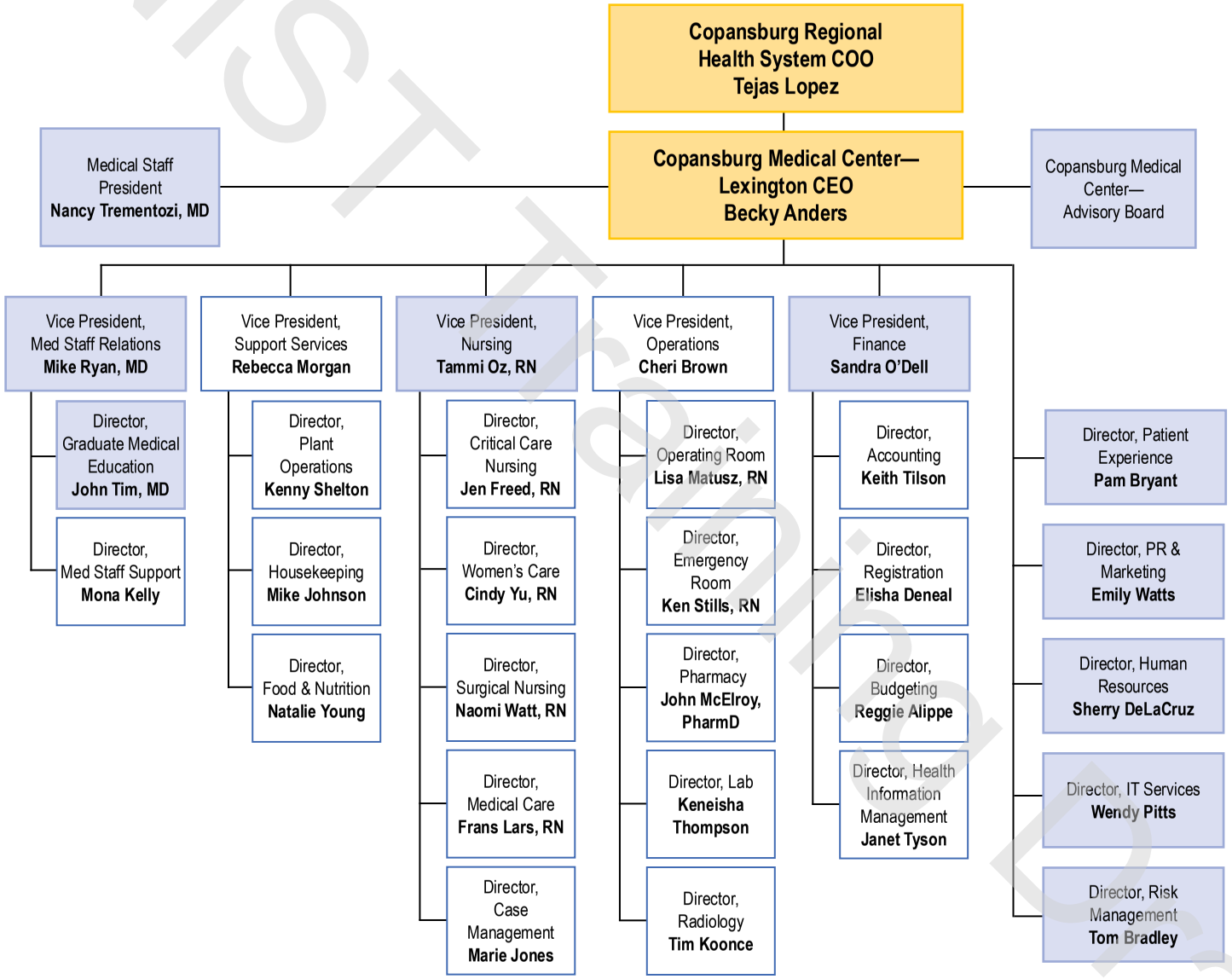
Copansburg Medical Center—Lexington Organization Chart

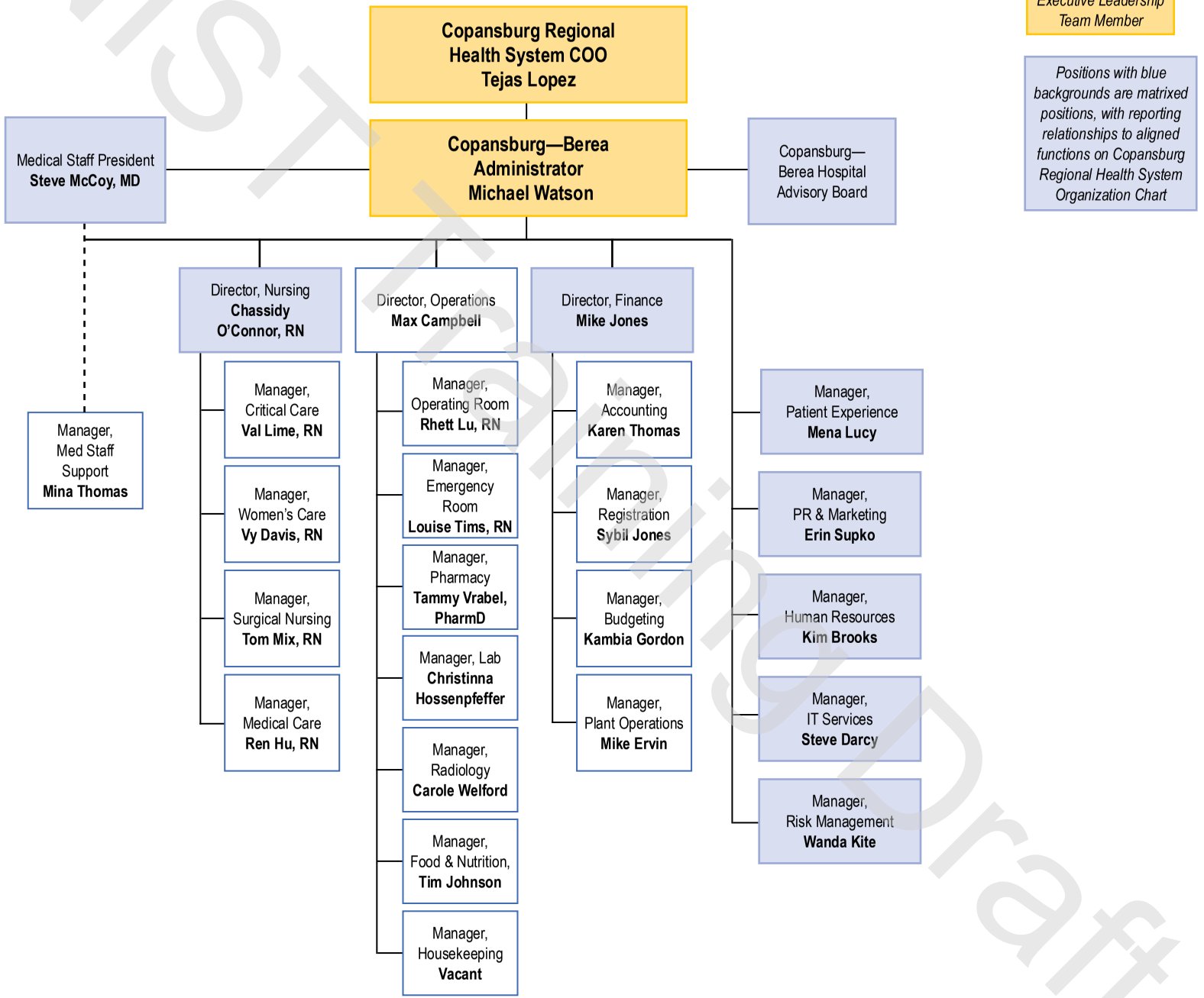


Designates Executive Leadership Team Member

Positions with blue backgrounds are matrixed positions, with reporting relationships to aligned functions on Copansburg Regional Health System Organization Chart

NIST Template Draft

Copansburg—Berea Organization Chart



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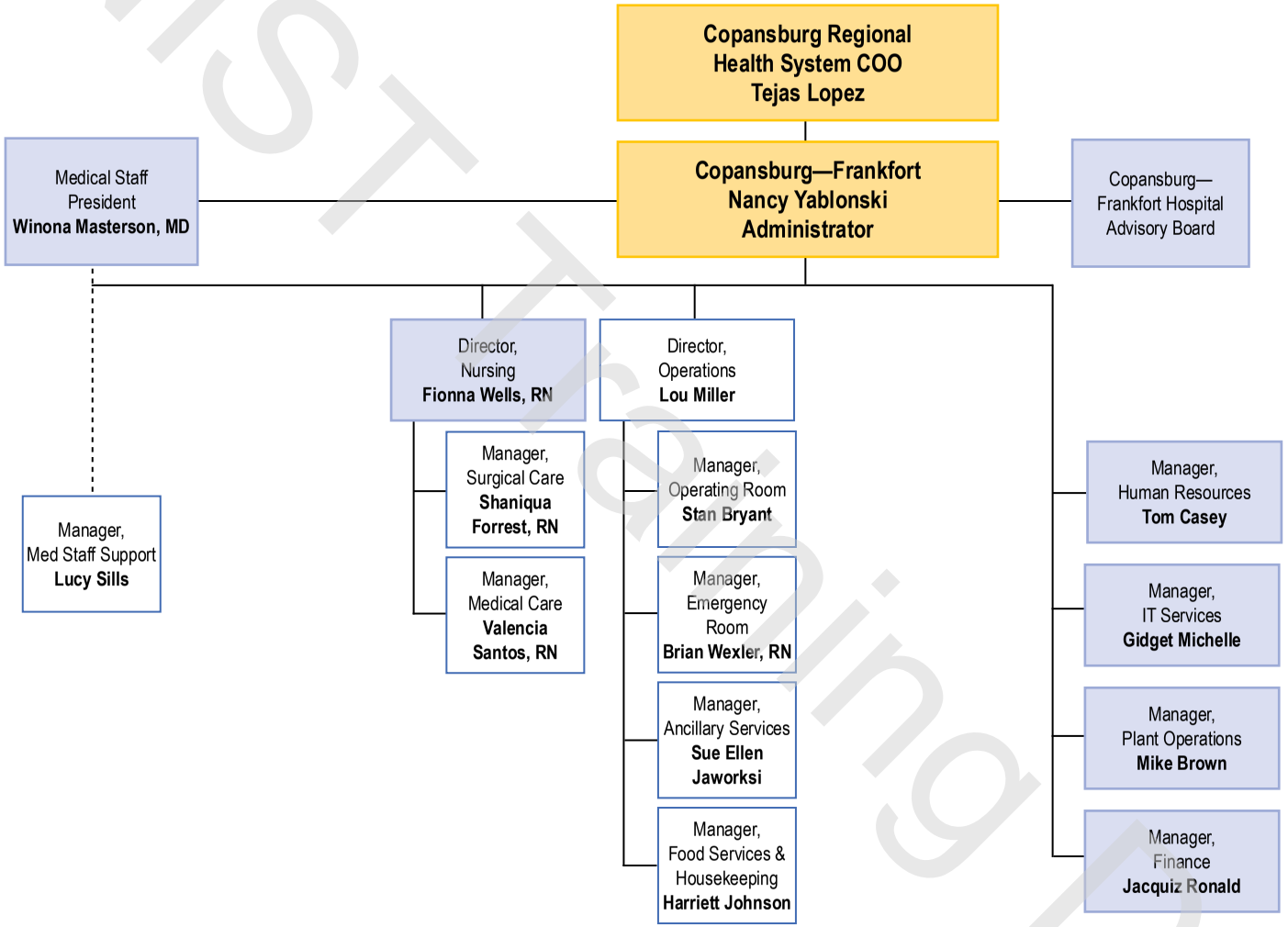
Copansburg Medical Center—Frankfort Organization Chart



Designates Executive Leadership Team Member

Positions with blue backgrounds are matrixed positions, with reporting relationships to aligned corporate functions on the Copansburg Regional Health System Organization Chart

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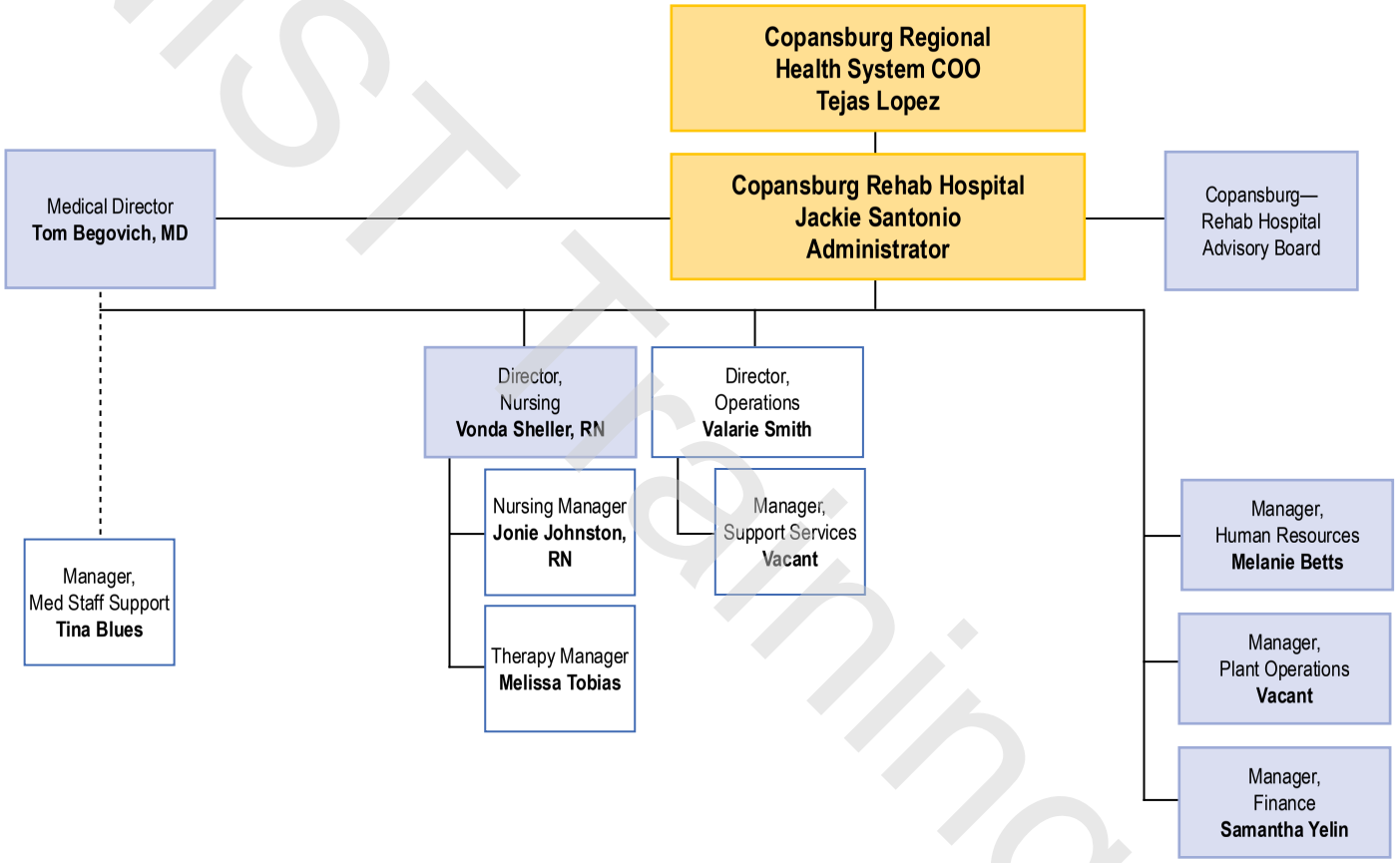
Copansburg Rehab Hospital Organization Chart

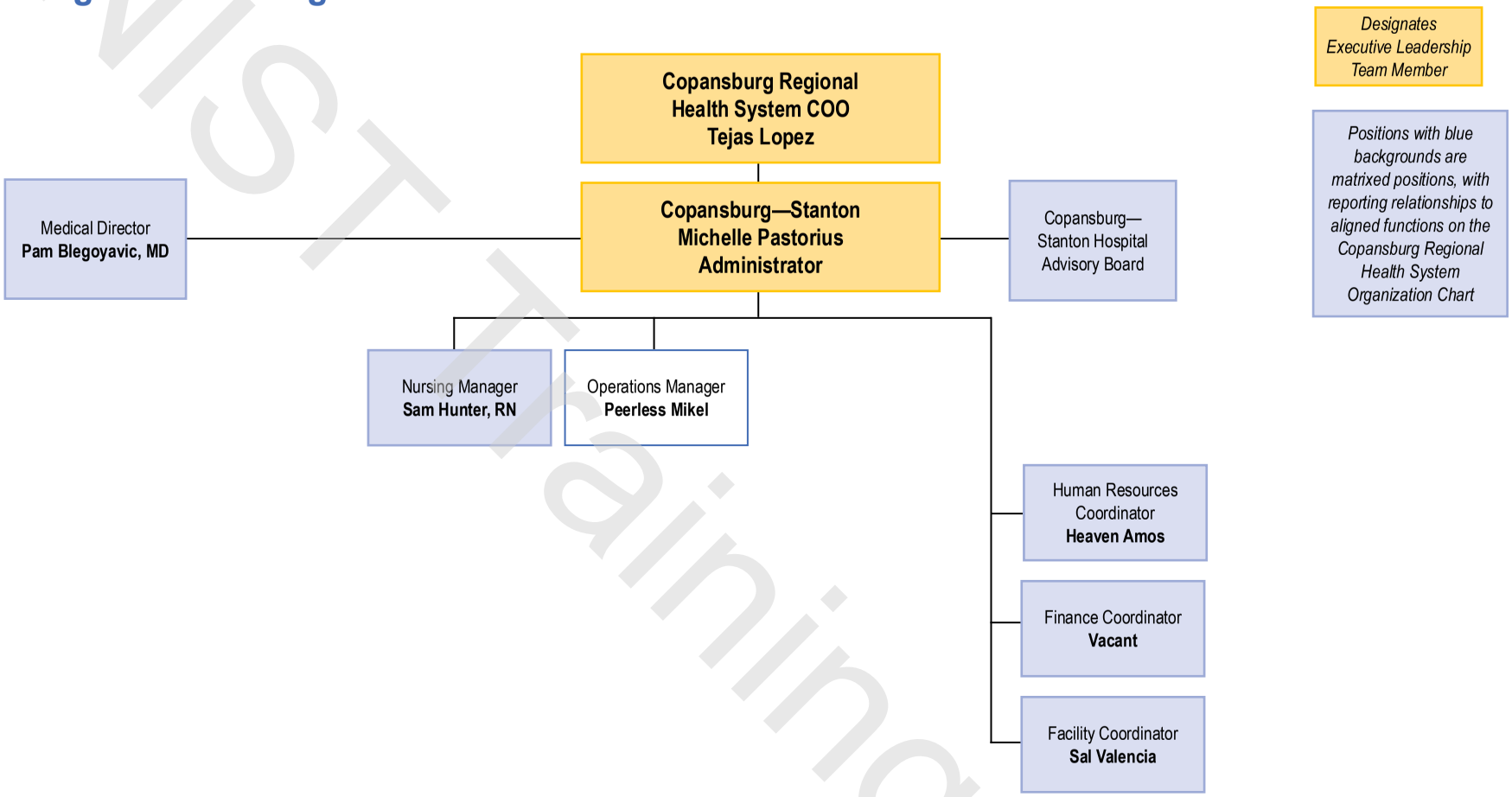


Designates Executive Leadership Team Member

Positions with blue backgrounds are matrixed positions, with reporting relationships to aligned corporate functions on the Copansburg Regional Health System Organization Chart

MST Training Draft

Copansburg—Stanton Organization Chart



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PAGE A-1 OF THE 2022 AWARD APPLICATION FORM

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2022 Award Application Form

Malcolm Baldrige National Quality Award®

OMB Clearance #0693-0006
Expiration Date: 07/31/2023

1. Your Organization

Official name	Copansburg Regional Health System
Mailing address	1000 Copansburg Boulevard Lexington, KY 40517

2. Award Category and Criteria Used

a. Award category *(Check one.)*

- ☐ Manufacturing
- ☐ Service
- ☐ Small business. The larger percentage of sales is in *(check one)* ☐ Manufacturing ☐ Service
- ☐ Education
- ☒ Health care
- ☐ Nonprofit

b. Criteria used *(Check one.)*

- ☐ Business/Nonprofit
- ☐ Education
- ☒ Health Care

3. Official Contact Point

Designate a person with in-depth knowledge of the organization, a good understanding of the application, and the authority to answer inquiries and arrange a site visit, if necessary. *Contact between the Baldrige Program and your organization is limited to this individual and the alternate official contact point. If the official contact point changes during the application process, please inform the program.*

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Cody St. Ours
Title	VP, Performance Improvement
Mailing address	☒ Same as above
Overnight mailing address	☒ Same as above *(Do not use a P.O. box number.)*
Telephone	Office: 502-555-1357 Cell: 502-555-2468
Fax	502-555-5678
E-mail	Cody.StOurs@crhs.orgs

4. Alternate Official Contact Point

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Devon Koonce
Telephone	502-555-9753
Fax	502-555-5678
E-mail	Devon.Koonce@crhs.org

5. Release and Ethics Statements

Release Statement

I understand that this application will be reviewed by members of the Board of Examiners. If my organization is selected for a site visit, I agree that the organization will

- host the site visit,
- facilitate an open and unbiased examination, and
- pay reasonable costs associated with the site visit (see *Baldrige Award Process Fees* on our website [https://www.nist.gov/baldrige/baldrige-award/award-process-fees]).

If selected to receive an award, my organization will share nonproprietary information on its successful performance excellence strategies with other U.S. organizations.

Ethics Statement and Signature of Highest-Ranking Official

I state and attest that

(1) I have reviewed the information provided by my organization in this award application package.

(2) To the best of my knowledge, this package contains no untrue statement of a material fact and omits no material fact that I am legally permitted to disclose and that affects my organization's ethical and legal practices. This includes but is not limited to sanctions and ethical breaches.

Keith Turley	02/12/2022
Signature	Date

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Printed name	Keith Turley
Job title	President and CEO
Applicant name	Copansburg Regional Health System
Mailing address	☒ Same as above
Telephone	502-555-1234
Email	Keith.Turley@crhs.org
Fax	502-555-5678

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GLOSSARY OF TERMS AND ABBREVIATIONS

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Glossary of Terms and Abbreviations

A

A: Annual

A3: A3 quality improvement process

A3E2: Ability, Agility, Aspiration, Engagement, Exposure

A3E3: Ability, Agility, Aspiration, Engagement, Exposure, Emotional Intelligence

AB: Advisory Board

ACO: Accountable Care Organization

ACR: American Collect of Radiology

AMD: Advance Medical Directive

AOS: Available On-site

APP: Action Planning Process

ASC: Ambulatory Surgery Center

ASG: American Surgeons Group

ASQ: American Society for Quality

B

BAR: Baldrige Award Recipient

BM: Benchmark

BOT: Board of Trustees

BSC: Balanced Scorecard

BSN: Bachelor of Science in Nursing

C

C: Collaborators

CAH: Critical Access Hospital

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CAPA: Corrective and Preventive Actions

CB: Copansburg Hospital—Berea

CC: Core Competency

C&C: Capability and capacity

CCC: Corporate Compliance Committee

CCM: Capability and Capacity Model

CCP: Corporate Compliance Program

CDC: Centers for Disease Control and Prevention

CDI: Clinical Documentation Improvement

CDL: Commercial Driver's License

CEG: Community Excellence Group

CEO: Chief Executive Officer

CESB: Code of Ethical Standards of Behavior

CF: Copansburg Hospital—Frankfort

CGCAHPS: Clinician and Groups Consumer Assessment of Healthcare Providers and Systems

CHDMG: College of Healthcare Data Management Group

CHNA: Community Health Needs Assessment

CHRO: Chief Human Resources Officer

CI: Continuous Improvement

CIO: Chief Information Officer

CMCL: Copansburg Medical Center—Lexington

CMI: Case-Mix Index

CMS: Centers for Medicare and Medicaid Services

CNA: Certified Nurse Assistant

COE: Communities of Excellence 2026

COPs: Communities of Practice

COS: Culture of Safety

COVID: Coronavirus

CPT: COVID Process Team

CRH: Copansburg Rehab Hospital

CRHS: Copansburg Regional Health System

CS: Copansburg Hospital—Stanton

CT: Computerized Tomography

D

DDI: Data Drive Improvement

DEI: Diversity, Equity and Inclusion

DEIC: Diversity, Equity and Inclusion Committee

DME: Durable Medical Equipment

DOE: U.S. Department of Education

E

E: Employees

EBIDA: Earnings Before Interest, Depreciation, and Amortization

ED: Emergency Department

EDCAHPS: Emergency Department Consumer Assessment of Healthcare Providers and Systems

EEOC: Equal Employment Opportunity Commission

EL: Executive Leader

EL/SL: Executive and Senior Leader

ELT: Executive Leadership Team

EMR: electronic medical record

EOC: Environment of Care

EPA: Environmental Protection Agency

EPOP: Emergency Preparedness and Operations Plan

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F

F: Family

FAQ: Frequently Asked Questions

FDA: Food and Drug Administration

FM: Facilities Management

FMEA: Failure Mode and Effects Analysis

FQHC: Federally Qualified Health Center

FT: Full Time

FTE: Full Time Equivalent

G

GPO: group purchasing organization

GSF: Gross Square Feet

GYN: Gynecology

H

H: Hospital

HAC: Hospital-Acquired Conditions

HAI: Healthcare-Associated Infection

HAPU: Hospital-Acquired Pressure Ulcer

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

HDR: High Dynamic Range

HEDIS: Healthcare Effectiveness Data and Information Set

HH: Home Health

HHCAHPS: Home Health Consumer Assessment of Healthcare Providers and Systems

HIPAA: Health Insurance Portability and Accountability Act

HP: Health Plan

HPCAHPS: Hospice Consumer Assessment of Healthcare Providers and Systems

HR: Human Resources

HS: High School

I

ICU: Intensive Care Unit

IDT: Interdisciplinary Team

IM: Information Management

IP/Inpt: Inpatient

IRB: Institutional Review Board

IRS: Internal Revenue Service

IT: Information Technology

ITM: Integrated Talent Management

J

JV: Joint Venture

K

KPI: Key Performance Indicator

KSA: Knowledge, Skills and Abilities

KWH: Kilowatt-hour

KY: Kentucky

KY HA: Kentucky Hospital Association

L

L&D: Learning and Development

LDP: Leadership Development Program

LDS: Learning and Development System

LED: Light-Emitting Diode

LEED: Leadership in Energy and Environmental Design

LERC: Legal, Ethics, Regulatory and Compliance

LGBTQ: Lesbian, Gay, Bisexual, Transgender, Queer or Questioning

LOS: Length of Stay

LS: Leadership System

LWBS: Left Without Being Seen

M

M: Monthly

MA: Medicare Advantage

MADS: Maximum Annual Debt Service

MAP: Medicare Advantage Program

MCP: Multidisciplinary Care Plan

MD: Medical Doctor/physicians

MLP: Mid-Level Provider

MM: Middle Managers

MO: Medical Office

MRI: Magnetic Resonance Imaging

MS: Medical Staff

MVV: mission, vision, values

MYPHI: Patient electronic medical record

N

NDCQF: National Database of Care Quality Factors

NEO: New Employee Orientation

NHC: National Hospital Corporation

NHSN: National Healthcare Safety Network

NICU: Neonatal Intensive Care Unit

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NIST: National Institute of Standards and Technology
NSQIP: National Surgical Quality Improvement Program

O

O: Other
OB: Obstetrics
OC: Organizational Change
OCR: Office for Civil Rights
OIG: Office of Inspector General
OP/Outpt: Outpatient
OPPE: Ongoing Professional Practice Evaluation
OR: Operating Room
OSBC: Office of Safety and Business Continuity
OSHA: Occupational Safety & Health Administration

P

P: Partners or Projection
PA: Post Acute
Pandemic: COVID-19
PCP: Primary Care Physician/Provider
PCR: Polymerase Chain Reaction
PDCA: Plan, Do, Check, Act
PEO: Patient Experience Office
PESTLE+W: Political, Economic, Social, Technological, Legal, Environmental, Workforce
PET: Positron Emission Tomography
PFAC: Patient Family Advisory Council
PHI: Protected Health Information
PHQ-9: Patient health questionnaire for depression screening
PI: Process Improvement
PIC: Performance Improvement Council
PIP: Performance Improvement Plan
PIT: Process Improvement Teams
POAM: Plan of actions and milestones
PPDP: Performance and Professional Development Plan
PPE: Personal Protective Equipment
PSI: Patient Safety Indicators
PT: Part Time
Pt: Patient

Q

Q: Quarterly
QI: Quality Improvement

R

RCA: Root Cause Analysis
RN: Registered Nurse
ROI: Return on Investment

S

S: Semi-annual
SA: Strategic Advantage
SC: Strategic Challenge
SCM: Supply Chain Management
SCPE: State Center for Performance Excellence
SEEGs: Strategic Employee Engagement Groups
SHRM: Society for Human Resource Management
S/I: Strategy/Innovation
SL: Senior Leader
SLA: Service Level Agreement
SLT: Senior Leadership Team
SMARTER: Specific, Measurable, Aligned, Realistic, Time-bound, Evaluated, Reviewed
SNAC: Staff Nurse Advisory Council
SO: Strategic Opportunities
SObj: Strategic Objectives
SP: Strategic Plan
SPC: Statistical Process Control
SPP: Strategic Planning Process
St: Students
Su: Suppliers
SWOT: Strengths, Weaknesses, Opportunities, and Threats
SWPD: Service and Work Process Design

T

TAT: Turnaround Time
TB: Tuberculosis
tPA: Tissue Plasminogen Activator
TRAC: Teams Realizing Awesome Care
TUP: The United Practice
TV: Television

U

US: United States

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V

V: Volunteers

VBP: Value-Based Purchasing

VOC: Voice of the Customer

VP: Vice President

VPP: Voluntary Protection Program

W

WE CARE values: World-class medicine, Efficiency, Compassion, Accountability, Respect, Excellence

WF: Workforce

WHO: World Health Organization

Y

YTD: Year-to-Date

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ORGANIZATIONAL PROFILE

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Preface: Organizational Profile

P.1 Organizational Description

Copansburg Regional Health System (CRHS) is a large, not-for-profit, integrated delivery health care provider headquartered in the greater Lexington, KY region. The area and citizenry it serves is diverse. The urban hustle of Lexington gives way to the gently rolling fields of Kentucky. The service area is centered around Lexington (stretching roughly 40 miles from east to west and about 50 miles from north to south) and has a population of more than 1 million residents, encompassing both urban communities and rural areas of Kentucky.

Theirs is a region where people can enjoy the benefits of urbanity and the serenity of a breeze in the bluegrass. Quality of life is a driving factor in people's decision to live in their region. And CRHS believes the health care it provides enhances the attractiveness of the region.

It is against this backdrop that CRHS was formed in 2000, after the merger of two regional health care providers, Downton Health and Bluegrass Healthcare. Since 2000, CRHS has seen significant growth, both organically driven and through acquisition of additional hospitals in the region. In 2012, CRHS began using the Baldrige Excellence Framework® as a method to help it achieve a more systematic approach across its large network of facilities and services, which led to achieving the 2019 Excellence Award from the State Center for Performance Excellence. CRHS has learned much over the past decade and achieved tremendous improvement in operations and results to the benefit of those served.

P.1a. Organizational Environment

P.1a(1). CRHS includes five hospitals. They range in size from the system's largest hospital, Copansburg Medical Center—Lexington (CMCL), which is a teaching facility with an active residency program featuring 120 physician residents, to a 25-bed critical access hospital (CAH), Copansburg Hospital—Stanton (CS).

CRHS has service lines for cardiology, oncology, orthopedics, women's and children's, behavioral health/substance abuse, and neurology, with programming varying depending on hospital size, complexity, and local population needs. CRHS's hospitals and their related outpatient and post-acute services (home health, hospice, and durable medical equipment [DME]) generate more than 70% of the system's revenue and house most of the workforce, so they are of primary importance.

CRHS also has numerous outpatient diagnostic and treatment facilities, including:

- joint-ventured (JV) surgery centers,
- JV imaging centers,
- rehabilitation services,
- urgent care, and
- four medical office buildings.

CRHS boasts a 750-member employed, multispecialty medical group; 120 physician residents; and a broader medical staff that includes another 420 independent physician members. The employed medical group directly supports the operation of both hospitals and outpatient services.

CRHS also has numerous outpatient diagnostic and treatment facilities, including joint-ventured (JV) surgery centers, JV imaging centers, rehabilitation services, urgent care, and four medical office buildings. CRHS boasts a 750-member employed, multispecialty medical group; 120 physician residents; and a broader medical staff that includes another 420 independent physician members. The employed medical group directly supports the operation of both hospitals and outpatient services.

CRHS also operates health insurance plans with products in the commercial market for local employers and products in the Medicare Advantage market. Today, these insurance plans represent its fourth area of focus, although they may well take on additional importance as CRHS grows in the future.

Finally, the 1,290 physicians on the medical staff and CRHS facilities form the region's largest accountable care organization (ACO), participating in Medicare's NextGen ACO program as well as multiple value-based contracts with private insurers. The ACO continues to be an entity that focuses on Medicare's triple aim of providing high-quality care, with high levels of patient satisfaction, in the most efficient way possible.

CRHS is proud to be a heavily decorated health system with an impressive list of accolades, accreditations, and certifications, including CMCL and Copansburg Hospital—Berea (CB) attaining Magnet status, CHDMG Most-Wired Hospital, Kentucky "Best Place to Work" designation, LeapCore A ratings, LEED/Practice Bluefit Excellence Award, The United Practice Stroke and Orthopedic certifications, trauma center designations, specialties with Wooland Health top 100 designations, and Voluntary Protection Program (VPP) star status (from OSHA) for workplace safety.

P.1a(2). During the merger proceedings between Downton Health and Bluegrass Healthcare, the leadership teams and boards of the two hospitals began discussions about the desired mission and vision of the potential new combined regional health care system. From those discussions, the ultimate mission and vision of CRHS was born. And, although the new leadership team and board reviews the mission and vision annually, they have remained remarkably unchanged since 2000.

In 2002, new CRHS leadership team members embarked on a process to clearly define the values they use each day in pursuit of the mission and vision. From this effort came CRHS's WE CARE values.

In terms of culture, CRHS is a reflection of its region and the people it serves. CRHS is inclusive and diverse, and it understands how important a great quality of life is to both patients and the workforce.

It is because of the mission, vision, values (MVV) and culture that CRHS has developed its core competencies (CCs). The combination of safe, efficient, and high-quality care is the most effective differentiator for CRHS.

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Figure P.1-1: **Mission, Vision, Values, and CCs**	
Mission	To provide outstanding health care services to improve the health of all citizens in the service area
Vision	To be among America's best health systems
Values	(WE CARE) World-class medicine; Efficiency; Compassion; Accountability; Respect; and Excellence
CCs	1. Safe, high-quality clinical care 2. Efficiency in operations

P.1a(3). CRHS's key workforce members and their requirements are in Figure P.1-2. The recent pandemic did not change the make-up of the workforce significantly, but it did result in more nonclinical employees working remotely. The pandemic also caused CRHS to redouble its efforts around safety and wellness for the entire workforce. There are organized bargaining units for nurses at CMCL and for environmental and facility services employees at all hospitals. Health and safety requirements for all segments include safe environment, appropriate protective equipment, and appropriate safety education.

P.1a(4). CRHS's key assets include its five hospitals (with bed size):

- CMCL (600),
- CB (150),
- Copansburg Hospital—Frankfort (CF) (50),
- Copansburg Rehab Hospital (CRH) (50), and
- CS (25).

Other key facility assets are a corporate office building, substantial outpatient facilities including four medical office buildings, three six-suite JV surgery centers, six JV outpatient advanced imaging centers, and five urgent care and three rehabilitation therapy facilities.

Equipment assets include a full spectrum of imaging equipment, including 10 MRI machines, 3 PET scanners, 35 CT machines, and 5 3D mammography units. Advanced radiation oncology equipment includes a photon center, gamma knife, rapid arc, HDR, and stereotactic radiosurgery capabilities.

CRHS has e-ICU capabilities to support its rural hospitals. It also has state-of-the-art cardiology and neurosurgery equipment, including hybrid ORs for open heart and valve procedures, interventional radiology and neurology suites, and robotic assisted surgical capabilities at three hospitals. It also operates a mobile clinic to provide access to rural populations.

Nonphysical key assets are CRHS's Apex EMR (electronic medical records system) and its corporate health insurance plan and Medicare Advantage plan. Its telehealth platform through Apex is a key asset as well—it supports televisits with health care providers in the medical offices and facilitates specialty consultation at the smaller hospitals. Finally, both the residency curriculum and programming and the accountable care analytics platform are CRHS's most significant pieces of intellectual property.

Figure P.1-2: **Workforce Profile**

Workforce Segment	Workforce Group	Key Drivers of Engagement	Related Results	Educational Requirements
Employees (9,830)	Clinical (5,730) —MLPs (600) —Nurses (3,400) —Techs (740) —Therapists (540) —Other (450)	Support of clinical practice; Competitive compensation; Collegial working environment; Safe working environment; Appreciation & wellness	7.3-1 7.3-4 7.3-8–7.3-12 7.3-18	Appropriate degree; Appropriate licensure
	Nonclinical (4,100)	Collegial working environment; Competitive compensation; Appreciation & wellness; Ability to work remotely	7.3-4 7.3-10, 7.3-11 7.3-15 7.3-18	Variable–HS minimum, up to post-graduate
Physicians (1,290)	Employed (750); Residents (120)	Support of clinical practice; Competitive compensation; Staff competency; Wellness	7.3-2 7.3-7, 7.3-8 7.3-11–7.3-14 7.3-21	Medical degree; Licensure; Residency requirements
	Nonemployed (420)	Ease of practice; Staff competency; Support for service growth	7.3-11, 7.3-15	Medical degree; Licensure
Students (140)	Nursing students (100); Other students (40)	Safe learning environment; Expert clinical faculty; Career acceleration	7.3-16, 7.3-21	Variable—HS minimum, up to graduate
Volunteers (500)	Adult (400) Teen (100)	Meaningful work; Appreciation and wellness	7.3-6, 7.3-17	Variable

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P.1a(5). U.S. health care is one of the most highly regulated environments in the world. The most significant federal regulators include the Centers for Medicare & Medicaid Services (CMS), Occupational Safety & Health Administration (OSHA), Office of Inspector General (OIG), Office for Civil Rights (OCR), Equal Employment Opportunity Commission (EEOC), Food and Drug Administration (FDA), Environmental Protection Agency (EPA), Internal Revenue Service (IRS), and U.S. Department of Education (DOE).

In addition, the Commonwealth of Kentucky has state-level agencies with regulatory authority such as the Department of Health, Department of Insurance, Department of Medicaid Services, and Department of Emergency Medical Services.

A third layer of regulation exists at the industry level. Relevant regulators include The United Practice, American Surgeons Group (ASG), American Pathologists Group, Accreditation Council for Graduate Healthcare Education, Radiologists Group of America, and the Commission of Education Advancement.

P.1b. Organizational Relationships

P.1b(1). CRHS's highest-level leadership structure is a volunteer, 16-member Board of Trustees (BOT). Further, there are local Advisory Boards at each CRHS hospital that report to the BOT. BOT and Advisory Board members serve three-year terms and can be re-elected to the board to serve up to three terms.

The BOT officers include the chair, vice chair, secretary, and treasurer. BOT committees are Quality, Finance, Governance, Risk Management, and Executive. CRHS's president and CEO, Keith Turley, reports to the BOT.

The Executive Leadership Team (ELT) includes the president and CEO and his direct reports. Each business unit has a Senior Leadership Team (SLT) composed of the senior leader of the business unit and her or his direct reports. The corporate office provides key services for the organization, including strategic planning, marketing, finance, legal, risk management, accreditation, information technology, performance excellence, medical staff credentialing, materials management, security, facilities, biomedical services, and human resources. The Copansburg Foundation supports the efforts of the organization and has a separate, 12-member community-based advisory board.

P.1b(2). CRHS considers the patient its primary key customer. In a cycle of refinement driven by a board retreat in 2017, the organization added family members as a second key customer. And, it considers the broader community served as the ultimate stakeholder.

P.1b(3). CRHS's suppliers are those organizations from whom CRHS purchases the supplies, equipment, pharmaceuticals, and services needed for core operations. CRHS key requirements of its suppliers are quality of products/services, availability of products/services, and cost.

CRHS has four key equity partnerships and maintains at least 51% equity in each of these partnerships. It partners with more than 50 independent surgeons in three distinct JV surgery centers. It partners with a 40-member radiology group on six outpatient imaging centers. The JV structure provides a competitive advantage to CRHS, as physicians with an equity stake in these ventures are tightly aligned with CRHS and help CRHS drive performance and innovation in these services.

Recognizing the tremendous improvement in operations that CRHS has achieved as a result of implementing the Baldrige framework, CRHS has partnered with several local organizations to improve the performance of the community using the Communities of Excellence 2026 (COE) Baldrige-based framework. CRHS serves as a backbone organization for this community improvement effort, currently in its second year.

CRHS also has several key collaborators. These collaborators help the organization with workforce recruitment and training, and also with community health and safety initiatives. Collaborating with its local college and university has enhanced CRHS's ability to recruit and retain personnel in key areas. It has also worked with higher education and the health department on several innovative initiatives focused on community health. CRHS's key suppliers, partners, and collaborators are listed in Figure P.1-4.

Figure P.1-3: **Customers and Stakeholders**

Customer/Stakeholder Group	Requirements	Related Results
Customer: Patients • Inpatient • Emergency Care • Outpatient: Primary and Specialty Physician Care, Urgent Care, Imaging, Ambulatory Surgery, Rehabilitation Therapy • Post-Acute Care: Home Health/DME/Hospice • Insurance Plan Members	Access to care High-quality, safe care Service excellence Participation in care Value	7.1a 7.2
Other Customers: Family Members	High-quality, safe care Service excellence Communication Access to loved one	7.1a 7.2
Stakeholder: Communities Served	Access to care High-quality, safe care Value Scope of services Societal responsibility	7.1a 7.4-11–7.4-13

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Figure P.1-4: **Suppliers, Partners, and Collaborators**

Supplier/Partner/ Collaborator	Name (and Role)	Contribution to Innovation and Competitiveness
Suppliers (and roles)	• Bluebird and Hilltop (medical supplies, equipment, and pharmaceuticals) • Sarmac (imaging equipment) • Ingleton, Marcus, J & M (surgical supplies and equipment) • Apex (EMR) • Wellmed (emergency and anesthesia MD services) • Amwell GPO	• Introduction of supply or service improvements that result in better patient care at the lowest price point possible
Partners ***(CRHS has majority equity interest in bold, italicized partnerships)***	• ***Independent surgeons in surgery center JV*** • ***Radiology Physicians of Kentucky in imaging centers JV*** • Lexington City Government, Lexington Schools, Greater Lexington Chamber of Commerce, United Way of Greater Lexington, Lexington Mental Health, Lexington Health Department • University of Lexington School of Medicine (medical students and residents) • University of Churchill Downs (nursing, MLP, technologists and pharmacy personnel) • Nicholasville Community College (nursing personnel) • Excel Ambulance (ambulance and transport services)	• ***Surgery and imaging centers: Introduction of new procedures, technologies, and processes to improve patient outcomes*** • City, schools, chamber of commerce, United Way, and public health entities are key partners in Community of Excellence initiative • Universities and Colleges: Development of highly skilled workforce members to join the care team
Collaborators	• County Health Departments/FQHC (community health programming) • Regional FQHCs (care for the underserved) • Kentucky Office of Rural Health (care for the underserved)	• Collaboration on special initiatives focused on community health, particularly in urban and rural areas

P.2 Organizational Situation

P.2a. Competitive Environment

P.2a(1). CRHS is the market share leader for almost all clinical services in its region. That market leadership position has been cultivated over time. Its market position and sheer scope of services have become a significant advantage.

However, it does have some robust competitors in the service area. Hospital competitors (with bed sizes) include academic medical centers at University of Churchill Downs (400) and Rivertown University (450), a National Hospital Corporation (NHC) hospital (250), and independent hospitals such as St. Paul's Hospital (200) and Edwardia Hospital (150). Competition in the outpatient setting includes those same hospitals and some for-profit entities such as Rivers Imaging Centers, Trulent Surgery Centers, Movement Physical Therapy, and PatientNow Urgent Care. Competition in the health insurance space comes from national health insurers such as Ryland, Xyrus, Norwood, Haferty, and Briars.

P.2a(2). Since the merger that formed CRHS in 2000, the regional market has slowly been consolidating, and rumors swirl consistently about the remaining independent hospitals joining other large health care systems. In addition, two unaffiliated rural hospitals have announced they are closing.

This consolidation and uncertain future for some hospitals present an opportunity for collaboration, and CRHS is investigating an innovative rural health collaborative with the two unaffiliated rural hospitals to try to maintain access in those communities. Finally, a for-profit competitor in an ambulatory surgery center (ASC) has been approved to build a four-suite surgery center in Lexington. Competition in the surgery center space serves as a catalyst for innovation and collaboration within CRHS's JV surgery centers.

P.2a(3). Health care is blessed with significant amounts of comparative data both within and external to the industry, with the only real limitations being the timeliness of some data, and in-depth competitor data can be difficult to obtain. CRHS also experienced a disruption in comparative data related to the COVID pandemic. Its most substantial sources of comparative data include CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), Healthcare Effectiveness Data and Information Set (HEDIS), ASG, National Database of Care Quality Factors (NDCQF), Medical Agency Research and Quality, Bureau of Labor Statistics, Kentucky Health Group, Kress Daney, the Upwood Organization, National Data Sort Corporation, Carerank, Voorlan, LeapCore, Zandi's Rating Agency, and Craigly Rating Agency.

P.2b. Strategic Context

Each year, CRHS reviews and assesses its competitive position and context as part of the strategic planning process (SPP). As its market is relatively dynamic, as is the industry itself, CRHS has needed to change its lists of the most important strategic advantages, challenges, and opportunities for the system. See Figure P.2-1 for results from the most recently completed strategic planning retreat.

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Figure P.2-1: **Strategic Context**

Strategic Advantages:

1. System scale helps create a cost advantage over competitors
2. Integrated EMR for all entities in the system makes for a convenient experience for health care providers and patients and supports telehealth
3. Market share leadership allows for smoother development and deployment of new business lines
4. Resilience, as displayed in the organization's incredible response to the pandemic of 2020–2021

Strategic Challenges:

1. Workforce burnout and shortages in nursing, technologists, and some physician specialties inhibit growth
2. National and state health care payment changes threaten revenue and rural access
3. Increasing costs in pharmaceuticals, cybersecurity, and emergency preparedness threaten cost advantage
4. Difficulty in reducing health disparities in socioeconomically disadvantaged urban and rural communities

Strategic Opportunities:

1. Embedding resilience in operations
2. Increasing connectivity in rural and urban socioeconomically disadvantaged areas
3. Increasing health care access throughout the service area

P.2c. Performance Improvement System

CRHS uses the Baldrige framework as its overarching system to inspire performance excellence. All CRHS employees receive basic training on the Baldrige framework, and more than 50 leaders at all levels across the organization have received advanced Baldrige training, with more than a dozen serving as Baldrige examiners at the state or national levels. CRHS uses its Baldrige feedback reports as one input in generating performance improvement projects.

In addition, all employees receive training in the Plan, Do, Check, Act (PDCA) methodology; and they use this knowledge for day-to-day improvement work at the department/unit level. Each department/unit has a performance improvement board and is required to always be working on one rapid cycle improvement project. Departments/units meet with leaders weekly at the performance improvement board to review progress on these projects. These projects are specific to the department/unit and last 4 to 12 weeks.

At a system level, the CRHS's Performance Improvement Council (PIC) selects and sanctions performance improvement projects. Each selected project is assigned to a TRAC (Teams Realizing Awesome Care). The TRAC teams report monthly to the PIC on project progress. Within TRAC team projects, some Lean improvement tools are used.

There is a research department with an Institutional Review Board (IRB) that supports innovation in medical care, and the performance excellence and strategy teams at the corporate level help identify strategic opportunities to determine those that are intelligent risks to pursue.

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RESPONSES ADDRESSING ALL CRITERIA ITEMS

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Category 1: Leadership

1.1 Senior Leadership

1.1a. Vision and Values

1.1a(1). When Downton Health and Bluegrass Healthcare merged to form CRHS in 2000, the mission and vision of the new regional health system were established by the leadership teams and boards of the two original hospitals. The CRHS Mission, Vision, and Values (MVV; Figure P.1-1) are reviewed and affirmed annually to determine if any modification is needed.

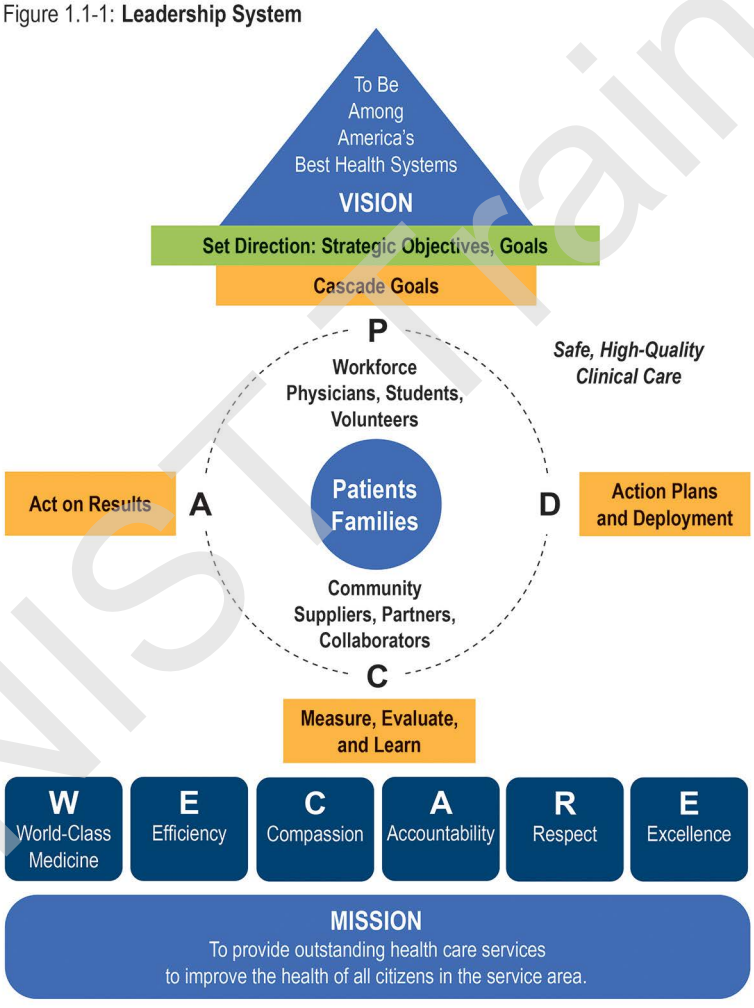
The ELT and SLT systematically deploy the MVV to all stakeholders throughout the organization via the Leadership System (Figure 1.1-1) and via multiple communication methods (Figure 1.1-3) to the WF, suppliers, partners, collaborators, patients, families, and key communities (other stakeholders). Since 2018, executive and senior leaders (EL/SLs) have incorporated real-life examples of the MVV in Action to the WF during each key gathering/meeting and to patients, families, and the community during community forums, focus groups, and via the website and bulletins. MVV in Action are stories describing how the WF have emulated the MVV in caring for patients, their colleagues, and/or their communities. The MVV and Code of Ethical Standards of Behavior (CESB) are incorporated into CRHS contractual purchase and service agreements with suppliers, partners, and collaborators to ensure their commitment in upholding these credos.

EL/SLs personally demonstrate their commitment to WE CARE in leading by example and emulating the values in all their interactions. EL/SLs highlight specific values that resonate with them at the beginning of their own division meetings and in business meetings with suppliers, partners, and collaborators. EL/SLs further demonstrate their commitment to WE CARE by ensuring that decisions made align with the MVV. During leader rounding, SLs specifically focus on conveying the values of compassion and respect in their interactions with the WF, physicians, volunteers, students, patients, and families. On a rotational basis, the SLs address the orientation sessions for new employees, volunteers, students, and medical staff members to discuss and share examples of the MVV in Action and to convey the personal and profound impact of the MVV on the key communities served.

1.1a(2). To promote a legal and ethical environment and ingrain these characteristics throughout CRHS's organizational culture, the ELT established a CESB that applies to the entire WF and all business operations. EL/SLs demonstrate their personal commitment to legal and ethical behavior using multiple approaches, beginning with modeling the CESB and leading by example in their interactions with the WF, patients, families, partners, suppliers, and other stakeholders. EL/SLs uphold ethical and legal standards in their individual communications and ensure they are maintained in business meetings and decision making. In their commitment to these standards as well as to transparency and accountability, EL/SLs openly discuss close calls to help raise awareness and provide an opportunity for learning. They also call out comments, behaviors, or actions that appear to cross the line and ensure the appropriate investigation and follow-up occurs. As a cycle of learning through COE, the Community Excellence Group (CEG) has identified how its members, inclusive of CRHS leadership, will demonstrate commitment to legal and ethical behavior through its Guiding Principles adopted in early 2020.

To further promote an organizational environment requiring legal and ethical behavior, the Medical Staff Code of Professional Behavior Policy was established by the Medical Executive Committee and applies to all medical staff members. Complaints of inappropriate or disruptive behavior are reviewed by the Chief of Staff and investigated and addressed within the Medical Staff governance. Issues such as bioethical medical care considerations are referred to the Bioethics Committee (a standing committee of the medical staff with multidisciplinary and SL representation). The Bioethics Committee provides a forum for discussion of clinical ethical considerations associated with CRHS's clinical, educational, and research activities.

Figure 1.1-1: **Leadership System**



1.1b. Communication

CRHS's Communication System (Figure 1.1-2) provides the framework to communicate information across the various business unit locations, service lines,

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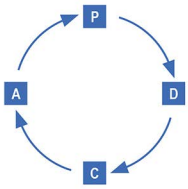
Figure 1.1-2: **Communication System**

WHAT	Information to be shared
WHO	Intended audience(s)
HOW	Method/mode of delivery (Figure 1.1-3 or other)
WHEN	Timing frequency
MESSENGER	Accountable SL

Act on the Results (repeat or modify, if needed)



Launch the Communication (using the optimal method, to reach the target audience, at the right time, via the best messenger)

Measure, Evaluate/ Analyze (feedback, data), **and Learn**

and stakeholders. It is structured around a system of Plan, Do, Check, Act (PDCA) for continuous evaluation, learning, and improvement (Figure 1.1-3). CRHS launches the communication and uses feedback (meeting evaluations/surveys or other data) to evaluate and determine the effectiveness and "reach" of its messaging, which allows it to quickly modify the method, if necessary. For example, when releasing news and information to the WF, CRHS learned from past experience that email and electronic newsletters are among the least effective modes of delivery for time-sensitive information. In this instance, during the C (check) step of the Communication System, it identified both a low frequency and delayed "open" and "read" rates using those modes of communication. These data informed the process under A (act on results), and CRHS pivoted to push news and information to the WF via desktops and workstations.

EL/SLs use multiple approaches to transparently communicate and engage the entire CRHS WF, patients, families, stakeholders, suppliers, partners, and collaborators, with an emphasis on providing forums and mechanisms to support two-way communication (Figure 1.1-3). To reach as many staff members as possible, the Round-the-Clock forums are scheduled each shift and are simultaneously livestreamed for viewing from any location. The base location is rotated to different care sites, to increase visibility and engagement across the entire health system. The sessions are recorded and made available on the intranet. CRHS has intentionally created redundancy in its communication methods to reach as many stakeholders as possible, across multiple locations, work shifts, and levels of access. Combined, these approaches serve as the primary means for communicating key decisions, needs for organizational change, news, and information impacting the organization.

Engaging the entire WF across multiple campuses is a high priority. CRHS continuously evaluates communication channels by analyzing data and information such as attendance/hits/read-watch rates and meeting effectiveness using evaluations and surveys. The communications team will recommend changes based upon what the data reveals.

In a 2017 cycle of learning, a section of the CRHS intranet was set up to provide informational updates with summaries of meeting topics and follow-up, to ensure the entire WF has access and is informed. Key decisions impacting the organization are further disseminated with the distribution of summaries and FAQs that are specifically geared to the stakeholder audience and used by leaders during department and business unit meetings. In 2019, CRHS incorporated stakeholder personas to better understand stakeholder groups and how they access information. The personas create reliable and realistic representations of stakeholders to support effective communication with each specific audience. This led to the use of short, monthly video messages from SLs to provide an easily accessed update. These proved especially effective during the pandemic, while people were not able to gather in person. As a result, CRHS continues to use video as a key communication method.

Figure 1.1-3: **Communication Methods/Modes** *(Sample; Additional Methods AOS)*

Communication Method/Mode *(Conducted by)*	Frequency	Type			Workforce				Customers, Stakeholders			Suppliers, Partners, Collaborators			Purpose
		In -Person 2 way	Electronic	Printed	Employees	Physicians	Volunteers	Students	Patient	Family	Other	Suppliers	Partners	Collaborators	
Orientation-Onboarding *(SL)*	M	X			X	X	X	X							MVV
Round-the-Clock Forum *(CEO, EL, SL)*	Q	X	X		X	X	X	X				X	X	X	MVV, D, OC
Senior Leader Rounding *(SL)*	D	X			X	X	X	X							MVV
Patient Safety Huddle *(SL)*	D	X			X	X	X	X							MVV
Nurse/Dept. Leader Rounding *(MM)*	D	X			X	X	X	X	X	X					MVV, D, OC
Unit/Department Meeting *(SL, MM)*	M	X			X	X	X	X							MVV, D, OC
Monthly Video Message *(CEO, SL)*	M		X		X	X	X	X	X	X	X	X	X	X	MVV, D, OC
Brown Bag It *(CEO, SL)*	M	X			X	X	X	X							MVV
CRHS Intranet *(CEO, EL, SL)*	D		X		X	X	X	X							MVV, D, OC
CRHS WE CARE (news) *(CEO, EL, SL)*	M		X	X	X	X	X	X	X	X	X	X	X	X	MVV, D, OC
General Med Staff Forum *(CEO, EL, SL)*	Q	X				X		X							MVV, D, OC

Leaders = CEO, EL (executive leaders), SL (senior leaders), MM (middle managers); Frequency = D (daily), M (monthly), Q (quarterly); Purpose = MVV (mission, vision, values); D (decisions), OC=(organizational change)

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1.1c. Mission and Organizational Performance

1.1c(1). Using the CRHS Leadership System framework (Figure 1.1-1), EL/SLs create an environment for success now and in the future, with the Mission and Values as the foundation and patients and families at the center of care. EL/SLs set the direction through the selection of objectives and goals as part of the SPP (Figure 2.1-1, step 6). Goals are cascaded throughout the organization via the development and deployment of action plans, measurement, assessment of performance to goal and acting on the results, through the performance improvement system of PDCA (Figure 2.2-1). A single action plan owner is designated and may be supported by a SL champion and/or a clinical champion, as appropriate, to facilitate engagement and to help break down barriers to improvement. The cascading of action plans, performance metrics, and goals extends to departments and service units (with accountable leaders identified) and are captured in the employees' Performance and Professional Development Plan (PPDP), so there is a clear line of sight from the SPP to employee.

EL/SLs create and reinforce a culture that fosters the engagement of patients, families, and the entire WF, supported by the framework of the Leadership System (Figure 1.1-1). The care model of inclusion places the patient and family at the center, with the health care team seeking to engage and partner with the patient and family in care decisions from admission through discharge (ambulatory and inpatient settings). During inpatient rounds, the health care team will meet at the patient's bedside whenever possible, to understand his/her preferences and to discuss his/her progress and plan of care. In ambulatory encounters, patient preferences are collected as part of the intake process and incorporated into the patient's health record. Leader rounding in all settings is focused on engaging the WF and listening to their ideas, needs, concerns, and challenges.

With the value of respect and a deep commitment to patients, families, and communities, SLs strive to ingrain equity and inclusion throughout all patient care and WF approaches. This includes understanding the diversity of communities and fostering diversity, equity, and inclusion (DEI) in the WF. In 2021, CRHS created a new position: Vice President, Diversity and Inclusion, responsible for the ongoing development, implementation, and oversight of the DEI strategy to ensure integration into the organizational culture, care delivery systems, and all program offerings.

SL commitment to a culture of safety (COS) and high-reliability principles are critical components of creating an environment for success. CRHS's CC of safe, high-quality care is supported by the organization's Just Culture, which emphasizes a systems approach, teamwork, transparency in operations, and a focus on learning with a nonpunitive approach to errors. Daily Patient Safety Huddles and leadership rounds are integral to promoting the COS as well as the ability to cultivate agility and resilience. These approaches provide leaders with real-time information to anticipate, understand, and prioritize issues requiring action. It is not uncommon for changes in patient volume, acuity, staffing, or supplies to result in changes to process or staff assignments throughout the day. During the pandemic, CRHS recognized the need to hold huddles more often due to the rapidly changing situation.

The CRHS Performance Improvement Council (PIC) and TRAC model and cultivate intelligent risk-taking behavior, creating a safe environment for risk-taking across the organization. TRAC teams are encouraged to propose ideas and potential solutions that reflect intelligent risks. TRAC team members test the ideas, learn from them, and are encouraged to modify and try again. All attempts (failures and successes) are rewarded to motivate intelligent risk-taking and foster innovation.

EL/SLs participate in succession planning and the development of future organizational leaders through the CRHS's Leadership Development Program (LDP; AOS). Within the LDP, EL/SLs and their direct reports identify individuals who exhibit high leadership potential and exemplify WE CARE as likely successors. EL/SLs and their direct reports will meet with the potential leaders directly to ascertain their interest in participating in the LDP (5.2c[4]) and serve as mentors and advisors.

1.1c(2). EL/SLs create a focus on action to achieve the CRHS mission through the Leadership System and cascading goals through all levels of the organization. Each organizational goal is cascaded to applicable divisions, departments, service lines, and individual members of the WF via their individual PPDP. Action plans are developed with WF input. Plans are deployed, and data are collected to measure the impact of the actions taken. Modifications are made, as warranted. Division and department/service line leaders track results, posting and sharing the information with their staff members. This approach creates a focus on action across the organization with accountability at multiple levels: EL/SLs, department, service line leaders, and individual WF members.

Organizational goals are established during the SPP with consideration of the value created for customer groups and/or stakeholders (Figure 2.1-1, steps 1 and 6). With the vision to be among America's best health systems, CRHS's CCs of Safe, High-Quality Clinical Care and Efficiency in Operations give priority to the processes and systems supporting the delivery of patient care, thus providing value to the patients, families, and stakeholder communities served. CRHS balances value for all patients, families, and stakeholders during the SPP, selecting goals and metrics that support each group and its key requirements (Figure 2.2-1, step 2).

SLs are personally accountable for business operations and results, participating in the monthly review of performance metrics. SLs demonstrate personal accountability for specific action plans as executive owners, setting expectations, leading regular reviews of action plan progress, and assisting in breaking down barriers that may impede improvement.

Additionally, cross-functional alignment and accountability are achieved by working closely with medical staff members, suppliers, partners, and collaborators. Recognizing the role of medical staff members in achieving the key performance indicators (KPIs) for patient safety and clinical excellence, the SLs and medical staff leaders incorporated evidence-based practice standards as part of the peer review process in 2018 and the ongoing professional practice evaluation (OPPE) process. In a 2019 cycle of learning, CRHS identified the opportunity to ensure that supplier, partner, and collaborator agreements reflect alignment with CRHS's strategic goals,

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and CRHS began incorporating performance and service expectations. These are reviewed annually after the SPP to determine the need for revision.

1.2 Governance and Societal Contributions

1.2a. Organizational Governance

1.2a(1). The BOT is the governing body of the CRHS, responsible for oversight of the health system's quality of care and financial health. Responsible governance of CRHS is ensured through multiple systematic approaches summarized in Figure 1.2-1. Further detail of each approach is available on-site (AOS).

The CRHS organized medical staff, a self-governing entity that is accountable to the BOT, with its own medical staff bylaws, rules, standards, and policies to manage medical staff activities. The CRHS BOT Governance Committee is charged with determining the membership of the boards and measuring the quality of performance of the BOT, the Advisory Boards, and individual board members.

The CEO Succession Plan is developed by the Executive Committee of the BOT and approved by the BOT. The Executive Committee is charged with tracking the successor's continued performance and progress throughout the year and provides recommendations regarding additional development, if needed, to the BOT. Annually, the CHRO provides a report on the CRHS LDP to the BOT.

1.2a(2). The Executive Committee of the BOT evaluates the performance of the CRHS president and CEO, assessing his progress in meeting the assigned strategic plan goals. The president and CEO evaluates the ELT, and the ELT evaluates the SLT based upon established goals, cascaded from the strategic plan as well as individual PPDP goals. The integration with the PPDP supports each leader's professional development while advancing his/her effectiveness. The president and CEO, EL, and SL base compensation is reviewed annually against similar positions in the industry to ensure competitiveness. This is augmented by an incentive performance-based model that

Figure 1.2-1: **Sample Approaches Supporting Responsible Governance**

Essential Aspect	Approach	Frequency
Accountability for SL's Actions	Standards of Behavior Violations	Ongoing
	SL Performance Evaluation Process, 360 reviews	Annual
	Community Focus Group Feedback/Input	Quarterly
Accountability for Strategy	SL champion—Action Plan Assignment	Ongoing
	TRAC Teams Reporting to the PIC on Project Progress	Monthly
	Review of SP Performance	Quarterly
	SL Performance Evaluation Process (includes cascaded SP goals)	Annual
Fiscal Accountability	Financial Reviews (organizational, departments, service lines, JVs)	Monthly
	Financial Audit (external)	Annual
	Bond Rating	Annual
	Contract Management (fair market value, compensation model)	Annual
Accountability for Patient Safety and Health Care Quality	Board Quality Committee—Review of Quality and Patient Safety Performance Metrics	Monthly
	Board update—National Quality and Patient Safety Trends	Annual
	Approval of Medical Staff Credentialing, Appointment, and Re-appointment	Ongoing
Transparency in Operations	Culture of Safety (disclosure of errors, patient harm events, emphasis on systems and learning)	Monthly
	Culture of Safety Survey	18 months
	WF Engagement Survey Results (staff, physician, volunteers, students)	Annual
	TRAC Teams Reporting to the PIC on Project Progress	Monthly
Governance Board of Trustees	BOT Governance Committee Selects Board Members (16 members, volunteers)	Ongoing
	BOT: 3-year terms; Term Limit: Not to exceed 3 total terms	Triennial
	Conflict of Interest Disclosure	Annual
Community Based Advisory Board	BOT Governance Committee Selects Members: 12 members, each hospital	Triennial
	Conflict of Interest Disclosure	Annual
Independence and Effectiveness of Internal and External Audits	Board Approval of External Auditor; Review Audit Findings	Annual
	Compliance Audit Results—Corporate Compliance Committee, Board Finance & Audit Committee	Quarterly–Annual
	Licensing and Accreditation Reviews and Findings	Ongoing
Protection of Stakeholder Interests	Community Health Needs Assessment (CHNA)	Triennial
	Community Impact Reporting (addressing CHNA strategies)	Annual
	Stakeholder Representation on Board	Ongoing
	Community Focus Group Feedback/Input	Quarterly
Succession Planning	CEO Succession Plan—Review	Annual
	Leadership Development Plan Report	Quarterly

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rewards EL/SLs, teams, and individuals for progress toward or attainment of goals, including those cascaded and linked to the strategic goals. The ELT and SLT evaluate the effectiveness of the Leadership System annually.

At the direction of the BOT Governance Committee, BOT and Advisory Board members complete a self-assessment of board and individual effectiveness on an annual basis. A set of standardized assessment tools support benchmarking the results to other organizations' boards. The BOT reviews the results to identify opportunities for improvement leading to cycles of improvement. This process led to creating a Board Quality Committee in 2009 in order to ensure that quality and patient safety efforts were prioritized, and in 2012, the BOT recognized the need to receive training in quality and requested an annual update on national quality and patient safety trends. In 2018, to improve meeting efficiency and effectiveness, the BOT moved to a consent agenda, placing trust in its committees and allowing it to focus on the most important issues.

1.2b. Legal and Ethical Behavior

1.2b(1). CRHS addresses current and anticipates future legal, regulatory, and community concerns with its health care services and operations through multiple methods. The CRHS corporate office provides direction and support for legal, regulatory, and accreditation compliance. The president and CEO and EL/SLs are actively involved at the regional, state, and national level as members of hospital association committees, accountable care collaboratives, health plan associations, and physician practice and advisory groups, along with their involvement in local community groups. These activities, combined with input received through voice of the customer (VOC)/listening posts, ensure that CRHS is well informed and aware of current and future legal, regulatory issues and community concerns with health care services and operations. In anticipation of potential concerns and/or in response to issues and concerns raised, CRHS forms a taskforce with WF representatives, customers, and stakeholders to gather information, evaluate current issues and risks, and identify a set of solutions.

CRHS includes key stakeholders in the planning and designs a new and/or expanded service. Consistent with the COS and a high-reliability preoccupation with failure, CRHS seeks to anticipate potential risks related to the service. As described in 6.1a(3), CRHS uses failure mode effects and analysis (FMEA) to anticipate what could go wrong and to identify the failure points, the likelihood of occurrence, and the significance of each. It benefits from the valuable input from customer, stakeholder, and objective outsider representatives in the FMEA process. This proactive approach allows CRHS to the determine what design changes are needed to avert or mitigate potential risks.

Key compliance processes include CRHS's Corporate Compliance Program (CCP), annual WF regulatory compliance training and education, an annual risk assessment, compliance plan, auditing and monitoring, and a compliance complaint hotline managed by the corporate Risk Management and Compliance Officer. The scope of the CCP includes all CRHS business units (hospitals, health plan, home health/hospice, JV surgery centers, JV imaging centers, and physician practices). Legal, ethics, regulatory, and compliance (LERC) audit data, as well as validated HIPAA complaints and compliance complaints, are reported to the Corporate Compliance Committee (CCC). An action plan is required for areas performing below target, followed by progress reports to the CCC until satisfactorily resolved. An Annual Report of LERC activities and results is provided to the CCC and Finance and Audit Committee of the BOT. CRHS maintains a Special Investigations Unit as required for health plan compliance.

CRHS tracks multiple measures that reflect performance within legal, ethics, regulatory, and accreditation processes with cross-functional stakeholders and impacts. See Figure 1.2-2 for a summary of key measures and goals.

1.2b(2). Through multiple systematic approaches, CRHS promotes and ensures ethical behavior in all interactions. These include the CESB that applies to the entire WF, business operations, and the CCP with clear roles, responsibilities, and processes to prevent fraud and abuse. CRHS investigates and identifies validated breaches of standards of behavior and/or practice through auditing, monitoring, event reporting, complaints, and hotline reporting, which may be used by anyone, including the WF, patients, families, partners, suppliers, and other stakeholders. WF and business operations violations are addressed by the accountable EL. The medical staff president and Medical Executive Committee address any physician-related breaches in alignment with the medical staff rules and approach(es). All breaches are reported to the CCC, where events are analyzed and aggregated to determine the need for process change.

1.2c Societal Contributions

1.2c(1). CRHS's Societal Contributions System revolves around key stakeholders, communities served, and the approach to meet their key requirements.

CRHS's commitment to its key communities served includes ensuring their representation and participation in the SPP, community focus groups, and new/modified service-planning groups. This representation ensures that CRHS considers the interests and key requirements of communities in the selection of strategic goals, design of services, and implementation of action plans, all of which are integrated into daily operations. Through measures of effectiveness, feedback received through VOC/listening posts, and application of PDCA, CRHS evaluates and determines the need for modification or course correction.

In addition, CRHS collaborates with local and regional community organizations, such as local schools, municipalities, and service organizations, in its efforts to support and strengthen social and economic systems (see approaches described in 1.2c[2]). It also partners with the City of Lexington to protect and improve the environment through "Live Green Lexington." Part of the Green commitment is to implement or improve an environmentally conscious practice each year. CRHS facilities have adopted energy efficiency methods since 2016, converting to LED lighting. In 2017, CRHS replaced drinking fountains with filtered water bottle refilling stations and eliminated plastic bottles from cafeteria and catering services. In 2018, it began purchasing products made from recycled materials, whenever possible. In 2019, it began composting kitchen and food waste

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Figure 1.2-2: **Legal, Ethics, Regulatory, Compliance and Accreditation Measures**

Category	Process	Measures	Goals	Results
Legal	Contract Review [all]	Required elements documented	100%	AOS
	Compliance Hotline [all]	Validated hotline calls	0	7.4-10
	Informed Consent [H, OP, MO, PA]	Violation	0	AOS
Ethics	Behavioral Standards [all]	Validated complaints/violations	0	7.4-10
	Conflict of Interest [EL, SL, BOT, AB]	Violation	0	7.4-10
	Patient Rights [all]	Violation of patient rights, privacy, confidentiality	0	7.4-10
	HIPAA Privacy and Security [all]	HIPAA Privacy and Security Violations	0	7.4-10
Regulatory–Compliance	Compliance: Coding Audit [all]	Coding Accuracy	95%	7.4-8
	Compliance: Billing Audit [all]	Billing Discrepancy	95%	7.4-8
	Compliance: Training [all]	Annual Compliance Training: Percent of WF	100%	AOS
	Environmental Safety [all]	OSHA Reporting Compliance	100%	AOS
	CMS Hospice Compliance	Hospice Eligibility & Documentation	100%	AOS
	Credentialing [all]	License, education, training verification	100%	AOS
	Sanction Screening [all]	Employees, physicians, partners, suppliers	None	AOS
	Vendor Audit [all]	Compliance obligations met	100%	AOS
Financial	External Audit [all]	Material findings, non-compliance	Unqualified	7.4-7
	CMS HAC [H]	Hospital-Acquired Conditions (HAC) Penalty	None	7.4-7
	CMS Readmissions [H]	Readmissions Penalty	None	7.4-7
Accreditation	Blood Bank Accreditation	Accreditation (every 3 years)	Accreditation	AOS
	Clinical Lab Accreditation	Accreditation (every 3 years)	Accreditation	AOS
	Stroke Certification	Recertification (every 3 years)	Certification	AOS
	Orthopedic Certification	Recertification (every 3 years)	Certification	AOS
	Hospital Accreditation	Accreditation (every 3 years)	Accreditation	AOS
	Trauma Certification	Accreditation (every 3 years)	Certification	AOS
	Imaging Services	Accreditation—American College of Radiology	Accreditation	AOS
Surpassing regulatory and accreditation results		Centers of Excellence, Leapfrog Safety Grade, Magnet Status, CHIME Most Wired, Watson Health Top 100, Best Place to Work, LEED/Practice Greenhealth, VPP star status (from OSHA) for workplace safety		7.4-9

MS = Medical Staff-related complaints and violations of the Code of Professional Behavior are addressed within the Medical Staff governance.
BOT = Board of Trustees, AB = Advisory Board, H = Hospitals, OP = Outpatient, MO = Medical Offices, PA = Post-Acute, HI = Health Insurance

in the cafeteria. In 2020–2021, it paused new methods due to the pandemic, and it plans to increase use of recyclables in 2022 by 15%.

CRHS recognized a greater opportunity to contribute to the well-being of not only the health but also education, economy, and quality of life for its community by partnering with others in the community (Figure P.1-4) to address these issues through COE, which is based on the Baldrige framework. Serving as a backbone organization, the president and CEO named the VP of the ACO and Population Health to lead this effort for CRHS in 2019. Other key leaders in the community were invited to serve as part of the CEG. To date, the CEG has developed its Community Strategy and Strategic Objectives and is establishing work groups to address the identified community priorities of "Live Green Lexington," health disparities in socioeconomically disadvantaged areas, and community revitalization. As a cycle of learning, these priorities will be incorporated into a Societal Contributions System (AOS).

1.2c(2). Community Health Needs Assessment (CHNA) findings are used to identify unmet health and social needs within the community to actively support and strengthen key communities. Past CHNA results led to the launch of trauma services, the expansion of urgent care centers, and the mobile health clinic. CRHS has continued to provide behavioral health services and substance abuse treatment, while other hospitals have closed these services due to the regulatory burden and poor ROI. In addition to ongoing collaboration with community stakeholders as CRHS improves and grows its health care services, EL/SLs actively serve community groups and organizations in varying capacities—whether as volunteers or on advisory committees or boards. Participating not only serves as a visible CRHS presence but also fosters an enhanced level of engagement by EL/SLs who often advocate on behalf of the communities served.

Key communities are those in which services are based, roughly 40 miles east to west and 50 miles north to south of Lexington. To promote and build community health, CRHS offers a quarterly community health fair, the location of which is rotated and staffed by the hospitals, urgent care centers, and ambulatory sites within the immediate community. The mobile clinic

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supports the health fairs, providing free health screening (blood pressure and diabetic screening), and CRHS partners with the local department of public health to provide free childhood immunizations, influenza immunizations during flu season and COVID vaccinations during the coronavirus pandemic. CRHS promotes healthy lifestyle choices and nutrition via the website and newsletters, which are available in waiting areas.

In recent years, CRHS has embarked on several initiatives to support its communities in new ways, which also further benefit the economic and social systems. In 2018, it began offering grants to encourage the WF to live near Copansburg Medical Center-Lexington (CMCL) to assist employees and support community revitalization. In 2019, CRHS and other organizations and businesses within the key communities came together to join the COE, which is helping CRHS and other members to recognize that its community is a complex ecosystem that requires a network of partnerships and new models to address community needs. CRHS is committed to leading and supporting these efforts.

Category 2: Strategy

2.1 Strategy Development

In 2012, when CRHS made the strategic decision to adopt the Baldrige framework, leadership assigned an administrative "champion" for each of the seven categories. Each champion systematically reviews applications of Baldrige Award Recipients (BARs) to evaluate processes and identify potential opportunities for improvement. Champions and leaders also attend the Baldrige Quest for Excellence® Conference to get ideas on how to evaluate and refine processes, approaches, and systems at the outset of each strategic planning cycle.

One key improvement that has resulted from this evaluation is that champions are no longer assigned to category 7, because a determination was made that it was better to keep the "ownership" of the results associated closely with the process that yields the results.

2.1a. Strategy Development Process

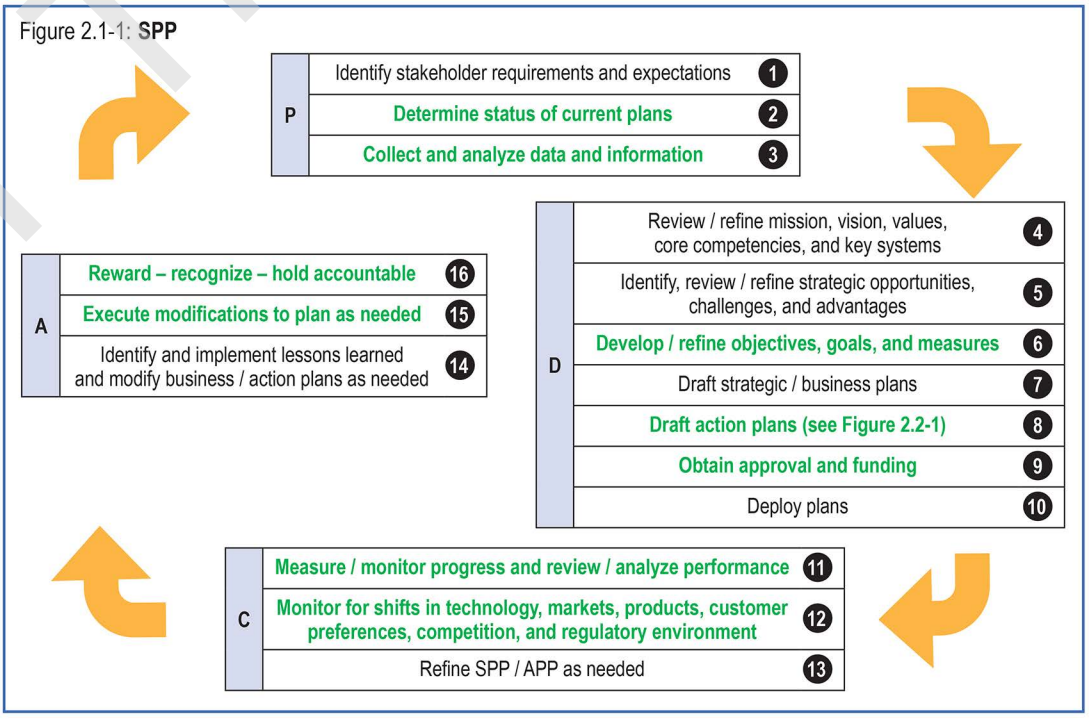
2.1a(1). The CRHS SPP (Figure 2.1-1) begins in August of each year. The key participants include the corporate ELT, business unit SLTs, and board members. Prior to 2017, strategic planning was a triennial event. During the evaluation of the SPP, the ELT and SLTs decided to change the planning horizons and "refresh" the strategic plan annually (**bold, green** font activities in Figure 2.1-1), with short-term goals and then conduct full long-term planning (all activities) every three years. Since 2019, CRHS also projects ultra-long-term (five- to ten-year) horizons specific to the IT and master facilities plans during the three-year cycle. Analysis of the success of those plans informed the need to begin planning for the highly resource-intensive aspects of CRHS further in advance, to ensure that sufficient funds and other resources are available. The one-year plan refresh enhances CRHS's agility, affords greater resilience, and makes resource allocation decisions aligned to the annual personnel and operations budgets. Like the strategic plan, the capital budget is a three-year projection that is refreshed annually.

The process engages senior leaders and the board in the actual formulation of the plan, while systematically gathering inputs to hear the "voice" of a much larger group of stakeholders, including customers, payors, suppliers, competitors, the community, and the workforce.

The SPP addresses the potential needs for change through the environmental scan and review of data during steps 1–3 (plan phase) of the SPP, with a focus on understanding key stakeholder requirements and expectations, the external environment, and current relative performance.

Step 1 includes analysis of qualitative and quantitative information from key stakeholders Step 2 evaluates current performance levels and the progress on current action plans. Step 3 looks externally at the environment, using a PESTLE+W format to evaluate political, economic, social, technological, legal, environmental, and workforce considerations. The CHNA, required every three years, also provides a robust analysis of the current status and needs of the region served. The timing of the CHNA was shifted in 2018 to align with, and provide input to, the full SPP, rather than being timed with the SPP refresh. This drove the strategic decision to focus on the health of the

Figure 2.1-1: **SPP**



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community, rather than remaining focused only on those who use CRHS services. In 2021, the CHNA was integrated with the COE assessment to better address health disparities and enhance community revitalization.

Steps 4–6 of the SPP are accomplished at a facilitated off-site retreat, held each September. Prioritization of change initiatives is based on alignment with and support of the MVV, as well as projections of resource needs of each initiative and availability of resources, including funding, workforce time, space, equipment, etc. The tight integration of plans—from the top-level system plan, down through the plans for each business unit, service line, and department, to the development plans for each individual—enables a clear "line of sight" to keep plans integrated when a change needs to occur, promoting organizational agility and resilience. For example, the change to enable telehealth visits during the height of the COVID-19 pandemic has been integrated with initiatives to expand outreach into the community, particularly the more rural- and socioeconomic-challenged portions of the region. Planning to use telehealth as a permanent tool enabled CRHS to "bounce forward" from the pandemic to help fulfill the mission to "improve the health of all citizens in the service area." As part of COE participation, CRHS has partnered with the Kentucky DigiRun Initiative to expand Internet access and build a stronger digital infrastructure in urban and rural communities across the commonwealth.

Following the September retreat, during steps 7–8 of the SPP, the draft objectives and goals are provided to the leaders of each business unit, who then hold their own retreats, using the same facilitator for continuity and communication. At these retreats, the business units each develop or refine plans that align with and support the system-wide plan. After consensus is achieved regarding the integrated draft plans, the action planning phase (step 8) begins (Figure 2.2-1). Action plans are highly specific regarding timelines, resource needs, and measurable milestones and targets for activities as well as performance.

2.1a(2). The SPP stimulates and incorporates innovation and identifies strategic opportunities through its systematic review of BARs from all sectors and the environmental scan process (step 3). Discussion of processes by the category teams during the review of current award recipients and after attending Quest stimulates ideas for innovation. Two years ago, benchmarking with an award recipient led to the creation of a "Shark Tank" program (6.1d). Throughout the year, members of the workforce are encouraged to submit poster presentations to the team of category champions. Those opportunities that represent the best cost-benefit potential are presented in person. The innovative ideas and strategic opportunities are prioritized using a matrix, including criteria of resource requirements, anticipated benefits, and ability to execute. Items decided to be "above the cut" are selected for implementation and included in the formal action planning process (APP), with the person or team that generated the idea receiving a cash prize. Those that fall "below the cut" on the matrix are held in the pipeline for future consideration.

The current strategic opportunities were amplified in the SPP cycle held during the COVID pandemic. The environmental scan revealed disparities in Internet accessibility, particularly in rural areas. This created issues during the pandemic when people were expected to participate in work and education activities and receive health care services through remote access.

2.1a(3). As described in 2.1a(1), relevant data are collected and analyzed through the SPP steps 1–3. Analysis includes trending and comparisons with goals and competitor performance. This model helps to ensure that potential changes and disruptions are identified, particularly in technology, innovations, regulations, and other aspects of the external environment that are likely to impact health care services and operations.

The environmental scan previously was based on gathering data and brainstorming. In 2019, CRHS began to ask board members and senior leaders to systematically reach out to their social groups, such as churches, sporting groups, scouting, etc., as informal focus groups to better understand the needs of the community and position the board members as "ambassadors" of CRHS. When the plan is completed, it is shared and discussed with the same social groups.

A key element of CRHS's process evaluation and improvement is achieving the appropriate balance between converting collected data into usable information through analysis, without introducing bias through the filtering of data and information. In 2020, when the planning process was conducted remotely due to COVID, all data were presented electronically. This new method of data presentation enabled "drill down" to multiple levels and layers of data, as well as a more robust segmented analysis through embedded hyperlinks, and the process was retained as an improvement.

Key strategic challenges and advantages are determined through a consensus process during step *5*. Since 2018, the planning team has used an expert planning facilitator during the SPP retreat to engage participants in "courageous conversations" that get below the surface and identify benefits and pressures that exert a decisive influence on success. The robust environmental scan and use of a facilitator also help to identify potential blind spots in the planning process and information.

The ability to execute the strategic plan is managed through integration of the APP (Figure 2.2-1) with the budgeting process, as described in 2.2a (steps 3–4). The timing of the SPP was shifted in 2013 to draft the strategic plan, business unit plans, and action plans by mid-October, just prior to the annual budget cycle kick-off in November (step 9), with approval at the December board meetings.

2.1a(4). The work systems for CRHS are Caregiving Services, Caregiving Allies, and Caregiving Support (Figure 2.1-2). Decisions about which key processes will be accomplished internally, and which by external suppliers, partners, and collaborators, are made by the SLT and grounded in the MVV, with a focus on providing the most efficient and effective care for community members. CRHS leadership firmly believes that "what is best for the community will be best for CRHS"—in the long term, even if not in the short term. For example, in 2017–2018, a major investment was made to enter the insurance market by offering a Medicare Advantage Program (MAP) in order to provide better health services to the community. In 2019, the program was expanded to offer plans to the commercial market. C&C—of CRHS, suppliers, partners, and collaborators—are the

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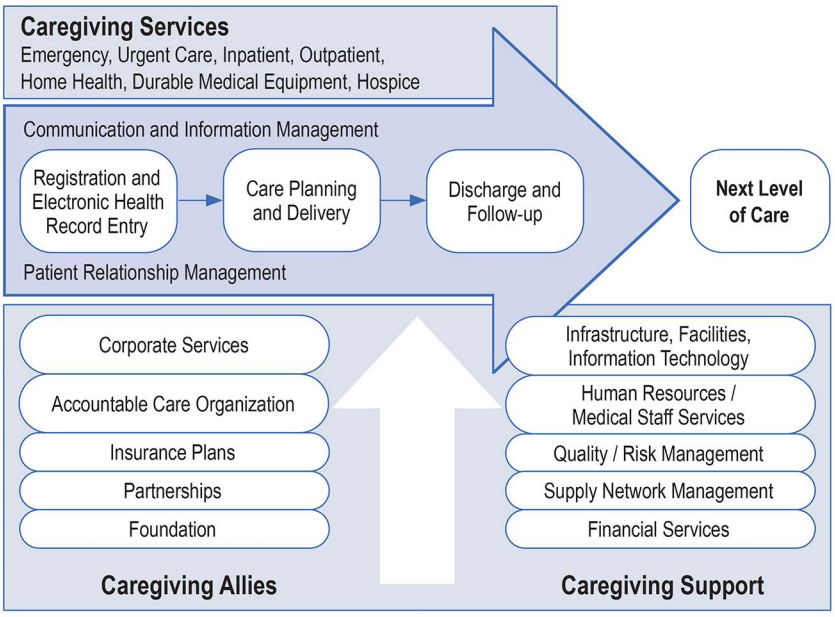
Figure 2.1-2: **Work Systems**



key factors used to decide whether to outsource processes. The primary focus is to close gaps in high-quality services offered to the community. When a gap is identified, a cost-benefit analysis is done and presented during the SPP retreat. If the team determines that the new initiative represents an intelligent risk, further due diligence is conducted, and then a business plan and associated action plans are developed. If the new initiative requires C&C, additional personnel may be hired and/or education provided to the current personnel. Should changes not fit within the current work systems (e.g., such as the MAP insurance), new work systems are developed to coordinate internal work processes and external resources.

2.1b. Strategic Objectives

2.1b(1). Key strategic objectives, along with their most important related goals, example action plans, and timetables, are shown in Figure 2.2-2 (remaining goals, action plans, and timetables are AOS). Key changes planned in health care services, customers, market, and operations include further outreach to impact community health, including telehealth services, use of the mobile medical unit, and screening/education events. There are no key changes planned for supplier and partner networks.

2.1b(2). Strategic objectives balance varying and potentially competing organizational and stakeholder needs primarily through the budgeting process inherent in the APP (Figure 2.2-1). In 2018, based on advice from the SPP facilitator, CRHS adopted a "top-down/bottom-up" approach to strategic planning and action planning (2.2a[2]).

Prior to finalizing the strategic plan, a discussion is held with the board and each business unit to achieve consensus that all strategic challenges have been addressed, and that the plan sufficiently leverages CRHS CCs and strategic advantages and gives due consideration to strategic opportunities. The board and leadership team also engage in discussion to ensure that the plan balances the needs of all key stakeholders.

The balance of short- and long-term planning horizons is primarily addressed through the three budgets: personnel, operations, and capital. The Copansburg Foundation assists in funding many of the long-term horizon items, using a capital campaign process for major initiatives. Additionally, the capital budget includes investment accounts that are grown for many years in anticipation of funding major projects from the long- or ultra-long-term plans.

Steps 11–16 begin after the budget is finalized and continue until the planning cycle begins for the following year. These "Check" and "Act" phases of the SPP integrate with the measurement system (category 4) and innovation/improvement systems (category 6). Steps 11–13 identify needed changes to processes and systems—including the SPP and APP—based on the results being achieved.

2.2 Strategy Implementation

Action plans are drafted in step 8 of the SPP, in September and October—immediately prior to the beginning of the budget

Figure 2.2-1: **APP**

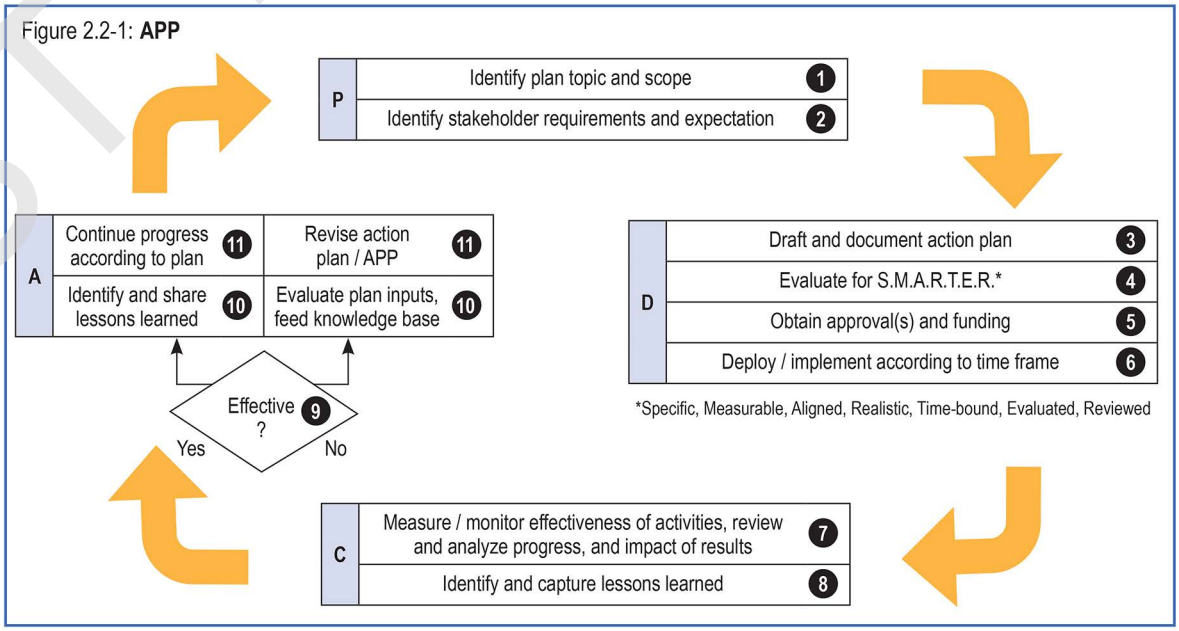


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Figure 2.2-2: **Excerpt of Strategic Objectives, Goals, Action Plans, and Results**

Objective	Goal/Action Plan	Key Performance Measure	Business Unit	ST/LT Projection	SC/SA/SO	Figure
Achieve top decile in customer excellence	Increase outreach to disadvantaged communities	Impact on community health	All, except Hospice	Multiple measures	**SC1,2,4/SA1,3,4/ SO2,3**	7.4-12 + AOS
	Enhance culturally competent care (DEI)	Reputation score/ Consumer Preference	All	4.2/4.6 44.3%/45.1%	**SC1,2,4/SA1,2,3,4/ SO1,2,3**	7.2-18 7.5-17
	Improve community health	% follow-up after screening/ Cancer Stage I at diagnosis	All, except Hospice	25%/30% 28%/31%	**SC1,2,3,4/ SA1,2,3,4/SO1,2,3**	7.4-13
	Top-decile satisfaction	Willingness to recommend/ Net Promoter score	All	79.3%/82.1% 59/64	**SC1,4/SA1,2,3,4/ SO2,3**	7.2-14 7.2-16
	Top Decile health care outcomes	CMS Core Measures HEDIS measures	All, except Hospice	Multiple measures	**SC2,4/SA1,2,3,4/ SO1,2,3**	AOS
Achieve top decile in workforce excellence	Achieve top-decile workforce engagement	Engagement score (segmented)	All	84%/86%	**SC1/SA3/SO1,2,3**	7.3-12
	Re-establish/grow volunteer presence	% of total workforce hours per volunteer (weekly average)	1	4.7%/5.2% 10/12	**SC1/SA3/SO1,2,3**	7.3-6
	Recruit physicians	Primary care panel size/ Patients per hospitalist	1,2,3,5	2,500/2,200 17/15	**SC1/SA3/SO1,2,3**	AOS
	Build workforce resilience	Workforce wellness score/ Physician burnout	All	195/220 31%/29%	**SC4/SA1/SO1**	7.3-8
	Decrease workforce vacancies	Workforce Retention/ Regrettable losses/ Time to fill vacancies	All	85-92%/>90% 6.3%/<5% Varies	**SC1/SO3**	7.3-4 AOS 7.3-5
	Balance workforce profile with that of the community (DEI)	Diversity variance	All	4-10%/<5%	**SC1,2,4/SO2,3**	**7.3-10**
Achieve top decile in financial excellence	Achieve operating margin	Operating margin	All	4.4%/5.2%	**SC2,3/SA1,3,4/SO1**	7.5-2
	Increase community support	Total community benefit	All	$480K/$520K	**SC4/SA1,4/SO1,2,3**	7.4-12
	Improve cash position	Days cash on hand	All	248.9/253.6	**SC2,3/SA1,3/SO1**	7.5-4
Achieve top decile in process excellence	Enhance access (telehealth and available appointments)	% within 15 days (primary care)/ % within 30 days (specialist care)	2,3	47%/57% 45%/52%	**SC3,4/SA1,2,3/ SO1,2,3**	AOS
	Implement cybersecurity framework	External score	All	250/600	**SC3,4/SA1,2,4/SO2**	AOS
	Enhance communication	% Very satisfied (workforce)/ % Very satisfied (patients)	All	4.4-4.6/>4.5 89%/91%	**SC1,3,4/SA1,2,3,4/ SO1,2,3**	7.4-1 7.4-2

KEY

Strategic Advantages, **Strategic Challenges**, **Strategic Opportunities** *(Figure P.2-1)*

Applicable Business Units:

1. Hospitals (including acute care, critical access, and emergency services)
2. Outpatient diagnostics and treatment (including JVs, ambulatory surgery, rehab services, urgent care centers, and mobile clinic)
3. Medical offices (including employed physicians and medical staff)
4. Post-acute care (including Home Health, Hospice, and DME)
5. Health insurance plans (including ACO)

cycle. Although a single step in the SPP, the APP is a multi-stage/multi-step system (Figure 2.2-1) with key short- and long-term action plans related to strategic objectives (Figure 2.2-2).

2.2a. Action Plan Development and Deployment

2.2a(1). Action plans are developed in a series of facilitated workshops, with the key intended outcome being an integrated set of detailed plans documented on the APP template. This template designates the specific owner of the plan, the alignment/support to strategic objective(s) and goal(s), a plan of actions and milestones (POAM), resource requirements, and measures of success with targets.

A 2018 refinement was to convert SMART into SMARTER—including how the plan will be *evaluated* for progress and success, and in which management venue(s) the progress will be *reviewed*. An additional refinement in 2020 was to require action plan owners to identify stakeholders who may be impacted by the success of a plan, especially if the impact could be negative. For example, the shifting of services from inpatient to outpatient and decreasing length of stay may cause some job changes for the workforce. This identification step enables the action plan owner to engage these key stakeholders early so that plans can be embraced, rather than resisted.

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2.2a(2). Although each action plan has a single owner to promote accountability, the creation, implementation, and deployment of plans (step 10 in the SPP Do phase) is usually accomplished by groups. Occasionally, existing teams or committees will implement a plan. More commonly, a specific team that includes the workforce and key suppliers, partners, and collaborators, as appropriate, will be chartered to create and implement a plan. There is an expectation that each department, business unit, and service line will be working on at least one action plan, but no more than five. This helps engage the entire workforce in propelling the CRHS toward its vision, while not becoming overextended in change.

The addition of the *evaluated* and *reviewed* elements for action planning ensures that key outcomes of those action plans are sustained. Action plans are integrated with the scorecard and dashboard systems (category 4) and improvement system (category 6). Typically, once action plans are fully implemented and "completed," tracking of measures is gradually tapered in frequency and/or sample size until the activities associated with the plan become a habit—and part of "the Copansburg Way." As long as tracking demonstrates sustainability, investment in ongoing monitoring is gradually shifted to other priorities.

2.2a(3). CRHS ensures that financial and other resources support the achievement of action plans through integration of the plans with the budgeting process. The action plan template includes requirements for all types of resources, including funds, staff time, space, and equipment. The budget process allocates these resources to support the plans. The action plan template includes analysis of the costs and benefits to calculate the overall financial impact of each plan. If insufficient resources are available, plans are negotiated—and occasionally may be scaled back or tabled for future consideration. Each business unit administrator and board have the overarching perspective of all plans within their business unit to allocate resources to provide appropriate balance, with the corporate ELT and board having oversight of all plans.

The structure of the action plan template clearly identifies costs and risks associated with the plans, including any potential negative impact of the plan being successfully achieved. Progress on the plan and the associated performance measures are evaluated in the specified venue, no less than quarterly, to ensure viability and progress—from both financial and operational perspectives.

The POAM also includes when support department resources will be required, so that those engaged in the Caregiving Support work system can optimize and allocate their resources. This avoids instances where multiple action plans would simultaneously require support from IT, HR, facilities, etc., and exceed their capacity.

2.2a(4). Workforce plans to support short- and long-term strategic objectives and action plans typically revolve around capacity and/or capability. These needs are managed through the "resources needed" section of the action plan template. For example, the requirement for commercial driver's licensed (CDL) personnel was identified as a capability need in the action plan to purchase the mobile medical unit. The initial plan was to hire "drivers," but CRHS discovered that it had nursing personnel who had maintained CDL from prior careers and were interested in transitioning to a role to provide care in the mobile unit. Over time, CRHS has achieved the status where everyone who staffs the mobile unit is CDL licensed, providing maximum flexibility in scheduling and enabling the mobile unit to operate full time.

2.2a(5). Key performance measures used to track the achievement and effectiveness of action plans are shown in Figure 2.2-2, with the associated results figures. The action plan measurement system reinforces organizational alignment in two primary approaches: First, based on a nonhealth care BAR, each action plan includes determining the "key intended outcome" prior to identifying the measures and metrics that will be tracked. Second, the action plan numbering system underscores the alignment of the plan(s) that support strategic objectives and goals. The supporting action plans are regarded as "leading indicators" of accomplishing the strategic objectives and meeting the goals. If action plan timing goals and performance targets are being met, but the progress toward accomplishing the strategic objective is not on glide slope, this is regarded as a trigger to evaluate the need for analysis and adjustment, or possibly the creation of new action plans.

2.2a(6) Performance projections are included in the POAM on the action plan template, and across the long-term planning horizon for strategic objectives and goals. Short- and long-term projections are included in Figure 2.2-2. Projections are calculated based on the trajectory of the historic trend for both CRHS and comparison/competitor organizations. If projections uncover gaps where CRHS performance is lagging, a cost-benefit analysis is conducted to prioritize closing the gap. If closing the gap is an intelligent risk and wise use of resources, a strategic action plan may be created (2.2a[2]); the PIC may charter an improvement TRAC, or PDCA projects may be launched to improve performance. The vision always compels CRHS to seek top-decile performance, which typically places CRHS above local competitors. When CRHS supports staff participation in conferences, participants are required to identify the "top-three" learnings to share upon their return. This has helped close many gaps.

2.2b. Action Plan Modification

Once approved, the action plan owner and the head of the system or business unit sign the plan. Signed plans are considered covenantal agreements—the key intended outcomes will be accomplished in exchange for the identified resources being provided, and resources are provided in exchange for accomplishing the key intended outcomes. When the POAM or targets are not achieved, the plan must be evaluated and modified as appropriate. Tracking performance (2.2a[5]) enables CRHS to recognize and respond when plan modification is needed.

When circumstances change, either externally or internally, that require rapid execution of new plans, a mid-cycle action plan is created using the same processes, approved, and signed rather than waiting until the next planning cycle. A contingency fund is included in the budget process, should resource requirements exceed the approved budget.

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Category 3: Customers

3.1 Customer Expectations

3.1a. Listening to Patients and Other Customers

Customers' needs and expectations—and how well CRHS supports and satisfies them—are critical to the system's near- and long-term success. Through its Voice of the Customer (VOC) System (Figure 3.1-2), knowledge learned from CRHS's various listening methods (Figure 3.1-1) provide the actionable information for corrective actions (service recovery through Complaint Management System) and systemic improvements (quarterly and annual analyses of VOC data providing improvement opportunities to business units and system-wide). System-wide opportunities are referred to the PIC for review and decision to assign or not assign a project to the TRAC. All types of change go through the PDCA improvement process. PDCA is also used to drive change within the VOC System.

3.1a(1). The general approach to developing custom listening posts is based on PDCA. CRHS "Plans" by researching the characteristics of each customer group. This is followed by focus group interviews to understand communication and service preferences. This leads to the initial design of a listening method. Then CRHS moves to the "do" phase where it tests the draft method, gathers feedback, refines the design, and prepares for a broader pilot of the method. Once the method is piloted, it "Checks" to assess effectiveness and make final revisions prior to implementation. Once the product/method is ready, the "act" phase is to implement the new method.

CRHS's approach to listening, interacting with, and observing patients and other customers across the patient phases of pre-service, service, and post-service is shown in Figure 3.1-1. These listening methods gather data from patients, families, and other customers prior to service (e.g., setting up appointments, completing paperwork at arrival, waiting for service), during service (e.g., in-patient, emergency room, outpatient), and post-service (e.g., follow-up, future care). It is important for CRHS to understand and respond to the needs of family, as well as direct customers.

Methods of listening vary depending on the type of customer and the service phase. For example, waiting areas (such as where families wait while a loved one is in surgery or where a patient waits to see the physician) have electronic "sounding boards." These laptop-sized sounding boards enable family and patients to write compliments and concerns anonymously. Each day, these comments are reviewed and stored in a database. At the end of each week, data are evaluated and categorized. The results feed into potential waiting-room improvement efforts. An example of a recent improvement is the addition of a customer wait-time board. Customers are given a number when they check in. A display board tells the customer the number being serviced and the expected wait times for other customers. This helps set expectations for patients and family members. Electronic boards also indicate patient status time in pre-operation, operating room, and post-operation.

For inpatients, CRHS listens with an electronic pain board (tablet-like device) where a patient can indicate their level of discomfort. CRHS also uses data from rounding and provides a quick daily four-question survey about meals (i.e., timeliness, quality, temperature, and taste). Automation of these methods two years ago enabled CRHS to move from responding to individual needs (reactive) to systemic improvements and comparisons across multiple facilities.

Telehealth is a service that is expanding. As a result, it is a key area of consideration when developing listening methods and improving CRHS's understanding of needs and expectations. With video meeting applications, CRHS physicians and nurses conduct virtual face-to-face in-home meetings. During these sessions, CRHS gathers data about ease of understanding, clarity of instructions, and other unique patient and family needs.

Figure 3.1-1: **Sample of Key Patient, Family Member, and Other Customer Listening Methods**

Methods and Comparisons	Patients										Family and Significant Others				Other Customers								
	Inpatient			Outpatient			Emergency Room			Mobile Clinic	Inpatient	Outpatient	Emergency room	Mobile clinic	Home Health/DME			Telehealth		Hospice			Health Plan Members
	Pre-	S	Post-	Pre-	S	Post-	Pre-	S	Post-	S					Pre-	S	Post-	Pre-	S	Pre-	S	Post-	
Comparisons																							
Kress Ganey			X			X			X								X		X			X	
CAHPS	X	X	X	X	X	X	X	X	X	X					X	X	X		X	X	X	X	
Methods																							
CHNA		X			X			X		X													
Social Media			X			X			X		X	X	X										
Complaint Process	X	X	X	X	X	X	X	X	X	X	X	X	X	X									
Rounding	X		X			X																	
Leader			X			X					X	X											
Physicians		X			X			X			X	X	X										
Nurses	X	X	X	X	X	X	X	X	X		X	X	X			X			X		X		
Telephone Calls															X	X	X	X	X	X	X	X	X

Pre- = preservice, S = service, Post- = post-service

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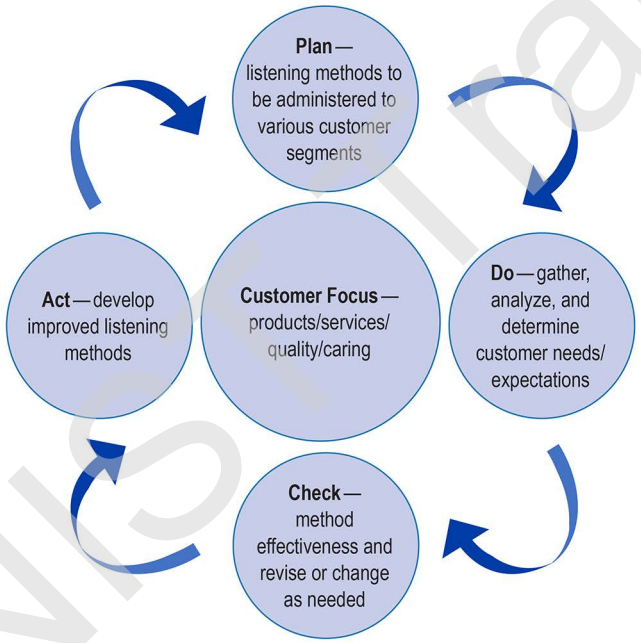
CRHS also works closely with physician groups that refer patients to its facilities for service. Outreach efforts increase awareness of services. Understanding needs and expectations is how CRHS obtains and maintains business. It gathers data on the types and numbers of patients being serviced and then works with operations to ensure it possesses the capacity to meet current and future demands. To meet customers' needs, CRHS recognizes that mental health, substance abuse, and obesity are three areas where service must prove to be responsive and capable (skills and capacity).

3.1a(2). CRHS uses its multiple listening posts, partnerships (Figure P.1-4), and public data sources to gather actionable information from competitors and potential customers. CRHS gathers various types of data throughout the year, while analyzing some quarterly and all annually. Annual analyses are considered with other customer data and evaluated as part of the VOC System (Figure 3.1-2).

CRHS reaches former customers through after-service surveys and telephone follow-ups. Potential customers are often reached through outreach activities such as the website, Lookbook, consumer surveys, focus groups, community events (fairs and farmer markets), and other venues. While these methods are ongoing, data are aggregated monthly and annually to detect trends and assess performance. In 2019, CRHS contracted with a marketing company to provide targeted advertising within Lookbook and various websites. This process improvement increased website unique visitors by 12% (Figure 7.2-17) over the previous year and showed significant promise based on the 2020 customer survey where 10% of first-time customers said they heard about CHRS).

Figure 3.1-2: **Voice of the Customer System**



Notes:
—Favorable and unfavorable analyzed by type of issue, type of customer, service phase, etc.
—Strengths shared and celebrated
—Opportunities grouped and evaluated using PDCA
—Low-impact, low-cost, quick, systemic remedies transferred to staff members for improvement
—Mid-impact, mid-cost, near-term to remedy—possible business plan adjustment or input to next planning cycle
—High impact, high cost (risk management and strategic planning)
—Process repeats quarterly, with annual results tabulated

Competitor data are difficult to acquire directly. As a result, much of these data are acquired through reviews of research studies, national health care data, and COE. CAHPS Surveys provide not only satisfaction data on customers and customers of competitors, but also comparison data so CRHS can identify relative strengths and opportunities. Areas of strength are used in "planning" outreach efforts.

3.1b. Patient and Other Customer Segmentation and Service Offerings

3.1b(1). Customer (satisfaction and dissatisfaction) and market data are the main drivers in determining customer groups and market segments. Each year, customer satisfaction and Consumer Preference Survey data are evaluated to detect shifts in preferences, types of service, and service delivery methods. CRHS's success in identifying new segments and markets is based on its willingness to use data to detect differences in customers and help identify segments and special populations. Data that have been collected and evaluated are used in the PDCA method to make fact-based decisions. For example, over the past four years, there has been a significant shift within established customer groups based on technology use. Heavy Wi-Fi users, a special population within each existing group, prefer electronic communications over face-to-face. This technology shift has helped CRHS to identify an entirely new segment of customers. Similar to the shift from stores to online shopping, a growing number of customers expect services from the comfort of their home. Understanding this new segment and the special populations within it (elderly, home-bound, and busy technology-dependent users) has helped CRHS develop a robust telehealth program that meets key patient, family, and community needs for value, access, and high-quality care.

3.1b(2). Determining service offerings begins with an internal analysis of CRHS's customers' needs and preferences, as well as current opportunities (dissatisfiers). Products and services meeting or exceeding current needs and expectations are kept and enhanced. Emerging preferences (such as home services through increased use of technology) and dissatisfiers (current preferences that are not being met) also provide opportunities for new products and services. All potential opportunities go through two types of basic assessments as part of the planning phase: (1) Is it a service enhancement or a gap (requiring a new service); and (2) does it align with CRHS's mission, vision, and CCs? This initial step in the planning phase of PDCA enables leadership to determine how the opportunity fits within the current product/service mix and if it could be delivered internally or through a third party. If the results of the initial planning phase are favorable, the information is forwarded to senior leadership with a recommendation on if and how to pursue this new service or product.

Data from the past three years have shown a definite shift in patients' preferences, becoming more accepting of the advantages associated with the use of robotics in surgical cases. CRHS used these data (increased acceptance of robotics) to launch robotic surgical programs in orthopedics and GYN surgeries, and is evaluating additional robotic-assisted surgical

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methods. CRHS also identified potential customers through a detailed PDCA analysis of external information. This includes information gathered through the Seekers Program, study of local competitor services, and use of national data sources.

As part of the Seekers Program, staff members research various demographics and travel into the communities to better understand customer preferences and why they exist. For example, do people not go to the hospital because they prefer telehealth options or are they unable to travel to the doctor? CRHS Seekers determined that many of the underserved people in the service area don't have access to transportation or the Internet. As a result, CRHS recently increased the number of mobile clinics to better serve these individuals (former potential customers that are now its customers). Through these mobile clinics, CRHS now has a new market with little to no competition.

Market research (services offered by competitors and national comparison data) also provides objective data as CRHS plans to identify potential new services or customer segments to pursue. For example, seeing services provided by competitors led CRHS to place time estimators in emergency departments (EDs). Patients are given a randomly selected number when signing in at one of its emergency rooms. A display board shows each number and the estimated wait time. The board is refreshed every 3 minutes. This provides patients and family members with an estimated wait time, reducing stress.

3.2 Customer Engagement

3.2a. Patient and Other Customer Experience

3.2a(1). Since 2013, CRHS has had multiple processes in place to acquire, manage, and retain new customers. Initially, these processes were based on traditional outreach activities: advertising on local stations and being active with community organizations. In 2017, CRHS took a more systematic approach to developing a brand image and acquiring customers. This three-phase approach includes (1) creating awareness, (2) experiencing services, and (3) becoming a repeat customer and promoter. To enhance phase I activities, CRHS began adding more proactive approaches to increase awareness. These included mobile clinics; participation in community fairs; and offering tours to local associations, educational group presentations/tours, and senior center briefings and outreach. These proactive enhancements have resulted in increased awareness and more first-time customers. In 2020, prompted by COVID-19, CRHS launched a virtual tour option, which has also been used by current customers wanting more detail of the facility prior to surgery or by family members wishing to learn more.

More recently, CRHS initiated two programs to address opportunity gaps (groups or segments of potential customers that are not touched by phase I efforts) identified during cycles of review and improvement. These opportunities resulted in the Seekers Program and a new Marketing Relationship Management System. The Seekers Program is used to target areas that are under-served, evaluate the root causes, and then develop programs to eliminate or reduce barriers, thus enabling CRHS to acquire new patient customers (3.1b[2]).

The transition to computers in society has also impacted health care. CRHS's efforts in phase I also recognize the growing segment of the population that uses technology (smart phones and computers). This segment is often not interested or able to travel to one of CRHS's facilities. These are often educated, busy people, who want service delivered to their home or business. Through online, proactive marketing (email and google searches), CRHS reaches these individuals and initiates a relationship that has translated into steady market growth.

Once CRHS acquires new customers and new markets (phase II), it quickly develops or adapts products and services to meet unique needs. The relationship management software provides the flexibility for potential customers to be introduced to products and services; then receive updates on CRHS initiatives; and once engaged, evolve into a personalized "My Health" Patient Portal account (phase III), where a patient's health information, provider information and communication, prescription information, scheduling, and bill-pay capabilities are housed. The goal is to provide each person with the care he/she needs in the way he/she wants it delivered. CRHS covers a large area, but services are usually delivered locally. As a result, great local service leads to customer loyalty. Loyal customers tell their stories through community interactions that further CRHS's brand marketing efforts.

CRHS's goal is to retain customers by exceeding expectations the first time and every time. It achieves this with a Life-Cycle Feedback and Adjustment System (Figure 3.1-2). From the first time CRHS communicates with a potential customer, until the last time it ever sees the customer, CRHS is interacting, understanding, and responding to his/her needs. Relationships are built over time through multiple positive interactions and customer awareness. Patient Experience Office (PEO) staff members work closely with operations to ensure that systems and people are customer focused, providing access, education/information, and high-quality care.

3.2a(2). Access is a basic driver of satisfaction and engagement. Drivers of customer satisfaction have been determined through multiple regression analyses of survey results. Various survey questions are correlated with overall satisfaction questions to identify those areas with the highest correlation. This analysis is repeated every second year to identify possible shifts in drivers or shifts in the level of priority among drivers. For the "access" driver, the options available to enable access are identified through focus group interviews and two questions on most of the surveys, asking, "How did you hear about us?" and "How did you obtain the information you needed throughout your interactions with us? Check all that apply." CRHS uses these data (annual analysis) to develop, strengthen, or eliminate access methods throughout the organization. The result has been to add access options/methods to maximize options and provide patients, families, and others with the ability to choose the mode that best suits their needs. Figure 3.2-1 shows various access options for customer groups.

The Seekers Program has been instrumental in identifying and refining unique access needs of specific customer segments. For example, potential insurance customers want to know costs, key services, and if the physicians and facilities they want are covered. CRHS leverages these types of information as key inputs to the "plan" step in the PDCA methodology, which it

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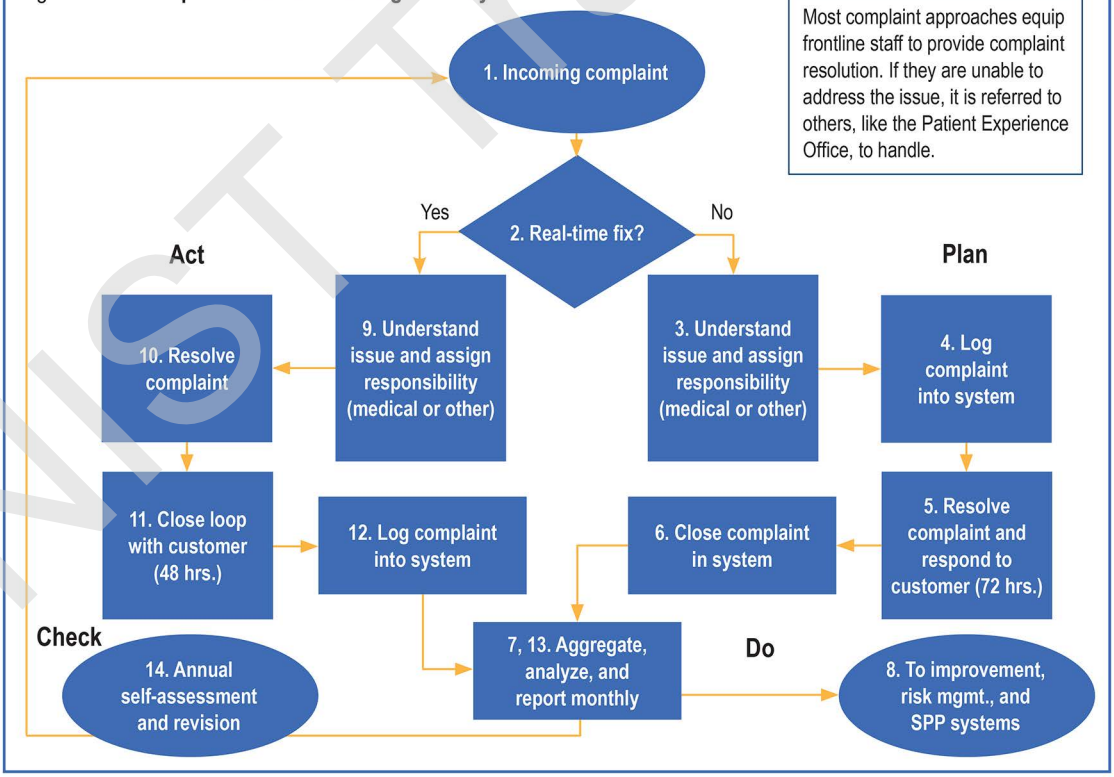
Figure 3.2-1: **Customer Access/Seeking Information Options**

Method or Mode of Access	Entry/ Support	Inpatient	Outpatient	ED	Mobile Clinic	Home Health/ DME, Hospice, Telehealth	Families	Insurance	Medical Offices	Other Stakeholders
Telephone										
Telephone						X	X	X	X	
Nurse Consults	Support	X	X	X	X					
Call for Contact, Appointment	Entry/Support	X	X	X	X	X			X	
Computer										
Website	Entry	X	X	X	X	X		X	X	X
Telehealth	Support	X	X	X	X					
Marketing	Entry	X	X	X	X	X		X		X
Face-to-Face										
Facility Tours	Entry									
Visit	Support	X	X	X	X	X		X		X
Mobile Clinic	Entry/Support	X	X	X	X	X				
Patient Portal	Support	X	X		X					
Outreach Events	Entry	X	X	X	X		X			X

uses to translate needs into access options and outreach materials. When working with customer information, PEO often leads cross-functional teams (operations, facilities, care-providers, etc.) through the analysis to ensure that recommendations and solutions are feasible, measured, and effective. The two main types of access CRHS focuses on are entry and support. Entry provides a means for entering the system to identify and decide to use the services. Support provides a means for re-entry and ongoing support/service.

3.2a(3). CRHS has a mature Complaint/Grievance Management System (Figure 3.2-2) with multiple sources of input, a high-level process flow, quick response (actionable), and periodic analyses (aggregated/evaluated) to identify systemic issues that could be addressed through process improvement or redesign. The process begins when a customer (patient, family member, insurance member, other) has a complaint and makes it known (step 1). If the complaint cannot be resolved in real-time, it is understood, assigned to an appropriate person or team (depending on the issue), and logged into the Complaint Management System to be tracked (steps 3 and 4). In steps 5 and 6, the issue is addressed by the person/team and the customer is informed on the solution. In steps 7/13 and 8, individual complaints are aggregated and analyzed monthly to identify potential systematic opportunities. These may result in process improvements and identification of new risks, and/or they may be forwarded to strategic planning if they highlight a potential resource-intensive solution. If the incoming complaint can be handled in real-time, it follows a different path. Steps 9, 10, and 11 are to understand, resolve, and then verify by closing the loop with the customer. Once this is done, step 12 is to log the complaint and resolution into the system. All complaints are aggregated and

Figure 3.2-2: **Complaint/Grievance Management System**



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evaluated in steps 7/13. PEO analysts periodically (monthly) aggregate and evaluate all complaint data to identify potential systemic improvements. These are then evaluated by the PIC and given to TRAC teams, as appropriate, to go through the PDCA process (step 8) where systematic opportunities are worked, larger items reported to strategic planning, and risks reported to risk management. Each year, the Complaint Management System is reviewed for potential improvements.

The Complaint Management System is used throughout CRHS and is integrated through a corporate database. CRHS meets or exceeds requirements set by CMS for handling grievances. A single Complaint/Grievance Management System enables it to slice and dice data by location, complaint category, etc., for analysis and for assessing the impact of improvements.

A key improvement to this system occurred in 2018 when CRHS added the step of documenting complaints that are resolved in real-time. Documentation of these real-time corrective actions has had multiple benefits. CRHS can now aggregate and analyze quick corrective actions. Often, these types of actions can lead to relatively simple, low-cost process changes/improvements. Improvements are then shared across the organization, resulting in fewer complaints, improved performance, and higher survey scores. An example of a simple improvement identified through this process: Patients have access to more people to respond to their needs. In the past, a patient would wait for a nurse to ask a question. Often these questions did not require a nurse. Now, when employees enter a room to clean, restock, etc., they check with the patient to see if they need something or have a question. The result is better service, more engaged employees, and patients receiving more responsive service. To encourage employees to input these types of complaints, CRHS has issued a monthly lottery. It pulls names from the list of quick-response complaints submitted the previous month and gives the person a $25 gift card.

The more complex, time-consuming corrective actions are also aggregated and evaluated. These issues and proposed recommendations are forwarded to SLTs for consideration.

3.2a(4). Variances in the accessibility of health care services mean that certain groups and locations are less likely to receive health care and are more likely to have unfavorable health care outcomes. CRHS leadership is sensitive to these variances and has implemented multiple processes to quickly identify, understand, and then address these opportunities. Traditional approaches included survey and patient demographics. This provided some information but gave an incomplete picture of the service area. In 2018, senior leadership charged the PEO with going beyond simply identifying underserved areas to identifying underserved people. PEO led a 12-month study to assess and quantify the extent of this opportunity. Reasons special populations within customer groups were underserved varied, including religion, culture, distrust, language, location, and work schedules. In 2019, senior leadership expanded educational outreach activities, which helped to educate some in health care opportunities and benefits; however, it did not significantly close the gap. In 2020, senior leadership approved the creation of the Seekers Program to research, study, and identify underserviced populations, and to engage, understand, and reduce barriers to minimize the risk of unequal treatment.

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

3.2b(1). Most satisfaction and engagement metrics for CRHS's customers are determined through surveys. The number of questions, types of questions, and timing of survey administration depends on the customer group. CRHS uses Net Promoter Scores to assess engagement and loyalty.

Patient surveys are tracked and periodically aggregated for analysis by business units. Surveys are administered on a continuous basis and updated annually. A follow-up survey is sent to inpatients and their families approximately two weeks after discharge from any service. Responses are aggregated monthly (for actionable process improvements) and annually (for larger, more complex systemic improvements) through the PIC. In 2017, CRHS began offering patients who provided their email addresses with electronic surveys (more convenient for them and less costly for CRHS). This improvement was implemented across all business units in 2018.

Family member engagement is almost as important as patient engagement. Key family requirements are high-quality care, safe care, and service excellence. Surveys are designed to assess these requirements for each of the main service lines. While the basic requirements are constant across different services, such as inpatient or home health, each has unique quality features. Focus group information enables CRHS to identify unique features and then assess those features through surveys. It can then aggregate data by basic requirement and still be able to analyze by location, service, or unique feature. (Data showing the overall satisfaction scores for these requirements are AOS.)

Health plan members and partner medical offices are also surveyed to ensure that their needs are being met. These two groups are often correlated. A favorable relationship with independent medical offices often translates into more health plan members and more customers when the need arises. Taken together, these surveys and the Complaint Management System capture critical satisfaction, dissatisfaction, and loyalty data.

Engagement is assessed through event counts. Prior to 2015, CRHS measured engagement through the number of hits on social media, the website, patient portals, and other access points; however, hits on a website or posts to social media are not a strong indicator of engagement. As a result, CRHS began tracking events, which are considered meaningful interactions where the customer is actively engaged (e.g., ask a question, set up an appointment, comment on a service). As a result, the counts decreased (approximately 30%), but CRHS's ability to assess effectiveness and the types of issues customers have has improved significantly. For example, by using this new methodology, CRHS is better able to target times for system updates, providing customers with access when they want it, not when it is convenient for CRHS. This has reduced the number of complaints regarding online systems and improved CRHS's ability to respond to inquiries.

3.2b(2). CHNAs provide a snapshot of local demographics and health issues. Data on age, gender, race, language, and

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education are available. This information enables CRHS to develop targeted listening methods to understand how it stands locally and nationally in these areas of importance to its customers. The third-party vendor that administers many of its surveys has certain core questions that are used across multiple customers and stored in their systems. These core questions enable comparisons to other organizations using the same vendor. As a result, CRHS can compare to the top quartile in the vendor database.

Traditionally, local information was the key to success. Now, technology (new ways of researching options and new ways of treating people over distances) has moved CRHS to compare and compete on a regional and national level. This shift in comparisons has driven it to higher levels of performance. With COVID-19 in 2020, this technology-driven transition was accelerated. Potential patients search the Internet and view more public information to identify the best health care options for their needs. That means, even though services are often delivered locally, the competition is often national. As a result, CRHS needs to be better than the local competition and nationally competitive to remain relevant.

CRHS uses multiple processes for gathering data relative to potential/future customers (AOS), including the Seekers Program, focus group interviews, research—national indicators such as CMS and health care studies, and COE. In addition, surveys include comparison questions to better understand how current customers view CRHS and why. All these sources of data go through its VOC System (Figure 3.1-2) to provide a better understanding of CRHS's relative strengths and opportunities (locally and nationally).

CRHS has entered into a data exchange agreement to share some selected, similar types of customer data (wait times, in-service overall satisfaction, and satisfaction with follow-up activities). Specifics about the type and way the supporting services are delivered are not shared; however, this information provides CRHS with general areas of strength and opportunity.

The Seekers Program looks at customers of others and of underserved groups. Through the work of the Seekers Program, CRHS is identifying and bringing in special populations and expanding its service delivery methods, thereby increasing market share and providing new opportunities.

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

CRHS gathers customer needs, expectations, and complaints through multiple systems. These data are aggregated, categorized, and evaluated to support recommendations and decision-making at multiple levels of the organization (e.g., front-line managers for quick process adjustments, mid-management for functional or single-facility changes, and senior leadership for new products/services and major investments).

The PEO is responsible for bringing customer-focused metrics and supporting culture to the organization. The PEO aggregates and analyzes VOC data on a quarterly basis to identify the needs and preferences of different customer groups and segments ("Do"). Then, depending on the initial results of the analysis, the process may involve performance measurement for monitoring and driving a customer-centric culture, a PEO improvement analyst for team analysis and improvement, or development of new recommendations for SLTs and the ELT. Each type of listening post and each customer segment is reviewed annually to ensure that segmentation is correct, preferences are understood, and assessment/listening methods are effective and efficient.

Metrics are the basis for building a customer-focused culture within CRHS. Customer access, satisfaction, dissatisfaction, etc., are corporate measures, facility measures, and functional measures; and they are included in individual performance standards. In addition, many of CRHS's operational metrics align with key drivers of satisfaction and loyalty. For example, through focus group interviews, CRHS determined that physician medical offices expected real-time access to a live person. Annual analysis determined through multiple regression analysis that for patients listening is a key driver of satisfaction.

Category 4: Measurement, Analysis, and Knowledge Management

4.1 Measurement, Analysis, and Improvement of Organizational Performance

4.1a. Performance Measurement

4.1a(1). CRHS tracks data and information on daily operations through its sophisticated, automated health informatics system known as Data Drive Improvement (DDI), which provides real-time results for key performance indicators such as length of stay (LOS), patient satisfaction, employee engagement, as well as dashboards posted in all departments in all hospitals. Other units, such as Urgent Care, Ambulatory Sites, etc., develop their own dashboards specific to their operations. SLs track overall organizational performance through the reviews described in 4.1b using scorecards.

CRHS selects, collects, aligns, and integrates data and information (Figure 4.1-1). Alignment and integration are reinforced through a set of dashboards that are cascaded from its system's strategic scorecard. CRHS tracks progress on achieving its strategic objectives and associated action plans through the applicable reviews described in 4.1b and a following color-coding system (AOS).

In 2019, in a cycle of evaluation and improvement, CRHS upgraded DDI to present most KPIs in statistical process control (SPC) format and strengthen its ability to analyze and respond to trends.

4.1a(2). CRHS selects comparative data that reveal how it is executing its mission and advancing its vision. This is not restricted to health care outcomes, but also customer satisfaction, employee engagement, leadership and governance, and financial and marketplace outcomes. To assess its progress, it selects comparative data that is top decile, top quartile, and verified benchmarks of world-class performance. Every KPI has an owner, and each owner is required to seek relevant comparisons that are the highest performance available. The sources of the comparisons are shown with the reports generated by DDI.

4.1a(3). CRHS ensures that its performance measurement system remains agile, and it assigns a standing agenda item

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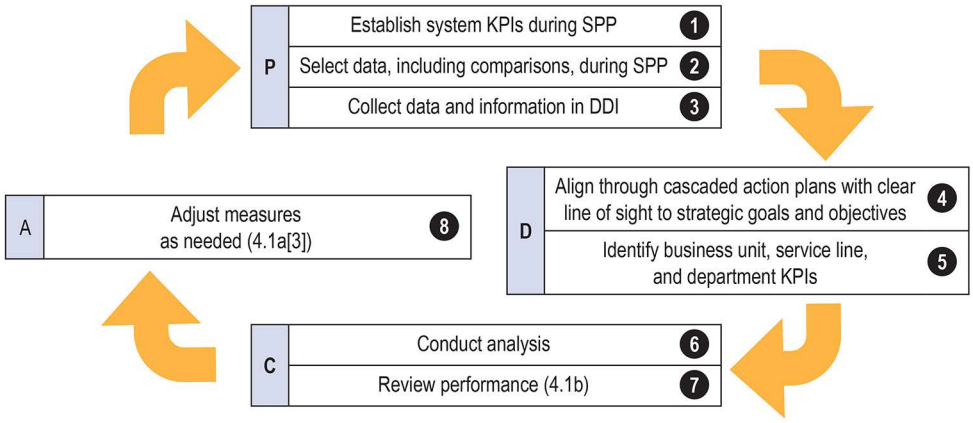
Figure 4.1-1: **Performance Measurement System**



CRHS's key organizational performance measures are shown in Figures P.1-2, P.1-3, 2.2-2, and 6.1-1. Performance measures are also tracked (Figure 4.1-2). Figure 7.5-18 shows strategic plan measures that are tracked but may not be included in the figures already listed.

to each review forum to discuss whether additional KPIs are needed and if any should be eliminated (Figure 4.1-2). This agility was demonstrated during the COVID-19 pandemic when CRHS implemented a COVID-19 dashboard that tracked new, key measures such as PPE inventory.

4.1b. Performance Analysis and Review

SLs use forums to review the organization's performance and capabilities (Figure 4.1-2). KPI owners report their results along with relevant comparative data, and the analyses are used to ensure conclusions are valid. These reviews contribute to CRHS's measurement agility (4.1a[3]). Results of financial and other key measures are presented quarterly to the board.

4.1c. Performance Improvement

4.1c(1). CRHS projects future performance by extrapolating trend data presented in the review forums (Figure 4.1-2) at a continuing rate of change. However, if it knows that there is an expected disruption to the process, such as an impending change in a regulation, CRHS will adjust the projection to account for that. In the case of the COVID-19 pandemic with comparative data changing on a moment-by-moment basis, CRHS adjusted its projections for some KPIs on a daily basis.

4.1c(2). CRHS uses the findings from the performance reviews (Figure 4.1-2) to develop priorities for continuous improvement (CI). When the rate of change is not sufficient for CRHS to achieve its strategic objective in the timetable identified, it looks for innovation to provide a breakthrough change. Action plans and new targets are assigned to a responsible leader for further evaluation. This person is responsible for engaging staff members, physicians, suppliers, partners, and/or collaborators as appropriate. This effort is supported by its Innovation Management System (6.1d).

4.2 Information and Knowledge Management

4.2a. Data and Information

4.2a(1). CRHS ensures the quality of organizational data and information through training on how to input and inspect data.

Figure 4.1-2: **Scheduled Reviews Ensure Strategic Goals Are Achieved and Daily Operations Monitored**

Approaches	Daily What (Who)	Weekly What (Who)	Monthly What (Who)	Quarterly What (Who)	Bi-Annually What (Who)	Annually What (Who)
Performance Data	• Quality improvements • Clinical concerns • Staffing • Timeliness and completion of medical records • Safety—falls, etc. • Discharge planning due to COVID • Daily huddles • VOC huddles	• Care team reviews (IDT) • Leadership rounding—all patient areas	• Budget reviews • Turnover rates • Stroke data • Sepsis data • Patient safety quality (data) • Leadership rounding—all employees	• BSC • HR staffing • Corporate compliance • Quality measures • Risk management • Utilization review • Finance review with the board	• BSC (SL, MM) • Progress of action plans to support the strategic objectives • Progress in the pursuit of strategic opportunities	• SPP • Finance committee • Annual budget • Operational and capital budget
Analysis	• RCA for variances/ trends • Observation status and LOS	• RCA for variances/trends • Patient experience reports to all directors when applicable for analysis and decision making	• Budget variances • Workforce feedback • Action plan evaluation • Clinical benchmarks	• Clinical benchmarks • Comparative data	• Financial trends • Strategic drivers review	• RCA for variances/ trends • Risk analysis • Environmental assessment (PESTLE+W)
Decisions Made/Used	• Service recovery • Operational adjustments • Medical reviews • Dashboard reviews	• Resource allocation • Clinical reviews	• Resource allocation • Modify action plans as needed • Workforce recognition • Clinical focus	• Modify action plans as needed	• Resource allocation • Action plan development	• Operational adjustments • Budget adjustments

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In addition, both its DDI and EMR have embedded "rules" that prevent the entry of data that would be impossible to be correct (for instance, prescription for an antibiotic for a patient with a known, documented allergy to it). CRHS ensures accuracy and integrity through training and system checks and balances. This is done through the limiting of text box fields in its EMR. In 2018, in a cycle of evaluation and improvement, CRHS developed standardized data dictionaries managed by the Data and Governance Committee. The data flow from the EMR and DDI is real time to all integrated systems, which ensures data currency. CRHS also reviews and edits social media posts about the organization as needed.

4.2a(2). CRHS ensures the availability of organizational data and information first by identifying the data and information required for each position and granting appropriate access. However, it also ensures the availability of organizational data and information through a robust information technology plan that includes hosting the system in the cloud. All mission-critical apps have also been moved from servers to be cloud-based. CRHS also uses redundant systems to systematically remove single points of failure (details AOS).

In 2015, CRHS implemented an electronic, visual bed management system that allows family members to track their patients (with a secure patient identification number) through the various stages of pre-op, in surgery, post-op recovery, and transfer to their in-patient rooms. This has been deployed to each hospital. In 2019, CRHS implemented an innovative online scheduling program that allows patients to book their own appointments at the date and time most convenient for them. It is currently piloting expansion of that program for outpatient services such as diagnostic tests and pre-surgery testing as well.

4.2b. Organizational Knowledge

4.2b(1). CRHS builds and manages organizational knowledge (Figure 4.2-1) utilizing a Create, Collect, Curate, Disseminate (Transfer), and Implement Model (Figure 4.2-2). Its Knowledge Management System has been fully deployed across CRHS.

Starting with its knowledge officer and implemented through its Knowledge Management Team, CRHS coaches each function through the process of identifying what knowledge is critical to its team, developing processes for capturing/creating that knowledge, and working with IT to curate the knowledge that is easily accessible to appropriate personnel across the organization. In 2010, CRHS had a homemade database when it started the Knowledge Management System, but it quickly became cumbersome. In 2015, in a cycle of evaluation and improvement, it implemented a TalkPoint site that has its hierarchy based on the Performance Management Institute's taxonomy of processes. In 2019, CRHS added step 6 and a PDCA loop (see Figure 4.2-1) to keep its knowledge assets refreshed with new information.

CRHS blends and correlates data to build new knowledge through the use of health plan data to gain insights into its health plan customers. For example, by analyzing claims data,

Figure 4.2-1: **Knowledge Management System**

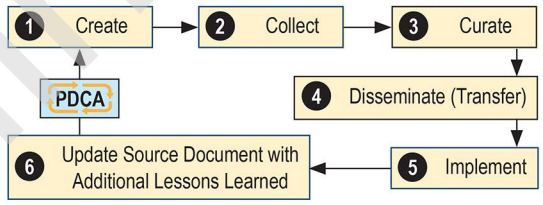

Figure 4.2-2: **Information and Knowledge Management System**

Knowledge Used By or For	Collection Methods: Communication (Figure 1.1-3), Voice of Customer (Figure 3.1-1)	Mechanisms for Deployment	Organizational Learning and Use of Knowledge	Evaluation/Measures
Workforce	• 1:1 interactions • Town halls • Rounding • SEEGs • COPs	• Orientation • Huddles • Staff meetings • Town halls	• Audits • Compliance standards • Performance evaluations	• Competency tests • Staff surveys • Regulatory compliance
Patients / Families	• Rounding • HCAHPS • Patient Experience	• Rounding • 1:1 interaction • Social media	• Family involvement in care • Decreased complaints/ grievances	• Satisfaction survey results
Other Customers, Suppliers, Partners	• Social media • COE	• Company updates • Education • Emails • COE meetings and shared website	• Learn best practices, obtain the best products, deliver best services • Knowledge about community, areas for collaboration	• Recommend to others • Reputation scores • Quality metrics • Contract performance evaluation • COE indicators
Identifying/ Implementing Best Practices	• Staff education • A3 projects	• BSC • Celebration of Excellence Day • Shark Tank • Grand rounds (e.g., physician education meetings)	• Convergence of Excellence as part of the town hall • Grand rounds • Annual Best Practices Sharing Day with poster sessions and "friendly" competition for top-three chosen by attendees	• Process and practice changes • Sharing best practices • Innovation • Add lessons learned to original source document for the best practice used
Strategic Planning	• Environmental scan • Review internal and external data	• Board retreat • Meeting minutes • BSC	• SWOT analysis	• Services aligned with requirements

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it identified that pain management among its oncology patients is a concern and that many patients were seeking alternative medicine approaches such as acupuncture, aroma therapy, and homeopathic remedies. CRHS subsequently developed an alternative medicine program within the cancer center.

In 2021, CRHS adopted two approaches used by a 2020 BAR to collect, transfer, and use its knowledge assets. The first approach is Communities of Practice (COPs), which connects employees with a common interest in the health care setting to come together in a virtual forum to exchange ideas, literature searches, active research, and more to further the understanding of the focus. CRHS currently has 12 COPs with areas of focus including patient-centered care, palliative care, diabetes management, post-partum depression, attention-deficit/hyperactivity disorder, and administrative functions (HR, finance, IT, etc.).

The second approach CRHS adopted was the establishment of Strategic Employee Engagement Groups (SEEGs). Employees may request the establishment of a SEEG, which must receive approval by the SLT. A SEEG must also have an executive champion. SEEGs generally are formed around workforce segments and are a key effort to approach DEI and a sense of belonging in a more proactive manner. CRHS currently has six SEEGs that include African Americans, LGBTQ, Hispanics and Latinos, People with Disabilities, Asian Americans, and Mothers with Young Children.

4.2b(2). As part of CRHS's review of organizational performance (4.1b), it identifies departments, units, or individual physicians who are achieving high-performing results. Then it identifies the processes, practices, equipment, and/or technology that contributes to those results. It proceeds to document, conduct training, and deploy them, as appropriate, across its system. Best practices also come from obtaining certifications, attendance at continuing educational conferences, reference materials such as online Cottervoy procedures and the Staff Nurse Advisory Council (SNAC). With its teaching hospital, CRHS also has projects being conducted by a wide variety of students, family medicine residents, and nurse residents.

In 2020, in a cycle of evaluation and improvement, SLs added a contest for the submission of administrative best practices since the majority had been directed toward clinical practices. "Traffic" to each submitted best practice was monitored for three months, and the submitters of the most sought-after best practices were recognized in the next town hall meeting and given a gift card to a local bookstore.

CRHS actively seeks evidence-based practices for a wide range of processes across multiple industries and sectors. For more than eight years, SLs have attended Quest to learn from BARs about their best practices. Upon return, they identify those most promising to be adopted or adapted and charter a team to first conduct a small pilot to test the change.

4.2b(3). Organizational learning is built upon CRHS's MVV, as well as the Baldrige Excellence Framework®. CRHS ensures organizational learning by having a systematic process that routinely measures performance and evaluates results to drive improvement. Submitting applications to CRHS's state program and following the Framework ensures that it receives valuable feedback on process effectiveness to help drive improvement.

Category 5: Workforce

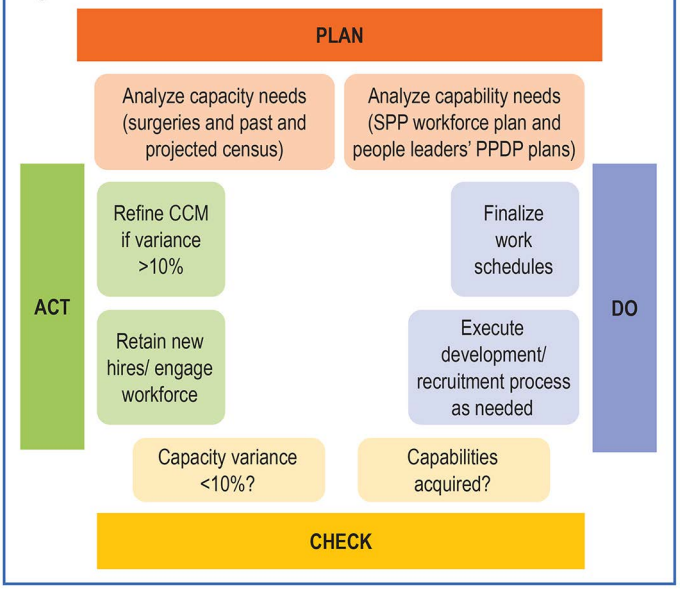
5.1 Workforce Environment

5.1a. Workforce Capability and Capacity

5.1a(1). SLs attend Quest (4.2b[2]) to identify best practices, often with specific issues in mind. After struggling for several years with optimizing capacity, leaders found that several BARs seemed to have better ways to assess capability and capacity (C&C). These ideas were brought back and augmented with research into other industries to develop the Capability and Capacity Model (CCM; Figure 5.1-1) in 2012, and it has been subsequently refined over several years. The model predicts short- and long-term variable needs for physicians, nurses, CNAs, and caregiving support staff such as transporters and environmental staff members. Other support staff members are more fixed in nature over normal volumes, such as accounting, finance, HR, IT, etc. The model determines capacity based on the surgery schedule and past and projected census/service volumes one year out, one quarter out, one month out, and one week out. A weekly meeting confirms needs for the following week so the workforce schedule can be finalized and part-time and contingent staff members can be deployed as necessary. The CCM was deployed first to the medical center and then over the next three years to the other hospitals, then to other business units. It is effective at predicting capacity needs in units that have fluctuating census. The capability part of the model is used in all business units, including those that have more stable and/or fixed capacity, such as hospice, home health care, the health plan, and DME. Capacity is evaluated annually by comparing predicted and budgeted labor to actual. Root cause analysis (RCA) is conducted when the capacity variance is greater than 10% and findings are used to improve the model.

Capabilities (knowledge, skills, abilities, specialties, and certifications) are assessed annually by people leaders during the Performance and Professional Development Plan (PPDP) review. In addition to considering the capabilities of their direct reports, people leaders also evaluate changes expected in their

Figure 5.1-1: **CCM**



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functional and service lines, such as purchase of new equipment, planned expansion of a service line, etc. This information is rolled up and used as an input to the P step of the SPP—collect and analyze data and information. The reconciliation of future capabilities between what people leaders have identified and the SPP has determined is needed is completed in the D step of the SPP—develop and deploy strategic and business plans, and the resulting workforce plan is deployed to HR and hiring managers, as appropriate. Since both C&C are integrated with the SPP, CRHS has rarely been faced with a talent shortage. During COVID-19, CRHS found that some caregivers were "poached" for higher salaries, and it faced temporary shortages in physicians, respiratory therapists, and critical care-certified nurses due to the quarantine. It added critical care nurses in late 2020, while the number of physicians and respiratory therapists stabilized in 2021. Some capabilities may be short-term, within the year, to develop and/or hire, while some specialty capabilities may take longer than a year.

In addition to the CCM variance, other C&C metrics include physician C&C, employees cross-trained, workforce retention, average time to fill, volunteer presence, and nurses with BSNs or higher. The CCM and other efforts have been instrumental in helping CRHS achieve the action plans to recruit physicians and re-engage/increase the presence of volunteers.

5.1a(2). HR and the hiring manager share responsibility for hiring the best-qualified candidates while keeping the diversity of the patient and hiring community in mind—not only in physical attributes, but also in educational background, experience, thinking, and ideas (details AOS).

HR is responsible for tracking current workforce profile demographic statistics, comparing them with the patient and hiring profile in the areas served, and annually updating a diversity report showing how aligned the system is with patient and hiring communities. A plan is developed annually to attract and recruit needed members of the workforce. The diversity report was developed at the system level initially and then expanded and deployed to each business unit. In another cycle of improvement in 2018, the report was expanded to the work unit level to increase the accountability of people leaders. The goal is to have work units within +/- 5% of the diversity of the patient and hiring community. This is more difficult to achieve for smaller and specialized work units.

CRHS also seeks candidates who hold values that complement its own. HR recruits from CRHS's own student trainees, interns, and residents for the professions and skills needed. CRHS also recruits from universities and medical schools that train in the skills needed and that themselves serve a diverse student population. For caregiving support and allied staff, it also recruits from state and local employment offices, which helps ensure that staff members reflect the hiring community. Recruiting ads are run in both English- and Spanish-speaking media. Positions are also posted internally.

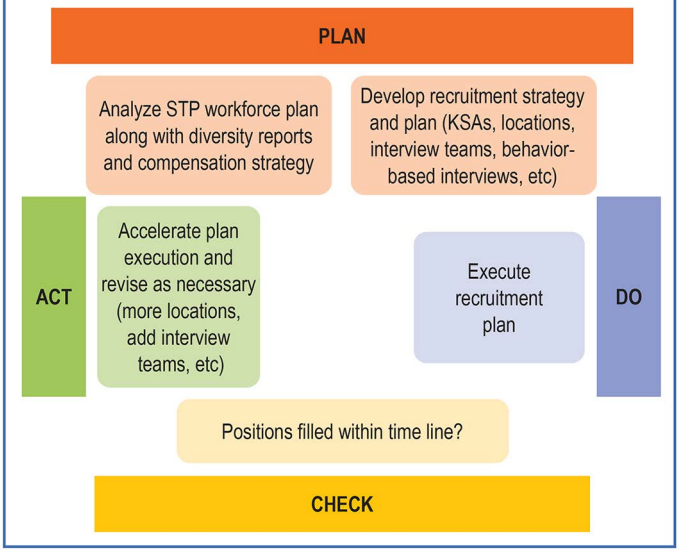
Potential hires are usually interviewed by the hiring leader, another leader, and two coworkers. The hiring team comes to consensus on each applicant. In a cycle of improvement after reviewing an adverse trend in first-year retention, behavior-based interviews were researched and added in 2018. The interview focuses not on behaviors candidates might exhibit, but on behaviors that they have exhibited in past situations. The behavior-based questions align with CRHS's values. A shorter and modified behavior-based interview is used for volunteers.

First-year retention has improved as a result of incorporating behavior-based interviews. To help address the challenge of shortages in nursing, technologists, and some physician specialties, CRHS has stepped up recruiting efforts for these positions and focused on closely monitoring the average time to fill these positions. In the short-term, CRHS has partnered with some specialty groups for tele-neurology, tele-dermatology, and other difficult-to-recruit specialties that can be supported remotely. CRHS is also working with nearby nursing programs to identify ways to remove barriers for potential nursing students. Being the backbone organization for the COE, which has a goal of making the community a great place to live, will also enhance CRHS's ability to recruit in the long-term (Figure 5.1-2).

Onboarding is a three-day program consisting of two days of introduction to the organization led by HR and SLs. Two SLs lead a half-day session on the MVV, CCs of safe care and efficiency, ethical behavior, and DEI. This is followed by a one-day structured orientation to the hiring department, led by a people leader. Thirty days after hire, new employees attend a session on valuing diversity and are encouraged to take the one-day class on Lean and CI tools. Onboarding is the same for all new employees—those based in hospitals as well as those based in other business units. Nonemployed physicians, volunteers, and students have a similar orientation (although shorter), and they receive diversity training after 30 days. New nursing graduates are partnered with an experienced nurse during the first 60 days. Nurses in specialty areas such as the OR and NICU require a longer orientation. Most new hires have a 90-day probationary period, after which the people leader conducts their first PPDP.

5.1a(3). CRHS balances the needs of the workforce with its own and minimizes reductions through disciplined headcount management, cross-training, the Take a Break Program, and other processes to enhance flexibility while retaining its high-performing workforce.

Figure 5.1-2: **Recruitment Process**



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The CCM is used to predict capacity one year in advance. HR partners with people leaders annually about the positions that are planned for the upcoming year. When the CCM predicts growth in the need for C&C, the cross-functional FTE Committee reviews these requests to ensure they are justified and to determine whether these capabilities already exist somewhere else in the organization rather than hire externally. The committee also determines if anticipated reductions in other areas may provide an opportunity for training staff members for reassignment. Once the need is confirmed, the committee considers all needed aspects, from physical space, IT needs, parking capacity, and additional training and development. A detailed plan is prepared and actions taken to prepare the organization up to six months in advance of new hires or reductions.

People leaders are expected to proactively manage the transitions of their direct reports, with support from HR, and seek out fellow leaders to discuss cross-training and opportunities for employees when one is no longer needed in a particular department, but may have skills suited for another department. People leaders also routinely evaluate whether a FT position may be shifted to a PT position or the reverse; CRHS also has a number of job-sharing situations, in which two employees would prefer to not be FT, but agree to share one position instead.

To increase flexibility, in 2018, CRHS began cross-training the nonphysician workforce to support and temporarily work in two different departments with a goal to have 100% cross-trained by 2023. These other departments are selected based on employee preference and functional needs. Nurses and CNAs work on at least two different units during the year to become familiar with those employees and unique circumstances. Volunteers participate in this as well; most volunteers have a favorite role, but CRHS has them serve in two other roles sometimes throughout each year. Working in different departments is already part of the student curriculum. CRHS actually cross-trained more volunteers than expected in 2020, particularly in caregiver support and caregiver allies, because they helped out in so many nontraditional roles during the pandemic.

To meet the diverse needs of the workforce as well as the organization, the Take a Break Program allows nonunion employees to go on furloughed or contingency status when the census or other circumstances dictate that they are temporarily not needed, either PT or FT. These opportunities are communicated to the classification of employees impacted, for example, a temporary over-staffing of medical coders. If more employees want to take advantage than needs dictate, the longer-tenured employee is offered it first, provided the employee is a good performer. When they are on a "break," they may be called in to cover for others as needed. As more permanent needs are identified, they may revert back to PT or FT status. There are no guarantees made, but there have been no involuntary reductions in force since the program started and no furloughs during the pandemic. These are unpaid leaves of short duration from a few weeks to a few months, which about 10% of the workforce has taken advantage of over the years since they became available. CRHS is working with union leaders to develop a similar program for its unionized members in the future. Results for this program are AOS.

5.1a(4). Caregiving workforce members are organized functionally under people leaders and assigned to Interdisciplinary Teams (IDT) to focus on the delivery of high-quality care. Caregiving support and allied employees are organized under people leaders in functional departments to further develop their functional skills and focus on efficiency of operations. Workforce members may also nominate themselves to join a COP.

To reinforce CRHS's CCs, people leaders are expected to deliver a safety message and the importance of reducing waste and rework at least once a week; most deliver these messages in daily huddles by the unit's performance improvement boards; many include them daily. All SL communications reinforce the CCs in their communications as well. Efficiency in Operations is reinforced through the expectation that employees routinely participate in PDCAs at their worksites. Since the introduction of Lean tools in 2018, employees are asked to work together to develop standard work in their units. Most of this has been completed. They also map processes that are experiencing issues. Some workforce members may also participate in cross-functional TRAC teams.

The cross-training discussed in 5.1a(3) proved invaluable during the pandemic when the caregiving workforce worked nearly nonstop, and caregiving support and allied workforce members filled in where possible, such as by administering COVID-19 tests and developing a process to sterilize and re-use PPE until more could be acquired, as well as many other tasks to relieve clinical staff. Agility and resilience were demonstrated from each individual as well as the organization itself.

Another impact of the pandemic occurred when all caregiving-allied employees and some support staff members who did not support patient care were transitioned to work remotely from home. While there were initially concerns about potentially lower productivity, effectiveness, and engagement, these concerns were not born out. A Pandemic Task Force was quickly established to address all aspects of the pandemic, starting first with the safety of caregiving employees, and then it moved on to ensure remote employees had what they needed to work safely at home with encrypted hospital-issued laptops. Employees were authorized to take home their ergonomic desk chairs and other supplies necessary to support their remote work. Many IT systems already provided for connecting remotely, and access was updated to ensure that employees working remotely were not hampered in their ability to be effective outside of CRHS's facilities. People leaders were trained in how to keep employees engaged and continued to hold daily huddles, even if at times these were video conferences or simple chats. A number of people leaders reported that employees seemed to be more productive, not less, likely due to the elimination of commute time.

As pandemic restrictions eased in 2021 and vaccines were widely available, it was determined that some employees could continue to work remotely, while others would adopt a hybrid solution. As a system, CRHS determined that maintaining the most flexibility as possible would be the default to better meet the diverse needs of the workforce. People leaders share their plans with their leader and HR generalist to assess risks and

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identify any obstacles. Today, about a quarter of the non-caregiving workforce are 100% remote, about a quarter are working in a hybrid mode, and the rest continue to work onsite. CRHS is evaluating space needs now and in the future as these modes of remote working become more permanent. It expects to have more space available in 2022 and beyond to expand patient care.

5.1b. Workplace Climate

5.1b(1). Workplace health is incorporated in CRHS's CCs and its focus on safety for patients and staff members. All members of the workforce are enrolled in Copansburg Wellness after 90 days. Once enrolled, they may take advantage of free offerings. A discount on health insurance premiums is available to employees who meet biometric objectives. Nonemployed physicians, residents, volunteers, and students are not enrolled in Copansburg Wellness, but they have full access to fitness centers and other free clubs and courses. The Wellness Committee identifies, develops, and communicates offerings.

Because burnout was already a concern for physicians and some nursing staff members prior to the pandemic, CRHS added considerably to the wellness program (Figure 5.1-3). These additions were kept in place in 2021, and CRHS is considering whether it will continue them into 2022 and beyond. For example, at each hospital, it converted a room into a meditation/rejuvenation space for caregivers and added additional mental health support, mindfulness, and weekly guided practice, along with a subscription to a calming app for those who requested it.

To address physician burnout, CRHS administered a short survey in 2019 and found that 34% of physicians were experiencing symptoms of burnout—5% greater than the national average of 29%. In response, physician leaders established a Physician Wellness Council that systematically takes actions to address burnout based on the Clairgrade Professional Fulfillment continuum, which addresses personal resiliency, efficiency of practice, and a culture of wellness. The 2020 and 2021 survey results show improvement.

CRHS administered a short survey to learn what would be most helpful to them to reduce their own stress. It learned that meals were valued, but so were other things, such as the relaxation rooms it put in place, massages, gift certificates, hotel rooms, and more. CRHS partnered with the community to find ways to deliver on these, with many businesses and residents making contributions to ease the stress of the workforce during this period. CRHS believes these efforts contributed to its ability to maintain high engagement despite the pandemic.

CRHS is focused on helping employees pursue work/life balance, with people leaders encouraging their direct reports to take appropriate time off. In January 2021, in recognition of the extraordinary resilience demonstrated by employees during the pandemic, CRHS made a special award of 16 additional hours of vacation time and encouraged employees to use them as early in the year as work allowed.

CRHS also implemented a short Wellness Pulse Survey that it administered quarterly during the pandemic and into 2021 to monitor progress on this issue.

Security is ensured through a comprehensive system. CRHS's goal is to ensure a safe environment (Figures 5.1-4 and 5.1-5), and when issues are encountered, to handle them internally and not have to rely on community emergency responders. Examples of safety tools are AOS.

Figure 5.1-4: **Safe Environment-Related Measures and Goals** *(See Figure 7.3-8 for Results)*

	Goal
CDC Worksite Wellness Score	220
Physician Burnout	29%
Wellness Participation	90%
Influenza Immunization Compliance	100% of Eligible
COVID Vaccine Compliance	100% of Eligible
TB Test Compliance	100%
Emergency Responders Required	15
Accommodation Requests Met	90%

Figure 5.1-3: **Sample Copansburg Wellness Program** *(additional details AOS)*

Offerings	Description
Run for the Roses	This is a running club with runs for all abilities and for all workforce members (nonemployed physicians, employees, residents, students, volunteers).
Walk for Wealth	These work units challenge themselves to walk as many steps as possible, with a goal of at least 10k a day, and compete for a cash incentive for the group that accumulates the most steps in a year for all workforce members. All stairwells were renovated in 2019 to encourage walking. Motion-sensor brighter lighting was added, wall murals were painted, and hand sanitizer was added to each floor outside the stairwells in 2021.
Bicycle Racks, Showers, and Lockers	These are available at every location with more than 50 workforce members.
$100 Incentive for Fitness Devices	Fitness watches, exercise bikes, and other fitness-enabling devices or equipment are available to employees.
Health and Wellness Coaching	This program is available to all employees and offers confidential nurse and dietician coaching for those affected by chronic conditions, such as obesity, diabetes, and hypertension; as well as for those recovering from surgeries and serious illnesses.
Home to Work	Described in 5.1b(2)
Take a Break	Described in 5.1a(3)
Workforce Assistance Program	This program provides confidential assistance for the workforce and their families to help them deal with stress and other personal issues. This service was originally targeted to the workforce, but it was expanded to include families in 2020 due to COVID-induced stress.
Subsidized Child Care	This is available at every hospital and to all employees, whether they work at the hospital or not.

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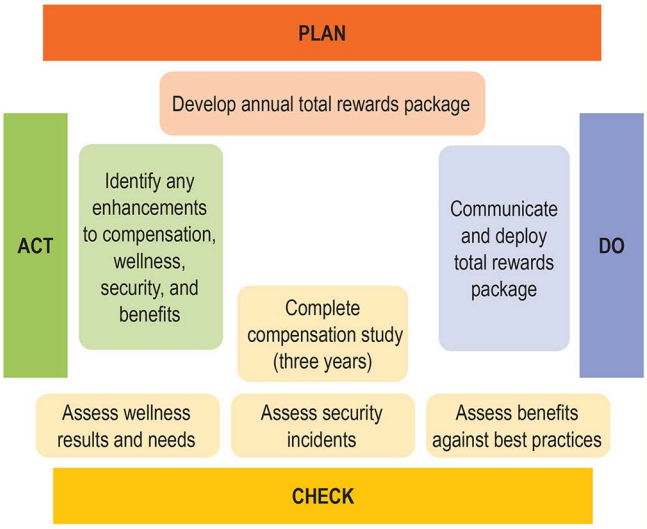
Figure 5.1-5: **Workforce Support System**



5.1b(2). Employees can take advantage of cafeteria-style benefit plans to choose those that best fit their needs (Figure 5.1-6). A basic plan provides access to health and dental care, a health savings account, life and disability insurance, and 403(b) tax-deferred retirement account. The enhanced plan costs more to employees, but offers access to these benefits and more, including vision care; legal services; and discounted home, auto, and long-term care insurance.

Figure 5.1-6: **Benefits**

	Employees	Nonemployed Physicians	Residents, Students, Volunteers
Health Insurance	X		
Dental Insurance	X		
Life insurance	X		
Long-Term Health Insurance	X		
Vision Care, Legal Services	X		
403(b) Participation	X		
Discounted Home, Auto, and Long-Term Care Insurance	X		
Flexible Health and Child Care Spending Accounts	X		
Tuition and Certification Reimbursement	X		
Take a Break	X		
Workforce Assistance Program	X and Families	Physician Wellness	X
Home to Work	X		Modified (Not Volunteers)
Cafeteria and Gift Shop Discount	X	X	X
Discounted Child Care	X	X	X
Copansburg Wellness Program (Figure 5.1-3)	X	Some	Some

An innovative benefit CRHS offers is subsidies to purchase a home in the twelve blocks surrounding the medical center to enhance the stability of the community and offer employees an opportunity to live close to work. The center is located in a community that was beginning to experience blight; however, given rising economic conditions in the area, it is starting to improve. With the Home to Work Program, employees receive an amortized annual benefit equal to 5% of the purchase price, which is not to exceed $60,000. If they stay in the home for twenty years, the home could be effectively paid off. The cost to the medical center averages $2,200 for every employee who takes advantage of the program (average cost of a home in the neighborhood is $44,000). Currently, this program impacts relatively few members of the workforce; results are AOS.

To provide a similar benefit to residents and students, who need housing support more than many, the medical center purchased a small apartment building nearby; the area has many single-family houses, but few apartments. Units are offered to residents and students at cost, and there has been a waiting list since this Home to Work Program was launched.

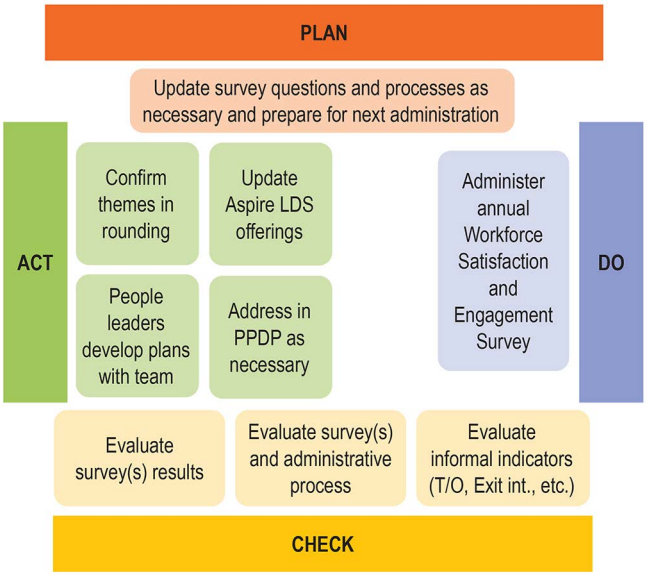
5.2 Workforce Engagement

5.2a. Assessment of Workforce Engagement

5.2a(1). The Upwood Survey is administered annually, and CRHS has added a set of questions on satisfaction and a set on engagement. It also asks the workforce about the extent of agreement with statements, as well as how important that statement is. The most important statements, key workforce engagement drivers, are re-validated through focus groups every three years. Only minor tweaking to descriptions of a couple of drivers was identified in the re-validations in 2015, 2018, and 2021. Key drivers of engagement (Figure P.1-2) have been determined for all major workforce classifications, including students and volunteers.

5.2a(2). The Upwood Survey, which is part of CRHS's Workforce Engagement System (Figure 5.2-1), is sent to the entire workforce. All people leaders are expected to work with their

Figure 5.2-1: **Workforce Engagement System**



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teams to develop an annual action plan to address both Engagement and Satisfaction Survey results. If work unit survey results do not improve for a people leader over a two-year period, HR will assign a coach.

5.2b. Organizational Culture

The most important way CRHS fosters the organizational culture it values is to ensure that every leader, from executive leaders down to supervisors, role model the culture. It makes clear that this same behavior is expected of every member of the workforce.

In addition to regularly scheduled staff meetings and town halls, daily huddles (of 5 to 15 minutes) by people leaders on each shift reinforce the message of the day linked to culture (e.g., the vision, WE CARE, improvement ideas, weekly safety message). Everyone's ideas are welcome, and employees are expected to work together to solve problems in their work units and develop standard work.

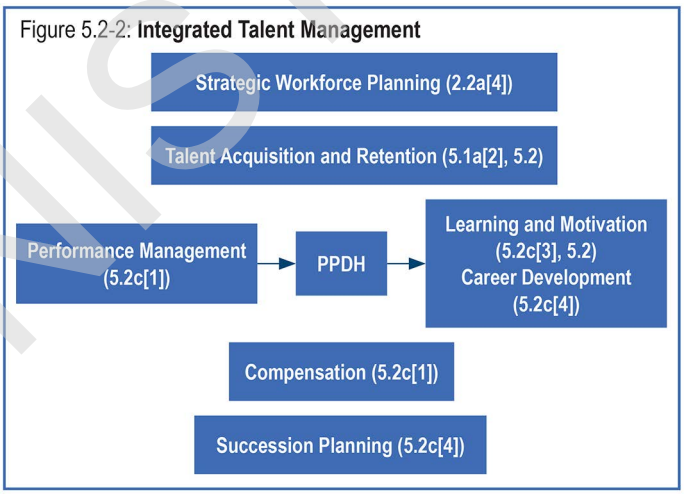
In 2020, CRHS formed a system-wide Diversity, Equity, and Inclusion Committee (DEIC) to identify issues, programs, and initiatives to promote DEI and ensure that it benefits from the ideas of its diverse workforce. The SEEGs (4.2b[1]) also promote DEI. CRHS transformed its culture since its Baldrige journey began in 2012 to one that is empowered and relies on the engagement and ideas of the entire workforce.

5.2c. Performance Management and Development

5.2c(1). CRHS adopted Integrated Talent Management (ITM; Figure 5.2-2) in 2017 after being frustrated with the length and complexity of the existing performance management process, as well as the disconnect from and lack of focus on professional development. It researched best practices and found successful organizations outside of health care that had adopted this model.

As part of adopting ITM, CRHS developed the PPDP to not only align performance and development, but also to integrate these two elements. In the performance evaluation section of the PPDP, goals are set at each level with organizational goals cascaded down, departmental goals linked to these, and individual goals linked to departments. In this way, every employee has a clear line of sight to strategic objectives and action plans. If goals are met, employees are eligible for the incentive plan. If they are exceeded, the incentive is increased commensurately.

Figure 5.2-2: **Integrated Talent Management**



These linkages ensure that everyone is contributing to goals important to the organization and aligned to the CCs. Leaders are evaluated on how they developed or contributed to intelligent risks. Employees are evaluated on how many PDCA/Lean activities and safety initiatives they contributed to, and how they contribute ideas in the daily huddles. They are also evaluated on behaving in accordance with the WE CARE values to reinforce that while results are important, how results are achieved must also be in balance.

The evaluation process requires that employees self-evaluate and then have a discussion with their people leader. The PPDP is deployed to all employees, including employed physicians. Volunteers receive feedback and recognition with an annual lunch and gift cards.

CRHS periodically benchmarks total rewards best practices through the Human Resource Society (HRS) and GWA. Compensation is targeted at 5% above median compensation in CRHS's service area for each classification. A compensation study is completed every three years.

5.2c(2). Annually after the SPP, HR analyzes the workforce plan, identifies the necessary KSAs, and plans for how they may be obtained. For those that are best suited to a training experience, courses are developed and made available to employees, and online courses are also available to volunteers and students. The workforce is highly encouraged to take the one-day course on PDCA, as well as Lean and CI tools. Annual courses are required in ethical behavior, HIPAA, safety, WE CARE, and current-year strategic objectives. A short refresher called Valuing Diversity is also required.

In a cycle of CI, course descriptions now note the learning objectives and ideal background and experiences of learners who want to register for the course. Course evaluations are reviewed after each class and also annually across multiple classes delivered that year. As a result, courses have been revised, added, and dropped. Courses have also changed modality (in-person to online and vice versa).

During the PPDP process, after evaluating their current year performance, the employee and people leader discuss future development. CRHS adapted the Ability, Agility, Aspiration, Engagement, and Exposure (A3E2, with Emotional Intelligence) approach developed by the University of Michigan. It then added a third E, Emotional Intelligence (A3E3), because of its importance to CRHS's leadership style. It uses A3E3 in PPDP discussions. The system quickly learned that aspiration was a key gap; almost no people leader was aware of his/her direct reports' aspirations for the future. Since CRHS adopted it in 2017 and trained leaders to use it, as well as coaches, employees are more satisfied with the development they receive and their relationships with their leaders. Development not achieved or mastered in one year is rolled over to the next and the PPDP refined/updated. The PPDP is not intended to necessarily be completed in one year.

Deficits in performing the current role are the first priority. From there the employee and leader can develop the plan for the next year and beyond to make progress on development priorities. The plan uses the 70-20-10 formula (AOS).

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5.2c(3). Courses are evaluated based on Kirkpatrick's model, with the attendees' people leaders required to submit a short evaluation 90 days after the course to report whether they are seeing their direct reports exhibit changes to their behavior as a result of the course. This survey was adopted in 2020, and results are AOS. As a result of the pandemic, CRHS also improved the registration process so that participants may register for courses from anywhere. The overall Aspire Learning and Development System (LDS; AOS) is evaluated by HR with input from people leaders on a scale from 1–10 annually based on participation and outcomes achieved; it is then also correlated to workforce and patient engagement results.

5.2c(4). Career ladders have been developed for all positions, including for nurses who want to eventually go on to become certified registered nurse anesthetists or attend nurse practitioner schools. These are competency-based and allow employees to enhance current competencies and develop new ones. They do not automatically lead to promotion; CRHS's philosophy is that some employees do not want to lead people and/or may not excel at it, but they still want to grow in capability, competencies, and compensation. CRHS values individual contributors just as much as people leaders. People leaders are expected to encourage all employees to follow the career ladder and seek opportunities and development. This is part of the PPDP professional development discussion.

Managers and above are required to identify three potential successors; if three are not identified within the department, or the department is so small that this is not practical, HR assists with identifying persons outside the department. The Leadership Development Program (LDP) was developed in 2016 and is targeted to high-performing potential leaders and those identified as potential successors. The Physician Leadership Academy is a similar development program for physicians, launched in 2018. The LDP was developed after benchmarking top workplaces for leader development and GWA and HRS organizations, and it is enhanced every year. LDP focuses on leadership behaviors to support the culture and on emotional and social intelligence. Potential successors develop a plan with their leaders to enroll in the LDP and gain the necessary experiences (e.g., assignments in other areas, serving on TRAC teams, leading action plans, serving as interim leaders, participating in external courses and conferences, and others). Participants may also request a mentor other than their people leader. These high-potential development plans are usually three years in duration, with increasingly visible and challenging assignments in year three. About a third of current SLs are graduates of the LDP. Directors and above have the opportunity to also request executive coaching that is external to the organization and focuses on emotional and social intelligence.

5.2c(5). HR reviews performance results and investigates unusual patterns. Performance evaluations must be signed off on by their next-level leaders. Data are tracked on the demographics of the workforce identified as potential successors and participating in career ladders and the LDP, as well as those taking courses in the Aspire LDS. These data are compared to the diversity report. If adverse patterns are identified, HR first coaches the leader and determines underlying causes. The workforce is expected to reflect +/- 5% of the diversity report for the area over time, which is easier to achieve in larger departments and challenging in small and specialty units. The DEIC and SEEGs also promote DEI and receive summary information about the diversity levels in business units, upon which the committee (DEIC) may make recommendations.

Category 6: Operations

6.1 Work Processes

6.1a. Service and Process Design

6.1a(1). CRHS has a defined Service and Work Process Design (SWPD; Figure 6.1-1). Service and process requirements are determined during the planning phase of the SWPD. Inputs include VOC (e.g., Kress Daney), stakeholder input, strategic objectives, regulatory requirements, regulatory changes, audit findings, technology changes, benchmarks, research, supplier/partner input, and best practices.

6.1a(2). CRHS's key work systems are Caregiving Services, Caregiving Allies, and Caregiving Support (Figure 6.1-2). Key health care work processes within each work system are focused on delivery of care. Key work processes for Caregiving Services are Inpatient Care, Outpatient Care, Emergency Care, and Post-Acute Care/DME. Key Caregiving Support processes include Finance, Supply Chain Management (SCM), Facilities

Figure 6.1-1: **SWPD**

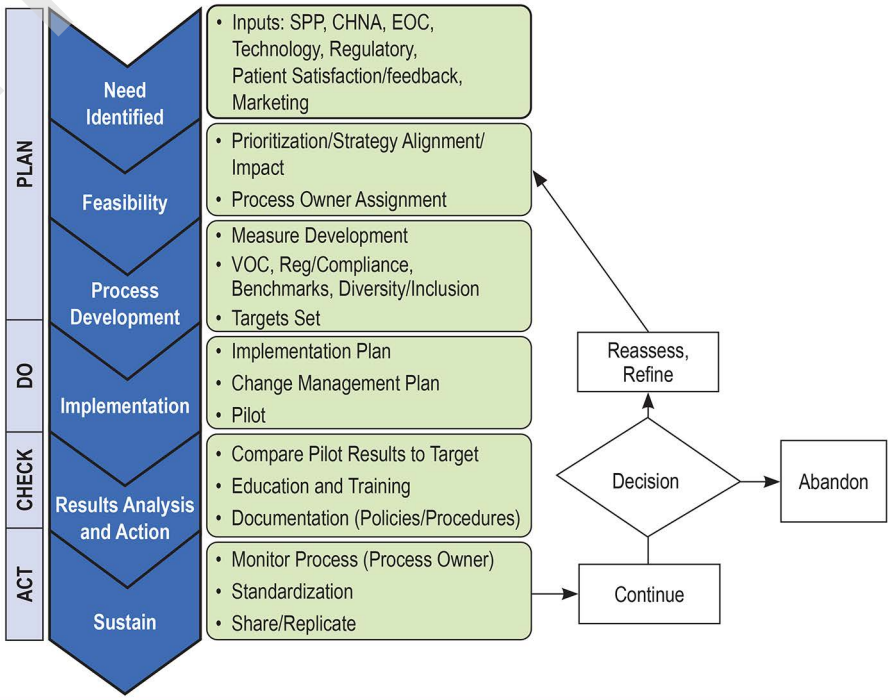

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Figure 6.1-2: **Key Work Processes, Requirements, and Results**

Work System		Requirements	Sample Process Measures	Results
Caregiving Services	**Key Health Care Work Processes**			
	Inpatient Care	High-quality, safe care	Preventable Harm Index	7.1-4
		Participation in care	Documented Care Plan	94%
	Outpatient Care	Access to care	Patient Primary Care Physician/Provider (PCP) appointment scheduled	7.1-23
		Value	Annual diabetic retina exam	7.1-18
	Emergency Care	Access to care	LWBS	7.1-19
		Service excellence	Lab ED TAT (Troponin)	7.1-28
	Post-Acute Care/DME	Access to care	Re-admissions	7.1-9
		Service excellence	PCP appointment at discharge	7.1-23
Caregiving Support	**Key Support Processes**			
	Finance	Accurate reporting	Monthly report availability	AOS
		Transparent processes	Internal audit findings	7.4-8
	FM, IM	Security	Encrypted devices	7.1-32
		Safety	Network availability	7.1-32
	Workforce Services	Wellness	Wellness participation	7.3-8
		Supportive environment	Time to fill new positions	7.3-5
Caregiving Allies	Corporate Services	Efficiency	Work order completion	7.1-33
	Insurance Plans	Response time	Time to approve treatment	AOS
	Partnership	Improve community well-being	Donations	AOS
			Conversion to LED lighting	87%

Management (FM), Workforce Services, and Information Management (IM). Key Caregiving Allies support processes include Corporate Services, ACO, Insurance Plans, and Partnership.

6.1a(3). CRHS's SWPD is used to design service and work processes to meet the requirements of its customers. This process is evaluated each year for effectiveness and has been updated and improved multiple times based on leader and process owner feedback. It was aligned to the PDCA process in 2017 to ensure a systematic approach that is considerate of learnings from past service process implementations.

Inputs for the need for a new process can come from any source or at any time (step 1). SLs authorize a feasibility analysis and further process development (steps 2, 3) and approve implementation (step 4). Process outputs are monitored and must undergo improvement if they are not meeting targets. Retrospectively, all current key service and work processes must have a process map created and reviewed for opportunities for improvement periodically even when meeting performance targets.

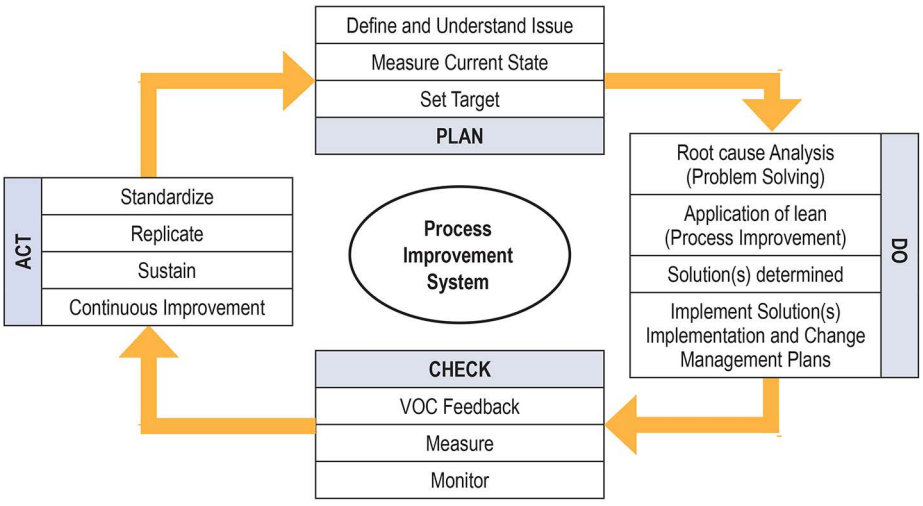
In 2018, the SWPD was updated to require a Failure Mode and Effects Analysis (FMEA) for design (or redesign) of complex processes to proactively identify process risks and failures. The most recent change to the SWPD came in 2020 to further define the societal impact by including a reflection on DEI into process development (step 3).

6.1b. Process Management and Improvement

6.1b(1). The consideration and definition of performance and in-process measures takes place in step 3 of the SWPD. All measures (Figure 6.1-2) are developed to the quality of outcomes and aligned with customer requirements. Process maps have been defined for all key processes and are evaluated for opportunities for improvement using the PDCA process (Figure 6.1-3). Any processes not meeting targets are also reviewed by the process owner and champion for further action using PDCA.

6.1b(2). Patient input is sought during each stage of the patient relationship. Care plans include setting expectations that include patient/family, rounding, and informed consent to enhance engagement in care decisions and ensure consistency with providing safe, quality care. Understanding patient expectations

Figure 6.1-3: **Improvement Process**



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and preferences begins with admissions (inpatient), scheduling (outpatient), intake (emergency/urgent care), and referral (post-acute care). A multidisciplinary care plan (MCP) is created, resides in the patient EMR, and is available and viewable (including updates by all members of the caregiver team). The MCP is created with input from the patient and includes patient preferences and the patient's desired outcomes and goals.

As a result of caregiver feedback about not being able to find Advance Medical Directive (AMD) information in a standard place and format, a TRAC team was assigned to work with a group of hospitalists and palliative physicians. Previously this information could be anywhere in the EMR or in paper forms, making it difficult to find when needed. Their work resulted in changes to the AMD process with EMR to be the designated place for AMD information and forms.

Reassessments are done throughout the delivery of care with input from the patient and the patient's family and documented in the MCP. Communication of the MCP is facilitated and reinforced through the use of white boards in patient rooms, patient electronic medical records (MYPHI), and rounding by caregivers. White board content is standardized to include information about the patient, the care providers, medication, and the treatment timeline to promote standard care and enhance communication. Translation services are available 24/7 through CRHS's contracted on-demand vendor. Inpatients are able to use the features of the interactive room TV monitors to order meals for themselves and their families. Normally, CRHS has open visiting hours, but when inpatient units were off limits to visitors during the pandemic, the TV monitors served to promote communication with family and friends through an interface with most phones. The interactive monitors also provide care and diagnosis-related educational content for patients that enhance their care and contribute to desired outcomes.

With a focus on understanding and documenting patient preferences outside of the hospital setting, a new "preferences" component was added to the patient portal in 2020. The portal allows patients to indicate their preferences prior to a scheduled procedure or visit, which the care team uses to validate care planning. This was especially useful to both caregivers and patients, providing a standard process for virtual visits that became commonplace during the pandemic.

6.1b(3). The SWPD is used to develop and define key support processes, as well as health care service processes, and ensure that day-to-day operations meet requirements (Figure 6.1-2). These day-to-day operational measures are reviewed at an appropriate frequency (Figure 4.1-2) to define unstable, out-of-control processes and for referral of improvement, correction, and CAPA. The use of Statistical Process Control (SPC) was adopted in 2019 to apply predetermined criteria and to standardize tracking of performance results.

6.1b(4). The Baldrige Excellence Framework® is the overall system that inspires excellence at CRHS. All employees receive basic training on the Baldrige framework. More than fifty system leaders have received additional training in the Baldrige Criteria. At least a dozen serve as Baldrige Examiners at the national level and for the State Center for Performance Excellence. The Baldrige application provides for a systematic review of CRHS as an organization, and the feedback report is used as an input to initiate performance improvement (PI) projects.

Work and support processes are improved using Model for Improvement, PDCA, and Lean tools based on the type of improvement (problem solving or process improvement). Lean was added to CRHS's improvement methods toolbox in 2016 to support its CC of Efficiency in Operations. Those areas where measures do not meet established targets or processes that demonstrate nonbeneficial trends and/or unacceptable variation require a PIP from the process owner or designee. CI of support processes is addressed in 4.1c(2). Process owners contact the TRAC Office for support in forming or re-forming Process Improvement Teams (PITs), examine the process, and carry out corrective actions. All new employees are required to complete a one-day class to familiarize themselves with the PDCA method, Lean tools (5S, waste reduction, process mapping, standard work), and common PI/QI tools (pareto, run/control charts, brainstorming) to prepare for day-to-day improvement work within their area/department and as PIT members. Depending on the scope of the process, a process owner may form a PIT to solve a problem by exploring the root cause, selecting a solution, and implementing the solution using PDCA or Lean tools to improve a process to reduce variability.

More complex processes with many stakeholders can be referred to the PIC where projects are assigned to a TRAC for facilitation of a cross-functional improvement team and expert coaching of the improvement project. Each TRAC is staffed by experienced PI practitioners who use PDCA as the PI methodology. The system-wide TRAC teams are led by experienced PI champions who can coach and manage system-wide projects. The focus on using champions rather than exclusive project managers enhances the flexibility of TRAC teams to facilitate the improvement process, implement solutions that address root cause, and enhance sustainability. TRAC teams report project progress and results monthly to the PIC. The system PIC convenes a semiannual Convergence of Excellence of entity PITs where problems, solutions, and successes are shared. An outcome of the Convergence of Excellence is to disseminate best practices throughout the system. An annual system-wide Celebration of Excellence solicits PI project submissions to highlight and promote a focus on improvement and includes awards for teams that demonstrate successful projects meeting the excellence criteria (details AOS).

6.1c. Supply-Network Management

CRHS centralizes management of its supply network at the system level through its GPO and through the SCM (Figure 6.1-4). SCM coordinates the purchase of supplies, equipment, contract negotiations for services and supplies, pricing, and contract utilization of the GPO. The GPO can secure competitive pricing for more than 80% of supplies and services and adds value in handling screening and evaluation for these suppliers. When the best value cannot be obtained through GPO, or for non-GPO suppliers, SCM uses its internal supplier process. In 2018, CRHS created a revised supplier evaluation process that uses a decision matrix customized to product requirements and participation of users. In 2022, the GPO will assist the organization in reducing the chargemaster listings for orthopedic surgery

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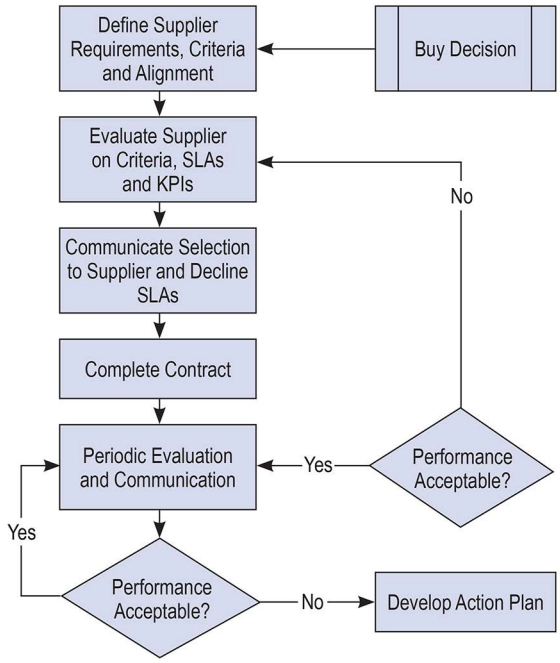
Figure 6.1-4: **Supply Chain Management**



in order to reduce costs. The GPO saved the organization more 80 million dollars in the cost of pharmaceuticals in 2019, a strategic challenge.

Suppliers are selected using a criteria-based evaluation that includes requirements, cost, outcomes, and quality. CRHS works with the GPO to define criteria that supports the MVV, SOs, and customer satisfaction. Vendors are credentialed through Bizplus to ensure alignment and qualifications. Key supplier requirements are quality of product/service, availability of products/services, and cost of acquisition.

Alignment and collaboration within the CRHS supplier network is accomplished through supplier credentialing and the monthly supply chain reviews. The supply chain review analyzes performance measures, results, and opportunities for new programs and is attended by representatives from each CRHS entity, which helps to recognize issues and determine if they are local or organization-wide. During the COVID crisis, weekly and often daily meetings were needed to address issues specific to the COVID-affected supply chain to be able to quickly move supplies from one facility to another based on projected need. Supplies from closed clinics were deployed to areas of need. SCM collaborated with Marketing and Communication in the early stages of COVID to procure donations from various groups outside the health care realm for PPE. Because of these agile efforts along with GPO support, CRHS never ran out of PPE and essential equipment.

Suppliers receive a quarterly scorecard reporting on contractual key performance measures. For suppliers who do not meet requirements, an action plan is created and reviewed periodically until performance targets are met or a decision is made to change suppliers.

The spirit of regional cooperation was demonstrated in 2020 when CRHS partnered with two unaffiliated rural hospitals to assist them with obtaining supplies during the COVID crisis.

6.1d. Management of Opportunities for Innovation

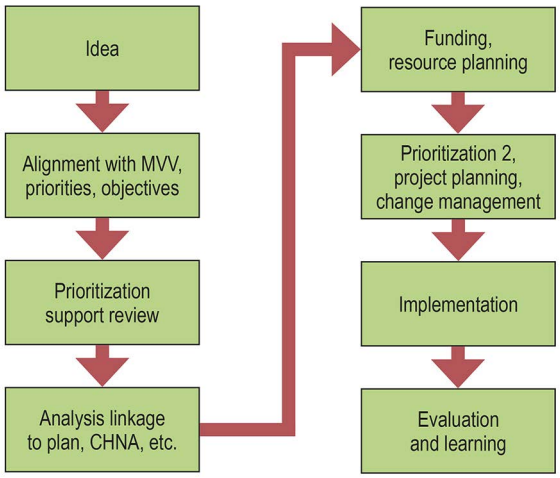
CRHS is focused on learning and understands that with innovation comes an element of risk and possible failure. Opportunities for innovation and SOs that are determined to be intelligent risks are part of the SPP (steps 1 and 11). The Strategy/Innovation (S/I) committee evaluates each idea using defined assessment factors such as risk, ROI, and alignment to the MVV. Those ideas and intelligent risks deemed worth pursuing are recommended to the SPP for inclusion in the plan (Figure 6.1-5). The S/I committee may also meet outside the SPP cycle and recommend ideas for SLT consideration for resourcing. This process ensures that resources (financial, human) are provided to effectively take advantage of the opportunity.

Department and higher-level meetings require innovation to be on meeting agendas to have all voices heard. The criteria for innovation is simple: The idea solves a problem in a unique or new way or takes the organization to the next level. The department Lean team evaluates ideas and may seek approval to implement (no/low cost) or refer to the next level for review. The department stoplight board report displays progress from yellow (in process) to green (implementation completed). Those suggestions that rise to higher-level meetings for discussion at leader and SL meetings are also displayed with the submitter's name. A review of predetermined measures (financial, regulatory, marketing) for all projects provides evidence of effectiveness. Objectives not meeting goals or no longer aligned with goals, changes in priorities, and cost-benefit are evaluated with a possible outcome being to discontinue.

In 2019, CRHS created its "Shark Tank" program (2.1a.[2]), adapted from a benchmarking partner. The entire workforce is invited to submit their posters representing improvement project or innovative ideas. These are judged against predetermined criteria with the highest scoring selected for implementation. The winners are recognized at the annual Celebration of Excellence.

To support our workforce during the COVID crisis, an innovative service was implemented for clinical and other essential staff. A commercial service outlet in a facility closed, and the space was reconfigured to provide for pick-up of ready-to-go meals prepared by food service.

Figure 6.1-5: **Intelligent Risk and Innovation Process**



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The organization's Research division includes an IRB and supports innovation in medical care. Performance Excellence and Strategy teams at the system level identify SOs to determine those that are intelligent risks to pursue.

6.2. Operational Effectiveness

6.2a. Process Efficiency and Effectiveness

CRHS's focus on Lean methods calls attention to waste in operational processes resulting in process modification or redesign (Figure 6.1-1). Respective measures and reviews for processes are used to manage cost, effectiveness, and efficiency of operations. FMEAs provide a proactive focus on risk management and mitigation in process design and redesign, thereby reducing the cost associated with process failures. The use of electronic checklists in rounding helps to minimize the cost of formal audits. CRHS prevents rework and errors and minimizes the cost of inspections, tests and process, and performance audits using its Lean PDCA methods that focus on error proofing, standard work, reducing variation, 5S, adoption of automation, and review of in-process measures (using SPC as appropriate).

When an error occurs, the RCA process includes a review led by a PI champion to identify opportunities for improvement and implement more robust processes. CRHS's Lean methods emphasize a focus on its customers and the customer perspective. Periodic process reviews require waste analysis from a customer perspective. This customer focus played a big part in CRHS's customer and patient satisfaction rating improvements going back to 2018 when Lean was adopted. Identification of process waste is a goal for all staff members and included in most job descriptions. In 2019, CRHS realized 19 million in operating room cost reductions because of process redesign and process waste removal. Beginning in 2018, all new buildings and clinical facilities (hospital and medical offices/ancillary services), refurbishments, and reconfigurations must be reviewed for a focus on Lean principles to eliminate or reduce waste.

6.2b. Security and Cybersecurity

CRHS uses the NIST Cybersecurity Framework to manage and reduce cybersecurity risk, which is a strategic challenge. The cybersecurity VP reports directly to the CIO; serves on the Emergency Preparedness and Operations Plan (EPOP) Committee; and oversees the IM Security Committee, which includes representatives from each facility. Security policies define operational and employee requirements and disciplinary actions for noncompliance. Processes to ensure security of sensitive data (such as protected health information [PHI]) include limiting access to data and information to those authorized to do so based on their job responsibilities. All employees, contractors, suppliers, and others with access to sensitive information and data must complete security and HIPAA training during onboarding and thereafter, annually. This training is updated each year to highlight current cyber threats. All workstations (including laptops) require anti-virus software and encryption. Downloads to nonencrypted storage devices are prohibited and monitored.

Device security is monitored when accessing organization IM systems, and devices are denied connections when equipment is noncompliant. Periodic vulnerability scans are performed on all servers and web-based applications. Systems with vulnerabilities must be mitigated within 30 days with noncompliance resulting in disconnection. An annual security audit is conducted by a third party and is the basis for the Information Security Protection Plan. Break Glass audits are conducted to identify unauthorized access to patient records. A new application, MYPHI, continuously monitors electronic health records for appropriate access to patient PHI.

Additional security measures include forced password changes every six months, two-factor authentication, badge entry to facilities, security cameras, spam detection, and user reporting. Any email correspondence containing protected health is encrypted using secure mail. Phishing testing promotes awareness of security and cyber threats with feedback provided to those that fail. The weekly online security and safety blotter report contains results on phishing testing using a case study and current issues to watch out for. Daily server backups to the cloud have replaced many redundant servers, resulting in cost efficiencies.

6.2c. Safety, Business Continuity, and Resilience

6.2c(1). CRHS has committed to providing a safe operating environment for its workforce and all who set foot in its facilities. The Office of Safety and Business Continuity (OSBC) at the system level oversees Biological/Chemical/Hazardous Waste Safety, Radiation Safety, Fire Safety, Occupational Safety, and Environmental Compliance to maintain a healthy, safe, and compliant work environment. Systematic processes to ensure workforce safety include preemployment screening, safety training at NEO aligned with job requirements, and policies and procedures. Audits are conducted to assess safety and compliance to requirements, and audit findings require action plans that include RCA, correction, corrective action, and preventive action (using PDCA). Incidents and near misses also require RCA and action plans. A significant learning in 2018 resulted in the formation of an Employee Safety Council comprised of safety officers and an employee representative from each facility. Council members meet quarterly to provide VOC, identify high-risk activities and processes, and provide suggestions for improving safety and implementing best practices.

Other safety programs that support workforce and operating safety include badge access, emergency call boxes at all campuses, on-demand escort service to cars and transportation locations, and "save your back" training. Ergonomic assessments are available on request to all employees. An online weekly security and safety blotter is used to report incidents internally and externally. Crime prevention and self-defense training are offered to employees, and workplace violence and active shooter training are required. Additional COVID safety precautions were implemented system-wide by occupational health to protect the workforce and include daily temperature checks, daily online monitoring (remote workers), free COVID testing, quarantine procedures, and no-cost vaccinations.

6.2c(2). CRHS's comprehensive safety program ensures the highest levels in patient safety. The patient safety officer heads the Environment of Care System with EOC coordinators for each business line. Monthly EOC patient safety audits are

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conducted at each business line with deficiencies requiring RCA and Corrective and Preventive Actions (CAPA). Findings are shared at department meetings and daily safety huddles. All patient safety events and near misses require RCA and FMEA with action plans to address CAPA. A dashboard on the system and business line websites displays patient safety results. At monthly PIC meetings, patient safety results are reviewed, and those metrics not meeting target or demonstrating nonbeneficial trends are referred to TRAC teams for investigation and action planning (PDCA).

In 2015, an analysis and review of patient safety events pointed to a root cause of lack of communication. To improve patient safety and promote effective communication and a commitment to teamwork, all patient care positions, including providers, now require TeamStepps Training. Largely, as a result of this training and a focus on CRHS's CC of Safe, High-Quality Care, its periodic Culture of Safety (COS) Survey has shown consistent improvement in the percent positive response in the areas of Teamwork Across Units and Overall Perception of Safety at each entity. The Medical Office COS Survey was to have been conducted in 2020, but due to COVID closures, it has been rescheduled for Q4 2021 (AOS). The survey will serve as a baseline to Medical Office COS improvement efforts. Even though patient safety events have decreased at each entity, that is not good enough. In 2021, CRHS is embarking on the journey to be a High-Reliability Organization building on its culture of safety, the use of methods and tools to improve the quality and safety of its processes, and a commitment to zero harm.

CRHS's Good Catch Program highlights employees who recognize errors and defects before they cause harm. Employees are recognized and rewarded, and the stories are published in the monthly newsletter.

6.2c(3). OSBC uses systematic processes (Figure 6.2-1) to ensure that CRHS anticipates, prepares, and recovers from disasters, emergencies, and disruptions to maximize survival, minimize injury, preserve property, provide for restoration of support structures and processes, resume operations, and promote self-sufficiency and collaboration.

These processes have been tested and improved not only because of events (e.g., tornado activity is 88% greater in Kentucky than the overall United States), but also through collaboration with state, regional, and city emergency entities and agencies who provide input from a customer, patient, and community perspective.

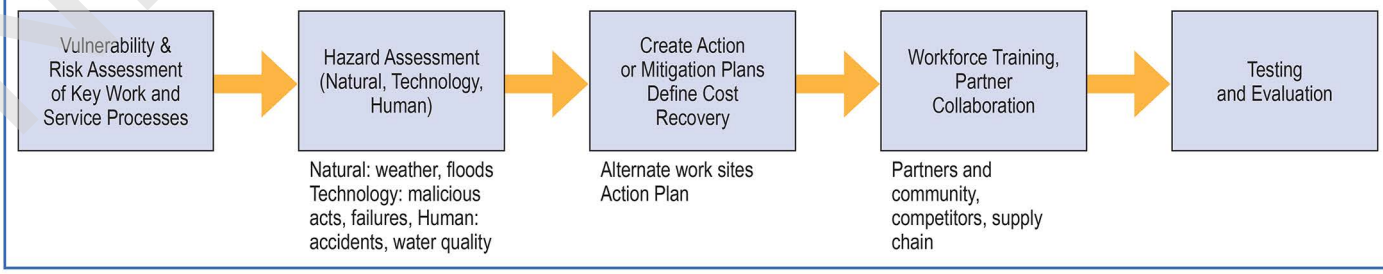
CRHS is a member of Lexington Squared Away and the Kentucky Crisis Association. Local and regional drills and disaster simulations reveal gaps in planning and require action plans/CAPA (PDCA) and feedback to the EPOP.

Reliance on CRHS's workforce, suppliers, and partners becomes critical during a crisis or disaster. The employees who are designated as critical (primarily patient care, facilities) are expected to report for work despite personal issues, especially during the pandemic. CRHS seeks to support the employees' families, as well as the employees themselves. Based on employee feedback, CRHS expanded support to include child care, pet care, transportation, housing, and food for essential staff members during the pandemic.

CRHS's response to COVID demonstrated the effectiveness of its EPOP as it transitioned from an expected short-term crisis to the indefinite, long-term new way of conducting business. At the system level, the COVID Command Center, established in March 2020, worked with all organization entities, along with community, state, and regional health care organizations, to assess and respond to daily changing needs. Designated COVID PI champions (recruited from TRAC) became the COVID Process Team (CPT) and considered patient, workforce, supply chain, and IM needs to support each key service and support process. Outcomes included establishment of the COVID Units (medical and ICU), safety precautions, and creation of a regional bed/ICU status reporting and response team to support surges. As the availability of vaccines started to become a reality at the end of 2020, the CPT planned logistics and implemented a regional vaccination site and partnered with local churches, synagogues, and mosques to set up neighborhood sites that significantly contributed to the now 100,000 fully vaccinated people.

This effort was greatly enhanced by the relationships established through COE. Other employee support services include workforce hoteling, mental health support, and retrofit of the COVID-closed on-site pharmacies to provide meals for employees to take home to their families. The regional PPE status board set up by the supply chain mitigated the scarcity of PPE for not only CRHS but also other health care providers and COVID testing sites in CRHS's service area. IM rapidly deployed laptops and conducted training on virtual collaboration tools for staff members who began working remotely. These tools promoted greater collaboration across all entities to enhance work processes made difficult with physical distancing. They now serve to increase productivity and efficiency in the current work environment.

Figure 6.2-1: **Risk Assessment Process**



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Category 7: Results

7.1 Health Care and Process Results

7.1a. Health Care and Customer-Focused Service Results

Note that all figures in this category contain 2022 data (when available) that are updated to March. Otherwise, unknown data may be identified as not available (n/a). Additionally, note that sources of comparisons in figures are DDI.

CRHS's quality is demonstrated by better-than- or near-top-decile performance in most measures recognized by national benchmarks. Results cover clinical and process outcomes throughout the system. Additional results segmented by condition, service line, and facility are AOS.

CMCL is the only hospital in the Lexington-Fayette area recognized by Caregrades, an online resource that evaluates hospital quality based on clinical outcomes, for achieving top 5% quality from 2018 to 2021 (AOS). In addition, CRHS has achieved better-than-its-peer CMS star ratings for health experiences (Figure 7.1-1) and projects outstanding ratings by 2022.

The CMS PSI-90 score, a composite of eight patient safety indicators, is part of the overall score for value-based purchasing (VBP), for which CRHS has achieved benchmark performance (Figure 7.1-2). For VBP measures, CMS benchmark performance is the mean of the top decile.

CRHS's infection control processes focus on hand hygiene, infection awareness, and education. COVID-19 has brought greater awareness to hand hygiene (Figure 7.1-3).

The preventable harm index includes actual events and near misses to assess patient harm accurately (Figure 7.1-4). In CRHS's quest to be a high reliability organization, it strives for zero patient safety events. The COS promotes a safe environment for increased reporting, and increased reporting provides data to support improvement activities to reduce events.

CRHS participates in the National Surgical Quality Improvement Program (NSQIP) and demonstrates excellent scores for surgical-site infections (Figure 7.1-5).

CRHS has made great strides in reducing the occurrence of hospital-acquired pressure ulcers (HAPU), exceeding the national benchmark and avoiding more than $13,400 in care costs (Figure 7.1-6).

CRHS measures its excellent care for all patients (see Figures 7.1-7 through 7.1-11). This includes monitoring CS, a CAH, even though CAHs are exempt from reporting at the national level.

CRHS's quality-of-care measures for stroke are the best in the region (Figure 7.1-12), and it received the Stroke Association USA's Gold Plus award in 2018 and 2021.

Case-mix index (CMI) adjusted, an indicator of reliable care, has remained stable even during the pandemic when each institution experienced higher acuity patients (Figure 7.1-13).

Figure 7.1-1: **CMS Star Rating (5-point scale)** ⬆

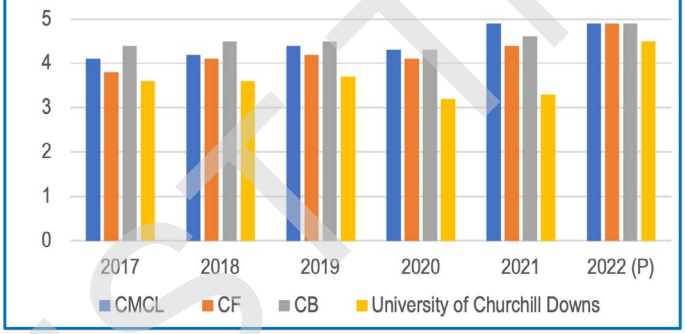

Figure 7.1-2: **Patient Safety PSI 90** ⬇

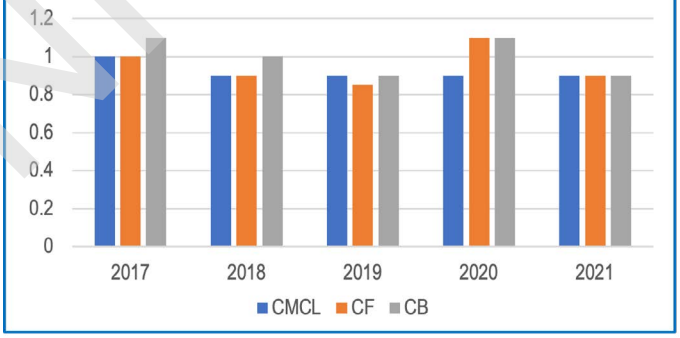

Figure 7.1-3: **Handwashing Compliance (%)** ⬆

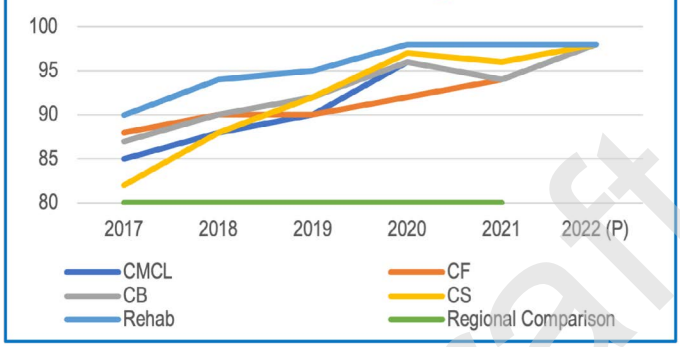

Figure 7.1-4: **Preventable Harm Index** ⬇

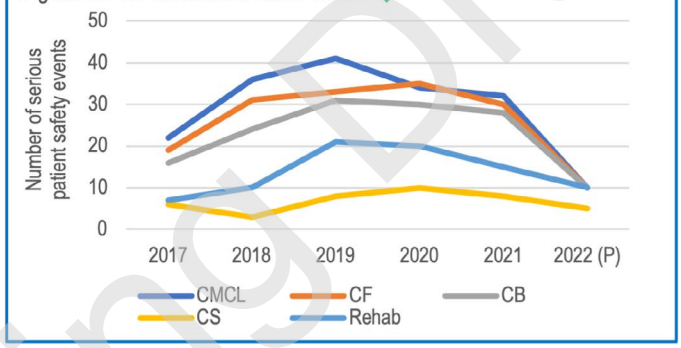

Figure 7.1-5: **Surgical Site Infections—Orthopedics** ⬇

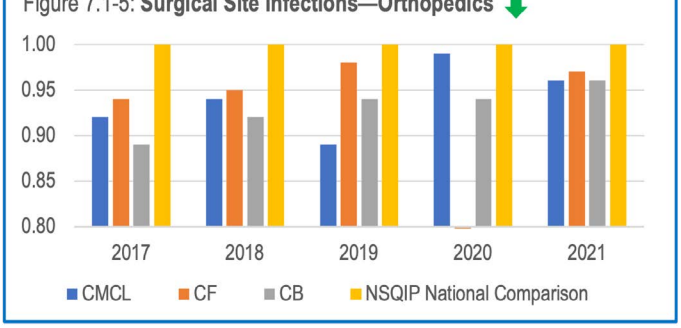

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Figure 7.1-6: **HAPU ICU Rates (Stage III & IV)**

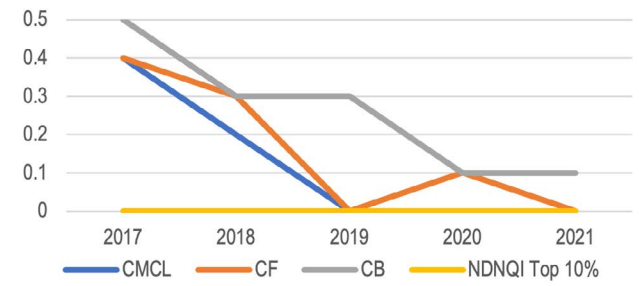


Figure 7.1-7: **Inpatient Mortality Composite**

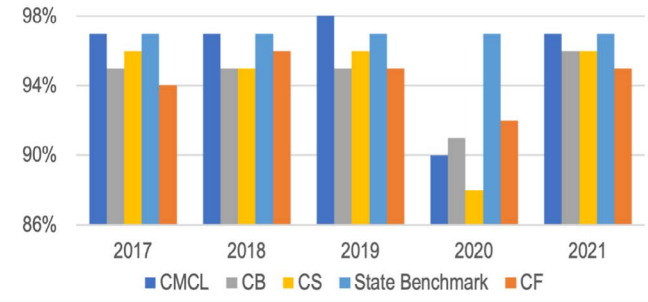


Figure 7.1-8: **Cardiovascular National Heart Failure Mortality**

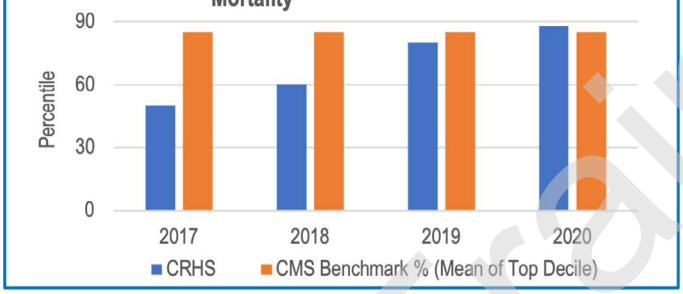


Figure 7.1-9: **Hospital-wide 30-day Unplanned Readmission Rate**

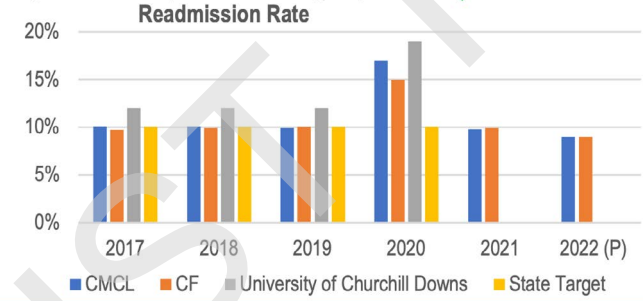


Figure 7.1-10: **Surgery Overall Surgical Care National Composite Quality Score**

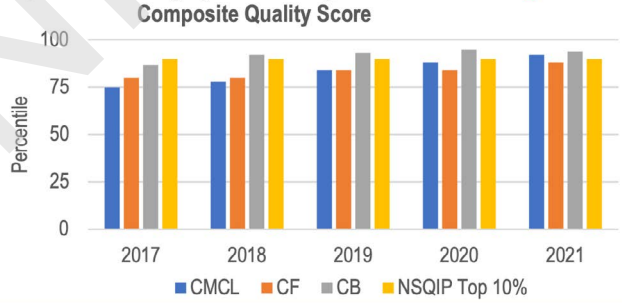


Figure 7.1-11: **Documentation of Current Medications in Office Visit Medical Record**

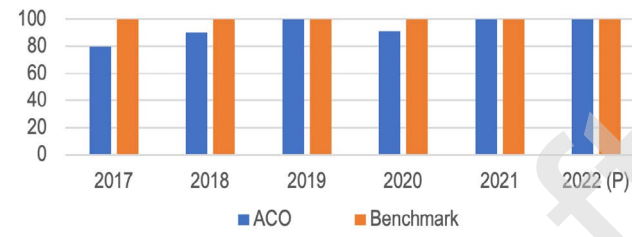


Figure 7.1-12: **Stroke Care—tPA Rate**

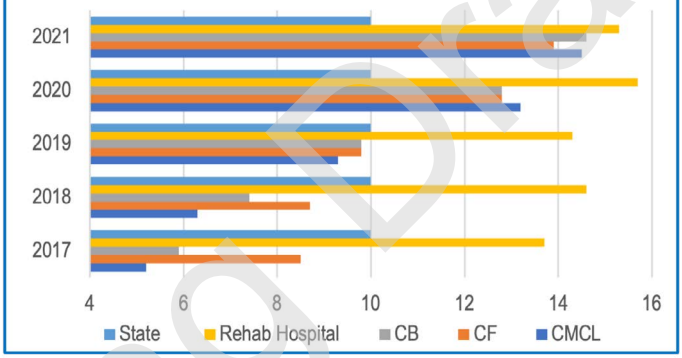
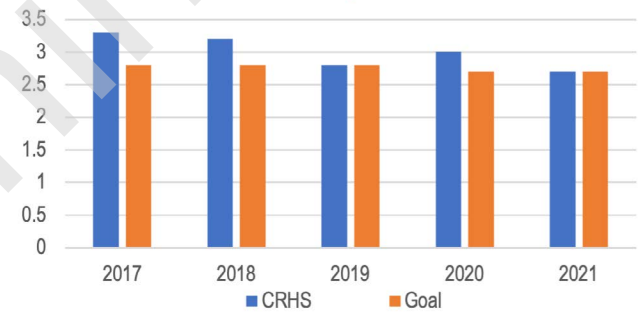


Figure 7.1-13: **CMI Adjusted LOS**



CRHS had no maternal deaths in 2021, outperforming the World Health Organization (WHO) national average (Figure 7.1-14). In addition, it participated in a state-wide initiative to prevent early elective deliveries (Figure 7.1-15) and is the trauma quality and mortality outcome leader in the region (Figure 7.1-16).

CRHS's focus on the continuum of patient care is intended to keep patients safe even after discharge. For example, the rate of pneumonia vaccination demonstrates top decile performance (Figure 7.1-17). In 2021, the ACO collaborated with the

Figure 7.1-14: **OB Mortality**

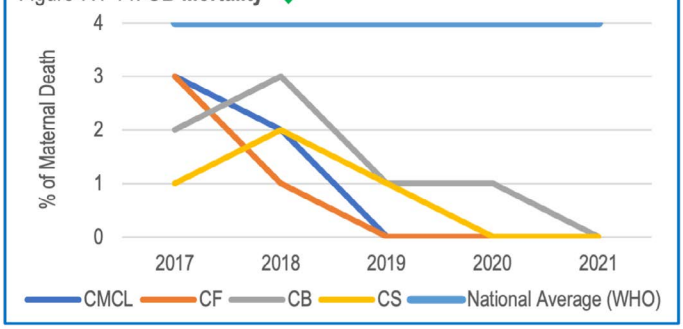


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Figure 7.1-15: **Elective Delivery Prior to 39 Weeks** ⬇

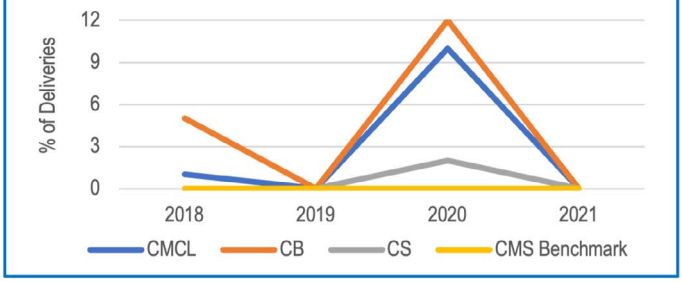


Figure 7.1-16: **Stroke Mortality Percentile Ranking** ⬆

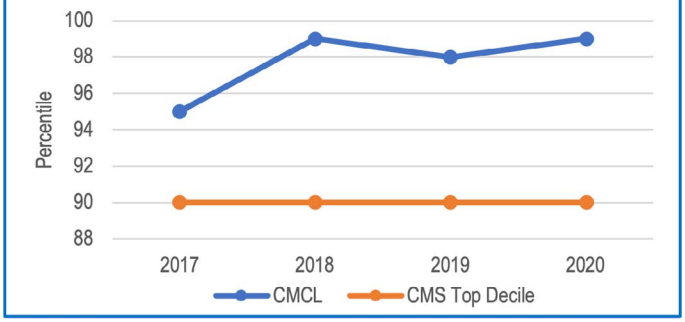
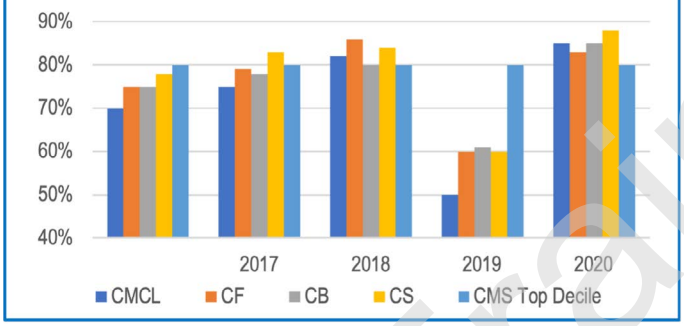


Figure 7.1-17: **Pneumonia Vaccination** ⬆



Kentucky Ophthalmology Group on a grant to improve diabetic preventive care (Figure 7.1-18).

Figure 7.1-19 shows the percentage of patients who left without being seen (LWBS).

CRHS performance is in the top decile for Home Health measures (Figures 7.1-20 and 7.1-21).

Hospice care enhances quality of life and provides services to patients' loved ones in dealing with loss and grief. A higher LOS indicates hospice care was initiated at a most appropriate time (Figure 7.1-22).

Figure 7.1-18: **Diabetic Yearly Eye Examinations** ⬆

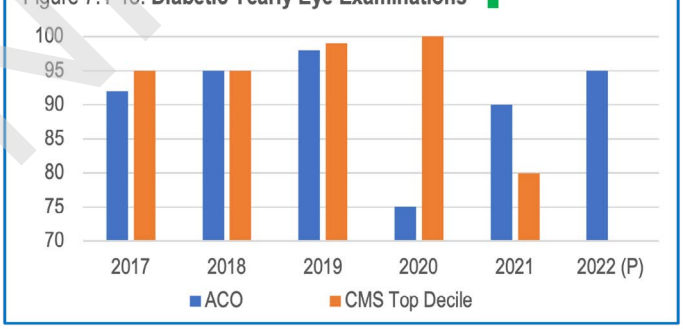


Figure 7.1-19: **ED Services LWBS** ⬇

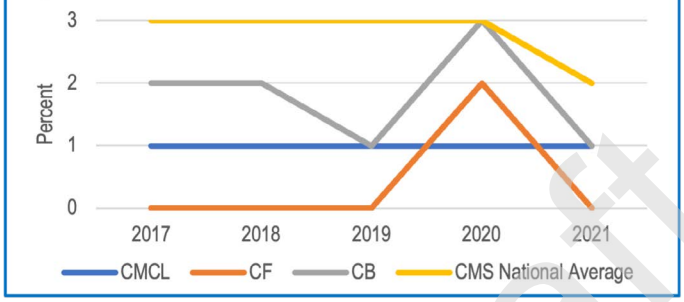


Figure 7.1-20: **Home Health Oral Medication Management** ⬆

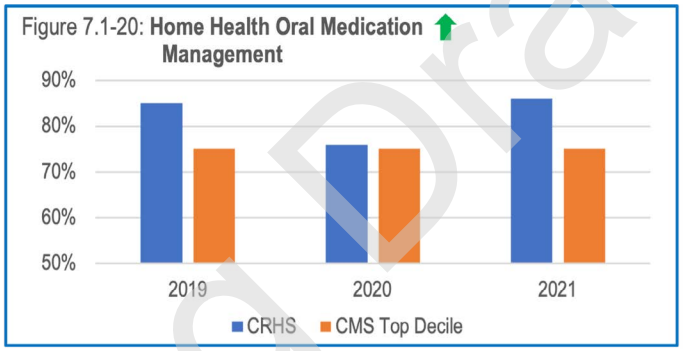


Figure 7.1-21: **Home Health Pain Management** ⬆

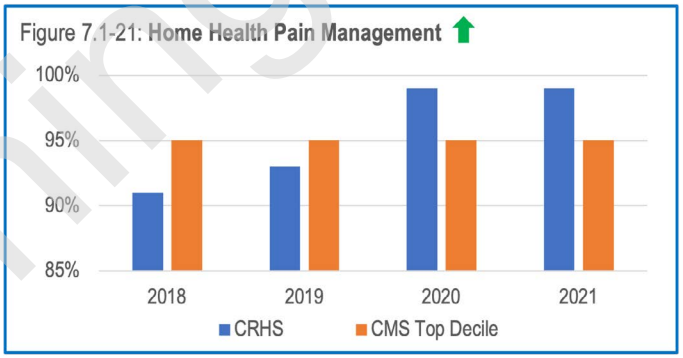
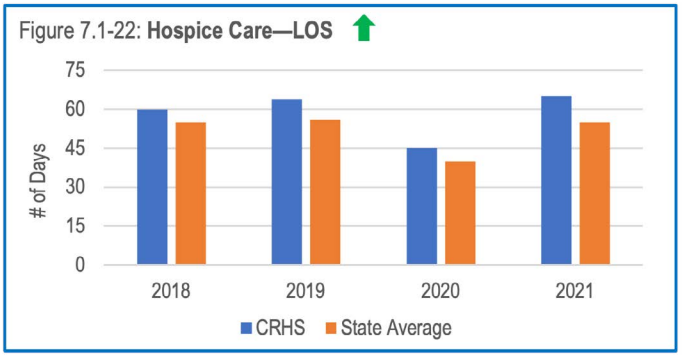


Figure 7.1-22: **Hospice Care—LOS** ⬆



Creation of a hospitalist discharge process at CMCL and CB has improved the goal for patients to see their primary care physician/provider (PCP) after discharge (Figure 7.1-23). These patients also benefitted from a lower rate of readmissions (AOS).

Readmission rates increased because of COVID, but they are now returning to pre-COVID levels (Figure 7.1-24).

A TRAC team at CMCL implemented multiple medication reconciliation process improvements that boosted documentation to benchmark levels. These improvements have been adopted at all facilities, which have also realized significant improvement (Figure 7.1-25).

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Figure 7.1-23: **PCP Appointment Scheduled at Discharge** ↑

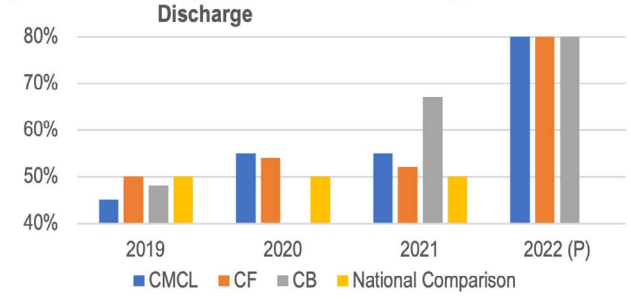


Figure 7.1-24: **Readmission Rate** ↓

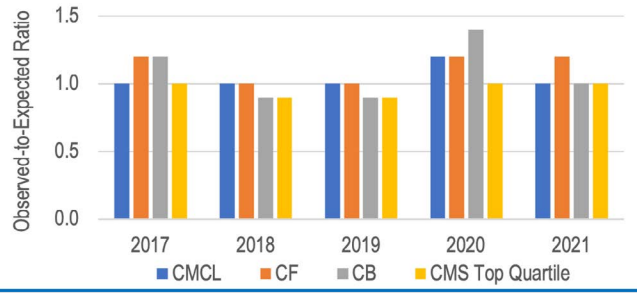
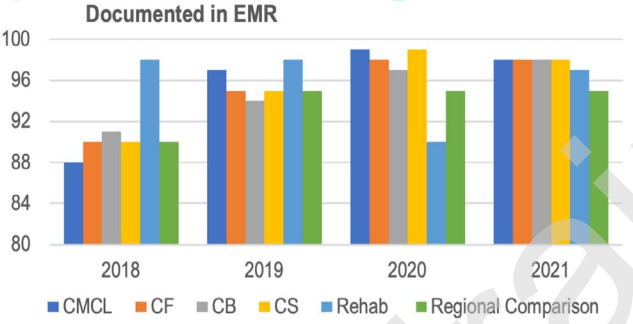


Figure 7.1-25: **Medication Reconciliation Documented in EMR** ↑



CRHS's work with community behavioral health agencies is supported by ensuring that patients are accurately assessed; one assessment tool is PHQ-9, a patient health questionnaire for depression screening (Figure 7.1-26).

MYPHI, the electronic medical record, provides a convenient way for patients to access their medical records and contact their providers. The pandemic helped to push use of MYPHI higher (Figure 7.1-27).

Figure 7.1-26: **PHQ-9 Completion Rate** ↑

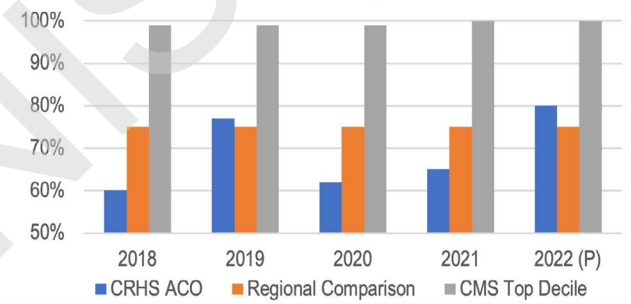
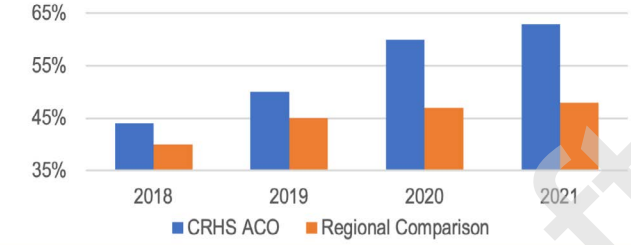


Figure 7.1-27: **MYPHI Activation** ↑



7.1b. Work Process Effectiveness Results

7.1b(1). Providing the best care is enhanced by CRHS's rapid turnaround times (TAT) for emergency services from the laboratory and imaging, with performance better than the national benchmarks (Figures 7.1-28 and 7.1-29).

CRHS's bed TAT is evidence of success in using Lean methods to improve discharge processes (Figure 7.1-30). In addition, operating room (OR) on-time starts is used to measure efficiency of surgical processes. Significant financial savings and surgical throughput (AOS) have been realized through

Figure 7.1-28: **Laboratory ED TAT within 30 Minutes (Troponin T)** *(Other tests AOS)* ↑

Figure 7.1-29: **Imaging ED TAT** ↓

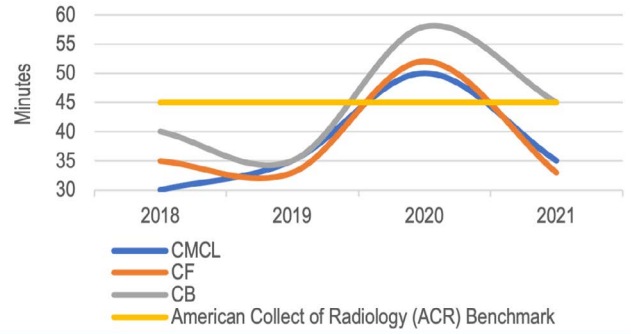
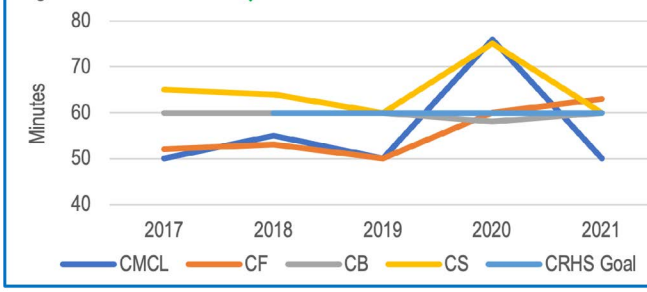


Figure 7.1-30: **Bed TAT** ↓



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cross-functional improvement teams removing waste from processes using Lean (Figure 7.1-31).

Service excellence is demonstrated by information systems and support services (Figure 7.1-32), and an emphasis on delivering service excellence to internal customers has resulted in an increase in service levels and satisfaction (AOS), including work order completion (Figure 7.1-33).

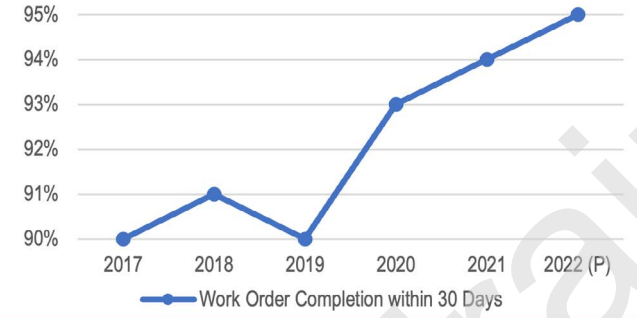
7.1-31: **OR On-time Starts Percent of On-Time Cases** ↑

	2019	2020	2021
JV Surgery Center	63%	65%	77%

7.1-32: **Information Management Services Metrics**

EMR Availability	2017	2018	2019	2020	2021	
Downtime (Minutes)	536	196	101	16	18	↓
Uptime %	99.1	99.5	99.8	99.8	99.8	↑
Support Desk 1st Contact Resolution	87%	94%	98%	92%	98%	↑
Support Desk Satisfaction	3.8	4.3	4.4	4	4.6	↑
Encrypted Devices	94%	97%	99%	99%	99%	↑
Workstation Antivirus Installed	74%	95%	99%	99%	99%	↑

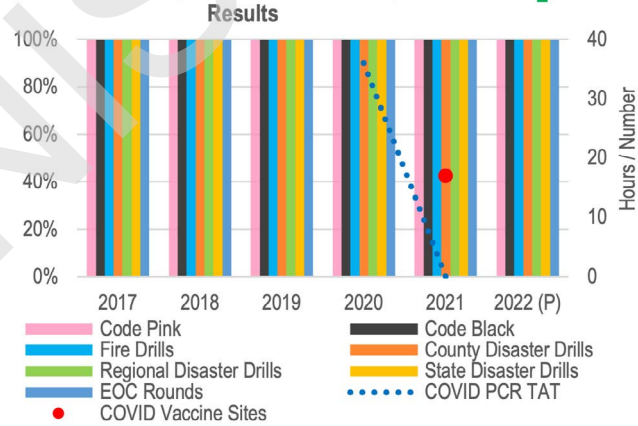
Figure 7.1-33: **Work Order Completion within 30 Days** ↑



7.1b(2). CRHS meets or exceeds all requirements for emergency and disaster preparedness. The pandemic posed challenges that were overcome by the organization and provided input for enhanced and more comprehensive action planning (Figure 7.1-34).

CRHS's COS Survey is conducted approximately every 18 months, and action plans to improve the culture continue (Figure 7.1-35). The COS survey for clinics and home health was initiated in 2022 (results AOS).

Figure 7.1-34: **Emergency and Disaster Preparedness Results** ↑



7.1-35: **COS Survey Results** ↑

	Overall Perception of Safety			Nonpunitive Response to Errors			Teamwork Across Units		
	2016	2019	2021	2016	2019	2021	2016	2019	2021
CMCL	54%	66%	67%	33%	41%	45%	69%	75%	83%
CF	60%	68%	67%	36%	43%	42%	68%	80%	80%
CB	58%	64%	66%	35%	41%	43%	68%	73%	80%
CS	65%	66%	66%	43%	48%	47%	75%	79%	85%
All Hospitals*	66%	66%	66%	44%	44%	44%	80%	81%	81%

**COS Survey Vendor Comparison*

7.1c. Supply-Network Management Results

Supplier management and inventory results are evidence of excellent relationships and processes (details and segmentation AOS).

7.2 Customer Results

7.2a. Patient- and Other Customer-Focused Results

7.2a(1). The national CAHPS Surveys are the primary method of collecting comparable, quantitative data on patient satisfaction. Figures 7.2-1 through 7.2-5 show CRHS's inpatient facilities' satisfaction relative to competitors and to national performance in areas of importance to its patients. CRHS is proud to be the market leader in patient satisfaction, with some facilities ranking in the top decile nationally.

Figures 7.2-6 through 7.2-11 demonstrate CRHS's success in achieving patient satisfaction in its EDs; physician practices; outpatient facilities; and services such as behavioral health, home health, and hospice. Further segmentation is AOS.

Figure 7.2-1: **Inpatient Overall Ratings** ↑

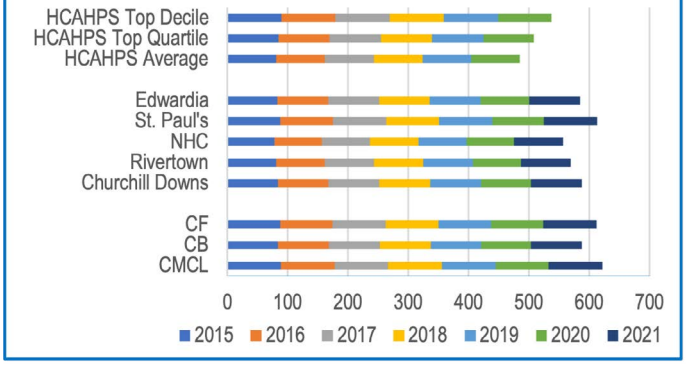


Figure 7.2-2: **Inpatient RN Communication (%)** ↑

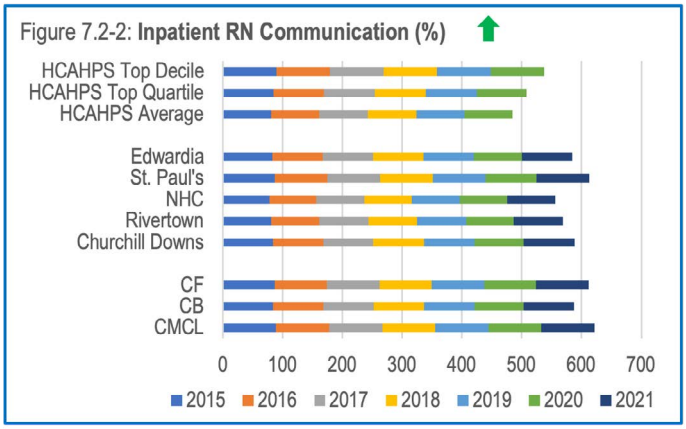


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Figure 7.2-3: **Inpatient MD Communication (%)**

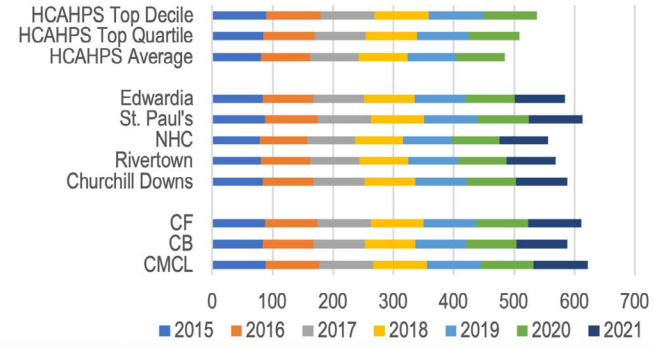


Figure 7.2-4: **Inpatient Discharge Information by SL (%)**

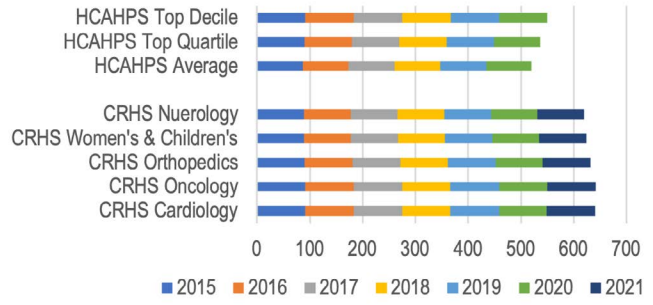


Figure 7.2-5: **EDCAHPS Overall (%)**

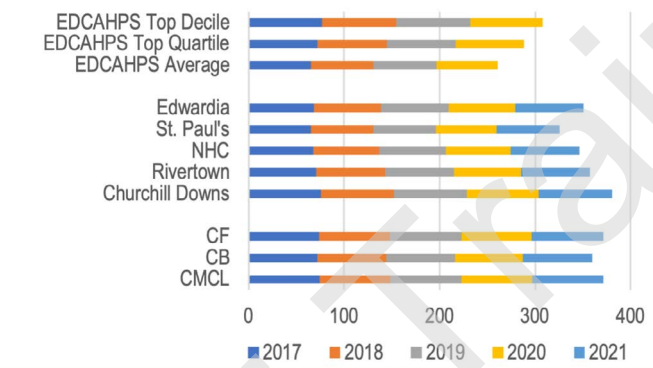


Figure 7.2-6: **CGCAHPS Overall (%)**

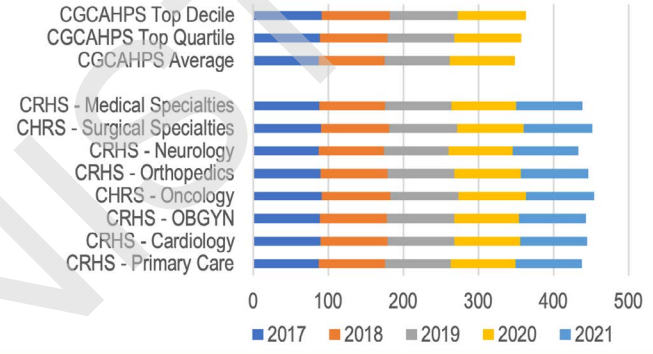


Figure 7.2-7: **Inpatient Rehab Patient Satisfaction**

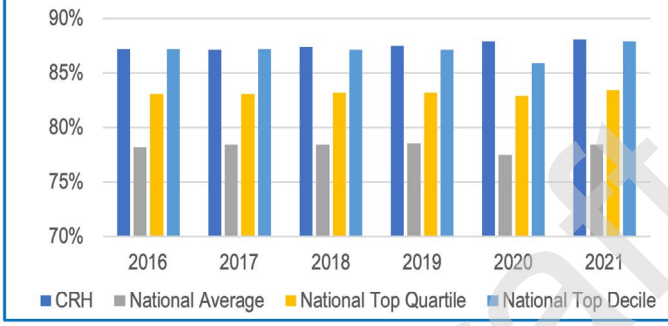


Figure 7.2-8: **Behavioral Health Patient Satisfaction (%)**

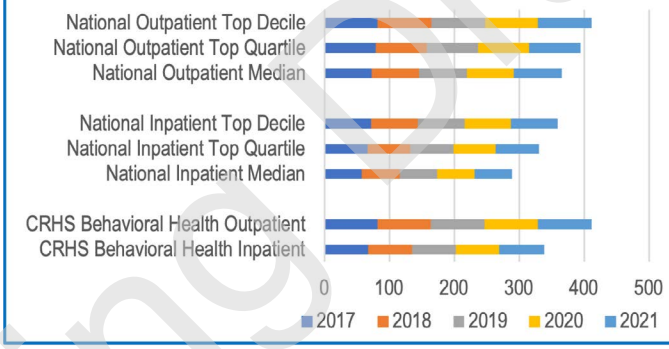


Figure 7.2-9: **Outpatient Satisfaction (%)**

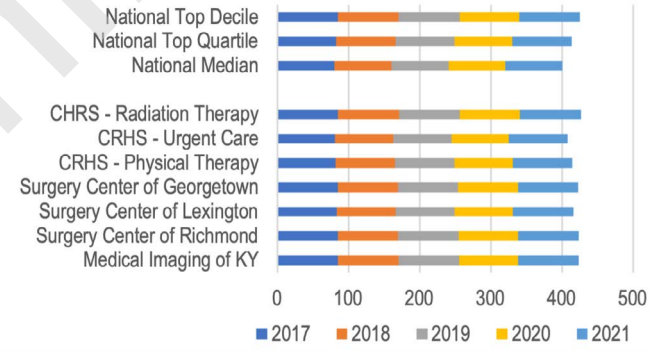
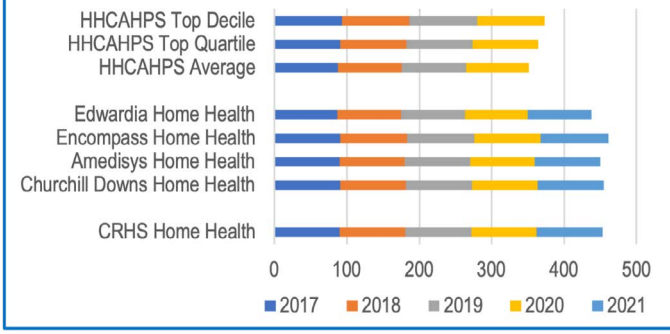


Figure 7.2-10: **HHCAHPS Overall (%)**



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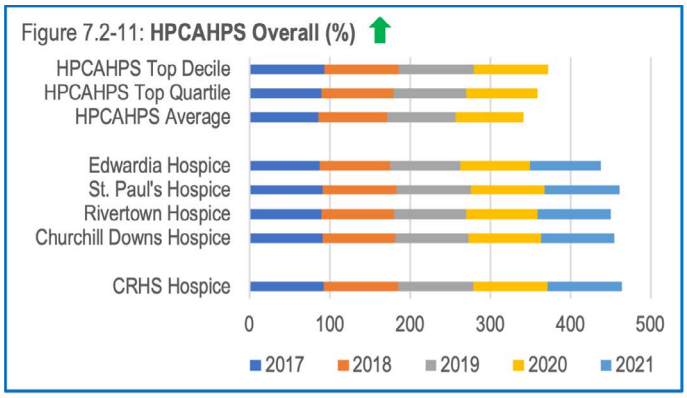
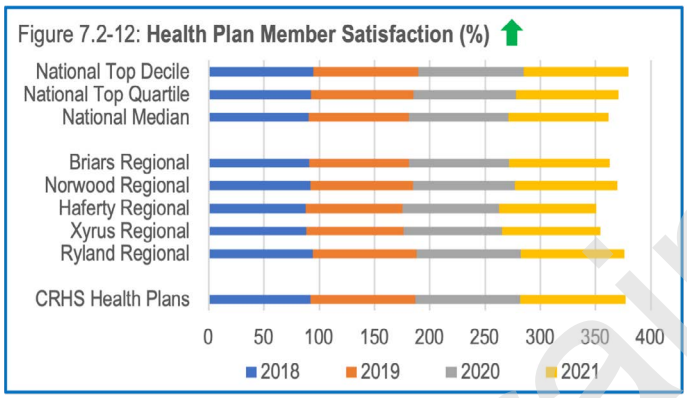
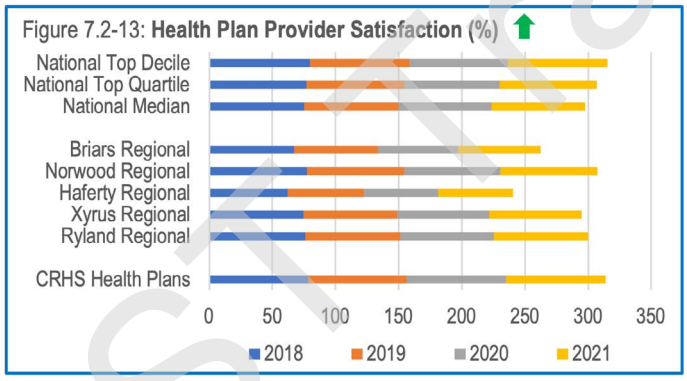


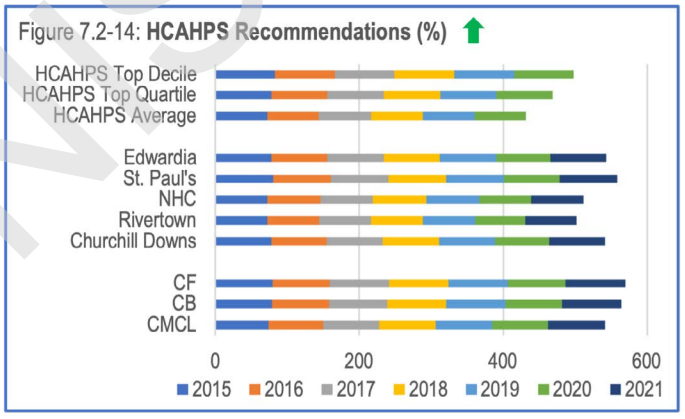
Figures 7.2-12 and 7.2-13 depict CRHS's strong member and provider satisfaction with its health plans.

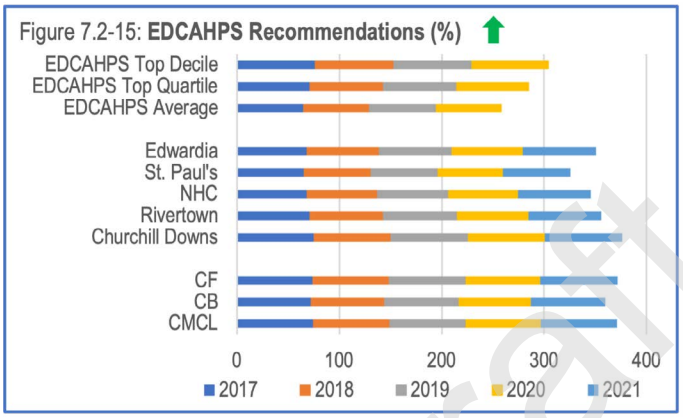
Figures 7.2-14 and 7.2-15 depict the likelihood of hospital and ED patients recommending CRHS's facilities. This type of data is AOS for all services.

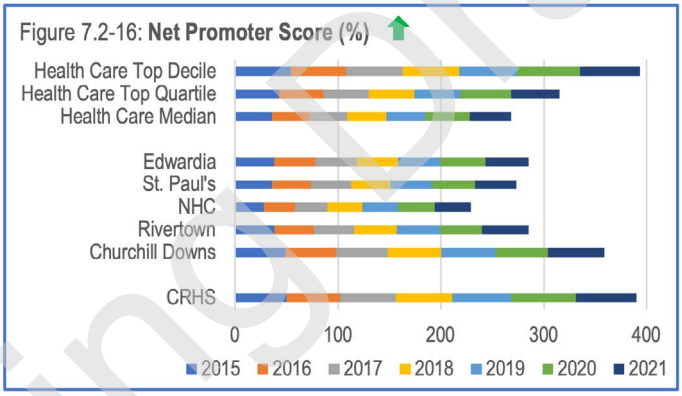
Family members are also considered to be customers. As such, Figure 7.2-16 shows CRHS's strong and improving











performance in Net Promoter Score; this is one measure for showing the satisfaction of patients' families.

7.2a(2). CRHS measures engagement in numerous ways. It also monitors social media vigorously to learn and improve its offerings. As such, its social media engagement and reputation scores (Figures 7.2-17 through 7.2-19) have continued to improve and are the best in the market.

In-person and virtual tours (AOS) were initially developed to introduce people to CRHS's products and services but now are sought for professional and educational group tours; tours serve as an outreach/marketing method to communicate with the community. Virtual tours are on-demand and often viewed by individuals who have a near-term need.

CRHS's relatively new Seekers Program (3.1b[2]) is another way it is working to engage patients and community members (Figure 7.2-20).

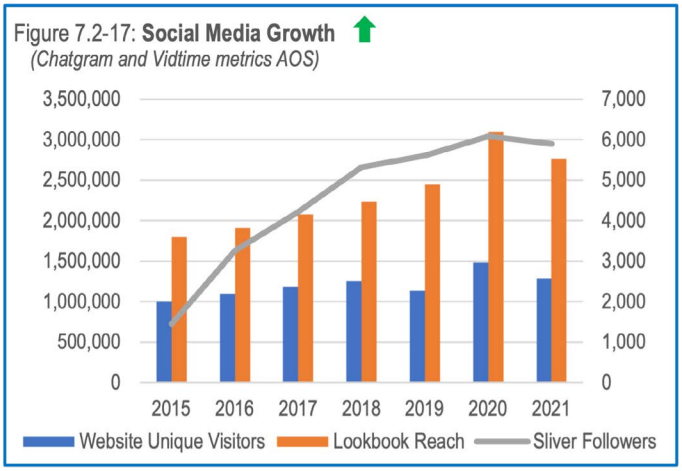


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Figure 7.2-18: **Reputation Score (5-point scale)**

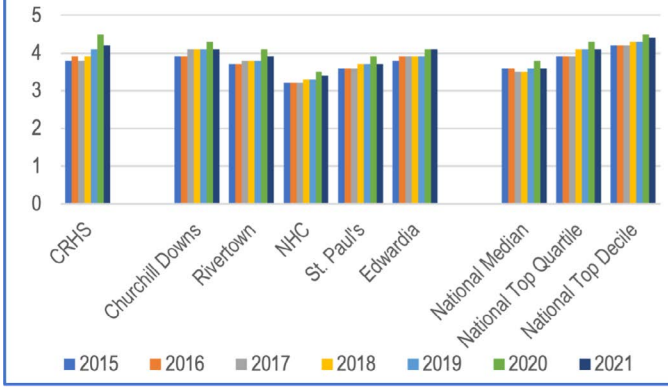

Figure 7.2-19: **Complaints Per 1K Patients Per Day**

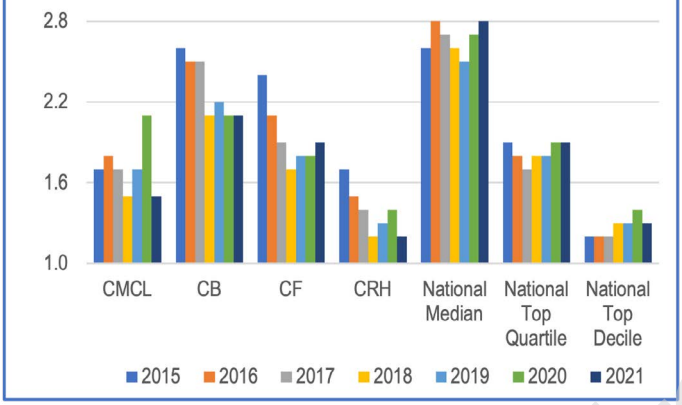

Figure 7.2-20: **Seekers Customers**

	Population	New Insurance	Care Customer
2020	8,000	6	952
2021	14,128	25	3,200
2022 Projected	15,000	30	3,500

CRHS is receiving ever-increasing interest and satisfaction from the community and potential patients (details and segmentation AOS). CRHS also monitors and manages complaints at a system and entity level. It continues to see an improvement in reducing complaints.

7.3 Workforce Results

7.3a. Workforce-Focused Results

CRHS disaggregates key results by the five business-unit groupings at the bottom of Figure 2.2-2. In addition, most results reported there are segmented by workforce classification and/or location, as appropriate. Many other segment results are AOS, down to the work unit level in many cases.

7.3a(1). Except for the pandemic effects in 2020, the CCM variance has improved since 2014. If the variance is less than 10% between predicted and actual labor costs, CRHS considers it effective. CRHS has searched for comparisons and has had little success other than from two previous BARs, which may measure the capability differently, but do provide a comparison (Figure 7.3-1). Data related to emergency services, outpatient diagnostics and treatment, medical offices, and post-acute care are AOS.

The results in Figure 7.3-2 show the number of physicians with admitting privileges, along with how well CRHS has retained residents.

Cross-trained employees were a lifeline during the pandemic. CRHS has a goal to have everyone cross-trained, as defined by their departments, by 2023 (Figure 7.3-3). It expects to achieve this goal.

Figure 7.3-1: **CCM Variance**

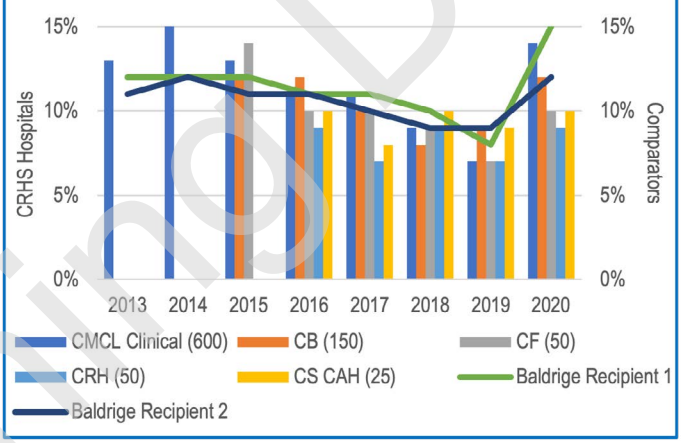

Figure 7.3-2: **Physician CC**

	2017	2018	2019	2020	2021
# Physicians w/Admitting Privileges	874	908	946	973	1,018
# New Practitioners	126	154	184	213	232
Resident Retention	49%	55%	58%	54%	64%
Comparators					
Baldrige Recipient 1 Physicians w/Admitting Privileges	412	459	539		
Baldrige Recipient 1 Resident Retention	24%	28%	41%		
Baldrige Recipient 2 Physicians w/Admitting Privileges		596	613	621	642
Baldrige Recipient 2 Resident Retention		25%	31%	34%	38%

Figure 7.3-3: **Cross-trained Workforce** *(By Location AOS)*

	2018		2019		2020		2021		2022 (P)	2022 (P)
	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Target	Target
By Business Unit grouping (Figure 2.2-2)										
Hospitals	21%	20%	36%	40%	52%	60%	76%	75%	90%	100%
Outpatient Diagnostic and Treatment	19%	20%	41%	40%	60%	60%	77%	75%	90%	100%
Medical Offices	23%	20%	42%	40%	63%	60%	75%	75%	90%	100%
Post-acute care	22%	20%	42%	40%	55%	60%	71%	75%	90%	100%
Health Insurance	48%	20%	55%	40%	71%	60%	78%	75%	90%	100%

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Overall workforce retention is important to maintain CC (Figure 7.3-4; ST represents short term, LT represents long term).

As shown in Figure 7.3-5, the metric for average time to fill has driven improvements in the recruiting process and especially helps CRHS monitor how quickly it is filling positions in nursing, health care technology, and some physician specialties. Segmented results down to specific positions are AOS.

Volunteers play an important role in expanding CRHS's capacity, and they were missed in 2020 when it asked them to stay away during the pandemic (Figure 7.3-6).

The result shown in Figure 7.3-7 is a good indication of nursing capability.

Figure 7.3-7: **Nurse Managers with BSN**

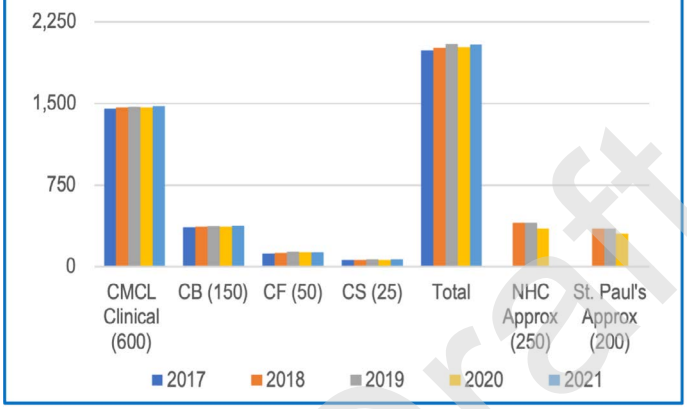

Figure 7.3-4: **Workforce Retention Overall** *(By Location AOS)*

	2015	2016	2017	2018	2019	2020	2021	2022 P	Goal	ST (P)	LT (P)
By Classification (More detailed segmentations AOS)											
Physician Retained (employed and non)	75%	78%	78%	81%	80%	82%	85%	85%	90%	86%	90%
Caregivers	83%	85%	86%	88%	88%	89%	91%	91%	90%	91%	90%
Caregiver Support	78%	79%	78%	83%	88%	84%	90%	90%	90%	90%	90%
Caregiver Allies	87%	88%	90%	89%	88%	90%	92%	92%	92%	92%	90%
Competitors											
Competitor 1	88%	90%	90%	90%	92%						
Competitor 2		84%	85%	86%	87%	88%					

Figure 7.3-5: **Average Time to Fill (Days)** *(By Location AOS)*

	2015	2016	2017	2018	2019	2020	2021	ST (P)	LT (P)
By Classification									
Physician (Days)	98	88	90	86	80	101	72	72	63
Nurses	42	43	45	36	39	53	40	42	35
Technologists	45	45	44	43	43	45	39	42	35
Other Caregivers	38	37	35	32	29	37	25	27	27
Caregiving Support	22	20	20	18	20	26	22	21	21
Caregiving Allies	21	24	25	22	22	23	22	21	21
Comparatives									
Baldrige Recipient Overall Time to Fill	48	35	30	60	45	n/a	n/a		
World at Work Median—Health Care Sector	50	52	51	48	55	51	n/a		
SHRM Best Performer—Health Care Sector	41	38	36	36	35	42	n/a		

Figure 7.3-6: **Volunteer Presence (Hours)**

	2017		2018		2019		2020		2021		ST (P)	LT (P)
	Number of Volunteers	Average Hours (Weekly)	Number of Volunteers	Average Hours (Weekly)	Number of Volunteers	Average Hours (Weekly)	Number of Volunteers	Average Hours (Weekly)	Number of Volunteers	Average Hours (Weekly)	Average Hours	
CMCL (600)	342	8	348	10	375	10	188	11	350	12	12	12
CB (150)	118	6	120	7	135	8	62	10	115	10	10	12
CF (50)	14	5	15	8	15	7	11	7	20	8	10	12
CS (25)	7	4	5	5	10	4	5	5	15	6	10	12
ToT	481		488		535		266		500			
NHC Total (250)	133		121		140		122					
St. Paul's Total (200)	88		90		95		43					

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7.3a(2). Figure 7.3-8 shows the results of the workforce environment metrics and goals discussed in 5.1.

Figure 7.3-9 summarizes CRHS's success in keeping the workforce safe. Additional segmented results are AOS.

Figure 7.3-10 shows the variance between the workforce and the diversity of the patient and community profile. The target is +/–5% variance, which is much more challenging in small and specialized work units.

Figure 7.3-8: **Workforce Environment**

Workforce Environment	2017	2018	2019	2020	2021	Goal	Projected ST	Projected LT	
CDC Worksite Wellness Score	n/a	188	193	182	195	220	195	220	↑
Physician Burnout	n/a	n/a	34%	33%	31%	29%	31%	29%	↓
Wellness Program Participation	75%	81%	88%	83%	91%	90%			↑
Influenza Immunization	90%	93%	97%	100%	100%	100%			↑
TB Test Compliance	92%	97%	100%	100%	100%	100%			↑
Emergency Responders Incidents	31	27	22	8	14	15			↓
Accommodation Requests Met	n/a	87%	88%	90%	92%	90%			↑

Figure 7.3-9: **Workforce Safety** ↓

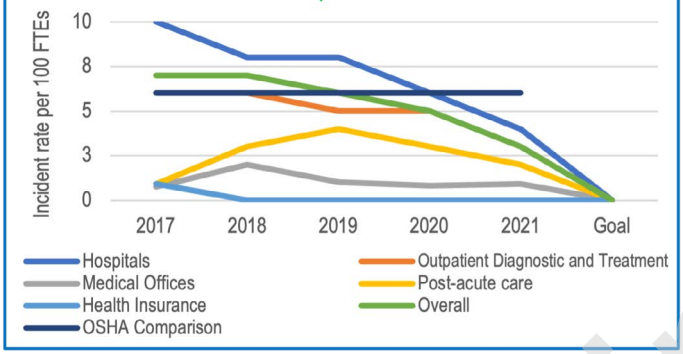
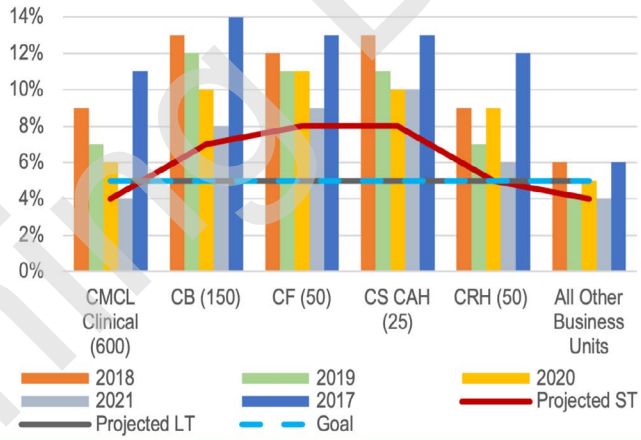


Figure 7.3-10: **Diversity Report Variances** ↓



7.3a(3). This version of the Satisfaction Survey (Figure 7.3-11) has been administered since 2018. More segmented data are AOS.

The results in Figures 7.3-12 through 7.3-17 demonstrate overall workforce engagement and engagement by employed physicians and residents, nonemployed physicians, other caregivers, caregiver support and allies, students, and volunteers.

First-year retention is an indicator of engagement with CRHS and the effectiveness of the recruitment and hiring processes (Figure 7.3-18). CRHS has focused on this indicator in recent years. Additional segmentation is AOS.

Figure 7.3-11: **Workforce Satisfaction** ↑

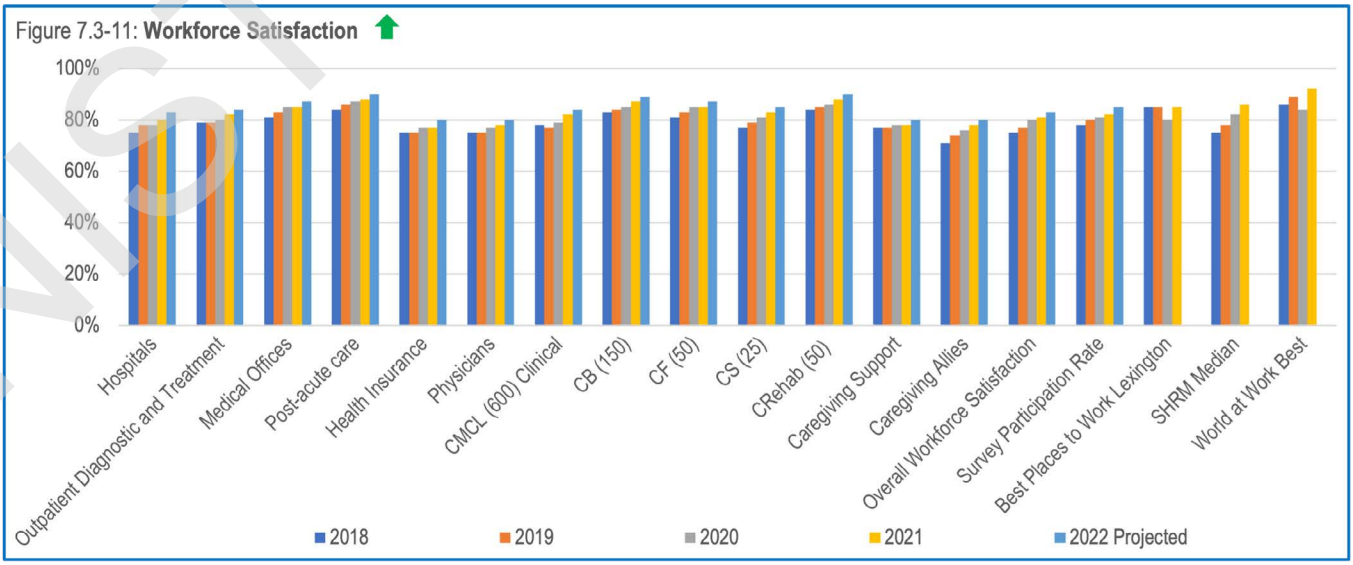


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Figure 7.3-12: **Overall Workforce Engagement** ⬆

		2018	2019	2020	2021	2022 (P)	ST	LT
Hospitals		81%	82%	83%	83%	84%	84%	86%
Outpatient Diagnostic and Treatment		81%	83%	82%	84%	84%	84%	86%
Medical Offices		80%	80%	82%	81%	82%	84%	86%
Post-acute Care		82%	83%	85%	87%	87%	87%	87%
Health Insurance		78%	80%	80%	81%	82%	84%	86%
Caregivers	Physicians	75%	76%	78%	79%	80%	84%	86%
	CMCL (600) Clinical	77%	79%	81%	82%	84%	84%	86%
	CB (150)	81%	80%	82%	84%	84%	84%	86%
	CF (50)	81%	83%	83%	84%	85%	85%	86%
	CS (25)	78%	79%	81%	80%	81%	84%	86%
	Rehab (50)	83%	84%	84%	86%	87%	87%	87%
Caregiving Support		78%	80%	81%	82%	82%	84%	86%
Caregiving Allies		76%	77%	78%	80%	82%	84%	86%
Overall Workforce Engagement		79%	80%	82%	82%	84%	84%	86%
Upwood Top Quartile		80%	80%	80%	80%			
Upwood Top Decile		90%	90%	90%	90%			

Figure 7.3-13: **Employed Physician and Resident Engagement** ⬆

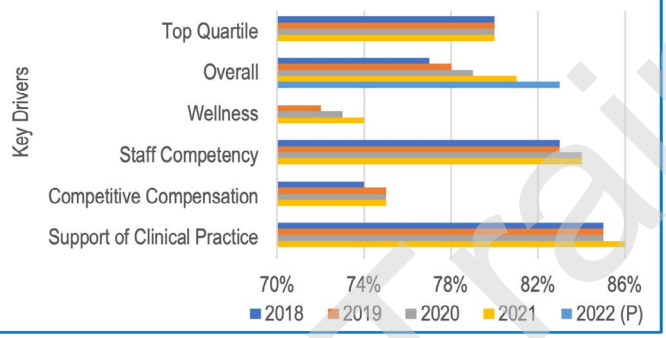
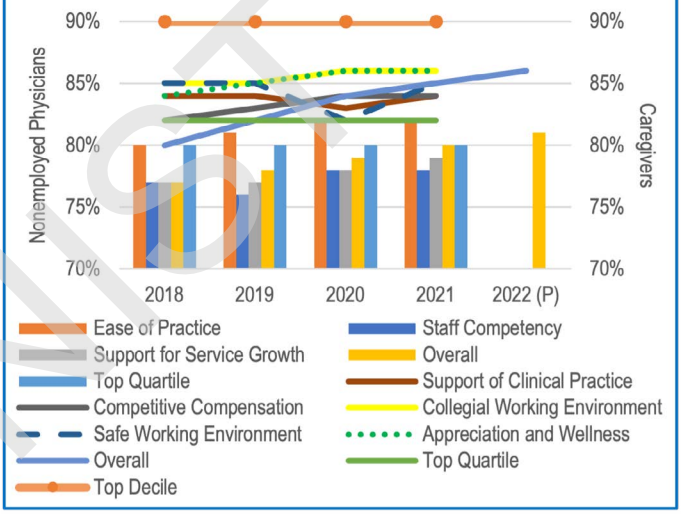


Figure 7.3-14: **Nonemployed Physician and Caregiver Engagement** ⬆



CRHS views the workforce's support of the community and participation in community health events to be another indication of engagement (Figure 7.3-19). Additional segmentation is AOS.

Figure 7.3-15: **Caregiver Support for All** ⬆

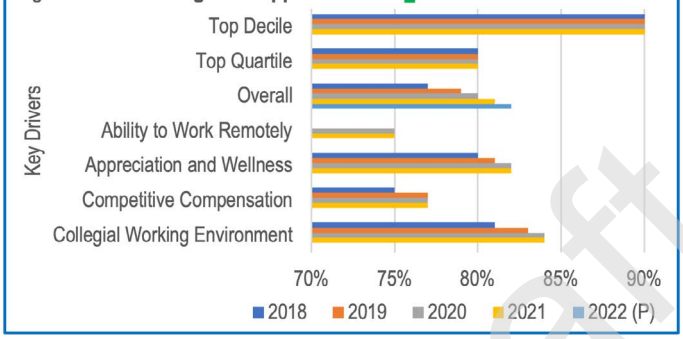


Figure 7.3-16: **Student Engagement** ⬆

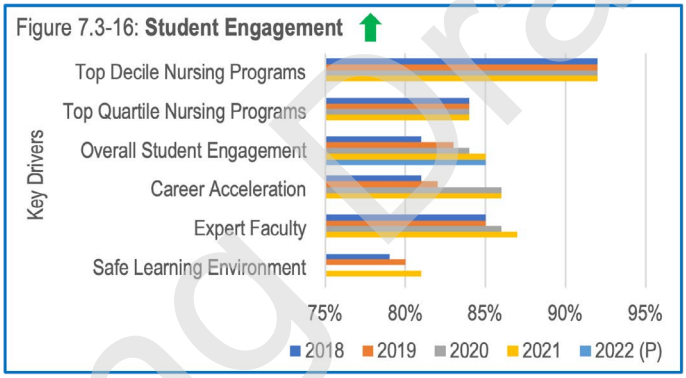


Figure 7.3-17: **Volunteer Engagement** ⬆

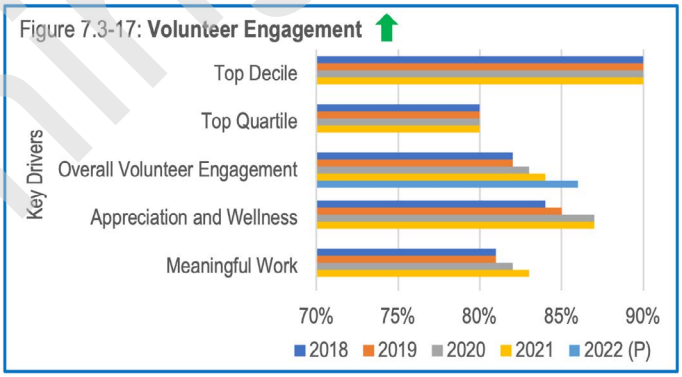
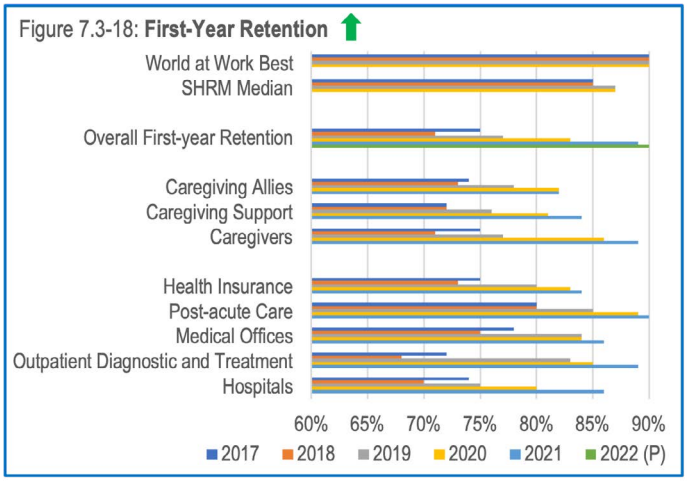


Figure 7.3-18: **First-Year Retention** ⬆



CRHS has only two collective bargaining units: (1) environmental and facilities employees at all hospitals and (2) CMCL nurses. CRHS monitors grievances filed as an indicator of engagement; it expects management to work with union leaders to resolve issues before they become formal grievances, if possible (Figure 7.3-20).

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Figure 7.3-19: **Participation in Community Health Events**

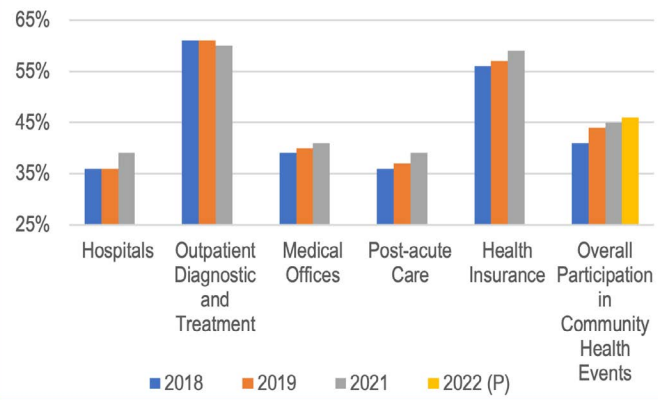
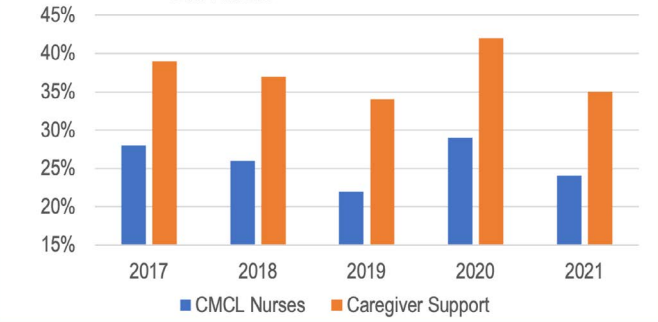


Figure 7.3-20: **Collective Bargaining Agreement Grievances**



7.3a(4). CRHS tracks the level of participation in the Aspire LDS courses (Figure 7.3-21). Additional segmentation is AOS.

CRHS is tracking the number of LDP graduates. After a slow start when initially introduced, LDP has a lot of interest from many members of the workforce, as they see the activities they can become involved in and the potential career advances that may result (Figure 7.3-22). Additional segmentation is AOS.

Figure 7.3-21: **Workforce Participation in Aspire LDS**

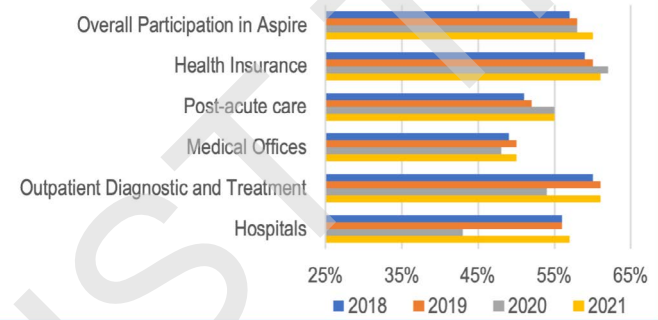
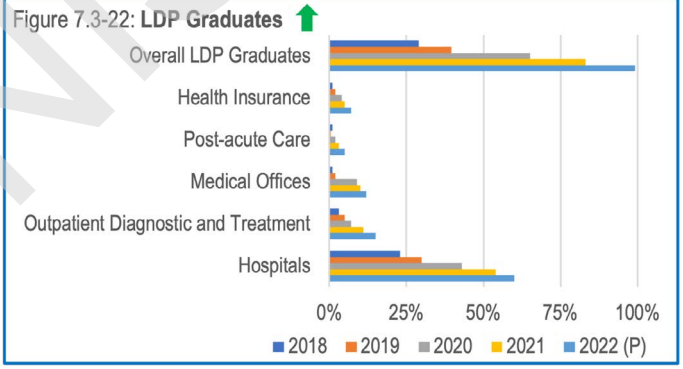


Figure 7.3-22: **LDP Graduates**



The LDS is evaluated annually, and results are correlated with patient and workforce engagement (Figure 7.3-23).

CRHS strongly supports members of the workforce continuing their education and obtaining professional certifications (Figure 7.3-24). Segmentation is AOS.

Figure 7.3-23: **LDS Effectiveness**

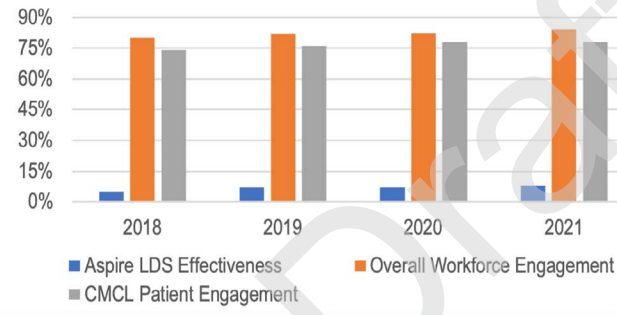


Figure 7.3-24: **Professional Development**

	2018	2019	2020	2021
Tuition Reimbursement #	207	213	113	244
Tuition Reimbursement $	$451k	$491k	$291k	$502k
Educational reimbursement #	393	420	372	423
Educational reimbursement $	$122k	$153k	$98k	$184k

7.4 Leadership and Governance Results

7.4a. Leadership, Governance, and Societal Contribution Results

7.4a(1). Workforce results are depicted in Figure 7.4-1 with CRHS meeting or exceeding benchmarks. (SL–WF communication results are captured via the annual WF Kress Daney Survey, and engagement is measured using the Upwood Q12 Survey.)

Figure 7.4-2 reflects SL communication and engagement with patients, families, the community, and partners. Measures of SL's personal actions supporting CRHS's MVV are reported in Figures 7.4-3 through 7.4-5.

Figure 7.4-1: **Sample of SL–WF Communication and Engagement**

	2015	2016	2017	2018	2019	2020	2021
SL–WF COMMUNICATION							
CMCL	4.4	4.4	4.3	4.4	4.5	4.5	4.5
CB	4.3	4.3	4.3	4.4	4.5	4.5	4.6
CF	4.3	4.3	4.3	4.2	4.4	4.4	4.5
CS	4.5	4.5	4.6	4.5	4.6	4.5	4.5
Rehab Hosp	4.3	4.4	4.4	4.3	4.5	4.4	4.5
Medical Offices	4.3	4.2	4.3	4.3	4.4	4.4	4.4
Outpatient	4.2	4.2	4.2	4.2	4.3	4.4	4.4
Post-Acute	4.2	4.2	4.1	4.3	4.4	4.4	4.4
Health Insurance	4.4	4.4	4.5	4.4	4.5	4.5	4.5
Corporate Service Center	4.3	4.3	4.6	4.3	4.4	4.4	4.4
Upwood Top Quartile	4.2	4.2	4.2	4.2	4.2	4.2	4.2
Upwood Top Decile	4.4	4.4	4.4	4.4	4.4	4.4	4.4

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Figure 7.4-1: **Sample of SL–WF Communication and Engagement** ↑ ***(continued)***

	2015	2016	2017	2018	2019	2020	2021
CARES ABOUT ME ***Upwood Q5: My supervisor, or someone at work, seems to care about me as a person***							
CMCL	4.3	4.3	4.4	4.4	4.6	4.5	4.5
CB	4.4	4.4	4.4	4.5	4.6	4.5	4.4
CF	4.3	4.3	4.2	4.3	4.5	4.5	4.5
CS	4.4	4.4	4.4	4.4	4.5	4.6	4.6
Rehab Hosp	4.3	4.3	4.3	4.3	4.4	4.4	4.5
Medical Offices	4.3	4.3	4.4	4.4	4.5	4.3	4.5
Outpatient	4.2	4.2	4.3	4.4	4.5	4.3	4.5
Post-Acute	4.2	4.2	4.3	4.4	4.4	4.3	4.4
Health Insurance	4.5	4.5	4.4	4.5	4.5	4.5	4.5
Corporate Service Center	4.3	4.3	4.6	4.3	4.4	4.4	4.5
Upwood Top Quartile	4.2	4.2	4.2	4.3	4.3	4.3	4.3
Upwood Top Decile	4.4	4.4	4.4	4.5	4.5	4.5	4.5
KNOWS WHAT IS EXPECTED ***Upwood Q1: I know what is expected of me***							
CMCL	4.5	4.5	4.5	4.5	4.6	4.5	4.5
CB	4.4	4.4	4.4	4.5	4.6	4.5	4.5
CF	4.2	4.3	4.3	4.3	4.5	4.5	4.5
CS	4.4	4.4	4.3	4.4	4.5	4.4	4.4
Rehab Hosp	4.2	4.2	4.3	4.3	4.4	4.4	4.4
Medical Offices	4.3	4.3	4.2	4.3	4.4	4.4	4.4
Outpatient	4.2	4.2	4.3	4.3	4.4	4.4	4.5
Post-Acute	4.2	4.2	4.2	4.2	4.4	4.4	4.4
Health Insurance	4.3	4.3	4.4	4.3	4.4	4.4	4.4
Corporate Service Center	4.3	4.3	4.4	4.4	4.4	4.4	4.5
Upwood Top Quartile	4.3	4.3	4.3	4.3	4.3	4.3	4.3
Upwood Top Decile	4.4	4.4	4.4	4.4	4.4	4.4	4.4

Figure 7.4-2: **SL Communication and Engagement with Patients, Families, the Community, and Partners** ↑

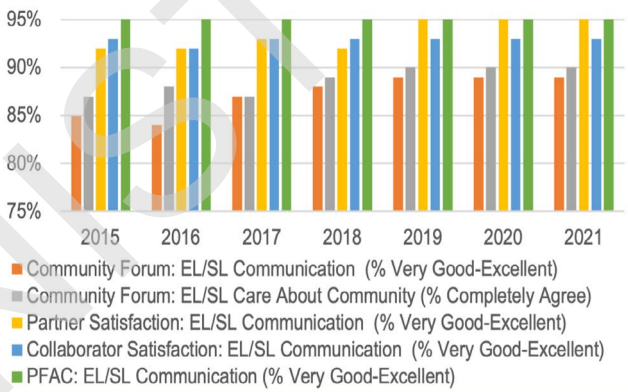

Figure 7.4-3: **SL Actions Support MVV, Percentile Rank: Employees, Volunteers, Medical Staff Students (Academic Medical Centers)** ↑

	2015	2016	2017	2018	2019	2020	2021
CMCL							
Employees	88%	87%	88%	89%	91%	90%	91%
Volunteers	89%	88%	89%	90%	90%	90%	90%
Medical Staff	88%	87%	88%	89%	90%	90%	90%
Students	89%	89%	90%	89%	89%	88%	89%
Churchill Downs							
Employees	90%	91%	89%	92%	92%	92%	92%
Volunteers	89%	89%	88%	88%	89%	88%	89%
Medical Staff	88%	88%	88%	89%	89%	89%	89%
Students	89%	89%	90%	90%	90%	88%	89%
Rivertown							
Employees	88%	89%	89%	90%	90%	90%	90%
Volunteers	89%	89%	89%	90%	90%	88%	90%
Medical Staff	90%	89%	89%	90%	91%	90%	90%
Students	90%	90%	90%	91%	91%	89%	91%

Figure 7.4-4: **SL Actions Support MVV, Percentile Rank: Employees, Volunteers, Medical Staff Nonteaching Hospital** ↑

		2015	2016	2017	2018	2019	2020	2021
200 Bed	**CB**							
	Employees	87%	87%	88%	88%	89%	88%	89%
	Volunteers	88%	88%	88%	88%	88%	86%	88%
	Medical Staff	88%	88%	89%	89%	90%	90%	90%
Competitor	**St. Paul's Hospital**							
200 Bed	Employees	81%	81%	80%	82%	83%	82%	83%
	Volunteers	81%	81%	81%	82%	82%	80%	82%
	Medical Staff	83%	82%	83%	83%	83%	83%	83%
150 Bed	**CF**							
	Employees	90%	90%	91%	91%	91%	91%	91%
	Volunteers	90%	90%	90%	90%	90%	89%	90%
	Medical Staff	90%	90%	89%	90%	90%	91%	91%
Competitor	**Edwardia Hospital**							
150 Bed	Employees	85%	84%	85%	85%	85%	84%	84%
	Volunteers	88%	88%	87%	88%	87%	87%	88%
	Medical Staff	83%	83%	83%	82%	82%	83%	83%
CAH	**CS**							
	Employees	91%	93%	93%	93%	92%	92%	93%
	Volunteers	88%	88%	88%	88%	88%	85%	88%
	Medical Staff	90%	90%	90%	90%	90%	90%	90%

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Figure 7.4-5: **SL Actions Support MVV (Employees)**

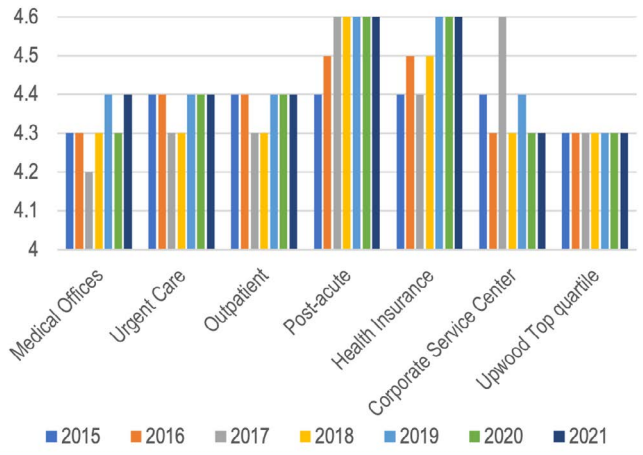

Figure 7.4-6: **Governance Effectiveness, Self-Evaluation**

	2017	2018	2019	2020	2021	KY Hosp Benchmark
Board's Fiduciary Role	98%	98%	98%	98%	98%	98%
Mission, Strategy, and Stakeholders	100%	100%	100%	100%	100%	100%
Governance and Leadership Effectiveness	99%	99%	99%	99%	99%	99%
Finance	99%	99%	99%	99%	99%	99%
Quality and Patient Safety	89%	93%	95%	95%	95%	95%
Board-CEO Relationship	98%	98%	98%	98%	98%	98%
CEO Evaluation Effectiveness	99%	98%	99%	99%	99%	99%
Board Member, Self-Evaluation						
Board Member Satisfaction	98%	98%	98%	98%	98%	98%
Stakeholder Trust	Using CRHS Survey					CRHS Goal
Stakeholder Trust in SL and Governance	3.7	3.6	3.9	3.8	3.81	3.79

7.4a(2). Governance accountability results (Figure 7.4-6) reflect the BOT's annual self-assessment using the Kentucky Hospital Association's Governance Survey and individual board member satisfaction. Fiscal accountability results (Figure 7.4-7) include external audits classified as unqualified for CRHS, the Foundation, Multispecialty Group, and Joint Ventures. CRHS has maintained the highest Zandi bond AAA rating since 2019; and as a result of its COS and top patient safety performance, CRHS has not received any CMS hospital-acquired conditions or readmission penalties.

Figure 7.4-7: **Fiscal Accountability**

External Audit	Corporation	Measure	2017	2018	2019	2020	2021	Benchmark
Venlot	CRHS	Audit Opinion	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified (NA)
	Foundation	Audit Opinion	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified (NA)
	Multispecialty Group	Audit Opinion	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified (NA)
	JV Surgery Centers	Audit Opinion	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified (NA)
	JV Imaging Centers	Audit Opinion	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified (NA)
Zandi's	CRHS	Bond Rating	AA	AA	AAA	AAA	AAA	highest rating AAA
CMS	CRHS (Hospitals)	Hospital-Acquired Condition Penalty	None	None	None	None	None	None
CMS	CRHS (Hospitals)	Readmission Penalty	None	None	None	None	None	None

(NA) = no adjustment

Finance-legal regulatory compliance audits are conducted internally as part of the Corporate Compliance Program to ensure process integrity and reduce compliance risk, while exceeding industry targets (Figure 7.4-8). Results of coding, clinical documentation improvement (CDI), and billing audits support that claims and revenue integrity exceed industry targets (Figure 7.4-8). Additional results of regulatory and legal compliance demonstrate a consistently high performance at 100% in almost all instances in support of CRHS's values (AOS).

7.4a(3). Figure 7.4-9 provides results for CRHS business units and service lines meeting and surpassing legal, accreditation, certification, and verification requirements. CRHS consistently surpasses requirements in comparison to competitors.

7.4a(4). Results for ethical behavior including breaches and complaints, WF training, and stakeholder trust in SLs and governance are reported in Figure 7.4-10. Segmentation by business unit is AOS.

7.4a(5). Key results for societal well-being and support of CRHS's key communities are reported in Figures 7.4-11 through 7.4-13 (segmented results by cancer type are AOS). As a result of published reports citing the limited impact of health fairs on community health, CRHS began collecting data focused on the percentage of patients seeking and receiving follow-up care based on health fair screening instead of simply reporting the volume of patients screened. An increase in patients seeking follow-up based on screening recommendations is seen from 2017 to 2021. The success of this approach is demonstrated in the *cancer stage at diagnosis*, which has gradually shifted to reflect a higher percentage of lower-staged cancers at diagnosis, reflecting the benefit of CRHS's early screening on community health.

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Figure 7.4-8: **Internal Fiscal Audits for Claims and Revenue Integrity** *(Billing Audit Compliance AOS)*

			2015	2016	2017	2018	2019	2020	2021	Industry Goal
Coding Audit Compliance	Hospitals	CMCL	93%	95%	95%	96%	96%	96%	96%	
		CB	94%	94%	94%	95%	95%	95%	95%	
		CF	95%	96%	96%	95%	96%	96%	96%	
		CS	96%	95%	96%	96%	96%	95%	95%	
	Medical Offices*		94%	95%	96%	95%	95%	95%	95%	
	Urgent Care*		97%	97%	97%	96%	97%	97%	97%	
	PT-Rehab*		97%	97%	97%	97%	97%	97%	97%	
	Surgery Center*		95%	96%	96%	96%	96%	96%	95%	
	Imaging*		98%	97%	98%	97%	97%	97%	98%	
	Home Health Hospice		93%	94%	95%	95%	95%	95%	95%	
	Industry Goal		**>95%**	**>95%**	**>95%**	**>95%**	**>95%**	**>95%**	**>95%**	
CDI	Review Rate		77%	79%	85%	84%	84%	84%	84%	**>80%**
	Query Rate		37%	38%	40%	39%	40%	40%	43%	**>40%**
	Response Rate		85%	88%	89%	93%	93%	90%	92%	**>90%**
	Agreement Rate		67%	68%	68%	70%	72%	72%	75%	**>75%**
	CDI/Coder Mismatch Rate		10%	9%	6%	6%	7%	7%	6%	**<10%**

Figure 7.4-9: **Surpassing Regulatory and Accreditation Results**

		CRHS	Churchill Downs	Rivertown University	NHC	St. Paul's Hospital	Edwardia Hospital
Service Line	Cardiology—Center of Excellence	X		X			
	Neurology—Center of Excellence, Stroke Certification	X	X	X			
	Oncology—Center of Excellence	X			X		
	Orthopedics Center of Excellence, Orthopedic Certification	X		X			
	Trauma—Center of Excellence, ACS Trauma Level I Verification	X					
	Women's and Children's—Center of Excellence	X	X				
	Behavioral Health/Substance Abuse—Centers of Excellence	X	X				
LeapCore Hospital Safety Grade		A	B	B	C	B	C
Magnet Status		CMCL, CB	X				
CHDMG Most-Wired Hospital		X	X		X		
Wooland Health Top 100		X		X			
KY "Best Place to Work" Designation		X	X				
LEED/Practice Bluefit Excellence Award		X			X		
VPP star status (from OSHA) for workplace safety		X					

Figure 7.4-10: **Results for Ethical Behavior**

	2017	2018	2019	2020	2021	Goal
Ethics: Breaches & Complaints						
Compliance Hotline: Validated Complaints, Requiring Corrective Action	0/5	2/10	0/13	0/11	0/8	0
Behavioral Standards (WF): Validated Violation, Requiring Corrective Action	0/8	1/7	0/5	0/2	0/2	0
Behavioral Standards (MS): Validated Violation, Requiring Corrective Action	1/6	2/9	0/4	0/3	0/3	0
HIPAA Privacy Complaints: Validated Violation, Requiring Corrective Action	0/4	0/5	0/3	0/3	0/5	0
Patient Rights Complaints: Validated Violation, Requiring Corrective Action	0/2	0/1	0	0/2	0/1	0
Conflict of Interest Violation	0	0	0	0	0	0
Ethics Compliance Training						
Code of Ethical Standards of Behavior Training (All)	100%	100%	100%	100%	100%	100%
Code of Ethical Standards of Behavior—Signed (All)	100%	100%	100%	100%	100%	100%
Stakeholder Trust	**Using CRHS Survey**					**CRHS Goal**
Stakeholder Trust in SL and Governance	3.7	3.6	3.9	3.8	3.81	3.79

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Figure 7.4-11: **Societal Well-Being—Environmental**

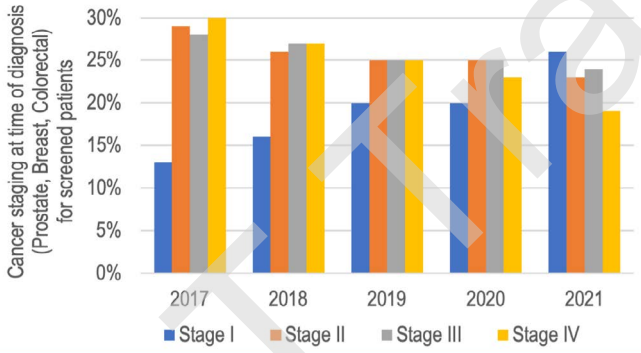
	Totals for Hospitals, Urgent Care, and ASC	2017	2018	2019	2020	2021	Benchmark	
Utilities	Utility Expense per Square Foot (Hospitals)	$7.98	$6.87	$4.37	$3.54	$3.10	$3.10	ASHE Top Quartile
	Electricity Consumption, kWh/GSF	56	47	34	28	21	21	ASHE Top Quartile
	Fuel Oil Consumption #2 Gallons/GSF	0.12	0.1	0.07	0.02	0.01	0.003	ASHE Top Quartile
	Water Consumption, Gallons/GSF	73	58	37	21	9	9	ASHE Top Quartile
Waste ($)	Solid Waste	$1.30	$1.20	$1.08	$0.09	$0.05	$0.03	ASHE Top Quartile
	Infectious Waste	$0.58	$0.52	$0.49	$0.35	$0.29	$0.21	ASHE Top Quartile
	Chemo Waste	$0.58	$0.56	$0.48	$0.43	$0.38	$0.27	ASHE Top Quartile
	Recyclables	$0.10	$0.08	$0.07	$0.05	$0.02	$0.02	ASHE Top Quartile

Figure 7.4-12: **Societal Well-Being—Community Support and Strength**

		2017	2018	2019	2020	2021
Charity Care ($M, IRS 990)	CMCL	$1,500,000	$1,650,000	$1,800,000	$2,100,000	$2,000,000
	CB	$650,000	$680,000	$720,000	$900,000	$860,000
	CF	$360,000	$420,000	$483,000	$520,000	$460,000
	CS	$86,000	$85,000	$73,000	$120,000	$90,000
Opioid Containing Tablets Prescribed		156	154	135	110	94
Naloxone Kit Distribution (Units)		980	1,600	2,450	1,900	2,780
Community benefit (Total $)		$360,000	$540,000	$610,000	$420,000	$480,000
Childhood Immunizations Provided at No Cost		3,050	3,700	3,850	1,875	3,040
Mobile Care Visits		430	565	798	148*	820
Community Revitalization Housing Grants		0	$150,000	$200,000	$100,000	$250,000
Community of Excellence Hours Donated		180	240	300	290*	320

**Pandemic impact*

Figure 7.4-13: **Societal Well-Being—Community Health Fairs and Impact** *(Segmented results by cancer type, AOS)*



7.5 Financial, Market, and Strategy Results

7.5a. Financial and Market Results

7.5a(1). Improvements and innovations in efficiency of processes of care have resulted in a steady increase in net patient revenue since CRHS's Baldrige journey began in 2012, with the exception of the financial impact of the COVID pandemic in 2020. During 2020, there was a moratorium on elective surgeries for many months, which decreased revenue. Additionally, structural changes to manage the many patients who needed to be placed in negative-pressure rooms with high-level filtration, as well as increased cost-per-unit and utilization of PPE, increased expenses. The net patient revenue recovered the beneficial trend in 2021, as the impact of the pandemic subsided (Figure 7.5-1).

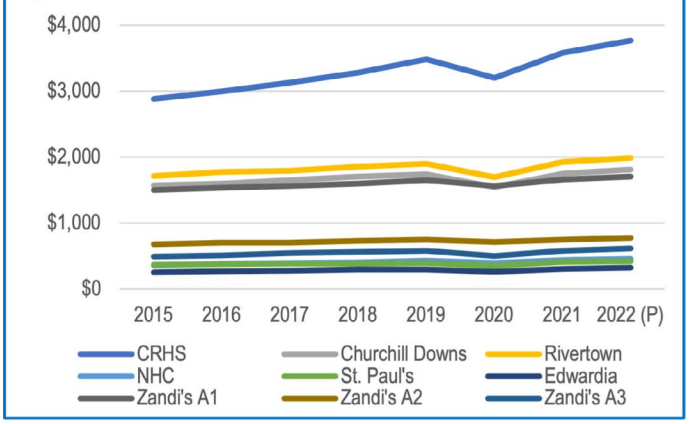
CRHS's operating margin has also steadily improved since 2012, when the Baldrige framework was implemented. There was a decline in operating margin in 2020 related to the financial impacts of COVID, which mirrored the 2020 decrease in all Zandi's ratings (Figure 7.5-2).

As with net patient revenue and operating margin, the operating earnings before interest, depreciation, and amortization (EBIDA) declined during 2020, but recovered significantly in 2021. CRHS is projected to continue the beneficial trend in 2022 (Figure 7.5-3).

Days of cash on hand also declined in 2020 at CRHS, as with virtually all hospitals and health care systems. Due to increases in efficiency gained during CRHS's cross-training of staff, as well as patients coming back to hospitals to receive services, the cash position fully recovered in 2021 and is projected to continue the long-term beneficial trend in 2022 (Figure 7.5-4).

The cash-to-direct-debt position declined in 2020, as with the other financial indicators. The debt increased in 2020, in part due to the CRHS leadership commitment to not have any staff layoffs or furloughs. The increase in debt in order to sustain the

Figure 7.5-1: **Net Patient Revenue**



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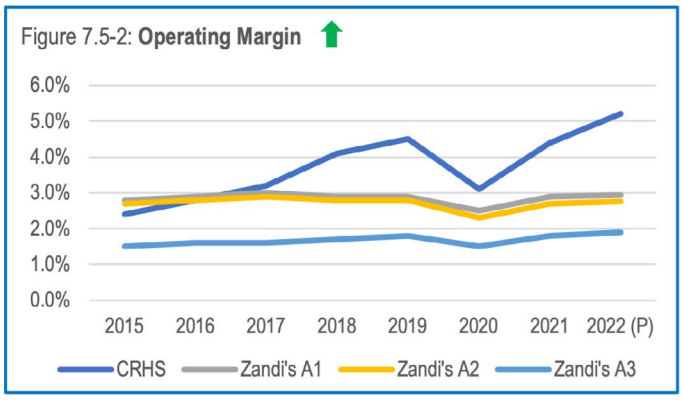
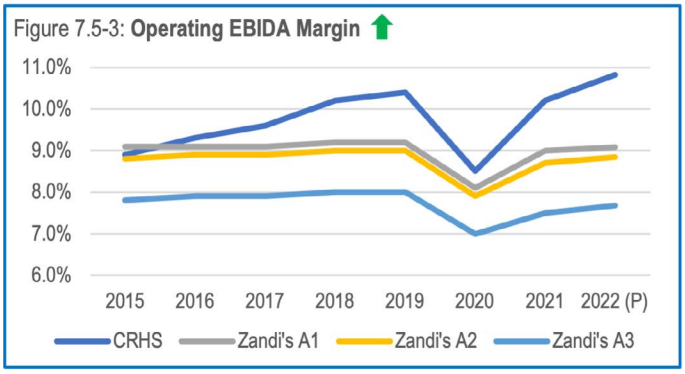
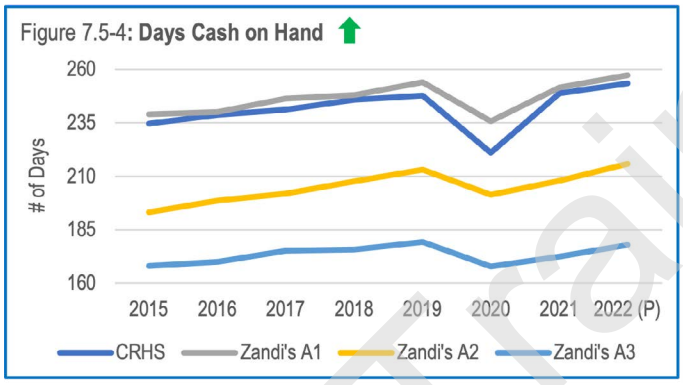
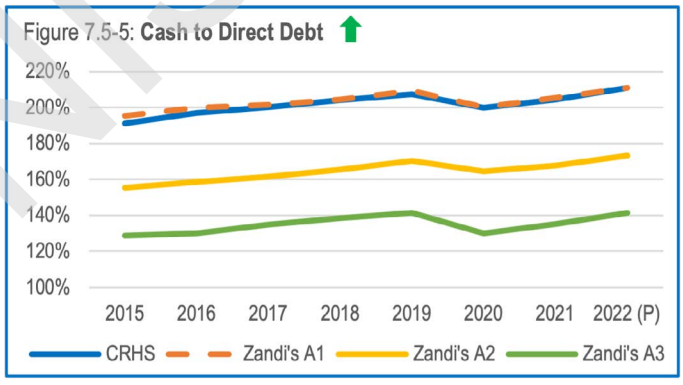






payroll throughout the public health emergency was significantly paid down in 2021, and the cash-to-debt ratio is projected to be completely recovered and improving by the end of 2022 (Figure 7.5-5).

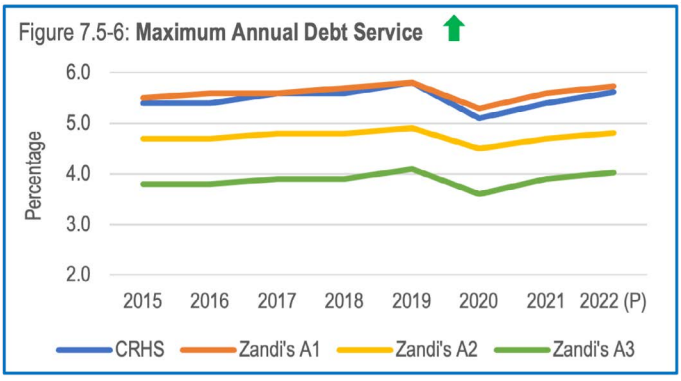
The CRHS debt has been commensurate with Zandi's A1 level for many years, until COVID. The commitment of the ELT and board to the workforce, despite the decline in revenue, resulted in an increased debt load in 2020. The entire workforce was "kept whole" and kept working, although in different roles and locations. This commitment resulted in the Maximum Annual Debt Service (MADS) slipping below Zandi's A1 rating. The ELT and board determined that demonstrating commitment to the workforce and the CRHS MVV was more important than the rating. CRHS anticipates achieving Zandi's A1 rating again by 2023 (Figure 7.5-6).



The debt-to-capitalization ratio also declined in performance compared with Zandi's A1 in 2020. Performance recovered in 2021 to nearly the level of 2019 and is projected to fully recover by 2022 (Figure 7.5-7).

Gains in efficiency and effectiveness, as well as the integrated network of services including insurance, primary care, acute care, and home care, were demonstrating a beneficial trend in spending per Medicare beneficiary. This integration contributes to earlier intervention and the ability to deliver more care on an outpatient basis or through home care, resulting in increased patient satisfaction and better clinical outcomes at a reduced cost. COVID was particularly devastating in the elderly (Medicare) population and very expensive to treat—with some very long lengths of stay. CRHS made a commitment to patients that they would be retained in the hospital until the disease had run its course, rather than discharged to a nursing home or to home and risk further spread of disease into the community. The Medicare spending per beneficiary has declined in 2021 to below the 2019 level, and it is projected to decline even more in 2022 (Figure 7.5-8).

Similar to the Medicare spending per beneficiary, the inpatient expense per discharge increased in 2020, although CRHS expenses remained below the national average (Figure 7.5-9). This is one aspect of performance where the goal is NOT top decile. The commitment to the MVV balances outcomes and patient satisfaction with expenses, and the boards, ELT, and SLTs do not try to "cut expenses to the bare bones" in order to



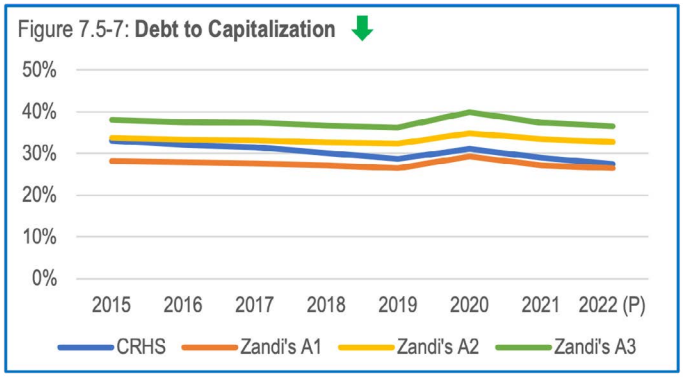


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Figure 7.5-8: **Medicare Spend per Beneficiary**

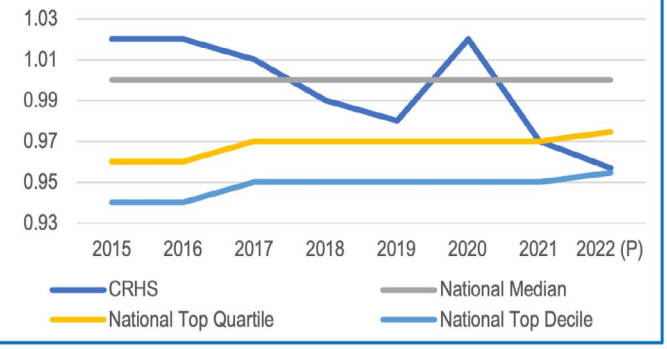
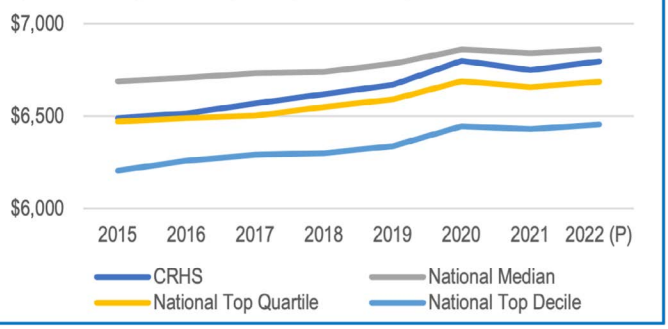


Figure 7.5-9: **Inpatient Expense per Discharge**



be top decile. As long as the operating margin is positive, being at or near the top quartile in this metric is acceptable. Inpatient expenses per discharge, segmented by both service line and facility, is AOS-site.

7.5a(2). CRHS is the market leader for its service area, far outpacing any of the competitors, and approaching the market share of all competitors combined. The communication to and care of the community during the pandemic, and restoring trust in the safety of seeking hospital care, were key in gaining additional market share in late 2021 and early 2022, with a significant increase in inpatient market share projected for 2022 (Figure 7.5-10).

CRHS is the market leader for all service lines, with cardiology having a higher market share than all competitors combined (Figure 7.5-11).

CRHS is also the clear market leader for home health and other post-acute care services (Figure 7.5-12).

Figure 7.5-10: **Inpatient Market Share**

	2015	2016	2017	2018	2019	2020	2021	2022 (P)
CMCL	31.7%	32.1%	32.5%	32.9%	33.2%	33.1%	33.0%	33.6%
CB	9.4%	9.6%	9.6%	9.9%	10.2%	10.3%	10.5%	10.7%
CF	4.1%	4.0%	4.1%	4.3%	3.9%	4.0%	4.1%	4.1%
CS	1.0%	1.2%	1.2%	1.4%	1.4%	1.4%	1.2%	1.4%
Total CRHS	46.2%	46.9%	47.4%	48.5%	48.7%	48.8%	48.8%	49.8%
Churchill Downs	17.9%	17.7%	17.8%	17.5%	17.1%	17.1%	17.1%	16.9%
Rivertown	20.1%	20.0%	19.7%	19.5%	19.5%	19.1%	18.5%	18.5%
NHC	6.9%	6.8%	6.5%	6.7%	6.9%	6.9%	7.2%	7.1%
St. Paul's	5.1%	5.0%	4.9%	4.5%	4.5%	4.6%	4.9%	4.6%
Edwardia	3.8%	3.6%	3.7%	3.3%	3.3%	3.5%	3.5%	3.3%
Total Competitors	53.8%	53.1%	52.6%	51.5%	51.3%	51.2%	51.2%	50.2%

Figure 7.5-11: **Cardiology Market Share** *(Total = 100%)*

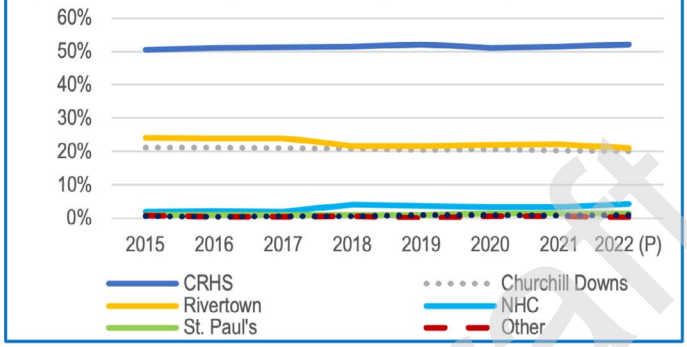
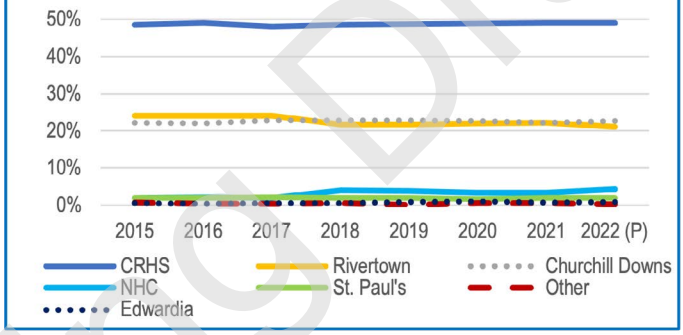


Figure 7.5-12: **Oncology Market Share** *(Total = 100%)*



CRHS has maintained 55–55.5% of the market share for outpatients for many years, and it expects the trend to continue (Figure 7.5-13). Segmented data for various outpatient services are AOS.

CRHS is not "one of the big players" in the insurance market, although market share has steadily increased since entry into the market. Preference for the CRHS product is generally attributed to the ACO aspects being focused on health, not simply treatment, and the "personal touch" of a local company (Figure 7.5-14).

Similar to the MA insurance plan, the commercial plan offered by CRHS has been steadily increasing market share since inception (Figure 7.5-15).

As with most hospitals across the country, the ED visit count decreased in 2020 due to COVID (Figure 7.5-16). Some of the ED volume has been appropriately drawn off by the opening of the Urgent Care facilities and the extension of their hours to better serve the community. Segmented data for the Urgent Care centers, showing their increase in encounters, are AOS.

Market share dominance is not only related to the locations of the CRHS facilities. Even when more rural residents are seeking care, they may bypass a competitor to come to a CRHS facility. The messaging provided by CRHS during the public health emergency contributed to the increase in preference for CRHS during 2020. As the pandemic subsided in 2021, people who needed health care were more likely to go to the nearest facility, but preference for CRHS is projected to recover to its 2019 "all-time high" in 2022 (Figure 7.5-17).

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Figure 7.5-13: **OB Market Share** *(Total = 100%)*

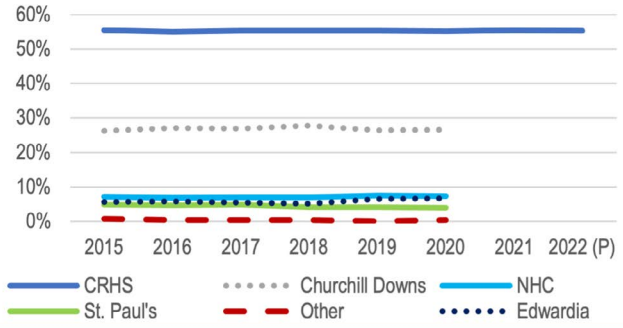


Figure 7.5-14: **MA Plan Market Share** *(Total = 100%)*

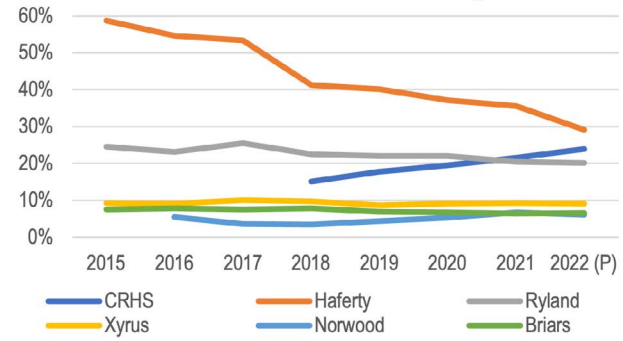


Figure 7.5-15: **Commercial Plan Market Share** *(Total = 100%)*

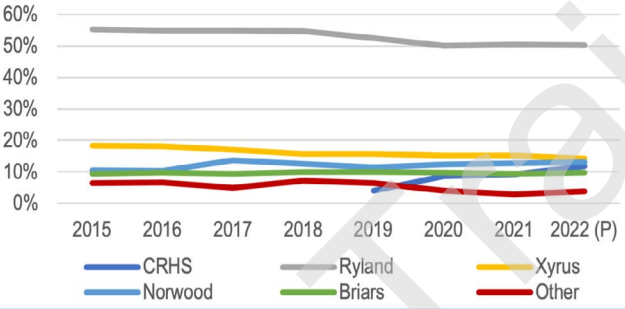
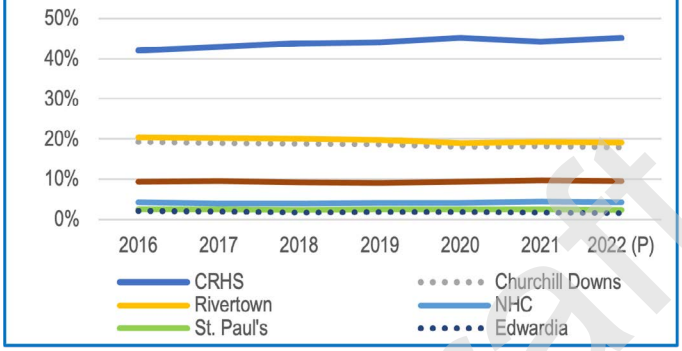


Figure 7.5-16: **ED Visits**

	2015	2016	2017	2018	2019	2020	2021	2022 (P)
CMCL	73,180	73,190	73,876	74,389	76,901	68,976	75,276	76,673
CB	28,567	28,871	28,761	28,763	29,671	24,290	27,897	28,508
CF	18,272	18,141	18,241	18,761	19,019	14,873	17,864	18,390
CS	7,901	7,998	8,009	8,176	8,976	7,110	8,709	9,035
Total CRHS	127,920	128,200	128,887	130,089	134,567	115,249	129,746	132,606
Churchill Downs	42,497	42,654	42,871	42,901	43,851	38,972	44,137	44,432
Rivertown	44,920	45,901	44,851	44,970	45,290	40,987	45,110	45,091
NHC	23,701	23,951	24,009	24,111	24,871	21,754	25,129	25,379
St. Paul's	20,731	20,590	20,765	20,853	21,256	18,987	21,364	21,496
Edwardia	11,509	11,785	11,780	11,631	11,654	9,876	11,726	11,740
Total Competitors	143,358	144,881	144,276	144,466	146,922	130,576	147,466	148,137

Figure 7.5-17: **Consumer Preference** *(Total = 100%)*



7.5b. Strategy Implementation Results

Please see the results figures referenced in Figures 2.2-2 and 7.5-18 related to achievement of organizational strategy and action plans. Additional detail and segmentation are AOS.

Figure 7.5-18: **Sample of Strategy Implementation**

Goals/Action Plans	Key Performance Measures	Figure
Objective: Achieve top decile in financial excellence		
Achieve Operating Margin	Operating Margin	7.5-2
Increase Community Support	Total Community Benefit	7.4-12
Improve Cash Position	Days Cash on Hand	7.5-4
Objective: Achieve top decile in process excellence		
Enhance Access (Telehealth and Available Appointments)	% within 15 Days (Primary Care)	AOS
	% within 30 Days (Specialist Care)	
Implement Cybersecurity Framework	External Score	AOS
Enhance Communication	% Very Satisfied (Workforce)	7.4-1
	% Very Satisfied (Patients)	7.4-2

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