








Alaska Native People Shaping Health Care

2011

Malcolm Baldrige National Quality Award

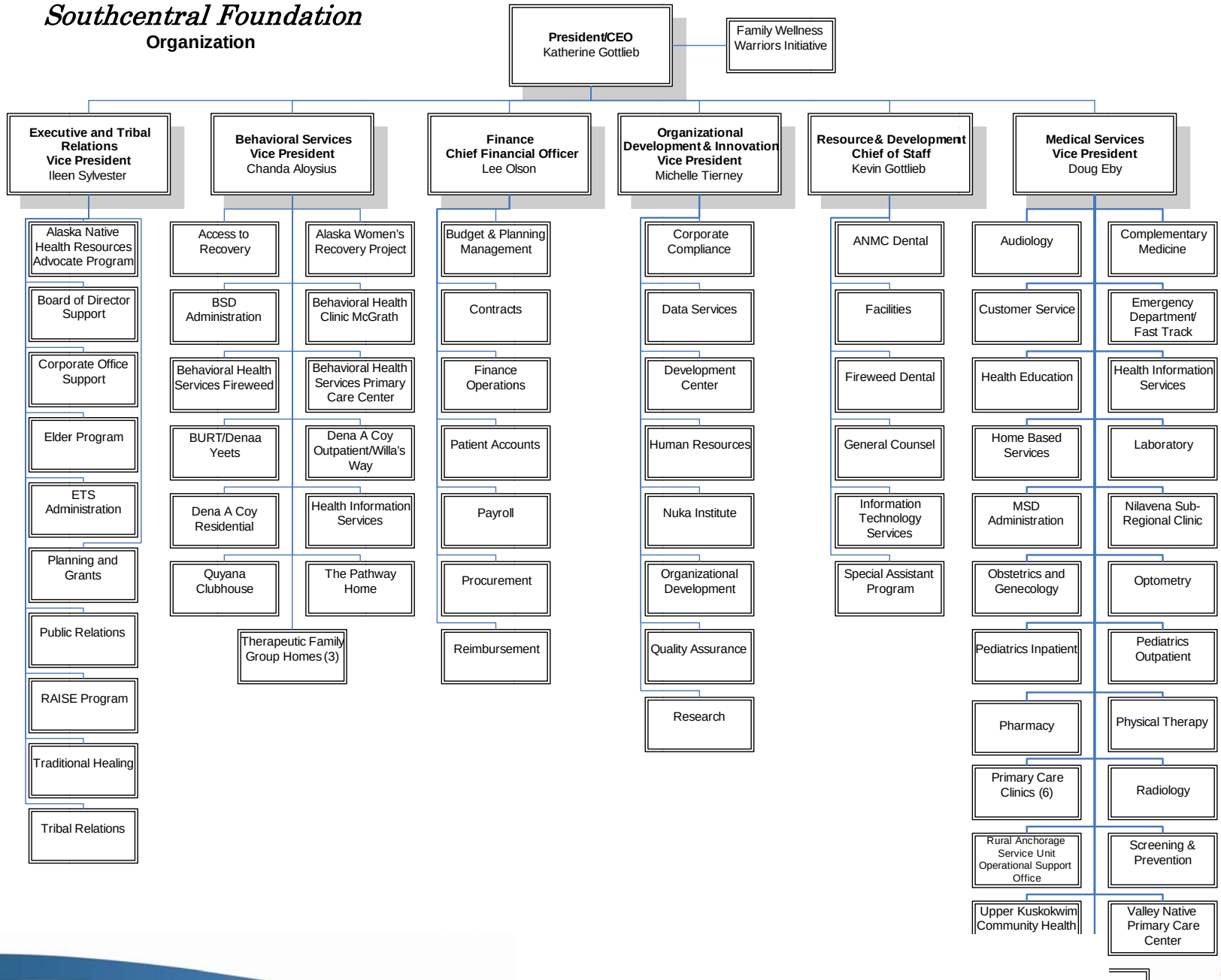
Application

Southcentral Foundation

TABLE OF CONTENTS

Organization Chart

Southcentral Foundation
Organization



APPROVED 08/30/2011

Southcentral Foundation

Glossary of Terms & Abbreviations

GLOSSARY TERMS AND ABBREVIATIONS

SYMBOLS

$ dollars
# number
& and
% percent
%tile percentile
= equal
< less than
> greater than
▲ upward or higher results is better
▼ downward or lower results is better
◄ ► Lower or higher results is not necessarily better

A

A1c Laboratory test (average control level of blood glucose or blood sugar)
AAA Authentication, Authorization, Accounting
AAAHC Accreditation Association for Ambulatory Health Care
AAPT Automated Annual Planning Tool
AAPP All Alaska Pediatric Partnership
ACE Advancing Customer Excellence
AFN Alaska Federation of Natives
AK Alaska
AN Alaska Native
AN/AI Alaska Native/American Indian
ANCAC Alaska Native Consumer Advisory Committee
ANCC American Nurses Credentialing Center
ANHB Alaska Native Health Board
ANMC Alaska Native Medical Center
ANN Anchorage Native News
ANPCC Alaska Native Primary Care Center
ANTHC Alaska Native Tribal Health Consortium
AP Annual Plans
APEX Alaska Performance Excellence award program
APQR Annual Plan Quarterly Report
APU Alaska Pacific University
ARC Accreditation Readiness Committee
ARO Annual Reorientation
AS Administrative Support
ASTP Administrative Support Training Program
ASU Anchorage Service Unit
Avail Available
Avatar Avatar International/Intelligent Surveys
Avg. Average

B

B/P Blood Pressure
BCBG Behavioral Care Core Business Group
BCU Background Check Unit
Bench Benchmark
BFA Beauty for Ashes
BHC Behavioral Health Consultant
BME Board of Medical Examiners
BMI Body Mass Index
BOD Board of Directors
BSC Balanced Scorecard
BSC/DB Balanced Scorecard/Dashboard
BSD Behavioral Services Division
BSD CM Behavioral Service Case Manager
BNQP Baldrige National Quality Program
BURT Behavioral Health Urgent Response Team

C

CA Clinical Associate
Ca Cancer
CAHPS Consumer Assessment of Healthcare Provider & Services
CAP College of American Pathologists
CAP Corporate Annual Plan
C.A.R.E. Connect, Appreciate, Respond, Empower
CARF Commission on Accreditation of Rehabilitation Facilities
Cat Category
CBG Core Business Group
CC Core Competencies
CCDB Customer Comment Database
CDC Centers for Disease Control and Prevention
CDR Character-Driver-Risk
CEO Chief Executive Officer
CFR Code of Federal Regulations
CFRS Customer Feedback Reporting System
CG Corporate Goals
CI Corporate Initiatives
CIRI Cook Inlet Region, Inc.
CITC Cook Inlet Tribal Council
Clev Cleveland Clinic (comparative data source)
CLIA Clinical Laboratory Improvement Amendments
CM Committee Manager, Web-based tool
CMA Certified Medical Assistant
CME Continuing Medical Education
CO Corporate Objectives
COC Compliance Committee
C-O Customer-Owners
COMC Communications Committee
COO Chief Operating Officer
CPA Certified Public Accountant
CQ Commitment to Quality (SCF KP and CG)
CQ# numerical reference to Commitment to Quality CO
CS Customer Service
CSC Customer Service Committee
CSP Corporate Strategic Plan
CSR Customer Service Representative
Ctrl Control
CVD Cardiovascular Disease
CY Calendar Year

D

DATC Data Analysis & Tracking Committee
DB Dashboard of operational performance indicators

GLOSSARY TERMS AND ABBREVIATIONS

DBMS Database Management System
DC Development Center – See DOL
DCBG Dental Core Business Group
DEA Drug Enforcement Agency
Dept Department
DHSS Department of Health and Social Services
DM Diabetes Mellitus
DOL Departments of Learning (DC Training Tool)
DOT Department of Transportation
DR Disaster Recovery

E

ECAF Employee & Community Assistance Fund
ED Emergency Department
EH Employee Health
EHR Electronic Health Record
Elder Senior of 55 years old or older
EMP Emergency Management Plan
EOS Employee Opinion Survey
EPA Environmental Protection Agency
EPE Employee Performance Evaluation
ER Emergency Room
ETS Executive and Tribal Services

F

Fav Favorable
FC Finance Committee
FCS Functional Committee Structure
Feedback Written, electronic, and/or verbal complaints, grievances, concerns, suggestions, comments and compliments
Fig Figure
FIN Finance
FMW Family Wellness (SCF KP and CG)
FMW# numerical reference to Family Wellness CO
FO Feedback Owner
FTE Full-time Equivalent
FWWI Family Wellness Warriors Initiative
FY Fiscal Year (October 1 to September 30)

G

GC Green Committee (a.k.a. Green Team)
GED General Equivalency Diploma
GPRA Government Performance and Results Act
GOC Grants Oversight Committee
Gov Government

H

H1N1 Swine Flu Virus
HbA1c Hemoglobin A1c — See A1c
HC Health Care
Health Ed Health Education
HED Health Education Department
HEDIS Healthcare Effectiveness Data and Information Set
HIC Health Information Center
HICS Hospital Emergency Incident Command Center
HIPAA Health Insurance Portability and Accountability Act
HIS Health Information Stations
HR Human Resources
HRC Human Resources Committee
HVA Hazard Vulnerability Analysis

I

IA Improvement Advisors
ICEHC Infection Control & Employee Health Committee
ICPA Indian Child Protection Act
ICT Integrated Care Team
ID Identification
IHI Institute for Healthcare Improvement
IHS Indian Health Service (comparative data source)
Inpt Inpatient
IPC Improving Patient Care
IRB Institutional Review Board
IT Information Technology
ITIL Information Technology Infrastructure Library
ITC Information Technology (IT) Committee

J

JC Joint Commission
JOB Joint Operating Board

K

KP Key Points
Kronos Time-keeping software

L

LDS Leadership Development Sessions
L&D Learning and Development
LMS Learning Management System
LOV Living Our Values
LPN Licensed Practical Nurse
LT Long-term (plans, goals, or objectives)

M

Mat-Su Matanuska-Susitna Valley
mg/dl milligrams/deciliter measure of bG (blood glucose)
MGMA Medical Group Management Association
MHS Military Health System
Mil $ Million dollars
MRT Measurement Rules Template
MSD Medical Services Division
MV Mission, Vision
MVKP Mission, Vision, Key Points
MVKP/OP Mission, Vision, Key Points, Operational Principles

N

N or n Number
N/A Not applicable or Not available
NCQA National Committee for Quality Assurance
NHO New Hire Orientation

GLOSSARY TERMS AND ABBREVIATIONS

NMO New Manager Orientation
NPIRS National Patient & Information Reporting System
NRC National Research Corporation
Nuka System of Care – Term used to describe SCF's entire relationship-based system of care.

O

OD Organization Development
ODI Organizational Development and Innovation
OFI Opportunity for Improvement
OHRP Office for Human Research Protections
OIG Office of Inspector General
OP Operating Principles
OPE Operational Excellence
OPE# numerical reference to Operational Excellence CO
Opt Optometry
OPS Operations Committee
Org Organization
OSHA Occupational Safety and Health Administration
OTP Office of the President

P

P&P Policy and Procedures
P/CEO President/Chief Executive Officer
PC Personal Computer
PCC See ANPCC
PCCBG Primary Care Core Business Group
PCCIII ANPCC 2009 expansion
PCP Primary Care Provider
PDP Performance Development Plan
PDSA Plan-Do-Study-Act Rapid Cycle Improvement Model
PEP Passive Education Panels
Perf Performance
PI Process/Performance Improvement
Pop Population
PPC Policy & Procedure Committee
PR Public Relations
PTC Project Team Charter

Q

Q&A Question and Answer
QA Quality Assurance
QAC Quality Assurance Committee
QI Quality Improvement
QMC Quality Management Courses
Q**uantros** See CFRS and/or SRM

R

R&D Resource and Development
RAISE Responsible Adolescents in Successful Employment
RCA Root Cause Analysis
RCC Revenue Cycle Committee
RD Registered Dietician
RMC Risk Management Committee
RN Registered Nurse
RN/CM Registered Nurse/Case Manager
ROC Research Oversight Committee
RPMS Resource Patient Management System

S

SA Strategic Advantage
SA# numerical reference to a specific strategic advantage
SAMHSA Substance Abuse and Mental Health Services Administration
SAN Storage Area Network
SATO Similar Alaska Tribal Organization
SBIRT Screening, Brief Intervention, Referral, Treatment
SC Strategic Challenge
SC# numerical reference for a specific strategic challenge
SCF Southcentral Foundation
SharePoint a business collaboration platform
SID Strategic Input Document
SLA Service Level Agreement
SME Subject Matter Experts
SP Strategic Plan or Strategic Planning
SPC Strategic Planning Cycle
SPLC Strategic Planning Committee
SR Shared Responsibility (SCF KP and CG)
SR# numerical reference to Shared Responsibility CO
SRM Safety & Risk Manager system (Quantros)
ST Short-term (plans, goals, or objectives)
Survey Monkey Electronic survey software program
SWOT Strengths, Weaknesses, Opportunities, Threats

T

Trng Training

U

UCC Urgent Care Center
U.S. United States
USPHS United States Public Health Service

V

VA Veterans Administration
VNPCC Valley Native Primary Care Center
VP Vice President
VPLT Vice President Leadership Team, which includes the P/CEO and her team of VPs
VSMT Village Services Management Team

W

w/ with
Work Comp Workers Compensation (W/C)

Y

YKHC Yukon-Kuskokwim-Health Consortium

Organizational Profile

PREFACE: ORGANIZATION PROFILE

P.1 Organizational Description. Southcentral Foundation (SCF) is an Alaska Native nonprofit health care organization established in 1982 by Cook Inlet Region, Inc. (CIRI). CIRI is one of 13 Alaska Native regional corporations created by Congress in 1971 under the terms of the Alaska Native Claims Settlement Act. CIRI established SCF to improve the health and social conditions of Alaska Native people, enhance culture, and empower individuals and families to take charge of their lives. SCF provides a wide range of health and human services to Alaska Native and American Indian (AN/AI) people living in south central Alaska. In general, services are provided prepaid, based on legislative agreements and funding requirements, to members of the 229 federally recognized tribes in Alaska. Revenue sources include federal, state, and local government agencies; private foundations; and third-party payors.

While managing nearly two decades of exponential growth, including growing the workforce from fewer than 100 to about 1,400 employees and the operating budget from $3 million to $200 million, SCF has distinguished itself as one of the nation's leading health care systems. SCF hosts visitors from around the U.S. and the world, including representatives from more than 20 Indian Health Service sites, Oregon, Canada, Washington, California, Hawaii, England, Scotland, Norway, Sweden, Russia, China and Mongolia, who come to learn about SCF's Nuka System of Care. The Nuka System of Care is a term used to describe SCF's relationship-based health care, from service delivery to the systems that support that delivery. While SCF utilizes best practice ideas from around the world, the entire system of care is designed and driven by customer-owners (C-O).

P.1a(1) Service offerings. SCF is a comprehensive health care delivery system that provides a broad spectrum of health and health-related services to support C-O on their journey to wellness, including primary medical care, dentistry, behavioral health (including residential and day treatment programs), complementary medicine, traditional healing, and home-based services. It is important to note that SCF refers to patients as C-O, recognizing a system that is owned and managed by and for Alaska Native people. The approach SCF uses to provide delivery systems requires agility and flexibility and is based on using C-O feedback. By using multiple feedback approaches [Fig. 3.1-1] and associated process review using C-O input, SCF's delivery systems are continually evolving to best meet C-O needs and requests, and to determine the importance of each system.

SCF works with its partner, the Alaska Native Tribal Health Consortium (ANTHC), to ensure a seamless continuum of care by collaborating with ANTHC's Tertiary and Specialty Medical Services Division in providing services at the Alaska Native Medical Center (ANMC). Most SCF C-O live in and around Anchorage, where SCF has 26 facilities. Some C-O live in remote villages, most of which are accessible only by air. SCF uses a wide range of delivery mechanisms to provide health care service offerings, including ambulatory office visits (individual, group, and peer), home visits (including hospice), email and telephone visits, health information and education (classes, paper, Web), outpatient services, day and residential treatment, as well as consultation with and referral to higher levels of care. SCF clinical teams regularly travel to rural villages to deliver family medicine, dentistry, and optometry services. Where village clinics are staffed by local village health aides, SCF clinicians also make use of electronic communication, including state-of-the art telemedicine technology, to consult on assessment and treatment. In some cases, appropriate treatment requires SCF to bring customers from rural villages to Anchorage.

P.1a(2) Vision and mission. As an Alaska Native customer-owned system, SCF believes that effective relationships are key to improving overall health of the community. To create a supportive culture, SCF defined Core Concepts as key characteristics of our organizational culture. SCF's commitment to C-O is embedded in the Mission, Vision, Key Points (MVKP) [Fig. P.1-1].

Figure P.1-1: Vision, Mission & Key Points

Vision
A Native Community that enjoys physical, mental, emotional and spiritual wellness.
Mission
Working together with the Native Community to achieve wellness through health and related services
Key Points
Shared Responsibility
We value working together with the individual, the family, and the community. We strive to honor the dignity of every individual. We see the journey to wellness being traveled in shared responsibility and partnership with those for whom we provide services.
Commitment to Quality
We strive to provide the best services for the Native Community. We employ fully qualified staff in all positions and we commit ourselves to recruiting and training Native staff to meet this need. We structure our organization to optimize the skills and contributions of our staff.
Family Wellness
We value the family as the heart of the Native Community. We work to promote wellness that goes beyond absence of illness and prevention of disease. We encourage physical, mental, social, spiritual and economic wellness of the individual, the family, the community, and the world in which we live.

Figure P.1-2: Operational Principles

R	**R**elationships between the customer-owner, the family, and provider must be fostered and supported
E	**E**mphasis on wellness of the whole person, family, and community including physical, mental, emotional, and spiritual wellness
L	**L**ocations that are convenient for the customer-owner and create minimal stops for the customer-owner
A	**A**ccess is optimized and waiting times are limited
T	**T**ogether with the customer-owner as an active partner
I	**I**ntentional whole system design to maximize coordination and minimize duplication
O	**O**utcome and process measures to continuously evaluate and improve
N	**N**ot complicated but simple and easy to use
S	**S**ervices are financially sustainable and viable
H	**H**ub of the system is the family
I	**I**nterests of the customer-owner drive the system to determine what we do and how we do it
P	**P**opulation-based systems and services
S	**S**ervices and systems build on the strengths of Alaska Native cultures

Operational Principles (OP) [Fig. P.1-2], and Core Concepts. Two approaches are used to integrate MVKP into planning

and improvement. Key Points form the framework for SCF's Corporate Goals (CG) and Corporate Objectives (CO) Fig. 2.1-5]. The OP define characteristics of the RELATIONSHIP-based Nuka System of Care, and guide process and system design and redesign, as well as employee actions and behaviors, throughout the organization. In 2007, SCF added an annual SWOT analysis process to determine core competencies (CC), resulting in integration of CC [Fig. P.1-3] determination into Strategic Planning Cycle (SPC) [2.1a(1)].

Figure P.1-3 Core Competencies	
Communication & Teamwork	Openly, clearly and respectfully share and receives information, opinions, concerns and feedback in supportive manner. Work collaboratively by building bridges and creating rapport with team members within department and across the organization.
Improvement & Innovation	A capacity for rapid change and flexibility in order to make meaningful improvement to services, programs, processes, and/or organizational effectiveness that creates new value for C-O and employees
Customer Care & Relationships	Creating, developing and nurturing culturally appropriate interactions and connections with each other, C-O, and the community
Workforce Development Skills & Abilities	Necessary to provide quality care services – seek out additional learning opportunities to continue to develop the technical and professional skills needed now and in the future. Taking responsibility for all work activities and personal actions by following through on commitments.

P.1a(3) Workforce profile. SCF's diverse workforce population [Fig. P.1-4] is approximately 1,400 and all staff, including physicians, are considered employees. The medical staff is privileged according to Medical Staff Bylaws. Unlike other healthcare systems, it is important to note that all groups and segments of employees are subject to the same SCF personnel policies and practices, such as the Code of Conduct and performance evaluation and action planning. Medical staff are not managed differently than other employees. There are no organized bargaining units within SCF. The Indian Self-Determination Act allows SCF to give AN/AI applicants preference in hiring and supports a part of our mission and vision to recruit and develop AN/AI staff.

The workforce is segmented by job type and level – clerical, health care professional or technical, provider, leadership, clinical and non-clinical managerial, and various non-exempt personnel – for the purpose of reporting data, gathering input and feedback, and determining organizational performance related to key workforce requirements.

Key benefits include medical, dental, vision and prescription coverage, disability, life insurance, AD &D, Section 125 Cafeteria plan, and a retirement savings plan. SCF also has a generous leave package that includes personal leave, 12 paid holidays, educational, bereavement, jury duty, and military leave. Additionally, the benefit package includes employee wellness, education and professional development programs [5.2c(1)]. Workforce expectations and key factors include respect, effective communication, recognition, and fair compensation. The factors are determined through surveys, feedback from committees, and scheduled reviews. Given Alaska's small labor pool, SCF must compete for qualified employees. The competition for talent involves many different professional groups critical to SCF's operations, resulting in upward pressure on salaries. SCF determines the company's salary scale through an annual evaluation of the market, with salary range midpoints established at 90-100% of market midpoint. For difficult-to-fill positions, the midpoint is set at 100 percent of the market midpoint. SCF has established a hiring zone comprised of three ranges, enabling SCF to hire and train staff in support of MVKP, CG, and CO.

AN/AI people make up 54 percent of the workforce overall, including 50 percent of management and 95 percent of administrative support staff. SCF's work settings include office environments and a diverse array of health care delivery settings such as outpatient clinics, inpatient facilities, C-O homes, and community settings, such as dental and medical clinics in village schools. These settings present various health and safety risks, including equipment use, exposure to bloodborne pathogens and hazardous materials, and travel.

Figure P.1-4: Workforce Profile	
Profile as of FY 2011 Q1	
Ethnicity	Alaska Native / American Indian: 53.58%, Non-Native: 46.42%
Gender	Female: 73.55%, Male: 26.45%
Age	Less than 21: 2.42% 21-30: 28.74% 31-40: 25.35% 41-50: 20.76% 51-60: 17.79% 61-70: 4.28% 71-80: 0.60%
Job Classification	Full-time: 91.51% Part-time: 1.19% Temporary: 1.70% Intermittent: 5.60%
Job Category	Clerical: 25.24% Clinical Managerial:1.34% Health Care (HC) Professional: 15.69% HC Provider: 19.15% HC Technical: 14.28% Leadership: 2.73% Non Clinical Managerial: 7.78% Non Exempt Non Clerical Non HC: 5.33% Non HC Professional: 8.44%

P.1a(4) Assets. SCF owns, manages or leases 26 facilities, which represent approximately 670,000 square feet, including a newly expanded 80,000-square-foot clinical space in the Anchorage Native Primary Care Center (ANPCC); clinic building for dentistry, optometry, and behavioral health; and facilities for residential and day treatment, and transitional living; and Elder programs in Anchorage, as well as a 4,800-square-foot primary care center in the Matanuska-Susitna Valley. SCF also owns several administrative buildings and land for future development. Lastly, SCF co-owns and co-manages a 150-bed hospital in Anchorage, ANMC, which provides inpatient services to Anchorage Service Unit (ASU) [Fig. P.1-6] residents with tertiary and specialty services to AN/AI people statewide. SCF is committed to designing and

maintaining facilities that create the atmosphere of a gathering place for the Native Community – where people come for health services, but also for potlatches, dancing and singing, arts and crafts displayed and/or sold, and to visit relatives and friends. Every building project has the requirement to capture the essence of respect and culture of the Native Community.

SCF uses a wide array of equipment and technologies to deliver and improve care (e.g., pyxis pharmacy systems, digital radiology), and owns and manages a fleet of vans and buses to transport C-O and employees.

SCF's Information Technology (IT) department supports all programs. SCF operates primarily in a Windows environment with full Active Directory Services deployed, and the system is fully routed with over 16 locations. Primary applications are Exchange 2003, Serenic Navigator, Kronos, and other clinical applications. The SCF IT Department is actively involved in developing Web-based tools that are customized to SCF in order to continue to improve our systems. Examples of these Web-based tools include Committee Manager, Balanced Scorecard and Dashboard, Automated Planning, Online Job Application, and Development Center Training. SCF is also involved in the Alaska Telemedicine Project, enabling its clinicians to participate in medical services in remote locations through state-of-the-art telemedicine technology.

P.1a(5) Regulatory requirements. SCF operates in a highly regulated environment at the federal, state, and local levels. Requirements address scope of services and funding; protection of employees' and customers' health, safety, and privacy; environmental protection; the federal government's Annual Funding Agreement; and policies of Labor (e.g., Americans with Disabilities Act), Justice (e.g., Civil Rights Act), and Health and Human Services (e.g., HIPAA), to name a few. SCF addresses voluntary accreditation and recognition standards, such as Joint Commission (JC), Commission on Accreditation of Rehabilitation Facilities (CARF), and American Nurses Credentialing Center. ANMC has earned Magnet Recognition for Nursing Excellence. In addition, SCF complies with various assurances and meets requirements of foundations and grants.

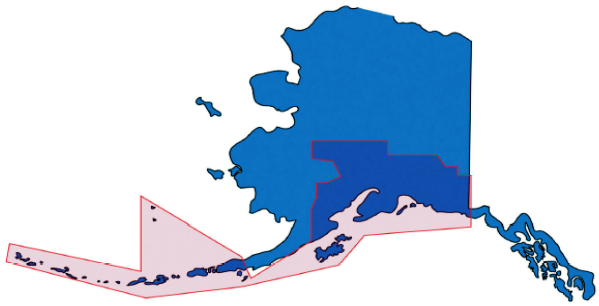
P.1b(1) Organizational structure. SCF is 501c(3) incorporated and operating under the tribal authority of CIRI. The CIRI Board of Directors appoints a seven-member C-O Board of Directors (BOD), from various career backgrounds, that serves as the chief policy-making body and exercises overall control and management of the organization's affairs. The P/CEO reports directly to the BOD, leads the Office of the President and its programs, and supervises seven divisions, each of which are led by a Vice President (VP).

P.1b(2) Customers and stakeholders. SCF has four key customer groups, defined according to geographic location. [Fig. P.1-5]. SCF recognizes that despite differences in geographic location and service level, all customers share a common set of requirements, shaped by cultural values and preferences. SCF translated these requirements into its Operational Principles [Fig. P.1-2], creating a set of design specifications to drive improvement and innovation.

Figure P.1-5 Customer Owner (C-O) Groups

C-O GROUP AS OF 12/31/10	SERVICES / SUPPORT
Anchorage and Mat-Su Valley SCF provides primary health and related services to 60,663 C-O (empanelled to named providers) in Anchorage and Mat-Su Valley.	Full access to all SCF services.
Cook Inlet Region (CIRI) Villages SCF supports CIRI Village efforts in village locations to optimize their own services by self-determination.	Support for local primary care delivery by village providers: funding, consultation, regularly scheduled on -site clinical services. Access to all Anchorage -based services.
Anchorage Service Unit Villages SCF supports services and activities to the 55 Anchorage Service Unit Villages, limited to the 10/1/97 level of service and availability of funding. The region may purchase additional services from SCF. The region is responsible for optimizing services under self-determination. [Fig. P.1-6]	Support for local primary care delivery by village providers: funding, consultation, regularly scheduled on-site clinical services. Access to most Anchorage -based services. Additional services for additional costs.
Alaska Statewide Support SCF fulfills the 10/1/97 obligation for those limited areas of statewide services.	Consultation to other regional health care centers and on-site Women's Health, Pediatrics, and Dental Health services. Access to residential programs and most Anchorage-based programs.

Figure P.1-6 Anchorage Service Unit (Red Outlined Area)



P.1b(3) Suppliers and partners. SCF works with diverse partners to deliver health care services, support education and training of Alaska Native people, and secure funding for SCF programs and staff [Fig. P.1-7]. SCF leverages the potential of partnerships to drive improvement and innovations by involving SCF BOD and senior leaders in committees with partner leadership and by engaging employees from both SCF and partner organizations in committees and improvement teams. To provide seamless care to our C-O, many of our employees participate in ANTHC committees and workgroups. We share and evaluate a number of specific measures with ANTHC, since many of our C-O use their services. Suppliers support service delivery to C-O, and include those that provide health care equipment and supplies, such as pharmaceuticals, lab and radiology products; office supplies, equipment and furniture; and contractors. Key requirements are timely delivery, product quality, and cost. Ongoing communication with suppliers includes one-on-one, group meetings, emails, telephone, fax and written communication. Contracts are in place for ongoing supply chain partners. SCF builds relationships and promotes communication in working with partners [Fig. P.1-7].

Figure P.1-7 Sample List of Key Partners

PARTNER	ROLE	RELATIONSHIP
Health Care Services		
ANTHC	Tertiary/specialty medical services Support for service delivery	Grant sub-awards & reporting, Service-level agreements (SLA), committees, two-way communication
CIHA	Short- and long- term housing	Facility Planning, Committees and two - way communication
CITC	Educational services and substance abuse counseling	Grant sub-awards & reporting, committees, and two-way communication
Education		
CIRI Foundation	Scholarships for Alaska Natives	Committees and two - way communication
ANHC	Educational services on Alaska Native culture	Committees and two - way communication
Universities: Alaska, Alaska Pacific, Washington; Career Academy, Lutheran Medical Center; Colorado	Education and training for employees and future employees	Contracts and two - way communication
Funding		
IHS; CDC; CMS; HRSA; SAMHSA; State of Alaska; Denali Commission; Rasmuson Foundation	Funding for SCF programs and staff	Grant reporting and two -way communication.

P.2 Organizational Situation

P.2a(1) Competitive position. Population growth in SCF's service area has soared, driven mostly by migration into the region from rural areas. SCF is the primary provider of care for Alaska Native people in Anchorage and the Matanuska-Susitna Valley. As of 2008, Southcentral Foundation had 46,787 empanelled C-O from these local regions. This represents nearly 100 percent of the Alaska Native population living in the area. SCF enjoys a unique competitive position in that AN/AI people and their families are entitled to prepaid services. However, many could pay or use insurance to get services elsewhere so SCF must provide services in a way that attracts C-O to use the system. This reinforces SCF's determination to excel in meeting C-O requirements. In Anchorage, most primary care, dental and behavioral health services are provided by small clinic practices rather than in large group practices. With nearly 100 percent of the local market, SCF focuses more on collaboration than competition, seeking partnership with key community members including the State of Alaska to address service gaps and establish a full continuum of services in Alaska. SCF works closely with our key partner, ANTHC, to identify needed services and to develop plans for closing gaps in providing these services. SCF identifies potential services gaps as part of its strategic planning process. SCFs business planning process requires identification of potential collaborators.

P.2a(2) Competitiveness changes. Key changes taking place affecting SCF's competitive situation are captured and reflected in SCF's strategic challenges and advantages, which are identified and verified annually in the SPC [Fig. P.2-2]. From an understanding of CC, advantages, and challenges, SCF has implemented innovations in access to care, developed multiple customer listening posts, established a center for employee development, and built on the foundation and inherent strengths of Alaska Native cultures.

P.2a(3) Comparative data. SCF's performance measurement system combines internal/external data sources [Fig P.2-1].

Figure P.2-1 Comparative Data

Performance Dimensions	Data Source	Comparison Type
Clinical	HEDIS & State of Alaska	External (National & State)
Customer-Owner Satisfaction	Avatar	Internal & External
Employee Satisfaction	Morehead Associates	External (National)
Human Resources	Saratoga-Price Waterhouse	External (National)
Financial	MGMA & Other Healthcare Organizations	External (National & State)
Regulatory	JC	External (National)

Internal sources, such as comparison charts, allow SCF to evaluate variability in health service delivery between clinic, team and providers. This information help clinic managers identify best practices for improvement efforts. External data sources, such as Health Plan Employer Data Information Set (HEDIS), allow SCF to compare its performance to national top performers. SCF has established the HEDIS 90th percentile (being in nation's top 10 percent) as a goal for clinical measures when like measures exist. SCF also uses Medical Group Management Association (MGMA) Benchmarks for its financial data. SCF has established the MGMA 90th percentile (being in nation's top 10 percent) as a goal for its financial measures when like measures exists. Saratoga-Price Waterhouse is a global leader in measurement and benchmarking human capital. They work with over 40 percent of the Fortune 500 companies in establishing benchmarks. Morehead Associates is a nationally recognized group that works with large organizations such as General Dynamic and Blue Cross & Blue Shield, providing them with employee satisfaction data and metric benchmarks. Avatar constructs a custom survey for each C-O that reflects the precise services and care received, including clinically relevant data on education, treatment and outcome items specific to their health condition. Avatar survey results highlight and provide feedback about the relationship between providers and C-O.

Occasionally, SCF develops performance measures that do not have national comparison data, but uses internally developed goals (e.g. for unique services that may not be delivered elsewhere). For regulatory measures, SCF is evaluated by external groups such as the Joint Commission (JC).

P.2b Strategic Context. Fig. P.2-2 outlines SCF's key strategic challenges and advantages. Sustainability depends on SCF's ability to balance, align, and integrate its responses to its key strategic challenges and advantages, while, at the same time, maintain and enhance the funding stream it needs to support growing capacity, achieve high performance, and meet increasing demands.

P.2c Performance Improvement System. SCF's approach to maintaining and supporting the organization's focus on improvement includes implementing PDSA Rapid Cycle, Balanced Scorecards, Annual Planning, reviewing high-performing organizations, and utilizing the Healthcare Criteria of the National Baldrige Quality Program as a framework. The PDSA Rapid Cycle Improvement Model, used organization-wide, offers a common language and framework for improvement and encourages small tests of change and learning before broad implementation. It is used at all levels – by individuals, work groups, project teams and committees – and is central to SCF's planning process and format.

SCF has a linked system of scorecards (strategic measures) and dashboards (operational measures) to track performance, quarterly for most measures. Defined thresholds and goals help identify improvement priorities. Annual Plans (AP) at all levels link to these key measures. Reviewing performance against AP promotes learning and allows for adjustment.

SCF regularly seeks to learn from high-performing organizations. SCF participates in the Quest for Excellence Conference, learning and improvement collaboratives sponsored by the Institute for Healthcare Improvement (IHI) and others, and other site visits, all of which provide opportunities to benchmark processes and results. In 2002, SCF adopted the Baldrige Criteria for Performance Excellence as its framework for periodic organization-wide review of its key processes and performance, performing a self-assessment in 2003, and submitting applications in 2005, 2006, and 2007. SCF received a Baldrige site visit in 2007. In 2009, SCF was the recipient of Alaska's APEX Award for Performance Excellence. As a result of learning from our Baldrige and APEX applications, we implemented a functional committee structure to promote communication and broaden involvement in decision-making [Fig. 1.1-2]; balanced scorecards and dashboards (BSC/DB) to support planning and performance review [4.1a(1), 4.1b]; a focus on seeking comparative data to evaluate performance [Category 7]; creation of a Web-based planning tool to deploy the annual planning cycle [2.2a(2)]; and P/CEO departmental site visits to enhance two-way communication [1.1b(1)].

Figure P.2-2: Core Competencies, Strategic Advantages, Strategic Challenges, and Corporate Goals

Core Competencies	Strategic Advantages	Strategic Challenges	Corporate Goals
CC1: Communication & Teamwork: Openly, clearly and respectfully share and receive information, opinions, concerns and feedback in supportive manner. Work collaboratively by building bridges and creating rapport with team members across the organization.	**SA1:** Engaged C-O; C-O who own and use the system **SA2:** Focus on multi-dimensional wellness for the whole community and for the whole life of each C-O	**SC1:** Understanding and responding to C-O expectations for service delivery	**SR-Shared Responsibility:** We value working together with the individual, the family, and the community. We strive to honor the dignity of every individual. We see the journey to wellness being traveled in shared responsibility and partnership with those for whom we provide services.
CC2: Improvement & Innovation: A capacity for rapid change and flexibility in order to make meaningful improvement to services, programs, processes, and/or organizational effectiveness that creates new value for customer-owners and employees.	**SA3:** Employee and workforce development focus, a learning organization **SA4:** Internalized passion for the Mission that results in willingness to continually change and innovate	**SC2:** Developing a recruitment and retention strategy that addresses the short-and long-term needs of SCF **SC3:** Compliance with changing regulatory environment	**CQ-Commitment to Quality:** We strive to provide the best services for the Native Community. We employ fully qualified staff in all positions and we commit ourselves to recruiting and training Native staff to meet this need. We structure our organization to optimize the skills and contributions of our staff.
CC3: Customer Care & Relationships: Creating, developing and nurturing culturally appropriate interactions and connections with each other, customer-owners, and the community.	**SA5:** Relationship focus as driver for all that we do	**SC4:** Ensuring the sustainability of current programs while developing new business opportunities **SC5:** Finding ways to engage C-O and families in their health care	**FMW-Family Wellness:** We value the family as the heart of the Native Community. We work to promote wellness that goes beyond absence of illness and prevention of disease. We encourage physical, mental, social, spiritual and economic wellness of the individual, the family, the community, and the world in which we live.
CC4: Workforce Development Skills, & Abilities: Necessary to provide quality care services – Seek out additional learning opportunities to continue to develop technical and professional current and future skills. Taking responsibility for all work activities and personal actions by following through on commitments.	**SA6:** Longevity in leadership and governance that provides consistency in direction and focus	**SC6:** Responding to the migration of C-O into Anchorage and Matanuska-Susitna Valley from remote locations in Alaska **SC7:** Building corporate infrastructure to keep pace with growth of programs and services (e.g., data management and reporting, utilizing IT to assist in delivery of services). Maintaining and improving our future funding stream to meet growth and C-O needs and expectations	**OPE-Operational Effectiveness:** We will develop and improve our operations that support delivery of services to our customer owners.

Responses Addressing All Criteria Items

1. LEADERSHIP

1.1a(1) Vision and values. SCF senior leaders (P/CEO, VPLT) use numerous approaches to deploy the MVKP to stakeholder segments [Fig. 1.1-1].

Figure 1.1-1: Deployment Examples of MVKP

Approaches	W	S	P	C
Anchorage Native News	✓	✓	✓	✓
Annual Reorientation	✓			
BFA/Arrigah House	✓		✓	✓
Brochures	✓	✓	✓	✓
Code of Conduct	✓			
Communicator	✓			
Core Concepts	✓			
Gathering	✓	✓	✓	✓
Gifts	✓	✓	✓	✓
ID Badges	✓			
Internet	✓	✓	✓	✓
Intranet	✓			
Living Our Values	✓			
Mouse Pads	✓			
New Hire Orientation	✓			
Performance Evaluations	✓			
Posters	✓	✓	✓	✓
PR Campaigns	✓	✓	✓	✓
Progression Checklists	✓			
SPC	✓			

Key: W=Workforce, S=Suppliers, P=Partners, C=C-O

In 1997, the senior leaders led a process with the workforce and C-O to renew the MVKP [Fig. P.1-1]. Input from focus groups, surveys, and formal and informal group processes was translated into simple, memorable, and enduring statements that are systematically evaluated, reaffirmed, and updated as needed during the annual SPC [2.1a(1)].

In 2001, the OP [Fig. P.1-2] were added as a tool to translate the MVKP into actionable language for employees. MVKP/OP are deployed in multiple ways [Fig.1.1-1]. In 2010, senior leaders improved the process of deploying MVKP to new hires by including a letter to new employees in the new hire packet from HR that outlines SCF's MVKP. Senior leaders present the corporate overview, including MVKP/OP at bi-weekly NHO and events such as the Annual Gathering which are attended by C-O, partners and stakeholders, and the workforce. The CG and CO, reviewed annually and modified as necessary by SCF's leaders and BOD, derive from and support the MV, and are organized and communicated in the framework of the KP. All APs explicitly support the CG and CO. Improvement project team charters articulate the linkage to the MVKP and improvement activities are measured against the OP to ensure alignment. The P/CEO demonstrates personal commitment to SCF values in many ways. For example, the P/CEO commits three days, multiple times annually, to personally facilitate Core Concepts training. Additionally, the P/CEO personally supported the development of an Employee Wellness Center by donating personal funds to supplement the construction costs. In addition, personal contributions were made by the P/CEO and VPLT to develop the ECAF, which was deployed in 2008, to further SCF's charitable purpose and to benefit the public.

1.1a(2) Legal and ethical behavior: Senior leaders foster an environment of legal and ethical behavior by personally demonstrating their commitment and leading by example. Senior leaders contribute to the development of the SCF Code of Conduct and reinforce its importance by (1) requiring all new employees attend NHO and all established employees, including the VPLT, revisit the Code of Conduct during annual re-orientation and attest, with their signature, to their commitment to SCF's MVKP/OP; and, (2) monitoring QA reports of completion rates.

Senior leaders provide direction and allocate resources to support the legal and ethical activities needed to support an organizational community that is committed to achieving quality, integrity, ethics and compliance. Senior leaders monitor compliance with standards and regulations through internal compliance auditing and monitoring activities as well as employee feedback. The SCF BOD, P/CEO and VPLT regularly monitor ethics and compliance through systematic bi-monthly reviews, approval of related policies and procedures, and quarterly and periodic compliance report reviews to ensure action is taken on all reported compliance incidents.

As role models, senior leaders promote open communications and improve team building by attending the bi-monthly Managers Meeting, quarterly Leadership Development Sessions (LDS), and department meetings to discuss current issues, outcomes, and lessons learned.

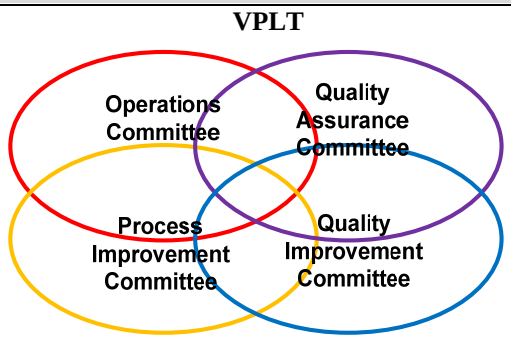
The SCF BOD and the Research Oversight Committee, including the three VPs on the committee, review research proposals to ensure that all initiatives and resulting publications conform not only to legal and ethical standards, but also to the cultural values of Alaska Native people.

1.1a(3) Sustainability. Performance improvement: SCF creates a sustainable organization through establishing an environment for performance improvement. SCF leaders design, deploy, and integrate multiple approaches and continually review these for opportunities for improvement. Examples include: job progressions; annual planning; and, AP reporting that occurs at the corporate, division, committee, and departmental levels [Fig. 2.1-5, P.2c]. In 2009, the Process Improvement (PI) Committee, under the direction of the VPLT, conducted a review of the Functional Committee Structure (FCS) [Fig. 1.1-2], to identify OFIs related to employee satisfaction scores around communication. As a result, SCF redefined membership and executive sponsors; deleted outdated sub-committees; and, added the Strategic Planning Committee. This review has now become part of the SPC. Additionally, the BSC supports systematic performance review and is used to monitor results and proactively identify improvement needs [4.1b, Fig. 7.1-34].

Innovation: SCF uses various methods to identify innovative ideas, such as integrating feedback from C-O and the workforce into the SID [2.1b(2)]; benchmarking and site visits to study innovative ideas that can be adapted to the SCF culture and needs of C-O; and using the SPC to prioritize, plan for, and implement innovative ideas. A specific example of using benchmarking research in the SPC is the implementation of "tele-behavioral health" via videoconferencing for psychiatric care. This technology allows C-O in rural areas to connect with a psychiatrist on a regular basis, thus minimizing the need for costly trips to Anchorage for care. In many cases,

the result is access to care that was previously not available.

Figure 1.1-2: Functional Committee Structure



OPS Sub Committees: FC (6*); HRC (5); PPC (1); SC (6); RCC (6); CSC (3); COMC (5); ITC (4); GT (5); GRC (1)

QA Sub Committees: COC (1, 4, 5); ARC (1); RMC (1, 3); ICEHC (5); SAFC (5, 6)

PI Sub Committees: SPLC (2); DATC (4, 7); ROC (4, 7)

QI Sub Committees: PCCBG (4, 6); DCBG (4, 6); BCBG (4, 6)
**Numbers represented in ( ) indicate the Baldrige category the committee primarily focuses on for review and addressing OFIs.*

SCF has identified 4 key functional areas of management to focus on: Operations, Quality Assurance, Process Improvement, and Quality Improvement. The functional committee structure provides a mechanism for providing ongoing feedback across the organization. There is intentional overlap within these areas and it is essential that all 4 functional areas be in balance and alignment in order to achieve business excellence.

Agility: Based on feedback from employees and SCF's first Baldrige assessment, senior leaders launched the functional committee structure in 2004, redistributing responsibility for decision making, formerly belonging to senior leaders, to four oversight committees and their subcommittees [Fig.1.1-2]. The restructuring enabled senior leaders to take a more strategic and less operational focus and direct their attention to long-term sustainability issues and changes in circumstances requiring agility in strategic decision making. This structure also speeds the pace for innovation and improvement, and allows further agility with respect to operational decisions, organizational knowledge transfer, cross-departmental/cross-disciplinary planning and action, and increased system integration. Functional oversight committee AP progress is reviewed at least twice annually with senior leaders, who also serve as executive sponsors of the committees, to emphasize the KP of Shared Responsibility. All functional committees have charters that outline their purpose in relation to the four oversight committees. All committees meet regularly and include employee representatives from various levels of the organization, an intentional design that promotes and improves communication and collaboration between internal customers.

Organizational and workforce learning: Numerous approaches are used to create an environment focused on learning. Senior leaders support organization-wide competency in the use of the SCF Improvement Process [Fig. 6.2-1]. They also provide resources to support learning and sharing, such as the SCF intranet, which makes goals and objectives, plans, and performance data available to all SCF employees. Senior leaders further demonstrate their commitment to organizational learning by teaching QMC [6.2b(4)], presenting at Managers Meetings, participating and facilitating at LDS, presenting during NHO, and using Baldrige Feedback Reports to facilitate discussions with the SCF BOD during the annual SPC.

Leadership skills: SCF leaders develop and enhance their leadership skills using various methods. For example, the CDR personality assessment is used as a tool to identify factors that influence their leadership style, and 360-degree evaluation (tied to the annual evaluation and individualized PDP) is used to identify areas for personal leadership growth. Another example of leadership development is the intentional transition of roles on external boards. Once the P/CEO has served as an external board member for an appropriate length of time, she transitions her board seat to another SCF leader. Finally, senior leaders learn from attending conferences, workshops, and collaborative activities, including site visits, to benchmark best practices and share our story.

Development of future leaders: The P/CEO has structured more formal opportunities for several VPs to take on many of her responsibilities, allowing them to gain experience in the top leadership role. Currently, two Alaska Native VPs are being mentored by the P/CEO, consistent with the mission of developing AN/AI employees at all levels. The P/CEO also mentors her executive assistant, using this example as a model for the VPs. VPs and directors are responsible for mentoring and developing their division management team and workforce respectively [5.1b]. Also, senior leaders are expected to mentor committee leaders. The Special Assistant Program, which reports directly to the VP of Resource and Development, gives potential future Alaska Native leaders project assignments from VPLT members. This long-standing program was reviewed in 2009 and restructured to ensure trainees receive more formal management training. Senior leaders actively participate in NMO, which was created in response to the recognized need for a more formal manager mentoring and development system [5.2c(1)]. Finally, senior leaders conduct trainings for the LDS or other DOL in the DC.

Culture of patient safety: Senior leaders create and promote a culture of C-O safety through a number of fully deployed approaches that include resources for process improvement, a focus on National Patient Safety Goals, a confidential compliance hotline, an automated patient tracer data tool, programs to improve medication safety, standardized code designations in alignment with state and national initiatives, and defined safety responsibilities for the QA Committee. C-O and employees are encouraged to use the SCF Employee Ethics & Compliance Hotline to self-report any incidents. The QA Committee oversees the Safety Committee [Fig.1.1-2], which is responsible for ensuring safe facilities, work environments, standardized clinical practices, and C-O care environments. Because of P/CEO and VPLT support, an innovative telepharmacy model was implemented to provide quality pharmacy services to rural health clinics that span 21 remote Alaskan villages. This provides distant populations "real time" services with improved medication inventory, safety and security. Because the SCF BOD, eligible senior leaders, and eligible employees and their families use SCF services, their personal stake drives SCF's focus on safety.

1.1b(1) Communication and engagement of workforce: Senior leaders have an open-door policy, as do all SCF

managers. Several of the corporate office areas, including the office of the P/CEO, HR and OD, and QA, were redesigned to "bring down the walls" and create a welcoming, congenial and transparent environment. All managers carry pagers and/or cellular phones and have remote access to the SCF intranet for email, to ensure their availability to the entire workforce. SCF uses multiple regularly scheduled events to encourage frank two-way communication [Fig. 1.1-2]. Senior leaders participate in and/or facilitate Core Concepts and use this opportunity to communicate as role models during the small group activities and by presenting their story during the module "Learn How to Articulate Your Story from the Heart." Senior leaders and managers visit SCF-managed remote sites, often joined by other Anchorage-based SCF employees such as HR, Facilities, QA, BSD and MSD. These visits serve three purposes: to introduce key SCF employees to rural site employees; to provide an educational opportunity; and to offer leaders opportunities to communicate key decisions and information with C-O and workforce in remote locations.

Reward & recognition: As committee sponsors or members, the VPLT interacts with a diverse group of employees across all divisions, and renders two-way discussions, recognition, and celebration. Senior leaders personally participate in the Employee Recognition Program [5.2c(1)], which emphasizes C-O focus, improvement and high performance, and actions that support the MVKP/OP, CG and CO, by doing the following:

- Actively participate in nomination, selection, and presentation of SCF's higher-level awards: "Living Our Values (LOV)" and "Honoring Our Successes."
- Support "Expressing Our Thanks," on-the-spot awards through special budget allocation.
- Hand-deliver "celebration packages" (e.g., cookies, spring planting tools and seeds, holiday ornaments) to departments three times a year.
- LOV recipients attend lunch with SCF BOD and the P/CEO where they are thanked and congratulated.

Key decisions and two-way communication: In response to employee feedback, senior leaders use various approaches for internal communications and visibility, as shown in Fig. 1.1-3.

Figure 1.1-3: Examples of SCF Communication

What/How	F	Audience	Purpose
SCF BOD Retreat (Two-Way)	A	SCF BOD, P/CEO, VPLT	Review/affirm MVKP; strategic planning
LDS (Two-Way)	Q	P/CEO, VPLT, Directors, Administrators, IA, Managers	A day-long learning session focused on a variety of topics relevant to Leadership
Manager Meetings (Two-Way)	BM	P/CEO, VPLT, Directors, Administrators, IA, Managers	For communication with P/CEO, VPLT, Functional Oversight Committees, and for strategic planning
Learning Week (Two-Way)	A	SCF BOD, P/CEO, VPLT, Workforce	Highlights SCF programs, projects
NHO (Two-Way)	BW	New Hires	Deploy MVKP/OP; introduce SCF policies and procedures, and SCF tools
Gathering (Two-Way)	A	SCF BOD, P/CEO, VPLT, Workforce, C-O, Partners, Community	Highlights SCF programs and gathers input on needs and C-O feedback
Functional Committee Meetings (Two-Way)	M	P/CEO, VPLT, Workforce	Strategic planning and monitor AP status
Core Concepts (Two-Way)	MA	P/CEO, VPLT, Workforce	Deploy MVKP/OP; build relationships
SCF Intranet	D	Workforce	SCF information, upcoming events, tools (AAPT, BSC, Data Mall, Evaluation Tool, Improvement tools)
Employee Satisfaction Survey	A	Workforce	Monitor staff satisfaction and engagement; strategic planning for improvement
QMC (Two-Way)	O	Workforce	Educational offerings through the DC related to improvement
Department Meetings (Two-Way)		Department employees	Communicate key decisions and issues
SCF Communica-tor	W	Workforce	Communicate key decisions and information; provide recognition

Key: F=Frequency: A=Annual, Q=Quarterly, M=Monthly, W=Weekly, D=Daily, O=Ongoing, R=Regular, BA=Bi-Annual, BM=Bi-Monthly, BW=Bi-Weekly, MA=Multiple Times Annually.

Note: Two-way communication approaches noted.

The Managers Meeting underwent a PDSA in 2009 based on manager feedback. Historically, the meeting was monthly and generally an opportunity to update managers on key decisions and various topics. After reviewing several cycles of meeting satisfaction surveys, the following changes were implemented: bi-monthly vs. monthly; managers given the opportunity to contribute to strategic planning, decision making and improvement; integrated networking opportunities with the updates on key decisions. Standard agendas now include updates as well as Q&A sessions with senior leaders (VPLT). The P/CEO personally conducts one of the meetings each year. Additionally, the P/CEO conducts four LDS annually.

1.1b(2) Focus on objectives, performance and vision: SCF's focus on action to reach objectives, improve performance, and attain the vision begins with the BOD, which holds management accountable for measurable improvement, supported by SCF's BSC system [Fig. 7.1-34, 4.1a]. The SCF BOD uses a subset of measures as key indicators to evaluate the performance of the P/CEO. This action and results focus is further reflected in SCF's cascading system of plans, performance measures and BSC that aligns actions at all levels down to the front line in support of SCF CG and CO. Senior leaders review BSC measures quarterly and take action based on their findings [4.1b]. To focus on actions for improvement, SCF uses the SPC [Fig.2.1-1] with metrics and timelines that are tied to the CG and CO, and defined in four BSC perspectives [4.1a(1)]. This tool helps ensure that SCF examines and addresses multiple, and sometimes competing, stakeholder priorities, and creates balanced value for C-O and other key stakeholders.

1.2a(1) Governance system: Through their oversight, review and feedback, the SCF BOD holds senior leadership accountable for fiscal and performance management.

Accountability for management's action: The SCF BOD holds the P/CEO accountable through the BSC, annual strategic plans and budgets, and operational performance reviews. The SCF BOD establishes performance goals and targets for the P/CEO and annually evaluates performance. Senior leaders take personal responsibility for specific strategic initiatives during annual planning cycle. Review of the achievement of the goals is included in annual evaluations for all levels of management, including senior leaders.

Fiscal accountability: The SCF Finance Department issues monthly financial statements, budget-to-actual reports, and key ratios to senior leaders and managers. The Finance Committee [Fig.1.1-2] analyzes financial performance across the organization and reports to the OPS regularly on improvement activities related to expenditure control. Grants management (6 percent of total budgeted revenue for 2010) and third-party reimbursement are two key areas in which SCF must demonstrate accountability. Third-party reimbursement progress is reviewed monthly by senior leaders, managers, and the RCC. Program Evaluation works with the Planning and Grants Department to support managers in meeting grantor requirements and a finance officer audits fiscal reports. Grant compliance reports are shared with the QA Committee. An internal auditor focuses on compliance with financial policies, procedures and practices. Results are reviewed by the SCF BOD and senior leaders at bi-monthly meetings.

Transparency in operations: SCF strives to be transparent in its operations by making policies and procedures available on the intranet to all employees. The process for policy and procedure approval includes review by appropriate committees [Fig.1.1-2], managers, and employees for input. VPLT meeting minutes are available to all employees via Committee Manager. The bi-monthly P/CEO reports to the BOD are also now available to all employees via a link on the intranet. In 2007, SCF's Communications Committee piloted use of electronic tools to communicate more effectively. Today, based on results of the PDSA, SCF utilizes SharePoint and offers an "SCFInsider" Twitter feed on its intranet to ensure important information is quickly disseminated to the workforce. Public events sponsored by SCF (e.g., Annual Gathering) provide an opportunity for anyone in the community to access SCF employees and program information, and ask questions.

Independence in internal and external audits: External audits are performed annually as required for programs funded by the federal and state governments. An independent CPA firm performs the annual financial audits, and the Board Audit Committee and SCF leadership receive the audit reports. As needed for specific issues, qualified outside professionals perform special audits or reviews. SCF leaders use the Sarbanes-Oxley criteria to review and update financial policies/procedures as the best-practice measure.

Protection of stakeholder interests and stewardship of funds: The SCF BOD is comprised of C-O invested in ensuring SCF's sustainability. Policies and procedures are in place to identify and address conflicts of interest, and the SCF BOD is required to read and abide by SCF's Code of Conduct, including Conflict of Interest Disclosures. Annually, the SCF BOD reviews the performance and compensation of the P/CEO, as well as all external audit findings.

1.2a(2) Leadership evaluation and improvement: SCF evaluates performance of senior leaders in several ways. The CIRI Board annually evaluates and reappoints SCF BOD members. BOD terms are three years. Using 2007 Baldrige feedback, the SCF BOD determined they wanted to find a self-assessment tool that provided national comparative data from boards of other health care organizations. SCF benchmarked a Baldrige recipient and national company, The Governance Institute, as a source to assess performance, through tools, resources and other services. As a result, the following changes have occurred: agendas are more strategic; discussions and updates have been expanded to include succession planning; and further educational needs and opportunities for the SCF BOD have been identified. Members of the SCF BOD come from diverse backgrounds, but are all Alaska Native people and C-O. The SCF BOD annually elects the P/CEO. The SCF BOD evaluates the P/CEO and awards incentive pay based on this evaluation. Key factors include goal achievement and 360-degree feedback. Since 2005, the SCF BOD has used quantitative results from key measures on the BSC as the basis. The P/CEO evaluates the VPs. A 360-degree review is the basis for this evaluation, with feedback from the P/CEO, other VPs, and direct reports. Senior leaders use Baldrige assessments, Avatar Customer Satisfaction results, and the Morehead EOS to evaluate their effectiveness as a leadership system. The functional committee structure implemented in 2004 is a leadership system improvement based on 2003 Baldrige assessment findings and employee feedback.

The VPLT engages in individualized leadership evaluations through developmental processes, such as the Society for Organizational Learning and CDR assessments. They use the findings to improve their skills by means of a formal leadership development plan that is part of each VP's annual PDP. From the P/CEO to front-line employees, SCF's approach to performance evaluation is based on achievement of goals developed through the SPC, which aligns CG and CO with individual performance plans at every level [5.1a(3)]. All levels and positions, including the VPLT, use the same performance action plan tool.

1.2b(1) Addressing adverse impacts to society: SCF participates in national, state, and local health care committees and organizations that maintain listening and learning sensors attuned to changes in accreditation, regulatory, and legal matters affecting health care. Examples include: Joint Commission, CARF, CLIA, and State of Alaska Department of Health and Social Services. Through participation in workshops, meetings, and webcasts, SCF has access to education programs and information that enable it to keep current on changing public concerns. In addition, SCF receives electronic alerts as well as information from clinical licensing boards to stay abreast of changes and requirements related to accreditation and/or compliance. The CBG reviews information on public concerns and changing requirements to determine the approach SCF should take to address changes for current and future services and operations.

Anticipate and prepare for public concerns: SCF leaders participate in local, state, and national committees and on boards of various organizations to keep abreast of public concerns, and to integrate community feedback into service improvement strategies and the SPC. SCF utilizes various communications tools – including its Anchorage Native News publication – and proactive media relations with local, state and national new sources to communicate key issues and address potential concerns. Through ongoing external communications and community relations, SCF maintains a bank of goodwill with its targeted publics. SCF addresses conservation of natural resources through its attention to recycling and minimizing waste. SCF's Green Team meets to identify opportunities and implement green approaches, such as use of recycle bins and refillable water bottles or paper products instead of disposables in meetings and gatherings. SCF also participates in community action planning with other member organizations of the U-Med Green District.

Processes, measures and goals to achieve/exceed regulatory, legal, and accreditation requirements: Fig.1.2-1 summarizes examples of SCF's overall integrated system, processes, practices, measures, and goals deployed to comply with the large number of accreditation, regulatory, and legal requirements. The SCF Compliance and QA Departments collaborate to monitor and track measures that support accountability to SCF's stakeholders and to the public. These measures are collected and reported through the Compliance and QA Committee structure and reported quarterly to senior leaders and the SCF BOD. The SCF Corporate Compliance Department provides guidance to employees and leadership on compliance matters and acts as a resource to ensure legal and ethical criteria are integral to all program processes. In addition, periodic internal and external audits are conducted to ensure programs continue to be vigilant.

Addressing Risk: The SCF Compliance Committee has chartered a subcommittee to address specific areas of risk. The Internal Audit Subcommittee is tasked with evaluating risks and working with other committees to implement policies or procedures to mitigate these risks. The Compliance Committee and its subcommittees meet monthly, report to the QAC, and make recommendations directly to senior leaders. In addition, the SCF Compliance Department reports directly to the BOD on regulatory updates, compliance activity including the volume and type of inquiries, complaints, audits and education information. Data is tabulated to identify shifts and trends and used to indicate corrective actions. SCF conducts annual employee and C-O surveys to monitor the tone of ethics and compliance across the organization. The SCF Compliance Department also offers ad hoc training on particular ethics and compliance issues. The SCF Compliance Department, in-house counsel and risk management are co-located, which facilitates close coordination as they monitor rules and regulations.

1.2b(2) Promoting ethical behavior: SCF promotes a culture of ethics and compliance through its Compliance Program and Code of Conduct. The Code of Conduct is distributed to every person that provides services at SCF (employees, contractors, volunteers, residents, etc.). All contracts include language ensuring partners and suppliers will follow SCF's Code of Conduct regulations and legal obligations. Each person is required to attend training and to sign a Code of Conduct Acknowledgment Certificate that is maintained on file. This training addresses all aspects of ethics, conveys information on how to address and report ethics and compliance concerns, and includes other expectations related to confidentiality and security requirements. Required annual re-orientation includes regulatory updates and specific areas of compliance.

Figure 1.2-1: Accreditation, Regulatory, Legal, and Ethical Requirements, Practices, Measures, and Goals

	Agency	Compliance Practices	Measure	% goal
Accreditation	JC	•Standards for ANPCC – Leadership, Safety, Administration, Medical Staff, Services •Use of restraints, etc. •Disaster/Preparedness	JC Survey & Assessment Scores	100
	BME	Medical staff licensing	BME Requirement	100
	CARF	BSD residential programs - standards of care, quality and safety	CARF Requirement	100
	AAAHC	Ambulatory Accreditation (Opt, Dental, VNPCC, etc.)	AAAHC Requirement	100
	CLIA	Laboratory accuracy and reliability of testing	Current Certificates	100
Environment	EPA	Environmental pollution abatement	Agency Standards	100
	DOT	Biohazard management practices and medical waste disposal	Vendor Certificates	100
Workplace Health and Safety [5.1b(1)]	OSHA	Employee and contractor workplace safety regulations regarding infectious disease prevention standards, employee protection from hazards, fire safety, hazardous chemicals stored, etc.	Provide Required Report on Time	100
C-O and Patient Rights	DEA	Laws for dispensing medication or abuse of drugs or controlled substances	Provide Required Report on Time	100
	CDC	Infection control standards and practices		
	DHSS	Infection control reportable diseases		
	HIPAA	•Understand and participate in personal health care decisions •Patient privacy, security, transactions and code sets federal regulations	Signed Consents	100
Research	IRB	Ethical standards according to federal and state laws regarding research, investigations and clinical trials	•Follow IRB protocols •OHRP Audit	100
Employment Eligibility	ICPA	Ensure the Protection and Safety of C-O	Regulatory Standards	100
	Alaska BCU			
	OIG		Exclusion Data Base	0

Key processes for monitoring and enabling ethical behavior and responding to breaches: SCF tracks ethics training and education and reports information to senior leadership quarterly. In addition, the SCF Compliance Department is available to employees, managers, senior leaders and C-O during regular business hours, as well as via a 24-hour, seven day a week, toll-free SCF Employee Ethics & Compliance Hotline. Through this hotline, the SCF Compliance Department receives questions and requests for guidance; reports or allegations of suspected compliance concerns within the organization and with stakeholders; and requests for compliance reviews or audits. All requests are tracked and responded to and any allegation of wrongdoing is investigated. Findings are used to develop corrective actions that may include education, system modifications or employee disciplinary measures. The SCF Compliance Department works closely with SCF HR to ensure employee corrective actions are implemented in a fair and consistent manner without any real or perceived appearance of retaliation. Also, SCF reports to CIRI quarterly on compliance activity.

1.2c(1) Societal well-being: Societal well-being and benefit are key to SCF's MVKP and strategies and are deployed organization-wide as referenced in Fig. 1.1-1. MVKP/OP are used in strategic planning, day-to-day operational decisions, and improvement plans. C-O own and drive decisions that are made – whether it is a small operational change or a large scale strategic plan – with the goal of achieving individual, family and community wellness. SCF's approach recognizes that well-being and wellness are multidimensional (physical, mental, emotional, spiritual). An example of SCF's commitment to societal well-being is found in the CO FMW3-Reduce the Incidence of Suicide. During the 2010 Gathering, the Denaa Yeets' program hosted an information booth that drew in approximately 1,000 C-O for discussion, education, and resources on the topic of suicide [Fig.7.1-19]. Other examples include standardized use of the SCF Improvement Process to continuously improve services; ECAF [Fig. 7.4-9 and 7.4-10]; Green Team; Mayor's Task Force on Homelessness; Health Fair for the Homeless: sponsorship of events such as: Heart Run, City-Wide Clean Up, United Way Day of Caring; and other community benefit events.

1.2c(2) Key Communities and Community Health: SCF has identified its key communities as Alaska Native Elders, families, and children/youth. Key communities are determined through ongoing two-way communication with C-O. This feedback and information is analyzed by SCF to determine key communities and their needs.

Supporting Key Communities: SCF actively supports and strengthens key communities through approaches such as (1) fulfilling obligations for prepaid health-related services to AN/AI people; (2) seeking grants and collaborative partner-ships for innovative programs not covered by government funds or third-party payors; (3) recruiting volunteers from workforce and community; (4) being recognized as a model for health care practices; and, (5) regular communication and coordination with other CIRI nonprofit CEOs.

During the SPC, SCF determines where to focus community health resources based on Alaska Native community needs, the MVKP, and ongoing guidance from C-O. As "key communities," Elders, families, and children/youth receive special emphasis. To support these key communities, SCF aligns, integrates, and enhances its services with resources provided by employees and partners in the community to specifically meet their needs. For example, support is provided for age-appropriate summer activities for children on health, nutrition, and safety topics; car seat education for families; and health education during prenatal screening. SCF also promotes health for Alaska Native people through its leadership's teaching, mentoring and advocating. SCF leaders play an important advocacy role in community and governmental activities that align with the MVKP/OP. All organizations that SCF's leadership participates in have aims and values congruent with MVKP/OP. For example, the P/CEO serves as an APU Regent and an NLM Regent. VPs serve on the ANMC JOB, ANTHC Board, ANHB, the Rasmuson Foundation Board, Anchorage Regional Behavioral Health Coalition and the Mayor's Task Force on Homelessness. As faculty at IHI conferences, SCF leaders share best practices, including primary care system design, panel management, and Advanced Access scheduling, with audiences from around the world. SCF works directly with tribal organizations to help them improve their leadership systems, compact with the federal government, and achieve excellence in cultural competency and care delivery. SCF acts as a consultative resource for other regional (Kotzebue, Fairbanks, Bethel, Kenai and Southeast Alaska areas, etc.) and national indigenous health care organizations (such as IHS IPC collaborative), going beyond the range of just influencing SCF's immediate service area. The information sharing and support is evidenced by the frequent visits received at SCF's facilities and SCF's visits to other organizations' sites.

2. STRATEGIC PLANNING

2.1a(1) Strategic planning: SCF conducts strategic planning by following a continuous SPC [Fig. 2.1-1]. The cycle follows a calendar year. Key participants in the SPC include members of the SCF BOD, VPLT, Functional Committee Structure [Fig. 1.1-2], divisions and departments. Participants in the SPC are involved in national, state, local, and industry forums to learn about industry trends and best practices [4.1c(1)], which helps identify potential blind spots.

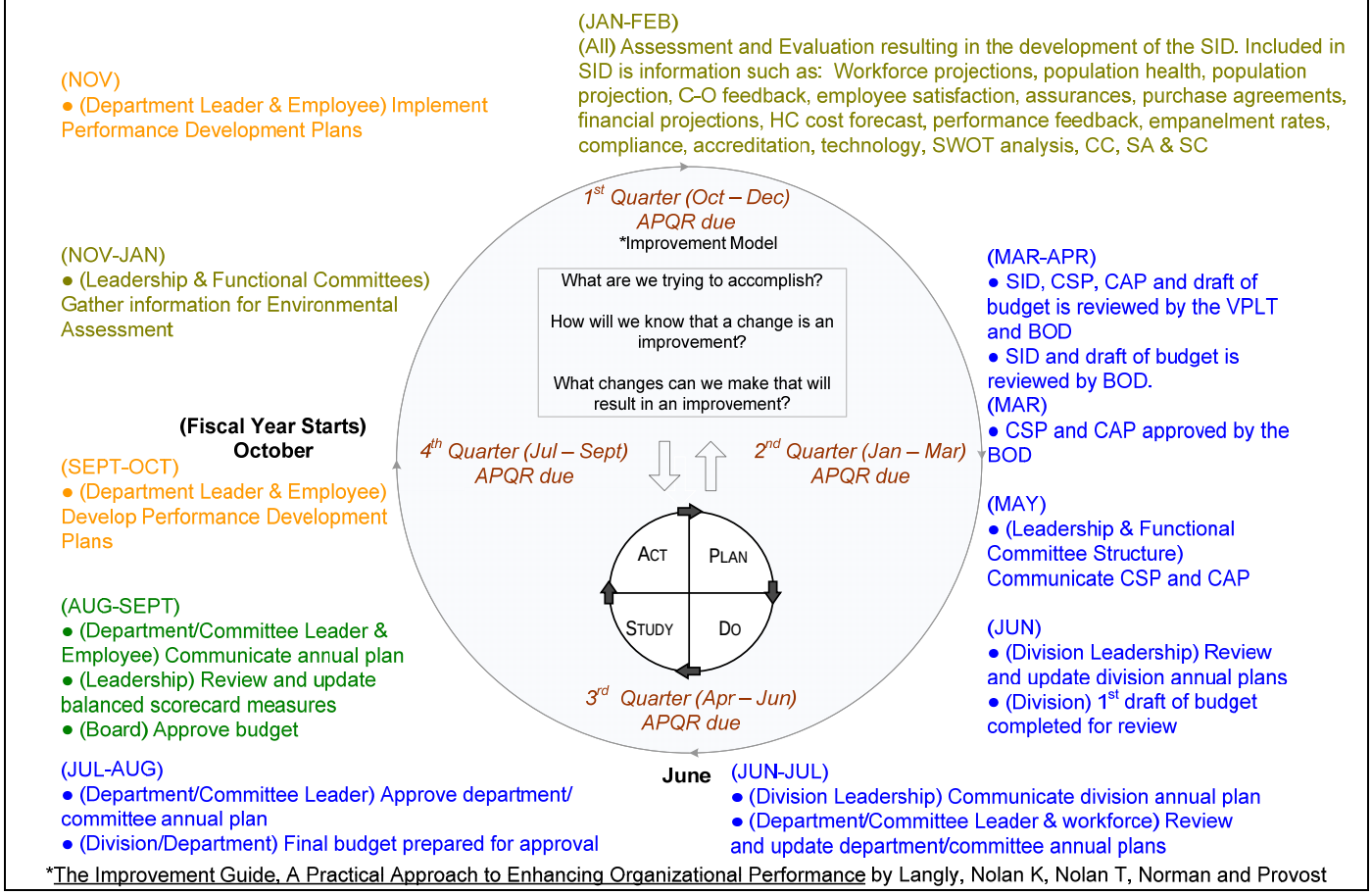
Key process steps: (Jan-Feb) The Strategic Planning Cycle starts with an environmental assessment. During the environmental assessment, key pieces of information are collected. Several subject matter experts provide a summary of key topics to consider for planning. The information is summarized in the SID. A draft of the SID is reviewed with employees who provide feedback on items missed. This is a way the process identifies potential blind spots. [4.2a(3)]. A SWOT analysis is then conducted by managers in a Managers Meeting format. The results are compiled and reviewed by members of the four oversight committees. The oversight committees use the SWOT results to determine organizational SC, SA, and CC [Fig. P.1-3, P.2-2]. A summary of the SWOT analysis, SC, SA, and CC are reviewed and validated by the VPLT. The results are included in the SID. [Fig. P.2-2].

A draft of the overall budget is developed by the VPLT.

(Mar-Apr) A comprehensive review of the SID is conducted by the VPLT and SCF BOD. This is another way the process identifies potential blind spots. The purpose of the review is to consider all information that may impact SCF's current SP, which includes CO and CI, executive sponsors and measures. CO and CI are affirmed or revised accordingly. Members of the VPLT are identified as executive sponsors of CO. Executive sponsors oversee the development of CO measures.

(May-Jul) The executive sponsor identifies an owner from division leadership to be responsible for overseeing CI, including defining appropriate measures for each CI. Changes made to the strategic plan, including changes in resources, are communicated by the VPLT through the Functional

Figure 2.1-1: Strategic Planning Cycle



*The Improvement Guide, A Practical Approach to Enhancing Organizational Performance by Langly, Nolan K, Nolan T, Norman and Provost

Committee Structure [Fig. 1.1-2] and AAPT. CO and CI measures are reviewed by the appropriate committees. CI are linked to CO and recorded in AAPT. This triggers a cascade of annual planning activity at all planning levels (division, department and committee). All planning levels review the approved SID, current AP and any changes to the SP. AP are developed for the upcoming fiscal year [2.2a(2)]. Divisions work directly with finance managers to draft budgets.

(Aug - Sep) Completed AP are reviewed and approved by leadership as defined in each AP approval chain. This is a way the process identifies potential blind spots. The VPLT reviews and approves the measures for CO and CI and selects which of the CO and CI measures are included in the BSC [4.1a(1)]. SCF's budget is reviewed and approved by the BOD.

(Oct - Dec) Approved AP are reviewed and employee PDP are developed [5.1a(3)]. All of the resources (SP, CAP, AAPT, SID) used in the SPC are accessible by all employees via the intranet. This is another way the process identifies potential blind spots.

Planning horizons: SCF leadership recognizes that the market is dynamic, and demand and resources are difficult to forecast with precision beyond three years. SCF leadership defines a rolling three years as its longer-term planning horizon. The changes made following the review of the SID by the VPLT and BOD, set SCF's strategic direction for the upcoming three fiscal years. This provides adequate time for anticipating significant capital commitments, market changes, and technological advancements. One year is the defined shorter-term horizon and provides adequate time for achievement of corresponding shorter-term goals and action plans.

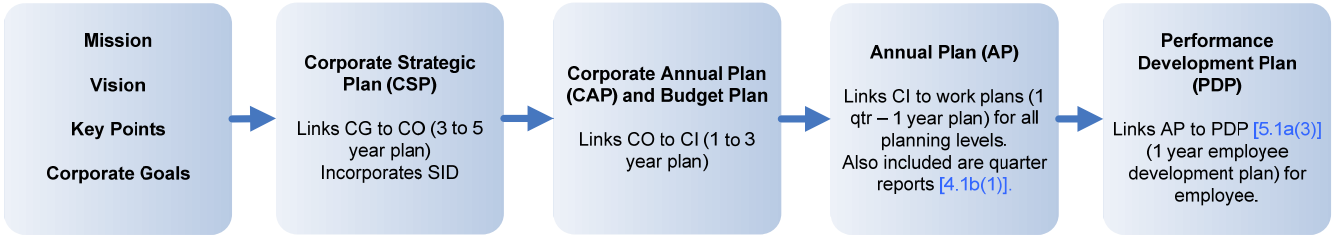
2.1a(2) Strategy Considerations: Data on key elements are collected and analyses occur with appropriate committees of the FCS [Fig. 2.1-2]. A summary of the analyses of key elements are included in the SID. Revisions to CO and CI incorporate strategic considerations included in the SID. Review of the final SID starts planning activity at most levels including SCF BOD, VPLT, division and department, resulting in AP.

2.1b(1) Strategic objectives: SCF's CO are key strategic objectives for the next (rolling) three to five years, are linked to a CG, are reviewed annually, have an executive sponsor from the VPLT, and have one of the four oversight committees as a responsible committee. They also may be included in the corporate BSC. Figure 2.1-5 includes a list of SCF's CO and an example of an important goal for each CO.

Figure 2.1-2: Strategy Consideration Examples

Strategic Input Data Collected for Key Elements (frequency)	Analyses occurs with	Addressed in SPC
Key Elements: Strengths, Weaknesses, Opportunities, and Threats		
SCF SWOT Analysis (annually) [2.1a(1), P.1a(2)]; Baldrige Feedback Report (annually)	Analysis is conducted by the Strategic Planning Committee and the four oversight committees. Results are reviewed with committees in the functional committee structure, VPLT, BOD, divisions and departments.	Environmental Assessment; CO, CI Review; Annual Plan Development; Annual Plan Quarterly Report Development
Key Elements: Shifts in Technology; HC Markets; HC Services; Customer and Stakeholder Preferences; Competition; and, Regulatory Environment		
Customer Satisfaction Surveys (quarterly); Health of the Community Analyses (annually); Population Projections (annually); Employee Satisfaction Surveys (annually); Workforce Projections (annually); Best Practices (on-going)	Analysis is conducted by the Customer Service Committee; Data Analysis & Tracking Committee; Human Resources Committee; VPLT; BOD	Environmental Assessment; CO, CI Review; Annual Plan Development; Annual Plan Quarterly Report Development
Key Elements: Organizational Sustainability		
Assurances; Purchase & Service Agreements; Financial Projections (annually); HC Costs (annually) ; Budget formula to address	Analysis is conducted by the Operations Committee; Finance committee for review by the VPLT; BOD	Environmental Assessment; CO, CI Review; Annual Plan Development; Annual Plan Quarterly Report Development
Key Elements: Ability to Execute Strategic Plan		
Organizational Performance via BSC, AP and APQR review (quarterly); VPLT compensation linked to CAP organizational performance (annually) [Fig. 2.1-5]; Planning Linkages between CG, CO, CI, AP, and PDP (annually); Executive Sponsors/Owners assigned to CO, CI and AP (annually); Review of SPC (annually)		Environmental Assessment; CO, CI Review; Annual Plan Development; Annual Plan Quarterly Report Development

Figure 2.1-3: Planning Linkages



2.1b(2): SCF's CO achieve strategic objective considerations as follows:

Figure 2.1-4: Strategic Objectives Considerations

Consideration	Examples of how COs are addressed
Strategic Challenge, Strategic Advantage	Are identified following a SWOT analysis and included in the SID. Through application of planning linkages [Fig. 2.1-3].
Innovation	Through application of Best Practices, Lessons Learned and PDSA. By establishing the ODI Division. By utilizing Improvement Advisors and Improvement Specialists. By providing professional development opportunities through the Quality Management Courses.
Core Competencies	Are included in the SID. Are Workforce Competencies. Linked to CO. SWOT analysis.
Challenges & Opportunities	Are included in the SID. Through quarterly review of AP (via APQR). Linked to CO.
Key Stakeholders	Input in the SPC occurs through the functional committee structure, manager meetings, division and departments. OP reflects voice of C-O.
Sudden Shifts	Captured by key stakeholders through participation in internal and external committees and conferences. Through application of best practices, lessons learned and the Improvement Model. Revise quarterly AP to modify plans.

2.2a(1) Action plan development: Department leaders facilitate a review of SID, CO, and CI to start the process of action plan development. Department leaders develop annual work plans with their departments. Key short- and longer-term action plans and key planned changes are listed in Fig. 2.1-5.

2.2a(2) Action plan implementation: During the May-July timeframe of the SPC, SCF develops and deploys action plans by using the AAPT to create APs. Steps are (1) CI are entered in the AAPT; (2) CI owners are identified and entered in the AAPT; (3) following communication from leadership, required AP by planning level and AP owners, generally a department leader, are identified; (4) AP owners proceed with creating an AP; (5) AP are developed by selecting or being assigned a CI which results in the AP auto populating with the CI; and, (6) for each CI on an AP, work plans are developed. Work plans provide a framework for describing the work to be started or completed in a plan year to achieve established goals for a CI. Each work plan includes a description of the work, process measure(s), work plan owner(s), partner(s) and due date. An AP owner is responsible for ensuring relevant work plans are included and linked to the appropriate CI. Completed AP are reviewed and approved according to the AP approval chain. The approval chain generally follows the reporting structure of the AP owner [Organizational Chart].

Figure 2.1-5: Representative Sample of SCF Strategic Plan

Strategic Objectives 2.1b(1) CC, SA, SC 2.1b(2)	Goals (CI) 2.1b(1)	ST & LT Plans 2.2a(1)	Key Planned Changes 2.2a(1) (HR) Key HR Plans 2.2a(4)	Key Performance Measures (Sample BSC) 2.2a(5)	Projections 2.2(b) ST	Projections 2.2(b) LT
Shared Responsibility - SR corporate objective addresses CC1, SA1, SA2 and SC1 [Fig. P.2-2]						
SR1- Ensure systems and services that are respectful and culturally appropriate **SR2-** Achieve excellence in C-O satisfaction **SR3-** Increase community awareness of SCF's services and programs	Improve customer satisfaction	ST: Improve CARE model ST: Increase survey marketing LT: Increase application of C.A.R.E. model	(OD) Increase % of current employees receiving C.A.R.E. model training	Customer Satisfaction [Fig. 7.2-1] Culture and Traditions Respected [Fig. 7.2-3] Continuity of Care with Provider [Fig. 7.1-30]	85% 85% 70%	91% 95% 80%
Commitment to Quality - CQ corporate objective addresses CC2, SA3, SA4, SC2 and SC3 [Fig. P.2-2]						
CQ1- Improve work environments and employee development systems with an emphasis on AN/AI employees **CQ2-** Ensure continuous improvement of systems and processes **CQ3-** Increase the number of AN/AI employees in all job categories	Improve employee satisfaction	ST: Implement on-line exit interviews [5.2a(3), 5.1c(1)] ST: Implement action plans to increase employee satisfaction [5.2b(1 & 2)] LT: Improve workforce readiness LT: Improve employee retention	Improve succession plans for clinical and managerial positions Integrate workforce competencies through HR functions [5.1a(3)] Increase QMC opportunities (DC) Improvements to key onboarding programs; Increase CME offerings	Morehead's Commitment Indicator Score [Fig. 7.3-1] % of AN/AI Employees [Fig. 7.3-15] Total and AN/AI Turnover [Fig. 7.3-13]	4.07% 54% 22%	4.11% 60% 15.56%
Family Wellness - FMW corporate objective addresses CC3, SA5, SC4 and SC5 [Fig. P.2-2]						
FMW1- Reduce the rate of domestic violence, and neglect **FMW2-** Reduce the rate of and improve the management of cancer **FMW3-** Reduce the incidence of suicide **FMW4-** Reduce the rate of obesity **FMW5-** Reduce the rate of substance abuse **FMW6-** Reduce the rate of and improve the management of diabetes **FMW7-** Improve oral health **FMW8-** Reduce the rate of and improve the management of cardiovascular disease	Improve clinical performance Increase integration of the FWWI philosophy across organization	ST: Core Concepts [P.1a(2)] ST: Improve screening rates LT: Improve workforce readiness	Continue building partnerships (DC) Implement succession plan [5.2c(2)] (BSD) Increase BSD FWWI training opportunities	NCQA - HEDIS performance measures. Includes eight measures 1. Breast Cancer Scr. [Fig. 7.1-11] 2. Colorectal Cancer Scr. [Fig. 7.1-9] 3. Child. Imm. [Fig. 7.1-12] 4. Diab. HbA1c poor control [Fig. 7.1-2] 5. Diabetes Annual Scr. [Fig. 7.1-1] 6. Cardiovascular (LDL<100)l [Fig. 7.1-7] 7. Cervical Cancer Scr. [Fig. 7.1-10] 8. Asthma Appropriate Meds. [Fig. 7.1-8]	Meet or exceed HEDIS 75th percentile (top 25%) for eight measures.	
Operational Excellence - OPE corporate objective addresses CC4, SA6, SC6, SC7 and SC8 [Fig. P.2-2]						
OPE1- Improve the management of expenses **OPE2-** Improve utilization of IT and data support systems and services **OPE3-** Improve SCF systems for third party revenue generations and collections	Improve financial position	ST: Achieve budget LT: Improve Medicare eligibility services	Implement EHR; Program Expansion; Joint Venture Construction Program (DC) Improve leadership development	Operating Margin [Fig. 7.5-1] Third Party Payor Revenue [Fig. 7.5-4]	Meet budgeted amount	

It creates multiple levels of leadership review of the AP before it is marked with an "Approved" status. At each level, the approver has the ability to provide feedback and return the AP back to the owner. This multi-level review ensures key outcomes are achievable and can be sustained. Once an AP is approved, the AP owner can proceed with recording frequent status updates as well as creating the required quarter reports. Work plan status updates are reported quarterly via the APQR and include details on process measures, progress made, lessons learned, and next steps. At the end of each quarter, the APQR are reviewed and approved through the approval chain. This process allows leaders to identify actions and resources needed to sustain or spread the outcomes of work plans. APs are available to all employees via the intranet. All employees can access and view AP, associated status updates, quarterly reports and all associated work plans within the organization. SCF also actively shares plans with key external partners [Fig. P.1-7]. The VPLT communicates SCF's plans to ANTHC during various meetings of the JOB, its subcommittees and Executive Management Team as well as other key partners [P.1b(3)], enabling the primary care (i.e., SCF) and specialty hospital care (ANTHC) to work collaboratively across the continuum.

Recent improvements to the annual planning piece of the SPC include involving a "coordinator" early on in AP development to review and provide feedback. This process includes reviewing APs with AP owners and a division designee to improve awareness of how work plans are linked to corporate initiatives. This provides another opportunity to capture blind spots. The FCS [Fig. 1.1-2] now also includes a subcommittee of the PI Committee responsible for facilitating the SPC.

2.2a(3) Resource allocation: SCF ensures that financial resources are available by planning, forecasting, and seeking partnerships and funding. Revenues for the next fiscal year (beginning October 1) are forecasted several months during the January-March period of the SPC. Forecasts are largely based on actual results from the most recent full fiscal year, and year-to-date results from the current fiscal year. Any other known or "forecastable" factors are considered to determine a final estimate to be used for budget preparation. Such factors may include inflation or volume assumptions, overall or by service lines; expected Congressional appropriation increases or decreases (a percent of SCF funding comes as an IHS appropriation); new or terminating grant funding; significant changes in Medicaid payment methodology (a substantial portion of third-party payments are from Medicaid); and, new programs planned. Financial projections for new business investments are based on market and payor information and include start-up, phase-in, and fully implemented or "mature" budgeted amounts. If the start-up, phase-in, or fully implemented new business is not expected to generate enough revenue to cover the expenses, an allocation from corporate reserves is identified and designated.

Assessment of financial risks is an ongoing process based largely on recent past and current financial results from operations, as well as general knowledge of SCF's marketplace and regulatory environment. SCF formulates long-term financial plans with the knowledge that it is not possible, or even desirable, to maintain operating margins at the levels experienced 10 years ago. Long-term financial planning at SCF includes evaluating levels of service which can be supported based on funding projections.

The VPLT also monitors the impact of the influx of AN/AI to the Anchorage area based on SCF's financial position. Because it is understood that this immigration of C-O is causing expenditures to grow faster than offsetting revenue, managers are held accountable for managing to the budgeted bottom line for each program. SCF's Finance Division tracks and monitors revenue and expenses and identifies deviations from anticipated levels. The Revenue Committee monitors and communicates third party net revenue results, addresses revenue-related opportunities for improvement and recommends opportunities to enhance net revenue. In order to increase funded services to its existing and expanding C-O base, SCF is implementing additional Medicare and Medicaid funded activities, improving cost reporting to enhance cost-based reimbursement, working with state service delivery departments and the Medicaid program, making revenue information available to managers in the Data Mall, reviewing its revenue cycle and hiring employees to implement revenue cycle improvement. The Revenue Committee sponsored a work group to research Medicaid enrollment trends and identify opportunities to enhance this critical revenue source.

SCF manages its costs by making expenditure information available to managers, involving managers in budget development, developing tools to track costs over time, changing its model of care to emphasize wellness and active management of chronic disease, addressing the family as a unit, eliminating duplication and multiple visits to the greatest extent possible, allowing employees to "work to the limit of their license," and targeting complex users of services to identify what type of services these C-O really need.

SCF takes an active role in its relationship with funding partners, including the IHS; the State of Alaska, its largest third-party payor via the Medicaid program; and the Alaska Mental Health Trust Authority, in policy and operational matters. The relationships serve to identify current and future needs, and allow for policy development, problem solving, identifying elements of risk and working together to resolve them.

To support appropriate workforce planning levels, SCF uses a comprehensive staffing formula that enable it to project, for every 1,200 C-O empanelled, the FTE and cost to sustain its action plan changes. Projected staffing needs drive HR's Corporate Recruitment Plan, which includes strategies for providers, clinical support staff, administrative support and other employees. These formulas serve to ensure that realistic budgets are set to accomplish long-term staffing needs along with short-term solutions, such as temporary and contract workers [5.2a(1)].

2.2a(4) Workforce plans: Growth in the AN/AI population in Anchorage and increased C-O demands for service have significant implications for staffing. SCF supports accomplishment of its CO and action plans with HR and DC APs. The HR and DC departments use a combination of formal and informal feedback to improve or add programs [5.1b(2)]. A major focus of these APs is building SCF's workforce capability by attracting employees, increasing the

percentage of AN/AI employees in clinical positions, improving retention, and increasing the number of employees who have demonstrated readiness for the next level of responsibility. The DC's AP include: redesign improvements to key onboarding programs (ASTP, NHO, NMO, CMA/LPN); implementing a new LMS; and, increasing the amount of educational offerings with CME and/or university credit. Other key HR plans include: improving employee satisfaction; aligning HR tools (progressions, competency assessments, etc.) around established workforce competencies; improving retention of entry-level employees and testing ways to attract past high-performing employees. [5.1a(2)].

2.2a(5) Performance Measures: Key performance measures are listed in Fig. 2.1-5 and linked to a CO [4.1a(1)].

2.2a(6) Action Plan Modification: Approved current year APs can be modified at any time during the SPC. All edits to an AP will trigger review and approval through the approval chain. Required APQR [4.1b] and reviews provide SCF leadership with the information needed to make modifications, and promote rapid development, deployment and adjustment of action plans. SCF's response to H1N1 provides an example of how AP were modified mid cycle. SCF deployed appropriate education, provided protective equipment, partnered with OSHA and CDC, and provided vaccinations early. Improvements to the FCS and membership are other examples of modified action plans [1.1a(3)].

2.2b Performance Projections: Performance projections are listed in [Fig. 2.1-5]**.** SCF sets short- and long-term performance targets. SCF's own past performance, trends, and comparisons with other organizations [Fig. P.2-1] are used as factors in setting the targets. Where practical, projected results are compared to comparable organizations and/or benchmarks, owners of CI are subject matter experts who determine appropriate performance indicators and projections which are then reviewed by the appropriate functional committee and/or division leadership. Progress, gaps and opportunities are identified and addressed at quarterly reviews.

3. CUSTOMER FOCUS

3.1a(1) Listening to Current Patient Stakeholders: SCF employs multiple approaches to listen to and learn from C-O and other stakeholders. SCF manages and uses listening post data and information to identify changing health care needs and to look for areas of opportunity to become more C-O-focused. Intentional listening [Fig. 3.1-1] is an essential component of the OP and the SCF culture. SCF enlists a variety of social media tools to solicit and assist in the capture of electronic C-O feedback, such as Twitter, Facebook, SCF website, discussion board on the SCF Communicator, and other blog sites. All primary care clinic areas are equipped with a computer setup, and C-O can immediately access the SCF website and enter a comment or complaint. Another key approach is that all SCF employees are empowered to act upon immediate service recovery opportunities. Examples of service recovery opportunities are captured with follow-up calls by the CM team, or during C-O's arrival or departure with availability of clinic supervisors located in the clinic front-desk areas, and supplemental manual surveys conducted in targeted service areas.

Figure 3.1-1: Listening Approaches and Frequency by Service Area Segments

Listening Posts	Listening Frequency	Anchorage & Mat-Su Valley	CIRI Villages	ASU Villages	State Tribal Members
Personal Interactions	O	X	X	X	X
Comment Cards	O	X			
Customer Satisfaction	O	X	X	X	
Survey Monkey	ASI			X	X
24-hour Hotline	O	X	X	X	X
Internet Email to the P/CEO	O	X	X	X	X
Nuka Conference	ASI	X	X	X	X
Listening Conference	ASI	X	X	X	X
Governing Board	ASI	X	X		
Advisory Committees	ASI	X		X	X
Community Leadership	ASI			X	X
Social Media (Facebook/Twitter)	ASI	X	X	X	X
Focus Groups	ASI		X	X	X
Service Agreements	ASI	X	X	X	

Key: *Italics* = listening post captures voice of potential and former users of services as well as active users.
Ongoing (O) = occurs continuously without interruption;
At Scheduled Intervals (ASI) = happens with some predictable frequency (e.g., monthly, biannually).

Employees in SCF Tribal Relations, the ANPCC Customer Service Kiosks, and ASU Support departments are also critical for stakeholder listening. Their primary purposes are to foster and support relationships with C-O. Tribal Relations coordinates with the VSMT advisory group to bring together the chiefs/tribal leaders of the ASU to provide feedback and advise the BOD on actions to take [6.1b(2)]. CSRs at the front line play an important role in C-O listening and encouragement to offer feedback. Assigned to specific C-O care areas, they circulate to talk with C-O about their experiences, spot and resolve problems, report to managers and supervisors, and enter findings in the CFRS database. All employees play a similar role for their respective C-O. The ASU Operational Support Department, within MSD, provides a direct contact for the ASU villages when they have concerns and suggestions regarding current and future services. As issues and other feedback are brought forward, they are entered in the CFRS and handled immediately. This approach ensures C-O are at the center of the system for determining actions.

The CSC and CBGs systematically review the data and information in the CFRS database to identify patterns and trends, and to set priorities based on SCF's OP, strength of particular themes, emergence of themes from multiple sources, and the C-O satisfaction survey prioritization process. The CSC prepares the APQR and BSC that reveal the needs and desires of key C-O groups and identifies OFIs. Quarterly reviews are conducted by the OPS, VPLT, BOD and JOB. During the annual environmental assessment of the SPC, these results are again reviewed and analyzed, then included as a key input into the SID [Fig. 2.1-2, 4.1b, 6.1, 6.2]. SCF's functional structure helps ensure that C-O feedback is integrated into plans, programs, services, and improvement opportunities. SCF also conducts periodic community needs

assessments. The results, from both C-O and non-C-O [3.1a(2)], are reviewed by leadership and included as input to the SID [2.1a(1)].

To boost the survey data review and analysis processes, SCF deployed a new series of trainings that educate employees in the science of data analysis and turning the results into pertinent, actionable items and improvement concepts.

3.1a(2) Listening to Potential Patients and Stakeholders: From listening posts [Fig. 3.2-1], SCF obtains data and information to understand current C-O, former C-O and non-C-O service needs. This information allows SCF to identify actionable opportunities that are used in strategic planning and improvement activities. The SCF workforce also participates in local community boards, committees, and conferences/events to understand stakeholder needs; to gain information about competitors' services, and how they are meeting potential and former SCF C-O needs; and to share information about SCF's services. In addition, the PI Committee annually assesses various conferences as learning opportunities and determines key events that SCF workforce will attend to study emerging health care trends and effective practices. These opportunities assist SCF in improving services and responding to emerging health care needs [6.2c]. Participants bring back information and present what they learned to the PI Committee, their own departments, and other committees if the information aligns with their strategic purpose and needs. Presentation materials are archived on the SCF intranet for easy access and use.

The SCF PR Department evaluates SCF's communications and social marketing campaigns, as well as community outreach activities, to determine the effectiveness of specific programs, activities, and events, particularly what impact the intended messages had on the target audiences. This ensures approaches and methods are current, responsive to community needs, and in alignment with the MVKPOP. The PR Department also gathers information regarding emerging needs and uses this data to identify current, past and potential C-O engagement, satisfaction, and dissatisfaction and to determine appropriate direction in communication plans. The FCS and reporting processes outline the needs and desires of key C-O groups, identifies OFIs and ensures that C-O data is integrated into SCF plans, programs, and services.

3.1b(1) Satisfaction and Engagement: Satisfaction and engagement are determined through C-O research, safety/risk management, feedback and daily interactions.

In 2002, SCF implemented a C-O satisfaction survey process. By 2007, through various cycles of learning, SCF acknowledged low response rates and reviewed C-O feedback. "Survey fatigue" and the length of the survey were reported by C-O as leading factors in their decisions not to respond. After reviewing alternatives, the CSC identified a new vendor in 2008 (Avatar International) that offered a viable solution to meeting cultural and C-O requirements. [P.2a(3)].

SCF uses this improved survey process to meet SCF's information needs. SCF intentionally focuses on improving response rates and gaining actionable data to help SCF exceed C-O expectations. A current pilot is being conducted with a new Avatar technology utilizing "Touch Stations," whereby survey feedback can be collected immediately after the point of service. All data is segmented by individual clinics to monitor each clinic's performance rates and understand areas for primary focus and improvement.

Fundamental key questions are woven into the C-O satisfaction survey instruments that integrate factors such as Access, Communication, Culture, Environment, Quality of Care and Key Results. These customized questions monitor sensitivity to and respect for Native cultures and traditions to help ensure that SCF captures the complete C-O experience and keeps current with C-O and stakeholder needs.

C-O feedback from daily interactions is shared during team huddles and meetings, and with functional committees as appropriate. The workforce is empowered to act on C-O concerns immediately. This engages the C-O and the workforce in the resolution process.

SCF leaders and committees systematically review C-O feedback data during monthly and quarterly review meetings. The satisfaction/dissatisfaction data is retrieved at a department/clinic level. MSD data is also forwarded to ANTHC and combined with their hospital data, to be reviewed by the EMT and JOB. The segmented results are used to identify targeted program improvements or may be blended for system-wide improvements. The CSC analyzes C-O comment feedback to develop a committee plan and APQR, and presents updates and improvement recommendations to the OPS and VPLT. The aggregation and analysis data is a key input to the SID and is used in SPC. The specific recommendations could include customer service improvements, such as workforce education, performance expectations, and technology needs. For example, based on survey feedback that C-O wanted more information about their health care, the CSC recommended a revision of SCF's Health Information website [4.2a(2)]. Passive display panels were also installed in the ANPCC to play various health information messages supplied by SCF HED.

3.1b(2) Satisfaction Relative to Competitors: SCF obtains information from multiple sources on the satisfaction of its C-O and other stakeholders, relative to their satisfaction with other competitors located in the state and affiliated with the IHS systems. The C-O satisfaction survey provides national comparisons to other health care organizations via the CAHPS database. Employees themselves are an important source of information, given the large proportion of SCF employees who are AN/AI, and share their own perspectives and those of family members and friends who have used other providers. A health care services survey was sent out to all employees via Survey Monkey with filters to identify those employees who are eligible for services at SCF, while keeping their identities anonymous. The survey results were summarized for leadership review and used in the planning process. This information helped SCF gain a better understanding of employees' experiences and requirements. Throughout the year, SCF also obtains local comparative information through various interactions between SCF leaders and C-O during advisory committee meetings, SCF Listening Posts, the Annual Gathering, C-O focus groups, and information sharing

with community and governmental organizations. This information allows SCF to study services provided by competitors and better understand needs and requirements.

3.1b(3) Dissatisfaction: Through direct feedback, SCF listens to the voice of the C-O to determine satisfaction or dissatisfaction. Dissatisfaction data is gathered and analyzed at the point of service to enable recovery and address the C-O's needs as quickly as possible. OFIs can be identified through both the Quantros Feedback and SRM modules. SRM events could trigger a RCA, or analysis of other trending events. At a minimum, the CSC meets monthly to review aggregated data to identify OFIs, or trends of dissatisfaction, and to analyze the data to understand evolving C-O requirements. Depending on the analysis, the CSC may forward this information to the functional committees, VPLT, or a specific division leader for use in planning and improvement activities.

3.2a(1) Health Care Service Offerings and Patient and Stakeholder Support: The 1997 federal legislative agreements were specific in identifying the distinct regions that each Alaska Native health organization must provide services to. These agreements determined SCF's key C-O and health care market segments [P.1b(2), Fig. P.1-4]. Within specified service requirements, SCF determines its priority focus for identifying and innovating health care service offerings by continuously collecting feedback, using dialogue with C-O, and integrating information on needs and expectations into the annual SPC [Fig. 2.1-1]. In addition, SCF leaders analyze ongoing feedback from C-O on a quarterly basis to stay abreast of service needs and expectations. Action plans are defined and implemented, as needed, in response to the feedback.

To attract new C-O and stakeholders, and understand their needs, SCF seeks feedback from existing C-O as well as potential eligible beneficiaries and their families who are seeking services elsewhere. For example, health care services and community awareness surveys are conducted at annual community events including The Annual Gathering and Nuka Conference and the Alaska Federation of Natives Convention. The survey data is used to determine how effective SCF is in communicating information about programs and services, to gain feedback in regards to C-O loyalty, and to gain input into opinions about service quality.

SCF is committed to innovating services to meet and exceed C-O expectations [P.2a(1)]. C-O expectations are defined in the SCF OP [P.1a(2)] and improvements are continually reassessed by the CSC based on current feedback and expectations. In pursuit of service excellence, SCF has developed and implemented the following:

Figure 3.2-1: Examples of Improvements/Innovations	
Facility	Renovations, PCCIII, Elder Program, FWWI, VNPCC, Parking, Walkways
Program	ICT, Wellness Center, BSD CM, Family Support Groups
Service	Tobacco Free Campus, ECAF, PEP, Satellite Pharmacy

Identify and anticipate key C-O and stakeholder requirements, services, changing expectations and importance. SCF's primary method of listening to C-O and stakeholders, to keep service delivery and directions current with changing needs, is accomplished through a culture of intentional relationship building with all AN/AI people in the service area. Engagement occurs through face-to-face interaction, surveys, two-way community messaging through PR publications, benchmarking, and involvement in targeted organizations and events such as the Quest for Excellence, IHI collaborations, and other professional organizations. This culture of sharing allows SCF to gather and use information from C-O about changing requirements and expectations throughout all phases of the relationship. This Nuka System of Care approach is how SCF hears the voice of the C-O and acts accordingly.

In listening to the needs of the C-O, SCF responded with a radical system redesign in the late 1990s. The aim was to move away from the traditional provider-centered model of care to one with the C-O and family at the center. Today, the OP is reflected across SCF in processes, practices, and facility design. An expressed requirement of the C-O was services and facilities that were culturally based. For example, C-O gave input on the design of the ANPCC early on in the planning phase. Circular and flowing spaces, soft colors from nature, use of light and Native artwork and crafts are ways of creating culturally welcoming environments. To further incorporate Alaska Native values and beliefs into the primary care system, the Traditional Healing Clinic brings traditional healing practices side-by-side with Western medicine in its own designated space. The primary care redesign, and establishment of provider teams and panels, involved more than 50 focus groups and scores of informal interviews in clinics with C-O and family members. To ensure the workforce understand the cultural sensitivity expectations of C-O and families, SCF integrates cultural requirements into selection, orientation, and ongoing education and training. In addition, SCF surveys the C-O using a set of cultural questions to monitor performance and gather information to anticipate future requirements and C-O expectations.

Another example of analyzing and using C-O data is the SCF BSD's multidisciplinary team tasked with improving C-O orientation. The intent is to improve intake assessment and better match C-O needs with department services. Through a PDSA process redesign, the team surveyed C-O to get input on changes. The team is in the post-implementation stage now, continuously collecting input to ensure C-O ideas and requirements are translated into practice.

3.2a(2) Patient and Stakeholder Support: SCF provides multiple mechanisms to support C-O use of health care services [Fig. 3.2-2]. To determine key support mechanisms, SCF gathers and analyzes feedback from C-O and other stakeholders using SCF's various C-O support and listening approaches [Fig. 3.2-2, 3.2-1]. For example, SCF hosts events that encourage two-way dialogue and an exchange of information with C-O. This allows SCF to gather input on how C-O learn about SCF, their care experiences, how and where they prefer to access services, and what role the Internet and email could play in their health communications. SCF has hosted special panel discussions with senior leaders and board members to hear direct feedback from C-O and to provide immediate responses, comments and/or answers to feedback. SCF also collaborates with ANTHC to support C-O with a care plan continuum [P.1a(1)].

The process for connecting with rural C-O and statewide tribal members [Fig. P.1-4] includes SCF leaders traveling to meet with village councils, tribal boards and attendance at tribal gatherings, leadership retreats and governmental conferences. A position in the ETS Division is responsible for consultation and coordination with village senior leaders to (1) modify and expand tactical and long-term strategic plans; (2) improve access to care; and, (3) develop and implement protocols intended to expand the services provided at rural social and health care delivery sites. Meetings with village leaders (including ASU) are designed to review information received from advisory committee meetings and to understand C-O requirements related to access mechanisms. The Nuka Conference is a week-long community-wide learning, social and cultural SCF event. SCF events celebrate Alaska Native cultural traditions and healthy lifestyles, and provide C-O with health education and information about services and accomplishments. Open forum sessions allow for two-way feedback and dialogue. Comments, concerns and compliments from all these listening posts are captured in the CFRS database and used by SCF to identify needed changes and improvements – these are incorporated into the SPC.

Figure 3.2-2: Customer Support Mechanisms

Customer Support Mechanism ↓	Anchorage & Mat-Su Valley	CIRI Villages	ASU Villages	State Tribal Members	General Public
Phone	SOV	SOV	SOV	SOV	SV
Website	SO	SO	SO	SO	SV
Letter	SV	SV	SV	SV	SV
Workforce Interactions	SOV	SOV	SOV	SOV	SV
The Gathering	SOV	SOV	SOV	SOV	SV
Listening Conference	SV	SV	SV	SV	SV
Publications	SOV	SOV	SOV	SOV	SV
Village Council Tribal Gatherings	SV	SV	SV	SV	SV
Scheduled Meeting w/Leaders	SV	SV	SV	SV	SV
Site Visits/Visitors	S	S	S	S	S
Community Events (other)	SOV	SOV	SOV	SV	SV
Gov. Lobbying & Advocacy	S	S	S	S	S

Key: S = Seek Information O = Obtain Services V = Verbal Feedback

SCF also uses review of operational measures [Fig. 2.1-5], as a means of deploying C-O support requirements to employees, with key communications standards such as calls answered within 30 seconds in all clinics [Fig. 7.1-28], appointments available at 8 a.m. [Fig. 7.1-25] and continuity of care with provider [Fig. 7.1-30]. Where possible, performance is reported to the level of the individual provider and care team via the Data Mall [4.1a]. The C.A.R.E. customer service standards [3.2b(1)] are designed to address the two principal modes of access used by SCF C-O: telephone and in-person. Education, training and scripting for the SCF workforce provides additional methods of deploying support requirements and processes. To sustain the methods for supporting C-O requirements, the DC has launched new curriculum to train employees in subjects such as Health Care Quality Approaches and Application, PDSA, Process Mapping, Survey Design and Administration, and many more.

3.2a(3) Patient and Stakeholder Segmentation: SCF gathers information on service needs and changing market requirements by using various approaches [Fig. 3.2-1, 3.1b(2), 4.1a(3)]. This data is used in committee review and analysis, as input to planning processes, and to identify improvement opportunities. In addition, SCF participates in national meetings, including health care industry collaboratives (e.g., IHI) and multi-sector conferences (e.g., Quest for Excellence) to gain information that is taken back to the organization via the "Lessons Learned" application for use in the SPC. Input from current, potential and future C-O through formal engagement approaches, such as the BOD, advisory committees (e.g., The Elder Council), AFN, and through informal interactions, are also incorporated into the SID for planning purposes**.** Other inputs to the SID are extrapolated from CAPHS, St. of AK Medicaid/Medicare Long Term Forecast of Enrollment & Spending, CDC, DoL, NPIRS and many others. These approaches for gathering and using C-O data and the subsequent analysis, use and segmentation of the data in the SP process, helps SCF identify future directions and services necessary to pursue in meeting C-O needs.

3.2a(4) Patient and Stakeholder Data Use: SCF uses input and experiences of its AN/AI employees, which averages about 54 percent of its workforce of 1,400, to identify ideas for marketing and messages that connect with the C-O culture and needs. In the course of their work, these employees bring the voice of the C-O into all their interactions throughout the organization. Employees recognize that their own family members, in many cases from several generations, use the system, and this relationship stirs both pride and a sense of responsibility to make their perspectives known and make the system better. Input is gathered and used by the SCF PR Department and incorporated into communication plans.

To identify opportunities for improvement and innovation, based on C-O feedback and the Baldrige Feedback report, the CSC created a work plan in its AP to survey eligible C-O on why they have chosen to seek services elsewhere using the Health Care Services survey [3.1a(2)]. Another example of how SCF uses information to reinforce C-O-focused culture is the use of C-O and stakeholder service offering information in the SPC, specifically in the SID [Fig. 2.1-2], including new and emerging needs as well as feedback from C-O. The voice of the C-O was the primary impetus and contribution to the improvement examples listed in Fig. 3.2-1.

3.2b(1) Building Patient and Stakeholder Relationships: Achieving SCF's aspirations of wellness depends on building strong, sincere and lasting relationships with C-O. SCF has responded to the campaign theme, "Your Voice Matters" by acknowledging C-O feedback and providing a care environment based on these principles. Through its programs and services, and the design of integrated care delivery, SCF emphasizes whole person wellness that reaches beyond just disease management. C-O are engaged in a three-way alliance that includes their families and the SCF provider teams. The ongoing feedback received from C-O supports the intentional design of relationship-building properties into care

experiences and is embedded in the Nuka System of Care [P.1]. The emphasis of this model is on relationships that allows C-O to experience high-quality services, increased preventative health care services and improved C-O satisfaction.

To demonstrate how C-O are valued, in 2002 SCF responded to feedback and suggestions for improved C-O service, listening, and learning by developing defined behavioral expectations for the entire workforce, ensuring the inclusion of improved listening practices. To support a culture of service excellence and improve C-O engagement, SCF adopted and deployed the C.A.R.E. ("Connect, Appreciate, Respond, and Empower") C-O service model from The Institute for Healthcare Communications. This standardized approach helps sustain C-O relationships. It also sets the foundation for attaining new C-O by ensuring the services will meet or exceed their requirements – from the initial relationship stages, throughout service delivery, and in connecting with them post-service through intentional engagement and follow-up. The larger group of C-O in the workforce provide real-time feedback about their own experiences and convey feedback from family and friends. The Elder Program redesign is an example of actionable feedback, which provided for more space and more convenient, on-site health care services.

Using the C.A.R.E. techniques, employees have learned how to listen to C-O, appreciate and respect their dilemma or issue before trying to resolve it, show understanding by restating what the C-O said, and capture all the facts in CFRS. This electronic system is used throughout SCF to capture C-O feedback at point of service, facilitate timely follow-up, and provide a method for tracking feedback by category.

SCF furthers the consistent deployment of C.A.R.E. standards through extensive scripting in C-O interactions, based on benchmarking the practice at Baptist Hospital, Inc. (Baldrige recipient, 2003). Scripts address a wide array of C-O contact situations, including C-O calling to make appointments or speak to providers, appearing late or canceling at the last minute. Virtually every script ends with the phrase "Is there anything else I can do for you today? Thank you for…" The purpose is not only to show respect, but also to take advantage of the opportunity to identify and address as many of the C-O's needs as possible at one time—a hallmark of a service culture designed around C-O needs and convenience. To monitor and assess ongoing employee C-O service skills, a new program was implemented called "Advancing Customer Excellence" (ACE) whereby employees are randomly called or contacted in person and evaluated on their adherence to the C.A.R.E. standards. Assessment results are distributed to the employee and their manager with further recommendations for CS training, such as C.A.R.E. Refresher or C.A.R.E. Repair. SCF has also integrated its focus on C-O care and relationships into performance evaluations [5.1a (3)] within the expected workforce competencies [5.2a(1)] and PDP. The C.A.R.E. model is evaluated for applicability and effectiveness on a biannual basis by the C.A.R.E. presenter team members, and in conjunction with the training and learning specialist at the DC. CSRs play a special role in maintaining the service culture and helping SCF stay current with understanding the needs of C-O and stakeholders. CSRs make rounds daily to interact with C-O and families, answer questions, resolve real or potential problems, and gather information that will correlate to the C-O satisfaction/dissatisfaction results. Their role is particularly important since some C-O are not comfortable sharing concerns or submitting comments on paper forms. From CSR interactions with C-O and families, SCF gained the awareness to include family members in the care experience, as supported by Alaska statutes.

SCF's Core Concepts curriculum [5.1b(2)] defines foundational characteristics of SCF's relational culture [P.1a(2)] and integrates these concepts into questions used in CFRS [3.2b(2)].

Courses for workforce and leadership development, with focused curriculum on C-O, are offered through SCF's DC [5.1b]. Strategic decisions are made to organize and manage work and jobs to ensure key C-O and process requirements are aligned and integrated [5.2a(3)].

3.2b(2) Complaint Management: SCF values C-O complaints, concerns, suggestions, comments and complimentary feedback and uses it to continuously improve services and C-O relationships. A C-O feedback procedure was developed to identify the individual, department, and/or committee responsible for monitoring each listening post [Fig. 3.2-1]. For example, the P/CEO manages the CEO mailbox on the SCF website; the QA Department manages the 24-hour C-O hotline; and, the SCF Compliance Department manages the SCF Employee Ethics & Compliance Hotline. To ensure that complaints are resolved promptly, the entire workforce is empowered to accept and record direct feedback immediately. The "feedback owner" (FO) is responsible for problem resolution and service recovery, and for overseeing the entry of relevant data and information into the CFRS. The system can be accessed by all employees via the SCF intranet toolbox, allowing feedback and final resolution to occur at point of service. After notification of feedback submitted to the CFRS database for their department, managers are responsible for follow-up within five days. The CSC segments feedback data by classification, location and satisfaction levels. Data is reported to various committees, CBGs and the JOB for review and to drive improvements [4.1a(3)]. Overall status monitoring, follow-ups and audits are conducted weekly by QA and OD.

4. MEASUREMENT, ANALYSIS, AND KNOWLEDGE MANAGEMENT

4.1a(1) Performance measures: To select, align, and integrate strategic and operational information, SCF has implemented a cascading performance measurement system that utilizes an organizational BSC. Measures are "balanced" among four perspectives: C-O, Workforce Development, Organizational Effectiveness, and Financial and Workload. The BSC and other aggregate performance measures can be reviewed 24 hours a day on the SCF DM with access through SCF's intranet site. Access is open and available to key partners, including hospital-based personnel. The BSC uses a balanced set of *strategic* measures, each tied to a strategic objective. These strategic measures have a long-term focus of

three or more years and assist SCF in evaluating its performance in critical areas related to organizational success.

To complement the BSC, SCF also tracks and evaluates *operational* measures. These measures relate to operational objectives that have a shorter-term focus. They assist management in decision making and support improvement of day-to-day work processes. Operational measures are available on the SCF Data Mall and are segmented to the appropriate level to take action.

BSC measures are selected (or reaffirmed) during the annual SPC [2.1a(1)], when leaders verify that CO (and supporting initiative) has a BSC measure to track progress [Fig. 2.1-5]. Every initiative is supported by at least one work plan with multiple action items. Each work plan, with its corresponding performance measures [Fig.6.1-1], has a scheduled timeline [Fig. 2.1-3] to facilitate on-time completion.

Most of SCF's clinical metrics focus on SCF's primary service delivery model around "outpatient" based care. It is important to note that SCF is not a hospital based system, so measures are not typical as would be expected for a hospital. However, SCF reviews "hospital" based performance metrics quarterly with its external partners. During these quarterly meetings, SCF reviews partner performance and makes recommendations regarding comparative data sources.

SCF collects performance data and information from a variety of sources: HR and financial information systems, electronic clinical record systems, individual program databases, and external sources such as government and vendor databases. The frequency of data collection is defined by need and may range from daily to annually.

Data is organized in a systematic format (trended, segmented, and with performance targets) that the BOD, VPLT, functional committees, and departments use to track performance over time; identify best practices for innovative ideas; look for variations in performance; and, compare performance against established benchmarks.

In addition to management, clinicians and their support staff use the SCF Data Mall to drive improvement and innovation. While management is primarily focused on aggregate-level data, clinical teams have access to individual population-based action lists. These action lists are designed to provide clinical teams with the evidence-based information they need to care for their C-O. The action lists capture the preventive, screening, and disease/condition status of each provider's panel. They allow a provider to see who on their panel needs immunizations or breast cancer screening, how a C-O is doing with diabetes management, and much more. SCF believes it is not enough to report a performance score, without giving clinical teams the ability to see who needs the care that impacted the score. Because action lists can be accessed by provider support staff, this process extends population health management to the ICT and makes the team more efficient.

Individual C-O information is secured so that only clinical teams have the ability to see detailed action lists with protected health care information. Because of its success, the action list concept has been integrated into other areas to include finance and behavioral health. Finance personnel now have action lists to track important, process-related actions tied to reimbursement.

The SCF Data Mall makes data actionable by providing both aggregate and individual data in one location. It supports national standards and guidelines outlined by NCQA for performance, and C-O-centered care. Information collected on the SCF Data Mall and elsewhere serves as input for the SID [Fig. 2.1-2] used in the SPC [2.1a(1)].

4.1a(2) Comparative data: To select and ensure the effective use of key comparative data and information, SCF established "measurement rules" as part of the BSC metric process. For every BSC measure, an individual, department or committee completes a standardized MRT that identifies the strategic objective measured, measurement owner, comparative data source, measurement targets and reporting frequency. The DATC reviews the completed MRT for verification and approval. Part of the approval process includes searching for comparative data sources with like methodologies. These comparative data sources may be at a national, state, or local level. When comparative data doesn't exist, internal performance targets may be used. In these instances, internal performance targets are based on literature reviews of best practices and performance is tracked over time. Through this process, SCF has identified, and continues to identify, relevant performance comparisons for health care, C-O, HR, and financial/operational data [Fig. P.2-1].

SCF's performance, as it relates to comparative data, is reviewed quarterly with external partners. SCF performance, against recognized benchmarks, is part of the SPC. Comparative data is also used as a way to identify high-performing teams and individuals, recognizing their performance efforts. Finally, SCF uses national comparative data to evaluate its innovative, integrative health care model against other models based on like methodologies.

4.1a(3) Patient and Stakeholder Data: Voice of the C-O data and information is collected from a variety of sources and methods [Fig. 3.2-1]. SCF's approach to data collection and questions asked are based on SCF's organizational objectives. Once collected and aggregated, C-O and stakeholder data is segmented and trended; then made available to all employees and stakeholders through SCF's intranet. Front-line managers access and review the data to identify OFIs. Performance results are integrated into team work plans and results are used throughout the organization to make meaningful decisions. One example would be using results and feedback in planning for future facility expansion efforts. SCF used voice of the C-O data to determine the need for an additional parking facility and the need to expand health care services that meet their cultural needs (Traditional Healing Clinic).

4.1a(4) Measurement Agility: To keep the performance measurement system agile and current, SCF's VPLT, functional committees and departments, assisted by measurement owners, annually evaluate their measures for relevance to SCF's CG and CO and other internal and external requirements, and make adjustments as necessary. The DATC provides additional expert support. SCF also keeps current through participation in external collaboratives and conferences, such as IHI and Quest for Excellence, which

provide a forum for learning about the measurement systems of other high-performing organizations. And, lastly, SCF is participates in ongoing consultation with respected measurement consultants and vendors.

Methods to ensure the performance measurement system is sensitive to rapid or unexpected organizational or external changes include the use of related process and outcomes measures (e.g., appointment access drives C-O satisfaction), data drill-down to department and work-group levels (e.g., early warning of change in one or more areas), and easy access to up-to-date data and information (updated weekly, monthly, quarterly as appropriate) via the SCF intranet for ongoing review and action as needed.

4.1b Performance Analysis and Review: SCF uses various forums to review organizational performance and capabilities [Fig. 4.1-1]. Reviews are linked and aligned by means of the FCS [Fig. 1.1-2]. The VPLT reviews the Corporate BSC regularly on a schedule aligned with quarterly reporting. The four oversight committees report to the VPLT at least twice annually, providing an assessment of progress on the AP, analysis of their committee BSC performance results, and identified opportunities for improvement. Each functional committee reviews its BSC results at least quarterly and reports progress on the AP to the appropriate oversight committee. Divisions and departments are linked and follow the same process of review, reporting from the department up to the division, and then on to the VPLT. Performance targets, performance comparisons, and variation and progress on quarterly action plans are reviewed at every level to assess progress toward accomplishing CO.

Figure 4.1-1: Organizational Performance Reviews

Format	Frequency	Reviewers	Performance Data Reviewed
Intranet	24/7	Workforce	BSC; AP
Huddles	Daily/Weekly	All Teams	BSC; AP; PDSA
Committees	Monthly	Members and Sponsors	BSC; AP; CM
Management	Monthly	All Mgrs.	BSC; EPE; Data Mall
Strategic Planning	Annually	SCF BOD; P/CEO; VPLT; Committees; Managers; Supervisors	SID; BSC; AP
New Hire Orientation	Bi-Weekly	All New Employees	BSC; AP; PDSA
All-Staff Meeting	Bi-Annually	Workforce	BSD; EPE; Data Mall

To facilitate data-based review and rapid, accurate interpretation of results, SCF provides BSC results on the intranet in a color-coded format, with a summary view of current performance that is designed to alert reviewers to results that merit further analysis and showcase where performance exceeds goals. Additional information is available, including drill-down detail, (e.g. by site and provider), time trends, and external comparisons, to support analysis and decision making.

4.1c(1) Best Practice Sharing: Best practice identification begins with a standardized evaluation process; one in which measures are clearly defined and have specific methodologies. The SCF Data Mall displays multiple comparison charts that highlight provider team performance on measures that are tied to the CO. Performance is segmented at the clinic, team and provider level. This open forum of evaluation allows provider teams to evaluate their current performance against their peers; their current performance against past performance; and their performance against nationally accepted benchmarks. Well-performing teams are identified and their processes are studied by other teams as well as committees. The FCS serves as a means, through planning and performance review processes, to identify SCF best practices, conduct rapid cycle improvements, and integrate best practices throughout SCF.

Best practices and innovated lessons learned at SCF are also shared with external C-O through collaborative projects, site visits, and national forums and conferences. An example is SCF's Nuka System of Care. SCF's Nuka Institute opens doors for organizations to visit SCF to study the successful approaches and methods that SCF has developed and implemented as part of its relationship-based Nuka System of Care. SCF has shared the Nuka System of Care with, and learned from, local, national, and international organizations such as YKHC, Care Oregon, IHS, Northern Health, and many others.

4.1c(2) Future Performance: SCF annually reviews and selects best practice benchmarks related to SCF organizational objectives. Many of these measurement benchmarks are dynamic, with performance measurement goals increasing each year. When applicable, SCF targets future performance on being in the top decile of nationally recognized benchmarks. Performance targets are made visible and displayed with all applicable performance measures.

4.1c(3) Continuous Improvement and Innovation: Translation of data review findings into improvement/ innovation priorities and plans occurs up, down, and across the organization through the BSC. Senior leaders, committees, and department managers review the trended data to determine the need for improvement/innovation. Gaps are identified in this review, red/yellow stoplights alert reviewers that action is necessary on the measure; green/blue stoplights indicate that goals are being achieved. If results warrant a change, directors meet with department managers and committees, as appropriate, to get input into priorities and options. A recommendation for improvement is then designed and implemented [Fig. 6.2-1, 6.2b], and the committee, project team, work group, and/or manager participating in the plan completes the follow through. When appropriate, SCF ensures alignment with suppliers and partners through joint committee meetings, or face-to-face interaction.

When a BSC is recognized as below target, the measurement owner takes action by developing a work plan to improve performance. The measurement owner makes sure the work plan is implemented and monitors and evaluates it to assess its impact on moving the measure toward the target. The measurement owner is also responsible for looking for changes in data collection or measurement rules.

Systematic data-based performance review enables SCF leaders to recognize performance gaps and form teams to carry out process evaluation and improvement using the SCF Improvement Process [Fig. 6.2-1]. Benchmarking plays a

major role. It is used to redesign a poorly performing process, as well as to proactively drive innovation. Through participation in professional associations and conferences, such as IHI and Quest for Excellence, SCF identifies high performers with whom to benchmark processes and results. Benchmarking with Pal's Sudden Service, for example, resulted in improvements in the recruitment and training of entry-level personnel.

4.2a(1) Data, Information, and Knowledge Management: As part of its commitment to quality, SCF recognizes the importance of having secure and confidential information systems that deliver accurate and reliable information to its employees and C-O in a timely and efficient manner. The following paragraphs outline how SCF addresses each of these components.

Accuracy: SCF uses both electronic and manual processes to periodically review the accuracy of its data. For example, current row counts from a table are compared to expected ones, and internal auditing procedures ensure accurate and appropriate coding for medical care. The SCF Data Services Department works closely with providers, auditors, and HR to ensure accurate data collection and reporting. SCF Data Services has deployed and integrated a number of proactive tools into its information systems to facilitate data accuracy; for example, diabetes action lists used for population health purposes identify how and when each diabetic was identified. If a coding discrepancy is identified, it can be quickly resolved by knowing the date and location of the discrepancy and the codes used to identify the diabetic. These proactive tools have improved accuracy and provider confidence in screening and condition management registries. SCF Data Services also conducts training and education with end-users, as requested by department managers, to ensure the workforce understands the approach and methodologies used in identifying individuals with specific health care needs. Lessons learned and how to resolve discrepancies have been integrated into the SCF Data Mall for dissemination and easy access for end-users. In addition to these approaches used to ensure data accuracy, the standardized MRT is easily accessible via the SCF intranet for all employees. It is used particularly by the service area and measurement owner to ensure measures and data used for evaluating the measure are thoroughly planned and accurately defined.

Integrity and reliability: The majority of applications that are in place at SCF use traditional DBMS tools such as Oracle, Microsoft SQL Server, and Inter-systems Cache' database platforms. The use of these industry-standard systems provide for system-level validation and security settings to minimize data corruption or manipulation. In addition, SCF performs routine audits according to industry standards to ensure data integrity.

Data reliability at SCF is managed by ensuring that multiple information systems have the ability to collect information in a centralized and standardized format and share that information among them. An example would be SCF's integrated use of a centralized Master Patient Index to track C-O information across different information systems.

Recent process improvement efforts around data reliability also led to the development of a template used by IT employees to standardize database requests. The new template has facilitated communication between internal customers and IT employees when developing new databases.

Lastly, SCF has deployed and integrated the following approaches to facilitate data reliability: standardized data and information collection and reporting tools, such as the AAPT and BSC tools; limited access for data entry or modification, such as authorizing specific individuals to enter BSC data; training employees in the use of information technology to ensure adequate knowledge and skills; and, working with key IT partners to ensure that information systems are easy to use, including considering number of screens and key strokes required.

Timeliness: SCF's approach to timely data involves understanding how the data and information will be used. Data systems used for point of care with C-O require real time up-to-the-minute data to ensure safe and effective care, while population management and reporting tools may not require as frequent updates (daily, weekly, monthly) [Fig. 4.1-1]. To ensure the timely availability of data and information, the SCF IT Department monitors the performance of its critical information systems, utilizes Web-based intranet tools and has implemented secure technologies such as remote email access and Microsoft SharePoint technology. These strategies facilitate timely, secure, and non-duplicative information sharing. Point of service tools used in direct C-O care are updated immediately as soon as information is entered. Analysis tools that are not as time sensitive are updated daily or weekly, based on analysis and reporting requirements. These tools and reports are available via the intranet and the SCF Data Mall. From an organization performance perspective, BSC reporting frequency requirements are part of the standardized MRT associated with each measure. These are reviewed by multidisciplinary teams for accuracy.

SCF's intranet provides the workforce 24/7 access to such things as an AAPT, Employee Evaluation Tool, Medelearn, SCF P&Ps, and organizational forms. Recently, SCF, at the request of its Green Team, added the ability for employees to view their payroll stubs electronically as soon as they are issued. This improvement eliminates the need to print thousands of payroll stubs every other week. The centralization of electronic data serves to facilitate standardization and timely data transmission. In addition, it preserves valuable server space and helps eliminate duplication.

Security and confidentiality: SCF ensures security through the AAA methodology: Authentication, Authorization, and Accounting. Authentication requires users to identify themselves by means of a unique username and password. Authorization enables the data author/manager to authorize access to the data. Accounting provides an access audit trail. In addition, SCF ensures protection from unauthorized access or revision to information by keeping up to date and implementing recommendations outlined in such documents as the "Security Standards for the Protection of Electronic Protected Health Information" found in 45 CFR Part 160 and

Part 164 and complying with the Privacy and Security Rules established by HIPAA. SCF's approach to security employs administrative, physical, and technical safeguards.

Administrative safeguards are deployed through assessments of potential risks. An SCF security and compliance officer is responsible for the oversight and implementation of data and health information security, including looking for vulnerabilities to confidential electronic protected health information from internal and external sources and processes. SCF's policies and procedures on confidentiality and use of technological resources are other examples of administrative safeguards.

Examples of *physical safeguards* deployed by SCF include having protected health information stored in locked, secure locations. Access into these secure locations is controlled and monitored by a badge access system. Physical safeguards regarding data backup are described in 4.2b, including how SCF makes data available in an emergency.

Technical safeguards deployed and implemented by SCF include such things as ensuring that each individual accessing information systems can be uniquely identified and that access to information is based on his/her role and responsibility within the organization. Username and password access has been integrated into all SCF information systems that have the need for restricted access. SCF's other technical safeguards include automatic computer log off after a predetermined time of inactivity and encryption of email and electronic protected health information. Confidentiality is the responsibility of every employee, and required by the Code of Conduct. This is introduced at NHO and is part of the ARO process as well.

Data and information shared between SCF and ANMC are on a closed network infrastructure. SCF uses a third-party solution, Zixcorp, as an email encryption gateway and content filter to ensure the confidentiality of the health information being sent out of the SCF system.

4.2a(2) Data and Information Availability: SCF systematically makes needed data and information available to employees, C-O, and suppliers/partners. SCF utilizes RPMS, an integrated electronic health care system, also used by IHS and VA for the management of clinical, business, and administrative information. This electronic system facilitates standardized and "centralized" health care data and information. Data regarding visits can be entered into the system and a set of pre-established report formats can be queried to give managers and end users valuable data and information. This promotes safe, evidence-based C-O care, efficient operations, and performance improvement.

Providers can view critical data and information required for C-O care, such as test results and up-to-date lists, and any other historical medical care information entered into the system electronically. This type of centralized system, with electronic review and sharing of data, facilitates safe and effective health care. Electronic information that is collected within the RPMS system is also used in evaluating health care quality and organizational performance. Having information in a centralized electronic format makes data analysis more robust; decisions are based on population parameters and not on sample statistics (used in paper-based systems).

Employees have broad access to data by means of the FCS. FCS meeting minutes and plans are posted to the CM tool on the intranet. All employees can use the intranet to view policies and procedures, BSC results, and other data and information needed to perform their jobs.

SCF's commitment to SR involves making data and information available to C-O, in particular to help them manage their health. For example, SCF offers the user-friendly SCF Health Information website, HIS in department lobbies (with computer access, videos, and print materials), classes and group visits, personal appointments, and phone calls or emails with the PCP and/or RN/CM. In addition to access mechanisms [Fig. 3.2-2, 3.2-1], HR enables the public to seek employment using SCF's online application process. Committee meetings, informal interactions, SCF's website and print communications are all ways SCF shares data and information with suppliers/partners.

4.2a(3) Knowledge Management: The management of organizational knowledge is an important component that supports the MVKP/OP. The exchange of internal knowledge is vital to employees' working relationships and to the quality of the services we provide to C-O, suppliers and partners. SCF seeks and utilizes knowledge provided by C-O to address the needs of the community.

Collection and transfer of workforce knowledge: The primary vehicle to capture and share workforce knowledge is the intranet, available to all employees at all locations. The intranet contains a wide range of data and information to support employee performance, including links to all corporate, division, and department policies and procedures, annual safety goals, C-O feedback, the Incident/Accident Reporting System, the Data Mall, case manager tools, AP tools, and CM. CM supports SCF's FCS, and provides all employees with full access to committee activities, including membership rosters and agendas, member attendance, and appropriate related documents.

Use of these automated tools to facilitate knowledge management and transfer is monitored electronically. Managers can see who accessed what reports and when. They can also see when notes were updated for specific reports. These reports automatically place date/time/person updating directly on the form.

A bi-monthly managers meeting involving all SCF leadership is a formal, systematic way to collect and transfer workplace knowledge. Each of the functional committees and their executive sponsors "own" portions of the meeting with the aim to plan for the future, improve and innovate systems and structures, network and relate to each other, and develop manager core competencies. More traditional methods for sharing knowledge, such as department bulletin boards, serve as program communication hubs, as well as just-in-time training, formal mentoring relationships, division leadership meetings, department meetings, P/CEO and VP walkabouts, ANN, one-on-one huddles and retreats. SCF uses these active approaches to manage and share organizational knowledge.

The SCF Learning Week supports peer learning and teaching. The PI Committee identifies critical learning opportunities that merit broad participation and executive sponsorship, such as Quest for Excellence. While attending the conference, participants gather lessons learned using a special worksheet to record innovations of potential value to SCF. The designated leader then collects the data and information for distribution to relevant committees. SCF's integration of behavioral health consultants into primary care teams, development of the SID resource for the SPC, and the BSC performance measurement system all originated as ideas brought back from conferences and disseminated throughout the organization.

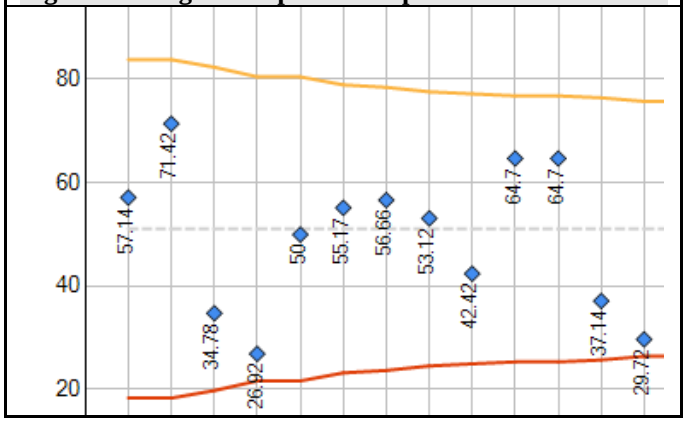
SCF leaders and workforce also participate in long-term external learning collaboratives, such as those sponsored by the IHI. Lessons learned are tested in the SCF environment of care using the Improvement Process [Fig. 6.2-1]. One example tested and implemented as a result of this process is the behavioral-based interviewing process; a strategy to improve hiring and reduce turnover.

Transfer of knowledge from and to customers and stakeholders: SCF's key C-O listening posts [Fig. 3.2-1] are the principal methods for gathering relevant knowledge from C-O and their families. Many of these methods provide for two-way communication, enabling SCF to give and receive information. SCF also transfers knowledge to C-O and their families, as well as the general public, by means of the Internet, internal publications, various news media, and community reports.

With key service delivery partners, SCF participates in formal structures and processes to share relevant knowledge. With ANTHC, for example, SCF representatives participate in JOB, Executive Management Team, Clinical Quality Council, and various SCF-ANTHC committees. The ANMC intranet, managed by ANTHC, contains information relevant and accessible to SCF workforce, such as infection control data and laboratory results. Leaders' informal interactions and personal relationships complement formal structures and processes.

Identification, sharing and implementation of best practices: Performance variation is tracked and monitored on the SCF Data Mall using innovated comparison charts [Fig. 4.1-2] that identify significant performance.

Fig. 4.1-2 Image Example of Comparison Chart



SCF reviews and analyzes comparison charts in department staff meetings and operational improvement project activities to identify lessons learned from top performers and share most effective practices and knowledge across the organization. In addition, physician mentors include focus on best practices in mentoring.

Assembly and transfer of knowledge for use in strategic planning process: Performance data and information are collected, aggregated and reported at all levels of the organization. A systematic process of communication and review helps bring together comprehensive performance data and information for the SID.

The SID brings together qualitative and quantitative data from internal and external sources [Fig. 2.1-2] to support the SPC [Fig. 2.1-1]. Information is gathered throughout the year by data owners, and is organized by ODI to facilitate use by SPC participants.

IT experts review industry publications and events for changes in technology and innovations in health care and other sectors that may benefit SCF.

A key internal partner is the multidisciplinary IT Committee, sponsored by the COO. This committee provides input to the SCF IT Department to drive innovations and improvements responsive to internal needs.

The SCF IT Department has adopted the ITIL model for service delivery. ITIL is an industry-standard, non-prescriptive framework for designing processes that improve service delivery and C-O satisfaction. The methods include evaluating services and their impact through the eyes of C-O, using C-O language to describe available services, and crafting SLA. Use of this model has promoted better communication between IT and its C-O, and has helped the department make sound business-focused decisions when setting priorities.

4.2b Management of Information Resources and Technology: Rapid changes in technology require SCF to be proactive in ensuring the hardware and software components of its information systems are reliable, secure and user friendly. SCF address these issues in the following manner:

4.2b(1) Hardware and Software Properties

Reliability: SCF promotes reliability through strong relationships with three major vendors, Cisco, Dell, and Network Appliance Inc. – each specific to different components of the system's architecture. They interoperate to work simultaneously. SCF's network infrastructure and telecommunications are primarily Cisco systems.

SCF has trained IT employees to support the Cisco telephones, voicemail system and call centers throughout the campus. To keep up with rapid changes with technology, SCF has invested substantially in training IT employees in the technology in use. SCF also has a standing arrangement with Dell, the supplier for PCs and laptops, to provide a standard configuration upon order. This standardization speeds the deployment of the PC. Dell also provides a technical portal for SCF technicians to utilize when needed. Network Appliance Inc. provides an integrated solution that enables SCF to store, deliver, and manage data and content to achieve business

goals. All vendors work closely with SCF to ensure standardization and consistency. Operationally, SCF promotes reliability by working with its Procurement Department to ensure employees have a standard process and catalogue of items available for purchase.

Security: SCF has implemented physical security mechanisms, such as badge-reader door locks and restricted access areas, so only authorized personnel can enter SCF's primary and backup data center locations. SCF also has video surveillance in place to view real-time or archived footage of our data centers. The video feed streams to an off-site secured location for archive in the event that the primary location is compromised. This prevents a scenario where an intruder breaks into a location and then removes or destroys the video evidence.

SCF has hired security officers in the past year, a change from the former process of contracting for security. Routine patrols of all SCF buildings occur 24/7. Some buildings also have alarm systems to monitor for intruders and alert the Security Team or Anchorage Police Department. The security officers are able to audit the badge access logs, successful and attempted, to determine if appropriate physical access controls are being maintained. A robust process exists today to issue each employee a unique badge, which is not only used to identify the employee in person, but also links to their Kronos Timekeeper and Payroll accounts, and permits them physical access to designated areas appropriate to their role within the organization. The employee's manager decides the level of access for an employee to common entrances or departmental resources. Only IT and Facilities provide access to more restricted areas, particularly IT resources where large depots of hardware and software are stored.

Another secure area, the SCF Purchasing Department, maintains a physical inventory of software media and licenses, as well as a depot of excess hardware being prepared for data destruction and donation.

User-friendliness: To ensure user-friendly solutions, SCF involves employees through the IT Committee and special workgroups in planning for new systems; proactively solicits input on needs and preferences; provides training; and, tracks user problems to be addressed, as appropriate, immediately or in future systems design and purchase. The IT Service Desk, which is available to teach, answer questions, and troubleshoot, sends out a survey to C-O with each closed service ticket seeking feedback on the user-friendliness, etc., of the services performed.

4.2b(2) Emergency Availability: SCF's emergency management plan, deployed to all employees during NHO and ARO, ensures SCF is prepared for an emergency or disaster [6.1c]. SCF stores its critical information on a SAN with hardware and features that insulate it from hardware failures, and has software that allows rapid recovery from accidentally deleting or overwriting critical data. In addition, in the case of a disastrous event, SCF replicates that entire data store to another facility. All data are fully replicated off-site at a maximum delay of 24 hours, and most systems are within one to four hours of real time, so in the event of failure or complete building loss, no more than one day's worth of production data is lost. Besides this replication strategy, SCF uses a tape archival system that supports a complete DR back-up daily from the secondary system, permitting huge data back-ups during the day without impacting internal customers performance. Tapes are stored at a different remote site for safekeeping. SCF uses a layer of software that allows a virtual snapshot of the server's memory, which is also stored on the SAN and replicated off-site. With appropriate server hardware at the alternate site, SCF can turn these failover servers on and resume operations from the last point of replication – often a point in the early morning of that business day.

SCF maintains fiber optic connectivity between the buildings that house a large number of users or data center facilities on its campus in Anchorage. Almost all of the buildings on the campus are connected to the fiber backbone.

All SCF facilities off campus are connected back to the centralized Data Center. If a remote site has more than 20 employees, it will have its own local file server as well as access to all centralized IT systems.

The SCF IT Department is responsible for providing a reliable data storage platform that allows for rapid expansion as demand is created. This platform has a high level of availability to all supported applications and end users. It also has an exceptional disaster recovery configuration that allows for complete system recovery, in less than four hours, to an alternative data processing site. Beyond disaster recovery, SCF has implemented a data protection solution that allows recovery of previous iterations of data on scheduled intervals, allowing unique pieces of data to be recovered or evaluated and compared to the current measurements or established benchmarks.

5. WORKFORCE FOCUS

5.1a(1) Capability and capacity: Skills: As part of the SPC [2.2a(3)], SCF annually determines workforce capability and capacity needs by means of the L&D Needs Assessment. This process ensures that SCF's workforce has the combination of knowledge, skills, abilities, and competencies required to address short-term and long-term organizational needs. The results shape future work plans. The DC tracks the breadth and depth of knowledge, skills, and abilities developed through SCF's L&D systems. These methods enable SCF to compare current workforce capabilities against the anticipated requirements of initiatives in the CSP and CAP, and address them through workforce-related plans such as the Corporate Recruitment Plan and the Annual L&D Plan.

Competencies: Competency is demonstrated by individual employees meeting established benchmarks outlined for their position, including targets for training, certification, demonstrated skills, and task completion. Documentation is collected during the year in individual competency folders.

Job and job level analyses enable SCF to assess capability of the current workforce. In 2009, the HRC developed key workforce competencies in alignment with the MVKP/OP [Fig. P.1.1, P.1-2]. The competencies have since been integrated into behavioral-based interviews, job descriptions, competency checklists, job progressions, succession plans, PDPs, and annual evaluations.

Staffing Levels: SCF uses a formula developed by its finance department to assess and plan for workforce capacity [2.2a(3)] based on current and future needs. At the division level, this occurs as part of the SPC as division leadership determines staffing requirements and budget impact for the next year and the future. Division and department leaders, within their areas of responsibility, assess and make adjustments in order to maintain staffing levels that ensure C-O safety and service expectations.

5.1a(2) New Workforce Members: SCF pursues a network-based approach to recruiting, recognizing that many AN/AI candidates learn about job openings from family members or friends. Open positions are advertised internally allowing the workforce to apply or share with family and friends. SCF also joins with community partners to recruit for positions including local trade/technical schools, Alaska Native corporations, high schools, and assistance offices. For hard-to-fill positions, SCF has adopted a proactive approach that involves continuing to seek out applicants regardless of openings. This includes continual advertising, job postings left open on SCF's website, talking to every candidate when contacted whether there is an opening or not, and keeping a database of applicants for when positions do come available. SCF uses lifestyle-based recruitment for hard-to-fill positions, nationally, to target applicants interested in living, working and playing in Alaska. This approach supports SCF's goal of long-term relationships between C-O and providers. Display booths, mailers, and marketing materials are designed to capture the attention of applicants drawn to the mystique of Alaska. Once attention is piqued, positions at SCF are blended into the idea of living and playing in Alaska while working at SCF.

Through specific outreach and educational programs, SCF recruits for the future. For example, SCF's RAISE internship program is dedicated to developing future workforce by employing AN/AI youth.

Hiring and placing: In 2002, HR partnered with IHI Impact to test behavioral-based interviewing with nursing positions. This method is based on the premise that "fit" with SCF is based primarily on behaviors vs. skills, as well as the importance of "sharing story" in Alaska Native cultures. After the initial pilot, behavioral-based interviewing was implemented for all positions in the organization to improve fit, and thereby retention. In 2009, the workforce competencies [Fig P.1-3] were integrated into the behavioral-based interview questions allowing SCF to evaluate candidates' behaviors in alignment with SCF's MVKP/OP and workforce competencies. Another example: HR tested a group selection process in which a committee of nurses interview as a team and determine if a nurse applicant is a good fit. This approach is now used for many jobs with positions in multiple departments or locations including CMA/LPNs, clinical associates, mental health workers, administrative support and management [Fig. 7.3-16].

Retaining: The HRC examines retention data and conducts tests of change to improve retention rates. To improve administrative support retention, SCF benchmarked previous Baldrige recipients and developed a training program for administrative support employees. The training program consists of formal and on-the-job training. Similar training programs have been implemented to address retention for CMA/LPNs, clinical associates, and RN/CMs.

Diverse Ideas and Cultures: SCF is committed to Native preference hire [P.1a(3)], and, in alignment with SCF's CQ, employees must be fully qualified for their positions. To achieve a workforce representative of the population served, managers are required to screen and take action on qualified AN/AI applicants before non-AN/AI applicants [Fig. 7.3-15]. HR, recognizing not all positions can be filled with AN/AI candidates, also encourages others to apply, thereby enhancing the diversity of ideas and cultures that enrich the workplace. As part of NHO, SCF sets the stage to ensure we address every employee's culture, ideas, and thinking by providing cultural orientation and C-O service training. The value of diversity is reinforced in Core Concepts training.

5.1a(3) Work Accomplishment: Accomplish work: Leaders manage, organize and reinforce SCF's C-O focus through the FCS, workgroups, and departments. This approach includes identifying key C-O and process requirements with defined work process steps, handoffs, interactions, and job relationships. For example, BSD programs utilize a multidisciplinary treatment team approach that offers consistency in care, community linkages to resources, and medication management in addition to individualized and comprehensive C-O treatment.

Capitalize on core competencies: SCF's workforce competencies align with its overall CC [Fig. P.2-2]. For example, one competency, Customer Care & Relationships, reinforces the overarching workforce and organizational importance of C-O, stakeholders and health care service focus. The four workforce competencies [5.2c(1)] are integrated into all HR functions, starting with the interview process [5.1a(1)].

Reinforce a C-O, stakeholder and health care focus: SCF has developed ICTs built upon the medical home model. C-O select a provider team which consists of a provider, RN/CM, CMA/LPN, AS, BHC, and RD. These multidisciplinary teams allow SCF and C-O to capitalize on each individual's unique set of skills with a focus on Customer Care and Relationships and communications and teamwork. Team-based models are used in administrative areas as well. HR generalists serve in a liaison relationship to specific departments, bringing HR knowledge to the operational team and linking the team to HR specialists when needed.

Exceed performance expectations and address strategic challenges and action plans: SCF keeps the workforce focused on exceeding performance expectations using the SPC. Through the organizational structure, teams are empowered and equipped to improve and innovate. BSC measures are created and, through the action planning process, plans are disseminated as part of the committee structure and individual PDPs. The PDP outlines goals, accountabilities and ways to achieve an "exceeds performance expectations" score on the annual evaluation, including measures. SCF uses action planning [2.2a(2)] and performance measurement [4.1a(1)] to keep teams focused on C-O requirements, improvement, innovation, and measures that address SCs. SCF's primary

care clinics incorporate real-time data to serve as a "report card" on panel management via Data Mall.

5.1a(4) Workforce Change Management: As mentioned in 5.1a(1) and as part of the SPC [2.1a(1)], SCF annually determines workforce capability and capacity needs by means of the Corporate Recruitment Plan and the Annual L&D Plan. This process ensures SCF is prepared to manage workforce growth or reductions. In addition, SCF leaders and managers prepare the workforce for capability and capacity changes through openly sharing organization direction, strategy, key initiatives, and performance, and by encouraging personal and professional growth and development. SCF prepares for capacity changes through division and department planning meetings, as well as workgroup interactions and one-on-one conversations, including the PDP process and guidance on career progression [Fig. 7.3-8, 7.3-9]. SCF helps prepare the workforce for capacity changes through its scholarship and educational leave programs, which enable eligible employees to attend college classes during work hours.

Changes in grant funding and project scope can create need for workforce reduction. For example, due to changes in national Head Start regulations in 2009, SCF could no longer manage the Head Start program. This decision affected workforce capacity requirements. SCF's approach to minimize the impact included encouraging the affected workforce to apply for open positions elsewhere in the organization, and encouraging management to interview these employees. As a result, nearly 100 percent of the affected workforce was offered a different position within SCF.

5.1b(1) Workplace Environment: SCF's Safety Committee manages and monitors processes related to work environment, health and safety in all work settings.

Figure 5.2-1: Health, Safety & Security Measures

Factor	Measure	2010 Target	Results
Injuries	OSHA-recordable cases per 100 FTEs	3.7 injuries/ 100 FTEs/year	7.3-19
Bloodborne Pathogen Exposures	# of needle stick/sharps exposures per 100 FTEs	< 1 incidents per year	7.3-20
Slips/ Trips/ Falls	# of slips, trips, and falls	2	7.3-20

SCF maintains and improves [Fig. 5.2-1] workplace health, safety, security, and ergonomics in a proactive manner by ensuring the workforce (1) understands related policies, procedures, and performance expectations, (2) acquires and systematically updates the knowledge and skills needed to promote safety and health, and (3) participates systematically with workforce experts in minimizing risks and addressing improvement opportunities.

Workforce health: SCF supports workforce health through a variety of programs. The SCF QA Department has established an Employee Health (EH) office to increase accessibility for the workforce. EH has established a proactive approach. For example, EH schedules bi-weekly visits to the ANPCC for the workforce to complete initial, annual, and outstanding health requirements, such as influenza vaccinations.

The SCF Employee Wellness Committee was created to integrate wellness into the workplace and uses workforce input to identify and prioritize wellness-related classes and events, such as the Lose to Win program for losing weight.

SCF's Health Education and Wellness Center, available to C-O and the workforce, offers a full range of health education programs and a well-equipped fitness center with group fitness classes and individually designed fitness programs.

Safety: SCF utilizes numerous approaches to maintain and improve workforce safety, beginning with inclusion of safety training in NHO. Environmental tours, global safety and security risk assessments, and regular safety classes are offered through the DC, and the ARO includes a safety module. Managers are held accountable for responding to all expressed safety concerns; including the workforce in resolving issues; and, soliciting support for corrections to maintain a safe work environment. All seven Joint Commission Environments of Care standards, goals and objectives are reviewed for performance on an annual basis by the SCF QA Department. A variety of workplace health and safety information is available on the intranet via the online Employee Handbook, including information on conduct in the workplace, harassment, diversity, conflict resolution, employee health, family wellness, and specific safety topics (e.g., fire, hazardous materials, emergency preparedness). Training is continually updated to address changes in policy and/or procedures, issues identified by the SCF Safety Committee, and changes in federal mandates or other external requirements. In addition, the safety team reviews regulatory and accrediting requirements, makes recommendations, and leads improvements under the oversight of the QA Committee. For example, recent improvements have included changes to medication storage to prevent access by children and fire emergency planning in the ANPCC. This systematic approach to safety increases participation and accountability of managers, standardizes approaches across the organization, and encourages and supports overall proactive management of safety in the workplace.

Security: The SCF QA Department expanded its security function to include workforce and work environment security. In 2009, the department hired security officers to respond to the workforce and C-O. Additional security features include (1) card-swipe access after normal working hours, (2) well-lit parking facilities, (3) ID badges, (4) panic buttons, (5) personal alarms, and (6) 24-hour non-emergency, safety, and security phone number. For example, the behavioral health clinics have strategically located panic buttons and personal alarms that are activated if a C-O becomes a threat.

5.1b(2) Workforce Policies and benefits: In alignment with the CG of FMW, SCF offers a comprehensive total compensation package to create a successful work/life balance for the workforce [P.1a(3), Fig. 7.3-21]. SCF uses the Hay System to evaluate job descriptions using three categories: know-how, accountability, and problem solving. This system allows HR the flexibility to systematically evaluate and conduct annual market review [P.1a(3)] of the compensation structure to remain competitive. SCF recognizes the rural workforce is unique and has creative compensation options available to meet recruitment and retention needs. For example, SCF increased its rural differential and offers

flexible work shifts, housing assistance to counter the high fuel costs in the villages, additional travel monies to fund CMEs, and an additional trip to Anchorage each year to support work/life balance for targeted positions.

Additional market reviews have led to changes in the benefits plan. In response to the needs of the workforce, SCF changed its health insurance plan to offer medical, dental, and vision insurance separately. This approach allows for a variety of health coverage options, thereby meeting employees' health care and financial needs.

SCF also offers nonstandard work day and work week schedules when efficiency and productivity can be ensured or enhanced. A robust leave package is provided to meet cultural demands of the workforce. SCF has established educational services to encourage professional and personal development [P.1a(3)]. SCF created ECAF [1.1a(1)] to provide an opportunity for the workforce, BOD and community members to make monetary donations to a fund providing temporary financial assistance to employees and the Alaska Native community who have encountered financial hardship. Lastly, the workforce is supported by a variety of wellness programs [5.2a(2)] through the Employee Wellness Committee.

5.2a(1) Elements of engagement: SCF uses Morehead's Employee Opinion Survey (EOS) [P.2a(3), 5.2b(2)] to determine elements of workforce engagement and satisfaction across three domains: organization, manager, and colleagues and job. The Morehead Commitment Indicator Score measures workforce engagement and satisfaction in response to six key items across the three domains. The EOS results and Commitment Indicator Score are segmented by job classification, workgroups, divisions, and various demographics, which allows for analysis of the elements. Managers share their department/division results with the workforce to identify actions needed and to understand the key elements related to engagement and satisfaction. Throughout the year, online surveys are utilized at the corporate and department levels to target and gauge workforce engagement and satisfaction and measure tests of change.

5.2a(2) Organizational culture: SCF uses multiple methods to foster a culture of open communication, high performance and an engaged workforce including intentional work design [1.1b(1)] to encourage collaboration; accessible information, via the SCF intranet, to engage the workforce; and educational opportunities to enhance knowledge and skills needed for high performance. SCF assesses communication and work environment through the EOS annually.

Open communication: SCF communicates through face-to-face interactions, electronic communications, formal and informal meetings, and events such as the All-Staff Meeting [Fig. 1.2-2]. Open work design fosters open communication between managers, workforce, and C-O and allows for visibility and accessibility. The CM tool, another method for encouraging communication and providing access to information, enables the workforce to stay current with committee work. Intranet and emails link employees to each other and their partners, and telemedicine technology connects SCF providers with regional hospitals and clinics [P.1a(1)].

High performance work: As part of the SCF culture, achieving the CG and CO is a shared responsibility. SCF fosters high performance beginning with the SPC [2.1a(1)]. Workforce PDPs are developed from the annual planning process [Fig. 2.1-3]. The workforce is evaluated and compensated annually based on achievement and high performance of the PDP. The SCF Data Mall allows for access to real-time performance data with comparative sources. This information gives daily feedback on high-performance work. Supervisors meet with individuals to evaluate performance throughout the year as it relates to their PDP, which is created at the beginning of the evaluation year. This process aligns goals and actions with organizational needs and the AP [Fig. 2.1-3], while supporting and setting mutual expectations [Fig 7.3-10, 7.3-11].

Engaged workforce: SCF's focus on a team-based approach begins with the FCS, which includes cross-functional members and engages the workforce in key strategic activities. SCF's divisions and departments engage with each other while working in various interdisciplinary committees and project teams. To ensure the entire workforce is engaged in supporting SCF's MVKP/OP, Core Concepts training builds relationships, common language and effective dialogue for the entire workforce, including leadership. Finally, as an Alaska Native health care organization, SCF places emphasis on wellness of its workforce and engages employees in Health Education and Wellness Center programming [5.2a(2)].

Diverse ideas, cultures, and thinking: As part of the recruitment and orientation process, SCF builds cultural awareness by setting the stage for affirmation of everyone's ideas and unique backgrounds. The cultural module of NHO focuses on each person's cultural connection in a respectful, non-threatening environment. This foundation of SR is reinforced in Core Concepts and department orientation, and threaded through all work settings. SCF expresses its strong relationship focus and commitment to SR in its widespread use of teams and committees. These structures further encourage and ensure diverse ideas and thinking in support of SCF's forward-thinking culture.

5.2a(3) Performance management: Multiple cycles of improvement have shifted the focus from performance evaluation (reactive) to performance planning (proactive), with compensation and rewards linked to achievement in strategic areas. After reviewing Baldrige feedback, SCF benchmarked approaches to better identify workforce competencies with tools to drive performance. Four workforce competencies were identified: (1) Customer Care & Relationships (reinforce C-O/stakeholder focus); (2) Communications & Teamwork; (3) Improvement & Innovation; and (4) Workforce Development Skills & Abilities (reinforce health care focus). These four competencies are integrated into PDPs. Individual action plans are defined to support each competency, including metrics to evaluate performance and deadlines for completion of the performance standards that are linked to annual compensation changes.

In 2005, EOS feedback drove the redesign of the recognition program. Leaders benchmarked Baldrige recipients and replaced loosely coordinated programs with an organization-

wide, three-part employee recognition program – Living Our Values, Honoring Our Successes, Expressing Our Thanks – that rewards both individual and team achievements. The highest award, Living Our Values, is awarded annually to honor exceptional contributions to the CG and CO, leadership within or on behalf of the Native Community, and improvement or innovation in health care delivery or community health. Nominations come from within the organization and senior leaders participate in selecting the recipients and presenting the awards [1.1b(1)]. Honoring Our Successes, available throughout the year, recognizes accomplishments at the division or department level. As a means of Expressing Our Thanks throughout the year, employees may reward each other with small gifts and personal notes of appreciation. In addition to internal awards, SCF nominates individuals and groups for a variety of local, state and national awards.

5.2b(1) Assessment of engagement: SCF assesses workforce engagement through the annual EOS, online surveys and daily interaction with the workforce. Results are segmented a variety of ways, including by division and job category [Fig. 7.3-2, 7.3-4], to explore differences among workforce segments and provide comparisons to other data in Morehead's National Healthcare Database. Before 2008, the EOS was conducted biannually. The EOS is now conducted annually, allowing SCF to consistently measure opportunities for improvement. EOS results are delivered through the organizational structure. Workgroups and committees identify OFIs and create action plans to improve enrichment. These plans are available via the CM and AP tools on the intranet.

Exit interviews are also used to assess workforce engagement. HR and HRC have identified the need to correlate exit interview questions with EOS questions to identify actionable OFIs. The exit interview tool used now allows HR to segment the data to mirror the EOS (division, department, occupational classification, tenure, etc.). HR generates exit interview data reports to provide feedback to the appropriate management and committee structure.

The HRC systematically reviews and addresses indicators of workforce engagement, such as retention and absenteeism, throughout the organization. If necessary, the HRC forms multidisciplinary workgroups to address such factors. For example, current workgroups include retention, succession planning, and increase AN/AIs in clinical positions.

5.2b(2) Correlation with organizational results: Leadership analyzes EOS results to identify high-leverage areas for organization-wide improvement. The HRC analyzes organization-wide Morehead EOS results and correlates them with other key workforce and organizational performance data, including turnover, salary and benefits surveys, and data and information about C-O satisfaction. The HRC makes recommendations to OPS and VPLT on key objectives related to the work environment for the AP. EOS results for each division are also shared with appropriate managers, and communicated through the division to departments and work groups. Managers use Morehead's action planning tools to identify OFIs and develop action plans that become part of each department's AP. In support of the MVKP/OP, an emphasis is placed on growing AN/AI leaders [Fig. 7.3-9] and increasing the AN/AI workforce [Fig. 7.3-15]. The DC ensures SCF's L&D approach for the entire workforce [Fig. 7.3-5] is designed, delivered, evaluated, and improved systematically to promote high performance, service to C-O, and leadership development [Fig. 7.3-8, 1.1a(3)].

5.2c(1) Workforce/leader development: DC was established in 2001 to support workforce development [Fig. 7.3-7].

Core competencies, strategic challenges, action plans: SCF's four workforce competencies are aligned with SCF's CC [Fig. P.2-2]. SCs are reviewed annually in the SPC. SCF has launched innovative approaches, including administrative support, CMA/LPN and RN/CM training programs [Fig.7.3-16], to onboard, orient and train the workforce in high-turnover and/or hard-to-fill positions. These programs reinforce CC and address organizational strategic challenges.

Performance improvement and innovation: The workforce is introduced to SCF's PI model during NHO. As a cycle of learning, a variety of PI topics are presented as QMC through the DC. To reinforce improvement and innovation, SCF has designated an improvement workforce of specialists and advisors focused on improvement projects in support of CO.

Ethical health care and business practices: Beginning in NHO and continuing through ARO, the workforce receives training on the Code of Conduct and False Claims Act from the SCF Compliance Department [1.1a(2), 1.2b(2)]. SCF Compliance and HR utilize a variety of L&D methods to train and support the workforce on ethical health care and business practices, including face-to-face interaction, reporting tools, printed media, and courses at the DC.

C-O and stakeholder focus: In support of the MVKP/OP, an emphasis is placed on growing AN/AI leaders [Fig. 7.4-9] and increasing the AN/AI workforce [Fig. 7.3-15]. The DC ensures SCF's L&D approach for the entire workforce [Fig. 7.3-5] is designed, delivered, evaluated, and improved systematically to promote high performance, service to C-O, and leadership development [Fig. 7.3-8, 1.1a(3)]. For example, when SCF identified an opportunity to improve workforce understanding of the MVKP/OP and a need to integrate FWWI concepts throughout the organization, Core Concepts training was piloted and implemented. Through this training, the workforce learns to better understand, relate, and respond to each other and C-O [P.1a(2)], 1.1a(1)]. Core Concepts is a holistic approach to incorporating the values and tools needed to build and sustain healthy relationships. The four learning objectives in Core Concepts are (1) understand how we impact others, (2) learn how to articulate story from the heart, (3) understand personal and professional aspirations, and (4) learn methods for good dialogue and productive conversations. All employees attend this three-day workshop, which is facilitated by the P/CEO and members of the VPLT [1.1a(1)].

In addition, SCF's Special Assistant Program identifies potential AN/AI leaders and offers a time-limited (18-24 month) training and learning program. The program includes work experience on projects and in management, including working closely with P/CEO, VPLT, SCF BOD, and managers [1.1a(3)]. Upon completion, special assistants apply for

leadership positions. To further advancement opportunities, training and mentorships have been implemented in a variety of positions, including physician, nurse, and clinical associate roles, and through FWWI's Advanced Leadership Education and Training for a range of roles.

Learning and development needs: Education and training are delivered by a variety of learning methods and formats, including classroom training, online options, on-the-job-training, on-site job-shadowing, and mentoring [Fig. 7.3-6]. The DC selects the delivery mode most effective for the content and audience. This is done by working closely with workforce, managers, and committees, and reviewing formal course evaluations and the annual L&D Needs Assessment. Methods to develop SCF leaders include formal initiatives such as NMO, quarterly LDS, bi-monthly manager meetings, Leadership Readiness Assessments, and CDR. The DC and HR departments gather and analyze feedback through a variety of mechanisms to identify L&D needs. The Workforce L&D Needs Assessment [5.2c(1)] is conducted annually to determine current and future needs as identified by the workforce, as well as the preferred delivery methods. The DC team uses the data to improve existing L&D offerings and to develop new ones in collaboration with internal SMEs. HR conducts an annual needs assessment face-to-face with department managers. Throughout the year, feedback is gathered from trainer-workforce interaction, post-training evaluations, manager feedback, and the DC's Training Tool Suggestion Box available via the intranet. The DC and HR use this combination of formal and informal information to improve existing programs or add new ones, working together to develop the year's schedule of offerings (i.e. trainings, workshops, presentations, and other learning initiatives).

Knowledge transfer from departing or retiring workforce: SCF's team-based approach allows for routine transfers of knowledge. Team sharing, coaching, and mentoring are a shared responsibility among the workforce. The CM and AP tools are used to document a decision-making history for use by new/current/future workforce [4.2a(3)]. Departments and workgroups have access to the shared computer drive allowing for transfer of knowledge to future workforce. Data is stored on the shared drives for departments, which are used as a central location for the workforce to share, store, and research documents. In addition, SharePoint sites allow workgroups to store information and transfer knowledge among the workforce. Departing employees meet with department members to ensure transfer of knowledge and, when possible, they mentor their replacements.

Reinforcement on the job: Following NHO, departments orient new employees for up to 45 days to reinforce knowledge and skills needed on the job. Upon hire or promotion, new managers attend a 90-day comprehensive program consisting of individual learning modules facilitated by various SCF leaders. Additionally, managers attend HR training for new managers, a three-day program focused on performance management. Other methods used in the L&D system are job shadowing, mentoring, and specific competency demonstration. For example, in the ANPCC, a new administrative support or CMA/LPN spends about four weeks in rotational assignments within the clinic to understand their role within the clinic system and team. After the initial training period, reinforcement continues with formal or informal mentors. Physicians and RN/CMs in the ANPCC also have peer mentors to reinforce clinical skills.

5.2c(2) Learning and development effectiveness: The DC systematically evaluates the effectiveness and efficiency of its learning systems. Employees evaluate each course they take. The DC team gathers and analyzes the feedback to identify improvements and to revise courses when needed. In 2009, the DC recognized an OFI in the evaluation process. The DC revised the evaluation process and is testing a multi-faceted survey tool that assesses course content, design, delivery and the instructor in alignment with adult learning principles. This process includes level one and two of the Kirkpatrick Model of Evaluation. Course evaluations are reviewed by the L&D evaluation work team and appropriate changes are made to ensure continuous improvement. For example, the DC offered Motivational Interviewing courses in half-day sessions at the DC. The clinical workforce found it difficult to reserve time away from the clinic for a half day. Based on this feedback, the DC now offers the course in the ANPCC during the lunch hour for four weeks, allowing clinical employees to attend without interrupting clinic time.

5.2c(3) Career progression: SCF's ability to reach its AN/AI hiring goals, as a Alaska Native-owned and -managed organization, is directly linked to its ability to support, train, promote, and progress internal candidates into leadership positions [Fig. 7.3-8, 7.3-9].

SCF uses a combination of approaches to develop the workforce's full potential in support of the SP. The performance management process helps the entire workforce gain the knowledge and skills needed to succeed and progress. During the PDP process, supervisors discuss job and career goals, and development and learning needs are integrated into the PDP for the coming year. Specific tools that contribute to this process include progression checklists and promotion pathways that define the competencies required before moving to the next level. Job progression and promotion pathways provide the workforce with a clear path to grow through the organization, allowing SCF to "grow our own" workforce into leadership positions [Fig. 7.3-9]. SCF's Special Assistant Program is an example of preparing AN/AI workforce for leadership roles [5.2b(2)].

In 2008, HRC and the DC created and completed a two-cycle PDSA in BSD on a formal succession and leadership readiness process that targets administrators, directors, and VPs. A formal succession planning process was developed to provide structured and ongoing forecasting and identification of key leadership positions and readiness; career and leadership planning, development, and assessment; retention; and, performance management. The succession plan includes CDR assessment, leadership readiness self-assessment, manager leadership readiness assessment, and 360-degree leadership assessment from subordinates and peers.

6. OPERATIONS FOCUS

6.1a(1) Design Concepts: SCF uses the SPC [2.1a(1)], ongoing performance review [4.1b(1)], and the SCF

Improvement Process [Fig. 6.2-1] to determine what work systems need to be designed and innovated. This process includes talking with C-O, gathering input from suppliers and partners [Fig. P.1-7], scanning the environment, surveying the workforce, and reviewing key performance data. The need for innovation may be determined at the corporate, division, department, or individual level. To determine which work systems will be outsourced, SCF considers work system factors: (1) consistency with the MVKP/OP, (2) within the scope of SCF's CC, (3) included among funding priorities, (4) best done by SCF vs. better by another, and (5) cost-effective for SCF to perform vs. more cost-effective for someone else.

SCF uses the OP [Fig. P.1-2], to ensure work systems and key work processes relate to CC [Fig. 6.1-1; Fig. P.2-2]. For example, whenever a new idea is considered, committee members or responsible employees assess/calibrate the suggested work system design or process idea by using the OP. This ensures alignment for strategic focus and capitalizes on CC. If the work system is to be outsourced, SCF determines if the organization (to whom it will outsource) has values and processes consistent with SCF's MVKP/OP. For example, SCF's primary care clinics identified chronic pain as a key C-O health issue. As a result, a multidisciplinary team designed a process to address chronic pain management that allowed most of the process to be managed internally; however, a few complex pain cases are referred to a specialist outside SCF for services that are beyond SCF's PCP scope. Other examples include specialty treatment for allergy, dialysis, and nuclear medicine referrals.

6.1a(2) Work System Requirements: SCF uses input from C-O and stakeholders to determine key work systems requirements [Fig. 6.1-1] and reviews their alignment with key health care processes and overall strategy. They provide infrastructure and resources essential to plan, perform, manage, and improve key health care processes, and accomplish SCF's CG and CO. As key requirements are defined, SCF identifies measures to assess if we are meeting the requirements. These measures are incorporated into various committee and leadership performance review cycles as well as maintained on the Data Mall or appropriate BSC. SCF does have a traditional reporting structure depicted in a 'usual' organizational chart for carrying out operational functions. The vast majority of improvement work, however, is driven through the FCS or 'four ovals' [Fig.1.1-2]. Most health care relies on 'operations' to do process improvement and clinical quality to do both quality assurance and clinical quality improvement. In order to drive whole system change and excellence, SCF believes that technical skills, excellence, and focused staffing needs to occur in all four functional dimensions – operations, process improvement, clinical quality assurance, and clinical quality improvement. These functional committees have membership across the entire company and are multidisciplinary. This structure assures work system design is driven by both external and internal customers, is consistent across all of SCF, and draw on the expertise of all disciplines. The 'four ovals' exist at all levels of SCF – they and their subcommittees evaluate, define, and drive the vast majority of improvement efforts at SCF. Initiatives, work plans, timelines, measurement requirements, mostly derive from this approach and structure.

6.1b(1) Work System Implementation: SCF work systems include Behavioral, Dental, Medical, Tribal, and Health Care Support [Fig. 6.1-1]. The review of the work system design is a required step in developing value-added health care services for C-O and stakeholders. The FCS aligns with the OP to ensure key processes in the work system will help SCF achieve sustainability and organizational success in accomplishing our MVKP. When the FCS was implemented, four dimensions of responsibilities were identified for management: QA, QI, PI and OPS. These dimensions ensure that SCF continues its focus on today's work while balancing resources with future improvement and innovation needs. Initially, SCF designed an improvement workforce that was assigned specific improvement projects at the division and corporate levels. In 2009, as a cycle of learning, the improvement workforce structure was changed. Improvement resources were assigned not only to the division and corporate initiatives, but also to department initiatives. This change in structure was supported by the development of the QMC, which assists the general workforce in integrating and aligning the use of improvement tools and methods.

6.1b(2) Cost Control: Rather than tinker with systems that are poorly designed, SCF often fundamentally rethinks and redesigns entire systems with the goal of minimized hand-offs, direct immediate responsiveness and co-location of all team members. For example the entire primary care system guarantees C-O driven same day access, locates all team members in the same group integrated care team space and then uses work flow analysis based on Lean Principles minimize waste. Such approaches have radically reduced total cost, visits to the system, and dramatically improved performance of required clinical interventions by bringing all services to the C-O and max-packing every visit and having every person 'work at the top of their license'.

To prevent rework and errors, SCF uses the improvement process [Fig. 6.2-1] to pilot, learn, and refine before fully implementing changes. SCF also emphasizes implementing known best practices and systems of continual learning and spread to reduce undesirable variation while continually supporting effective innovation. For example, the SCF BSD developed and standardized a new clinic orientation approach after testing the approach first on a small scale before deploying to all C-O calling for a behavioral services appointment. This process resulted in a group orientation structure greatly improving access while reducing cost.

To minimize costs of inspections, tests and audits, SCF ensures all work process teams have access to data to monitor and manage their efficiency and effectiveness. For example, SCF uses a comprehensive medical error reporting system that promotes the workforce stepping forward to report errors supported by the QA team and an error evaluation process. This approach has been fully deployed throughout the departments resulting in reduced error rates. The QA team also runs tracers to test process conformance. Measures are tracked and accessible to the workforce on the Data Mall.

Through this intentional system the need for unnecessary testing and inspection is minimized, thus reducing cost.

6.1c Emergency Readiness: SCF developed and maintains an Emergency Management Plan (EMP) addressing both employee and C-O safety in the event of an emergency or natural disaster. SCF's EMP guides the workforce on the appropriate response to disasters or emergencies. It has been fully deployed via the intranet. A Hazard Vulnerability Analysis (HVA) is conducted and approved by the SCF Safety Committee on an annual basis and rates different types of natural, man-made, and technological disasters that may affect SCF's operations. This analysis is also used to identify any deficiencies in the existing EMP. The EMP is reviewed annually and is updated based on changes in SCF's operations, modifications to the HVA, lessons learned from exercises, and changes in the community. SCF has also adopted the State of Alaska Mass Prophylaxis Clinic Plan for administration of mass vaccinations.

Prevention: The workforce receives basic training in emergency preparedness during NHO and ARO. The DC schedules quarterly emergency preparedness training available for the workforce to attend. The Safety Committee actively evaluates emergency preparedness through an annual performance objective in emergency management.

Management: SCF manages large-scale emergencies using an Incident Command System and an all-hazard approach. SCF participates in community-wide planning for natural and man-made disasters, participates in exercises, and performs after-action review to change plans based on lessons learned.

Continuity of operations for C-O and community: SCF is a member of the Anchorage-based Joint Medical Emergency Planning Group, which develops plans for disaster drills and training. SCF continues to work with other CIRI nonprofits to communicate SCF's EMP and develop relationships for responding to disasters.

Figure 6.1-1: Key Work Systems, Processes, Requirements, Measures, and Results

Operational Principles [Fig. P.1-2] | **Core Competencies [Fig. P.2-2]** | **Key Work Systems:** Behavioral, Dental, Medical, Tribal, Health Care Support

Key Process	Key Requirement	Sample Key Measure	Sample Results
Customer Perspective	Relationship fostered and supported	Staff Courteous & Respectful	Fig 7.2-4
	Emphasis on wellness	Wellness Care Plan with BHC Visit	Fig 7.1-14
	Locations that are convenient	Appointment When Desired	Fig 7.2-7
	Access optimized	Primary Care Access to Care	Fig 7.1-25
	Simple and easy to use	Would Recommend Services	Fig 7.2-9
	Family is the hub of the system	Aggregate Rating of Care	Fig 7.2-10
	Interests of C-O first	Continuity of Care with Provider	Fig 7.1-30
	Culturally appropriate	Culture& Traditions Respected	Fig 7.2-3
	Together with C-O as active partner	Ability to Give Input to Decisions	Fig 7.2-8
Financial and Workload Perspective	Services are financially sustainable	Operating Margin	Fig 7.5-1
	Whole system design	Overhead	Fig 7.5-2
	Interests of C-O first	Days Cash on Hand	Fig 7.5-5
Operational Effectiveness Perspective	Measures for continuous improvement	Baldrige/APEX OFI Completion Rate	Fig 7.1-35
	Whole system design	Organizational Recognition	Fig 7.4-11
	Services are financially sustainable	Board Assessment Results	Fig 7.4-7
	Population based	Core Concepts Participation	Fig 7.1-36
Workforce Development Perspective	Whole system design	Balanced Scorecard	Fig 7.1-34
	Together with C-O as active partner	Benefit Satisfaction & Org Support	Fig 7.3-21
	Emphasis wellness of whole person	Personal Life Balance	Fig 7.3-22

Evacuation: Each facility maintains a building evacuation plan that is exercised at least annually. Each evacuation is critiqued and evaluated to identify any opportunities for improvement. Each program has a plan to accommodate necessary operations during prolonged facility evacuation.

Recovery: The EMP addresses how SCF will recover from emergencies. IT systems are included in emergency planning [4.2b(2)]. The telephone system has three failure points to prevent loss of service. System failover is tested regularly.

SCF has a Capital Reserve Plan that provides for designated reserves to fulfill existing contractual or program commitments based on past revenues, facility and equipment replacement reserves, and other identified future obligations. The plan calls for a minimum Working Capital/Emergency Reserve of no less than 120 days of normal operating cash requirements — an amount sufficient for SCF to maintain near-normal operations during most emergencies or serve as a "bridge" until SCF can adjust its operations in a reasonably orderly manner to a sustainable level. SCF also carries liability and property damage insurance to cover losses from most risks, including earthquakes and flooding.

6.2a(1) Design Concepts: SCF designs and innovates work processes using the SCF Improvement Process [Fig. 6.2-1].

Figure 6.2-1: SCF Improvement Process/Model

1. A need for design, or redesign, improvement is identified and is checked for alignment with the OP
2. Complete PTC and/or start small-scale PDSA testing
3. Implement the process design or redesign; disseminate when applicable
4. Monitor and/or report using AAPT and/or BSC/DB

Detailed version available on site

The 4-step process (outlined below) is taught to SCF's entire workforce and deployed organization-wide.

1. When need for design is identified in alignment with OP, and approved, a team (typically multidisciplinary, multi-departmental, and often associated with an existing committee or subgroup) is established to oversee the project and follow process steps.

2. The PTC defines project aim, change concepts, key metrics, measures of success, and alignment with MVKP/OP and CO. The PTC helps identify the need for internal experts who may bring critical data and information about key

requirements, including regulatory requirements, or critical organizational knowledge to help the team succeed and align its work with organizational policies and practices. Using the SCF Improvement Process, the team designs its process, typically with multiple tests of change. Design, or redesign, projects are guided by SCF's FCS, and its four key oversight and coordination committees.

3. The team implements, standardizes, and disseminates process or redesign across the organization where applicable. Standardization occurs through development, redesign, and deployment and training of policies, procedures and processes.

4. Progress is tracked and reported on appropriate APs and quarterly reports to relevant committee, with updates including corresponding BSC/DB data available to the workforce in real time on the intranet.

For example, in response to C-O feedback, SCF identified the need to redesign a process that would provide consistent quality care to a large geographic region. Using the SCF Improvement Process, and incorporating new technology, an innovative telepharmacy program was implemented and subsequently recognized with a national award. SCF also utilizes guidelines and benchmarks to enhance organizational knowledge, evidence-based medicine, health care service excellence and the potential need for agility into the key processes. SCF allows high performing outcomes to shape or guide the process, rather than the process guiding the outcomes. An example of this would be an ICT with a high-performing outcome having their process that led to those outcomes spread to other teams. Focusing more on the outcome rather than the process allows for innovation and agility in the processes.

To ensure that cycle time, productivity, cost control and other effectiveness factors are considered in work process design, SCF uses a change concept checklist, which is linked to the improvement publication "The Improvement Guide" to guide the design and provide structure. The change concept is further emphasized in the design of the PTC and PDSA forms, which allow us to define a measure (such as cycle time, cost, productivity, efficiency, etc.) and demonstrate the impact of the improvement. These forms and other improvement-related tools are accessible on the intranet.

6.2a(2) Work Process Requirements: Driven by the MVKP/OP, SCF listens extensively and continually to the SCF BOD, all Alaska Native people using the system through many different ways, and the front line staff. Based on this, the SCF BOD, President/CEO and VPs have defined a system of services that must be provided, aligned, and integrated in order to address SCF C-O health needs. Key work processes [Fig. 6.1-1] are defined and it is through these processes that SCF delivers C-O and stakeholder value and organizational profitability, and performs as a sustainable health care system. As key work processes are designed and delivered to meet C-O requirements, SCF continually improves them by using C-O feedback, performance data, and new knowledge of C-O needs and expectations. To further ensure that work system processes contribute to delivering value and affecting organizational success, SCF incorporates scientific knowledge, proven best practices and national performance benchmarks in work system design, and also recruits and develops a capable workforce.

SCF's OP are based on input from many groups of C-O – key tribal leaders, individuals, their families, and the AN/AI workforce. All ideas and plans are scored for alignment with these OP and only aligned ideas are implemented. Listening approaches [Fig. 3.2-1] and C-O support mechanisms [Fig. 3.1-1] provide ongoing input which directly drives program design, process improvement, and ongoing changes in services provided. In addition, CSRs and other members of the workforce use the CFRS [3.2b(1)] to record comments (positive or negative) and suggestions for use in design and improvement of key health care processes. Active participation in formally structured meetings with tribal leaders and other care partners and collaborators (e.g., ANHB, VSMT, Medical Services Network Committee, and AAPP) further contributes to SCF's understanding of C-O requirements to drive key process design, management, and improvement.

SCF uses also a variety of C-O listening mechanisms [Fig. 3.2-1] to determine key work process requirements through the eyes of internal customers. At multiple levels, the SCF workforce serves as internal subject matter experts, ensuring that key external requirements are understood within the organization and incorporated in design/redesign efforts. This principle is fundamental to the FCS. The HRC, for example, enables HR experts to share knowledge and expertise with members of operations and other areas. The same is true for the FC, ITC, and SAFC.

Key health services and service delivery processes are reviewed and determined annually as part of the planning process. Key business and other support processes [Fig. 6.1-1] are determined based on their alignment with key health care processes and overall strategy. They provide infrastructure and resources essential to plan, perform, manage, and improve key health care processes, and accomplish SCF's CG and CO. SCF uses input from C-O and other stakeholders to identify requirements. As key requirements are defined, SCF identifies measures to assess if we are meeting the requirements. These measures are incorporated into various committee and leadership performance review cycles and are as maintained on the SCF Data Mall or appropriate BSC.

6.2b(1) Key Work Process Implementation: The key work processes [Fig. 6.1-1] allow SCF to meet strategic goals that relate to SCF work systems. SCF undertakes successive pilots of design/redesign changes before implementation on a broad scale to ensure that new or redesigned processes meet all requirements. Examples include (1) development of the ICT, a multidisciplinary integrated team of clinicians and team members providing primary care for the C-O; (2) depression screening; (3) tobacco use interventions; (4) integration of behaviorists in primary care; and, (5) the Access to Recovery program, which provides substance abuse assessment, clinical treatment and recovery support services. Functional committees and leadership ensure these meet design requirements through ongoing data review, including the BSC, SCF Data Mall and APs. Day-to-day responsibility for meeting key process requirements rest with the workforce assigned to the action plans. With SCF's focus on C-O

relationships, feedback from C-O is gathered [3.2a(1)] and used to update and improve processes where needed. Work processes [Fig. 6.1-1] have defined performance measures that are systematically reviewed and acted upon by SCF's FCS. Key work processes for access, relationship, wellness and performance review are systematically reviewed by operational and FCS to determine needed improvements.

6.2b(2) Patient Expectations and Preferences: SCF's most key principle is being C-O driven and extensive training and retraining is done to provide techniques and skills to assure C-O driven performance. C-O decide which PCP (and subsequent ICT) they will partner with and then get care based on their personal values, goals, and health plans – building on assets and goals they bring to the relationship,. Making the defaults that all family members have the same ICT (though this is not a requirement) promotes communication about and knowledge of the entire family's preferences and values. A long-term relationship with the ICT also promotes knowledge of expectations and preferences and establishes the trust and opportunities for communication that help in aligning goals and expectations. Additional examples include C-O and providers co-creating written treatment plans in BSD and C-O participating in the design of aftercare instructions in the Fast Track ED.

6.2b(3) Supply Chain Management: SCF supply chain management is imbedded in the day-to-day assessment of the effectiveness of our work. We utilize Native Preference when selecting suppliers, when possible, by utilizing other AN/AI nonprofits [P.1b(3)] in the management of our supply chain. For example, SCF partners in a Regional Supply Center with ANTHC [Fig. P.1-7] and can use their critical hospital supplies. To ensure suppliers are qualified and positioned to enhance our performance and C-O satisfaction, SCF uses competitive bidding in compliance with state and federal regulations. All vendors that SCF partners with complete a vendor packet that includes key information and terms. SCF evaluates supplier performance on a case-by-case basis through feedback from end users. Adjustments are made and shared through the FCS. SCF strives to develop relationships with vendors, resolve any ongoing issues and give reasonable time to make corrections. With poorly performing vendors, SCF first corrects any contributing SCF factors and then allows the vendor to make adjustments or improve. If SCF cannot resolve issues, then alternative vendors are sought.

6.2b(4) Process Improvement: At a system level, the use of the BNQP framework helps SCF achieve its commitment to performance excellence, and the annual focus keeps processes current with health care service needs and directions. SCF has used the BNQP criteria since 2003, including teaching Baldrige at NHO and as a QMC offered by the DC.

SCF deploys multiple ways of utilizing input from C-O, collaborators, and internal customers and then aligns all processes and activities to MVKP/OP and CO. In addition, improvements must fit within these guidelines.

SCF's improvement approach begins at the individual department level as they assess progress of APs [2.2a (2)] through extensive use of performance data and analyze plan performance. The analysis looks at process and project performance measures, outcome indicators, opportunities to improve processes to better serve C-O needs and business directions necessary to serve and meet C-O expectations. These feed up through operational and functional committee structures so they can be monitored and continually improved, while maintaining alignment and consistency of approaches.

The SCF Improvement Process balances removing undesirable variation with continual innovation and capture and spread of evolving best practices. To ensure there is a systematic evaluation and improvement of work processes, the PI and QI Committees are used for oversight. With cross-departmental and cross-disciplinary membership, these committees provide opportunities for sharing improvements and innovations as well as lessons learned across SCF. The QI and PI committees develop APs with improvement initiatives that are cross-departmental. The QI Committee oversees the work of three CBG: Primary Care, Dental and Behavioral Services. These groups include clinical leaders and front line clinical employees, with strong improvement support. This group arrangement ensures involvement from all levels of SCF and consistent application of data and quality while supporting innovation and spread at the same time.

In addition, to drive organizational learning and innovation, SCF encourages extensive external learning opportunities including publications, the Internet, meetings, conferences, learning collaboratives, and benchmarking visits to seek knowledge about changing health care services, standards and technology, and to identify best practices. The PI Committee annually coordinates involvement in learning conferences relevant to SCF, and management identifies attendees using a selection process. Attendees provide feedback via a conference summary document that is archived on the intranet. Additionally, the information gained is shared internally in department and committee meetings. This approach ensures SCF has knowledge of these innovations and best practices to use in process improvement activities. Internal approaches for learning and innovation include posting departmental and committee improvement plans on the intranet as part of the AAPT, and through SCF's organization-wide culture of sharing that encourages the spreading of improvement and innovative ideas. The workforce is encouraged to mentor and coach others [5.2c(1)] in all areas of learning, and share knowledge as a method for sharing organizational best practices and accelerating organization-wide change.

7. RESULTS

Aligned COs [Fig. 2.1-5] are referenced in each figure. As SCF is not a hospital but an outpatient health care system [P.1a(1)], SCF's results focus on outpatient, preventative care and not typical "hospital" measures.

7.1 HEALTH CARE AND PROCESS OUTCOMES:

7.1a Patient-Focused Health Care Results

Benchmarks: HEDIS 90th percentile (when ▲is better) or HEDIS 10th percentile (when ▼is better). When HEDIS percentile metrics are not available, SCF identifies other world-class performers using similar methods to benchmark against. When external benchmarks are not available, SCF sets internal targets based on performance expectations.

Trends: Historical clinical data is available on-site going back to 2000 for most measures displayed. Overall, trends continue to improve and demonstrate sustainable results.

Segmentation: Provider comparison charts, individual provider performance over time, and clinic-specific measure segmentation are available on-site and via DM.

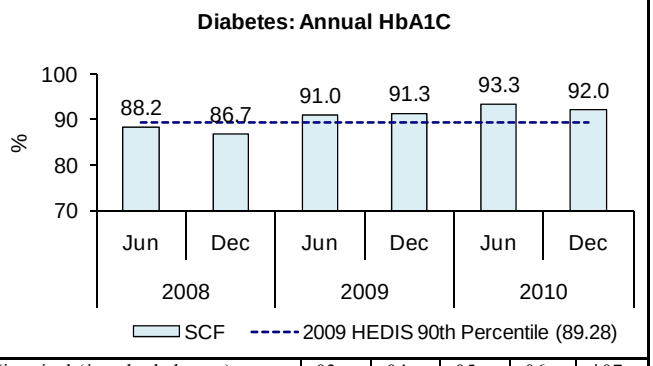
Integration: SCF has successfully integrated pharmacists, nutritionists, and behavioral health specialists into Primary Care. Health care is focused around the C-O, to ensure comprehensive and efficient delivery of services. C-O are empanelled to a "named" health care provider/team responsible for ensuring the C-O is up-to-date on preventive, screening and condition management needs. Each team member (provider, RN/CM, CMA, administrative support), is an extension of one another and perform tasks at a level appropriate for their skill set. Performance results are updated weekly and available for the organization and C-O to review. Teams compare their performance to one another and to nationally established benchmarks established by NCQA. Performance results are integrated into clinic/team work plans and are used in annual performance evaluations of employees, which are tied to performance bonuses. Integration extends into other areas outside of direct care. IT/IM personnel partner their work plans with clinic personnel to ensure that front-line staff have actionable information they need to deliver proactive health care. Action lists that identify the health care needs of the population are also used to plan for future facility expansion efforts and to determine if current capacity meets demand.

The results reported in Item 7.1 reflect process and outcome measures associated with care delivered to a unique and rapidly growing population base. These key indicators include both mandated and non-mandated results. Specific measures contain segmented data that SCF uses to evaluate variations in care and identify OFI. The measures included in Item 7.1 display industry-best comparative data. SCF compares performance against best practice benchmarks to encourage excellence and to identify needed process improvement initiatives. Although not displayed, SCF currently segments HEDIS measure metrics down to the clinic/team/provider level. In addition, SCF uses Provider Performance Comparison Charts to identify areas of best practice and OFI. Due to space limitations, detailed drill-down charts and graphs are available on-site. Accompanying each HEDIS metric measure is a Web-based action list to provide health care providers and team members with C-O-specific information regarding the need for clinical preventive services and/or condition management. The lists allow team members to take a proactive approach in health care delivery. Action lists also support forecasting demand for services and ensure current capacity meets demand.

Graphs are grouped into categories (prevention, screening, disease/condition management, behavioral health integration, utilization, and professional certification). They summarize SCF's commitment to the Population Health Principles recognized by NCQA. SCF's results demonstrate how empanelling to a named provider builds a sense of shared responsibility that leads to positive health care outcomes. In March 2010, SCF applied for NCQA PPC-Patient Centered Medical Home certification and was recognized by being awarded its prestigious Level 3 (Highest Level) Certification. The certification recognizes the importance of an ongoing relationship with your health care provider/team and taking "responsibility" for C-O care. Diabetes is one of the most costly and highly prevalent chronic conditions in the U.S. The overall age-adjusted prevalence rate for diabetes among AN/AI is more than twice that of U.S. adults overall, so SCF focuses on early stage detection and management of diabetes.

Figure 7.1-1: Diabetes Care: Annual HbA1C

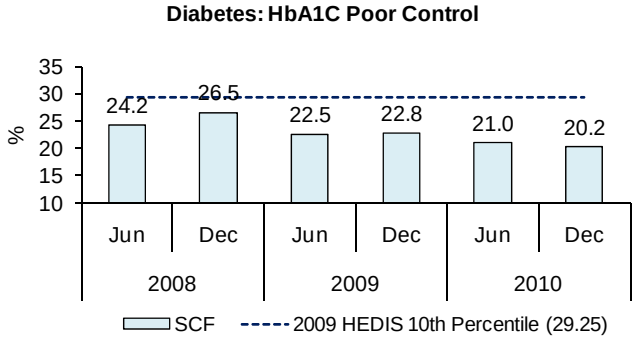
FMW6 | Exceeds 90th Percentile | ▲Better



Historical (*method change)	03	04	05	06	*07
Percentage	83	94	95	94	86

Figure 7.1-2: Diabetes Care: Poor Control

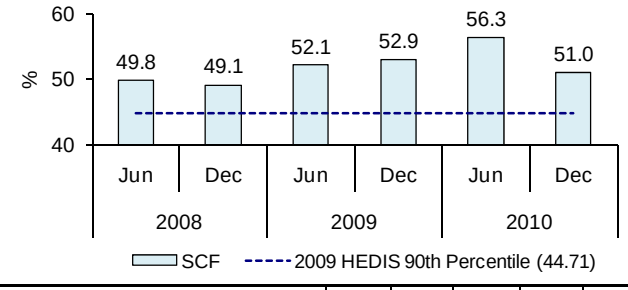
FMW6 | Exceeds 10th Percentile | ▼Better



Historical (*method change)	03	04	05	06	*07
Percentage	7	11	7	5	23

Figure 7.1-3: Diabetes Care: LDL < 100mg/dl

FMW6 | Exceeds 90th Percentile | ▲Better



Historical (*method change)	03	04	05	06	*07
Percentage	51	54	54	55	50

Fig. 7.1-1, 7.1-2, and 7.1-3 reports SCF ongoing focus on Diabetes management and demonstrates consistent exceptional performance to benchmarks over time.

Figure 7.1-4: Diabetes Care: Nephropathy

FMW6 | Exceeds 90th Percentile | ▲Better

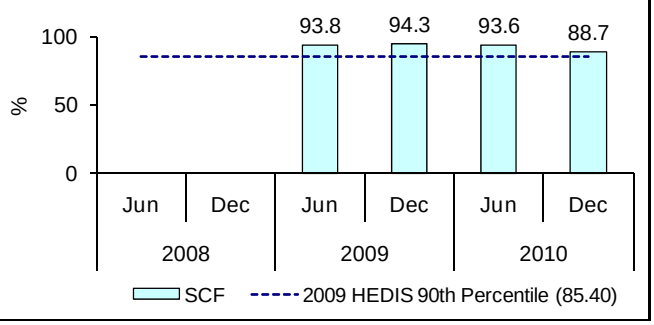
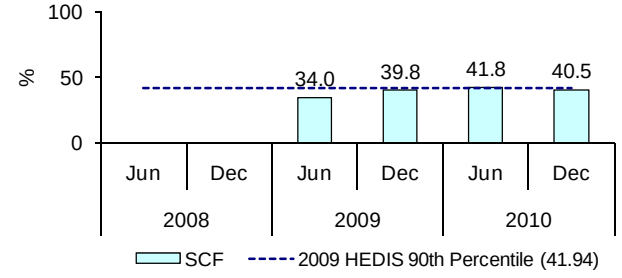


Figure 7.1-5: Diabetes Care: B/P < 130/80

FMW6 | 75th-90th Percentile | ▲Better



Figs. 7.1-4 and 7.1-5 were added in June 2009 to SCF's diabetes management evaluation. Eye exams [Fig. 7.1-6] are performing above the 50th percentile. Improvement efforts are targeted on the concepts referenced in the text box at the beginning of Item 7.1 (e.g. integration concepts). Fig. 7.1-7 assesses performance on cholesterol management in individuals with cardiovascular conditions.

Figure 7.1-6: Diabetes Care: Eye Exams

FMW6 | 50th-75th Percentile | ▲Better

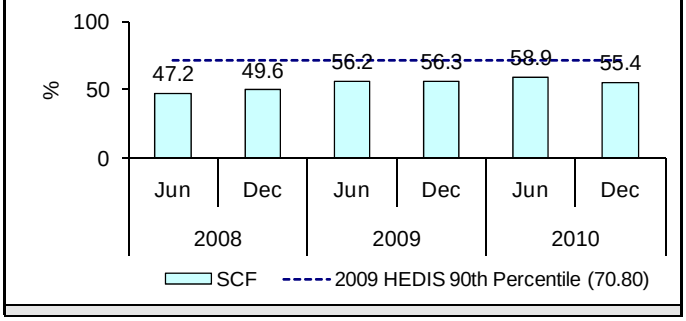


Figure 7.1-7: Cardiovascular: LDL < 100 mg/dl

FMW8 | 50th-75th Percentile | ▲Better

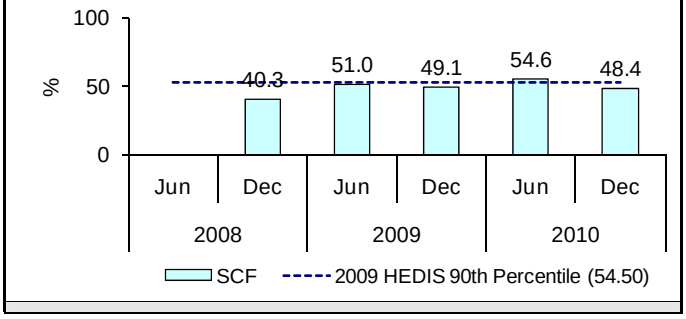


Figure 7.1-8: Asthma Appropriate Meds

FMW8 | Exceeds 90th Percentile (Ages < 18) | ▲Better

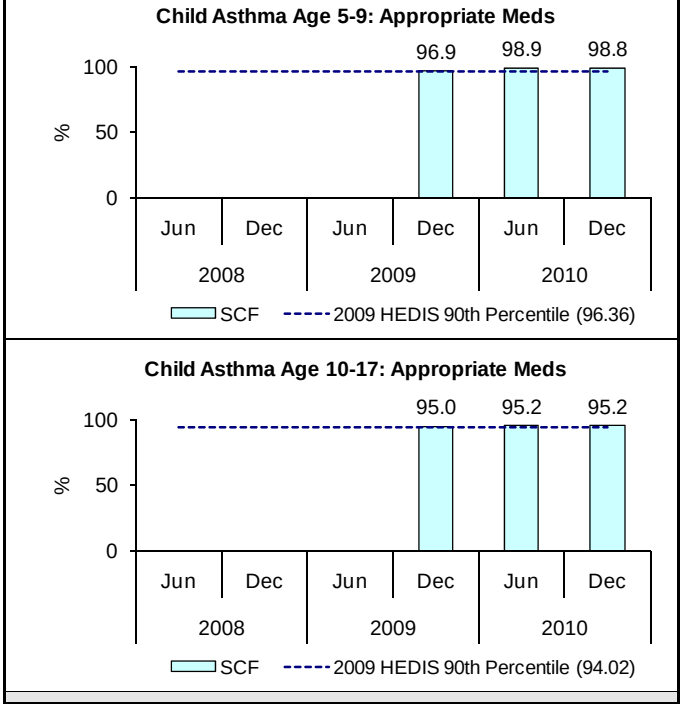
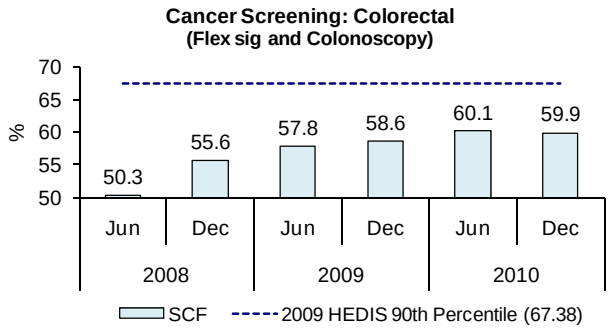


Figure 7.1-9: Colorectal Cancer Screening

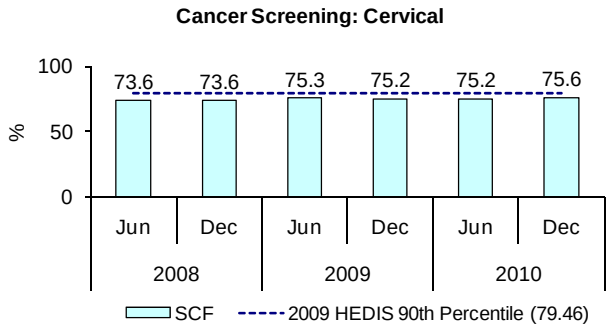
FMW2 | 50th-75th Percentile | ▲Better



Historical (*method change)	03	04	05	06	*07
Percentage	48	45	45	52	49

Figure 7.1-10: Cervical Cancer Screening

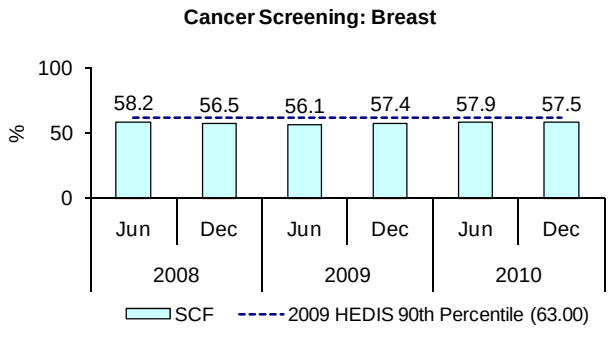
FMW2 | 75th-90th Percentile | ▲Better



Historical (*method change)	03	04	05	06	*07
Percentage	76	75	74	74	74

Figure 7.1-11: Breast Cancer Screening

FMW2 | 75th-90th Percentile | ▲Better

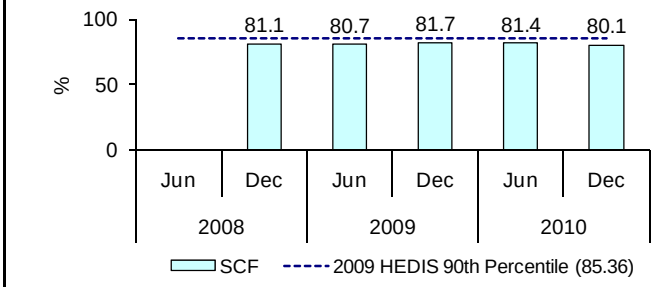


Historical (*method change)	03	04	05	06	*07
Percentage	67	65	68	69	59

Fig. 7.1-8, added in October 2009, evaluates performance associated with persistent asthmatics being prescribed medications acceptable as primary therapy for long-term asthma control. Success in screening and condition management is attributed to action list implementation and SCF's Nuka System of Care. Effective and efficient primary care promotes health through proactive screening and risk factor identification. Figs. 7.1-9 through 7.1-11 provide results for SCF's Cancer Screening Program. Alaska Native people have one of the highest prevalence rates in the nation for colorectal cancer. SCF has improved its colorectal screening rate from 48% in 2003 to 59.9% in 2009. SCF's approach to colorectal cancer screening (flexible sigmoidoscopy and/or colonoscopy) is more stringent than that used by HEDIS. A simple lab test, called a Fecal Occult Blood Test (FOBT), used in the HEDIS score calculation cannot be relied upon in the Alaska Native population and therefore is not part of SCF's standard of practice for colorectal cancer screening. SCF's benchmark, however, continues to be the HEDIS 90th percentile. SCF feels it can reach this benchmark with even more stringent methods and is committed to delivering the highest quality of care to C-O. Continued improvements in colorectal cancer screening by SCF can be attributed in part to Certified Gastroenterology Nurses performing flexible sigmoidoscopies, locating the capability in the primary care clinics and making screening a built-in system attribute. SCF worked with the Alaska State Board of Nursing to develop a training and certification program to meet C-O needs.

Figure 7.1-12: Childhood Immunizations

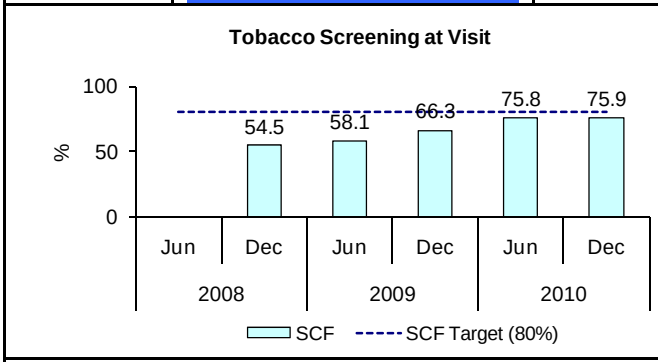
FMW1 | 50th-75th Percentile | ▲Better

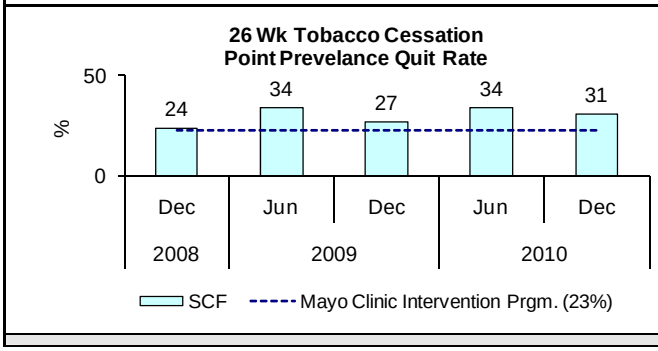


Historical (*method change)	03	04	05	06	*07
Percentage	88	90	93	89	80

Figure 7.1-13: Tobacco Screening & Quit Rates

FMW5 | Exceeds Benchmark | ▲Better



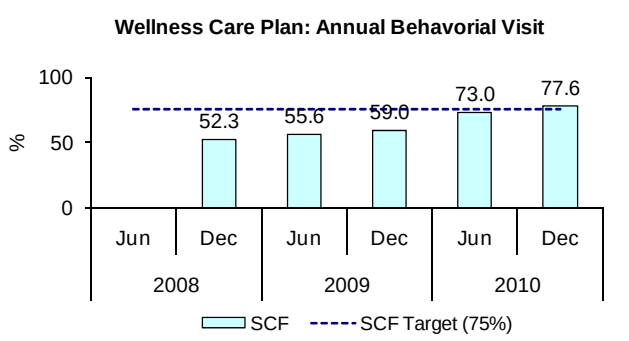


Immunizations are a basic method for prevention of serious illness. Fig. 7.1-12 shows SCF's childhood immunization rates on or before a child's second birthday. SCF attributes its improvements and sustainability in immunizations outcomes to focusing on wellness, active involvement with families, and an open access policy.

SCF addresses respiratory disease prevention with an aggressive tobacco screening program [Fig. 7.1-13]. SCF is a 100 percent tobacco-free campus. SCF's intense Tobacco Cessation Program includes counseling and pharmacotherapy.

Figure 7.1-14: Wellness Care Plan with BHC Visit

FMW3 | Improving Trend | ▲Better



Besides meeting C-O physical health care needs, SCF has integrated Behavioral Health Consultants (BHC) into primary care. BHCs are located at the point of care (without referrals) in the clinics to respond to C-O behavioral health care needs. Additionally, C-O who have increased behavioral health or complex medical needs are identified and, through proactive targeted case management, have a wellness plan of care established. The goal of the Wellness Care Plan is to coordinate and meet the increased physical, social, behavioral, and spiritual needs of our C-O. Part of this process is that each C-O with a Wellness Care Plan meets with a BHC [Fig. 7.1-14] annually to review their needs and adjust their plan of care. In addition to Wellness Care Plans, BHCs are also evaluate prescribed controlled substances; looking for any behavioral health risk factors that may put C-O at risk for substance abuse, addiction, or suicidal ideation. BHCs also make suggestions for alternatives to controlled substances for pain control [Fig. 7.1-15]. Internal targets are set since external benchmarks are not available for this innovated approach.

Figure 7.1-15: Controlled Meds with BHC Visit

FMW5 | Improving Trend | ▲Better

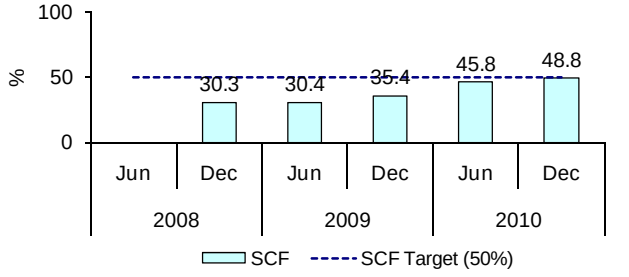


Fig. 7.1-16 and 7.1-17 demonstrate SCF's commitment to address substance abuse through screening, treatment and recovery. Access to Recovery was a 2009 Substance Abuse and Mental Health Services (SAMHSA) federally funded grant program that facilitated substance abuse treatment and recovery support services using a voucher system. The grantor required outcomes related to abstinence from drugs and alcohol, attainment of employment or enrollment in school, and increasing capacity for services. One of SCF's CO is to impact the rate of suicide among Alaska Native people by building healthy relationships with C-O and providing clinical and behavioral health services, including primary care depression screening [Fig. 7.1-18]. The crude rate of suicide among Alaska Native people [Fig. 7.1-19] living in the immediate area of SCF services has decreased since 2004.

Figure 7.1-16: SBIRT Annual Substance Abuse Screen

FMW5 | Consistent Improvement | ▲Better

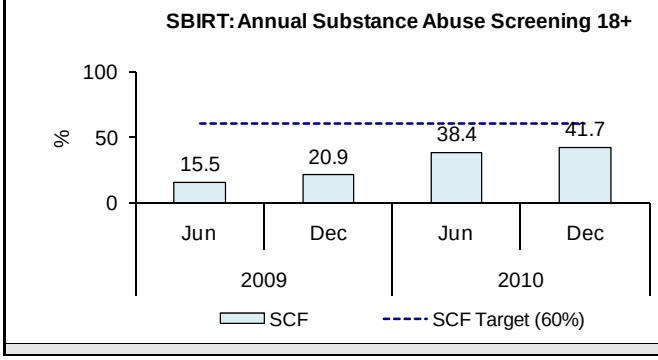
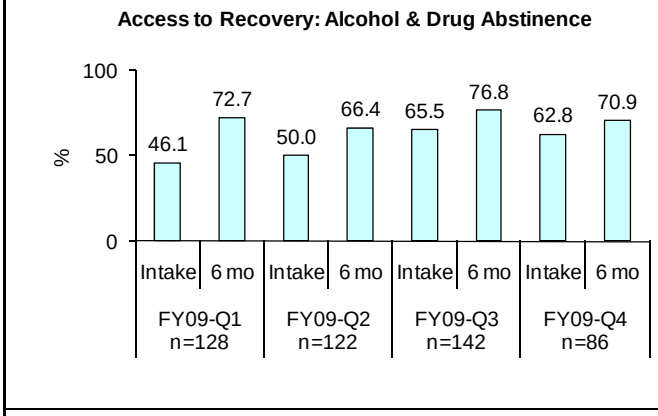


Figure 7.1-17: Alcohol / Drug Abstinence & Recovery

FMW5 | Consistent Improvement | ▲Better



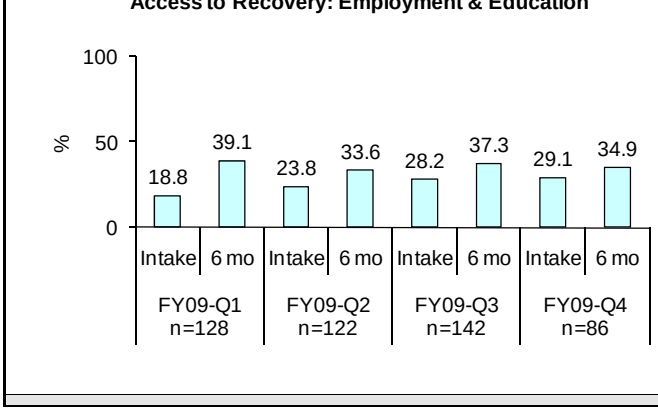


Figure 7.1-18: PRIME MD: Annual Depression Screen

FMW5 | Consistent Improvement | ▲Better

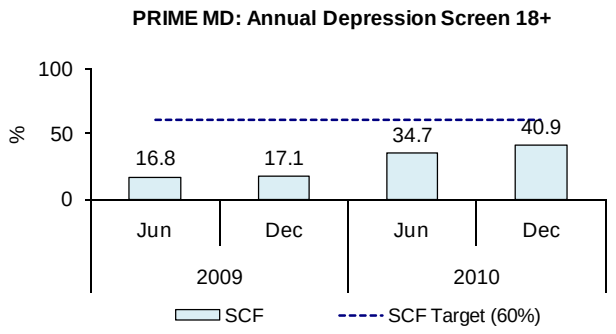
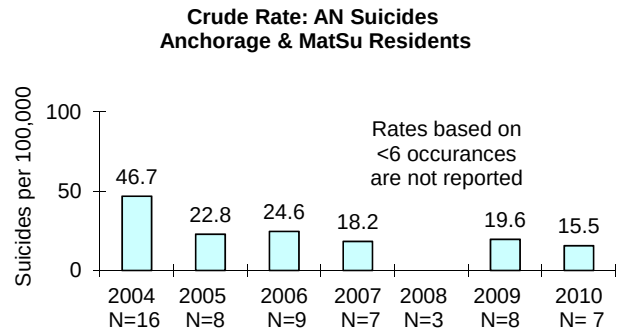


Figure 7.1-19: AN Suicide Rate Anchorage/Mat-Su

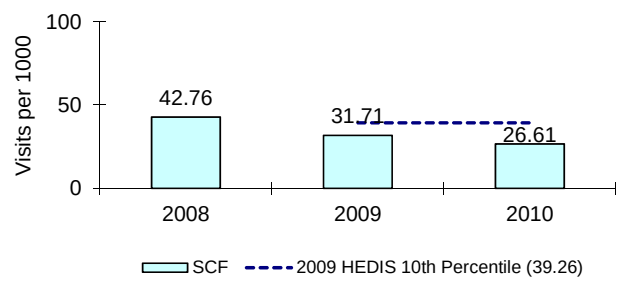
FMW3 | Monitoring Trend | ▼Better



Data Source: Alaska Bureau of Vital Statistics

Figure 7.1-20: ER Visits per 1000 Member Months

FMW2 | Exceeds 10th Percentile | ▼Better



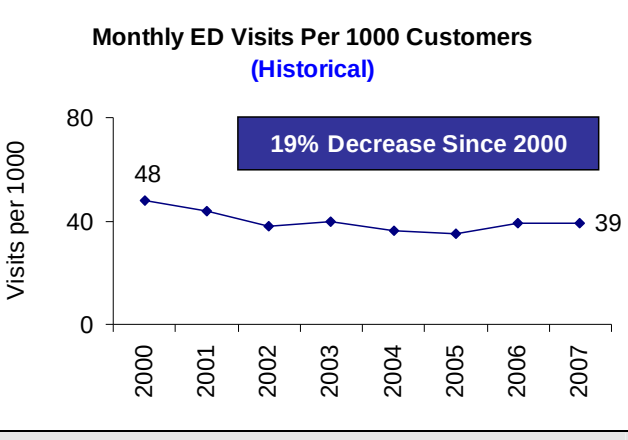
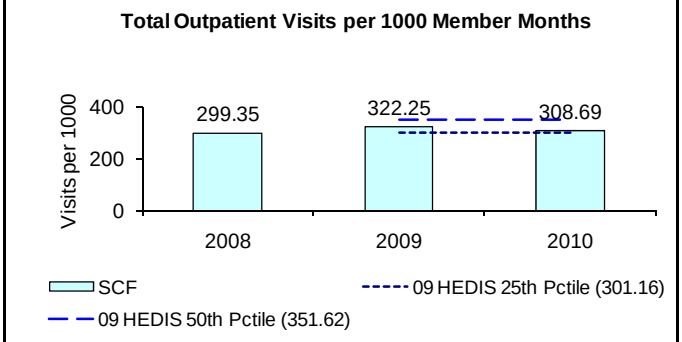
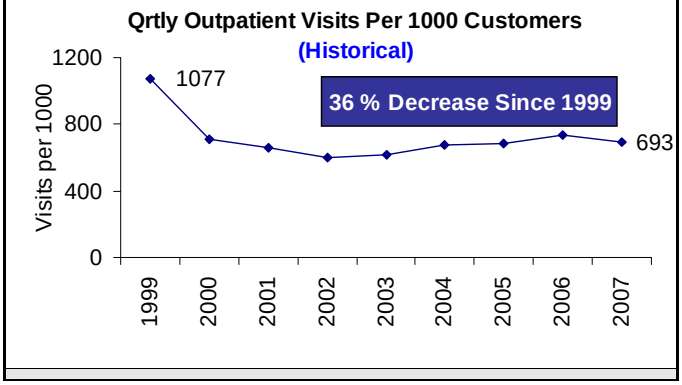


Figure 7.1-21: Outpatient Visits per 1000 Member Mos.

FMW2 | 25th-50th Percentile | ◄► Better

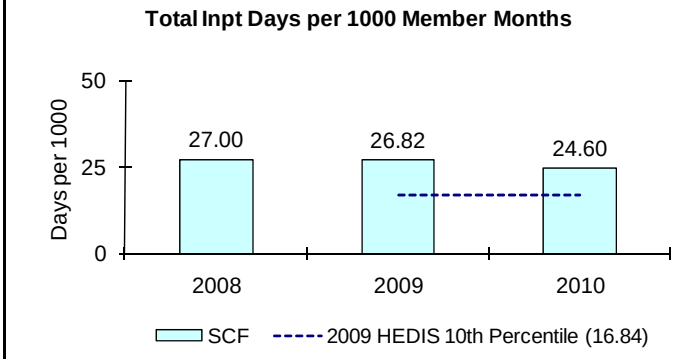




Use of service measures, such as those displayed in Figs. 7.1-20 through 7.1-23, provide outcome results that give SCF feedback on ambulatory service performance.

Figure 7.1-22: Inpatient Days per 1000 Member Months

FMW2 | 25th-50th Percentile | ▼Better



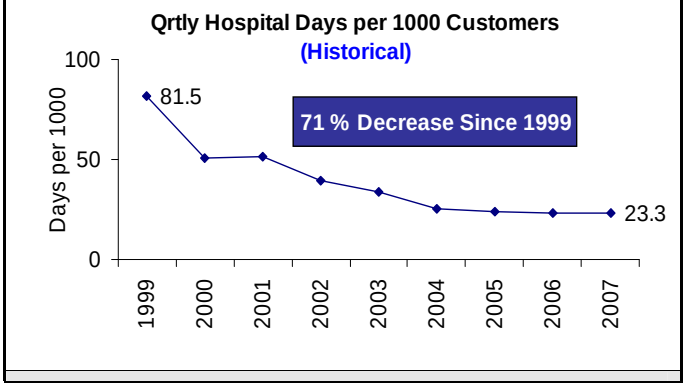
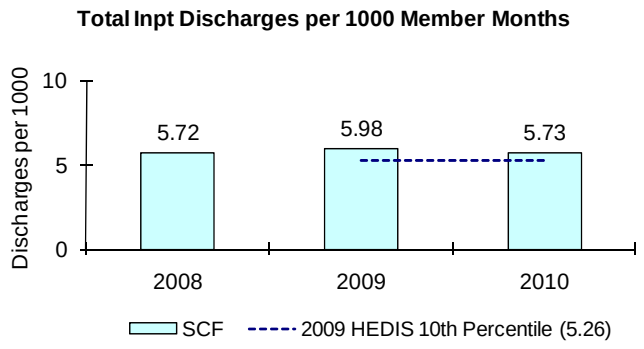
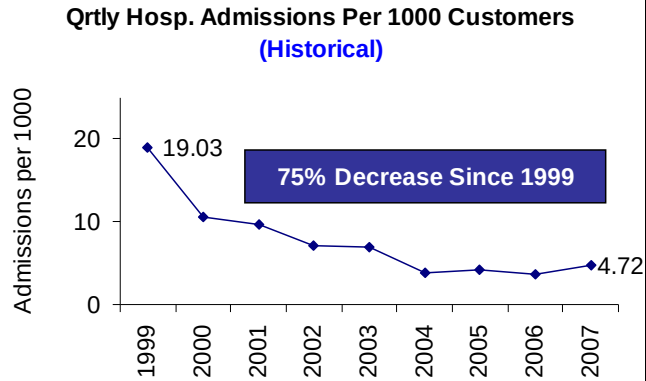


Figure 7.1-23: Inpt. Discharges per 1000 Mem. Months

FMW2 | 10th-25th Percentile | ▼Better

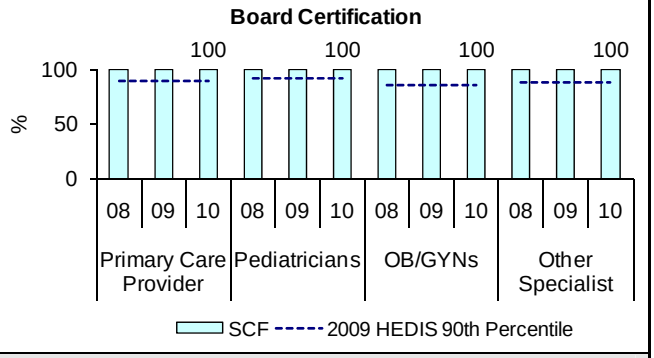




Although not a hospital, SCF monitors C-O visits to our partner ANMC [Fig. 7.1-20]. In the past, C-O who did not have established relationships with their provider, were more likely to use ED services in place of their primary care provider. SCF's approach (advanced access focus) has reduced ED visits and increased ICT visits. Fig. 7.1-21 evaluates outpatient care utilization. SCF encourages C-O to come in for preventive services that have the potential to prevent poor health care outcomes later in life. SCF is committed to ongoing care of C-O with our partner, ANMC, so we monitor and track inpatient data from our C-O's ANMC hospital utilization days [Fig. 7.1-22]. SCF recognizes it's better to be in the lower half (slightly lower is better), but not so low that C-O are discharged before they are ready.

Figure 7.1-24: Board Certification

FMW1 | Exceeds 90th Percentile | ▲Better



Board Certification from corresponding specialty organizations [Fig. 7.1-24] is tracked and segmented to demonstrate SCF's commitment to C-O to provide high quality service with credentialed providers.

7.1b Operational Process Effectiveness Results

SCF's RELATIONSHIP-focused system of care is based on establishing relationships with C-O by empanelling them to a named provider of their choice and then ensuring they have open access to that provider and their ICT. ICT members have access to timely data and information to proactively manage C-O panels effectively. The following results reflect SCF's commitment to measuring and monitoring progress in these areas. Benchmark, Trends, Segmentation and Integration are segmented out in this category to provide more detailed information for each concept.

Access to Care: Figures 7.1-25 through 7.1-29

Benchmarks: Merritt Hawkins & Associates, TRICARE's Military Health System (MHS), HEDIS, Expectation of Internal Customers and Industry Best.

Trends: Overall, trends continue to be improving and demonstrating sustainable results. SCF reviews data over time to understand trends and patterns. Additional years of data are available on-site.

Segmentation: For most measures, segmentation is available by division, clinic, or ICT. Detailed segmentation is available on-site. The ability of SCF to segment performance and track that performance over time contributes to SCF's success with access to care.

Integration: Access to care components are integrated into health care team schedules, operation times of clinics and support services, policies and procedures, appointment booking guidelines, staff education and training, performance measurements, individual and clinic work plans and performance evaluations. Segmentation down to the provider level lets managers know daily and weeks into the future how many appointments and minutes are available for each health care provider. This insight, combined with the strategy of doing all of today's work today and not creating an excess of backlogged appointments, allows SCF to meet the same-day access requirement of C-O. Outcomes are used to address process performance targets and to ensure processes exceed C-O needs. The FCS ensures integration and that actions are taken on process results.

Figs. 7.1-25 through 7.1-29 reflect SCF's commitment to the C-O expectation of open access to their health care system and the ability to seek an appointment the same day if they desire. Fig. 7.1-25 demonstrates SCF's ability to meet same-day access requests. The percent of appointments at 0800 for Primary Care became the new standard for access after consistently meeting the 3rd next available industry standard. This innovative measure pushes the limits on measuring what C-O really want. Comparing SCF to industry benchmarks in this instance doesn't correspond with what C-O want or expect. For example, Merritt Hawkins & Associates' 2009 Survey of Physician Appointment Wait Times (1162 medical offices surveyed) offers a snapshot of physician availability in 15 large metropolitan markets with some of the highest physician-to-population ratios in the country. Despite having

a high number of physicians per capita, many of these markets are experiencing appointment wait times of 14 days or longer. In Family Practice, average appointment wait times equaled or exceeded 14 days in eight of the 15 metropolitan markets. SCF provides same-day access for those who desire it. Other health care systems, such as TRICARE Military Health System (MHS), establish access to care standards and measure success based on "appointment type": 24 hours for Acute, 7 days for Routine, and 28 days for Wellness appointments. The average waiting time (Mar 2010) for an appointment within the Military Health System is: Acute < 1 day, Routine 6.03 days, Wellness 11.80 days, Specialty Care 11.82 days. A 2007 survey by the Medical Group Management Association (MGMA) found that 68.8% of 128 responding practices offer same-day access for "urgent" care. However, SCF has same-day access for all types of care and doesn't assign a "type" of appointment to restrict access. Use of appointment types allows health care providers to classify appointments based on what they feel is urgency to be seen, not necessarily what the C-O wants or desires. SCF doesn't categorize types of appointments, because C-O believes they should be seen the same day regardless of appointment type. SCF measures success based on SCF's ability to meet this expectation.

Fig. 7.1-26 demonstrates SCF's ability to meet access-to-care standards in specialty care clinics. Nationally, specialty care clinics typically have longer waiting periods than primary care because physician per capita numbers are not as high.

Figure 7.1-25: Primary Care Access to Care

CQ2 | Over 50% Available Daily | ▲Better

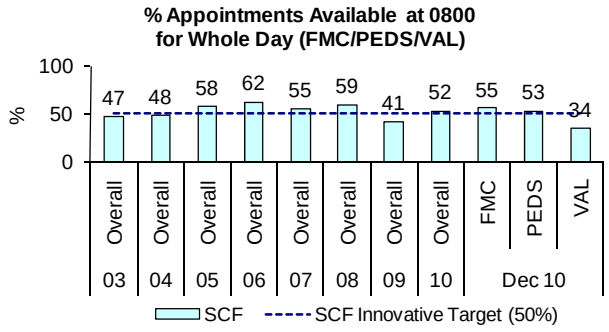


Figure 7.1-26: 3rd Next Available Appointment

CQ2 | Specialty Access < 1 day | ▼Better

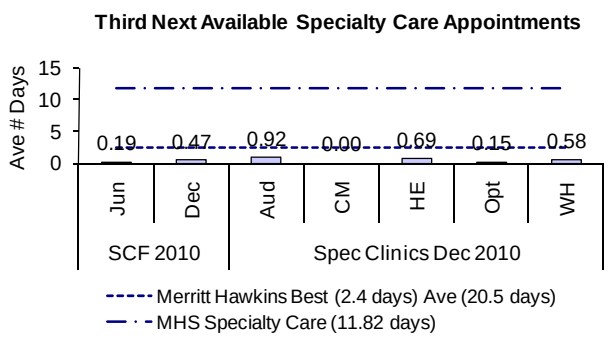


Figure 7.1-27: Fast Track: Left Without Being Seen

CQ2 | Exceeds Benchmark | ▼Better

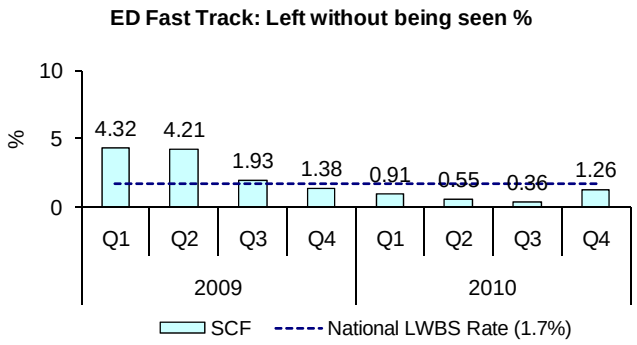


Figure 7.1-28: Call Answer Timeliness

CQ2 | 75th-90th Percentile | ▲Better

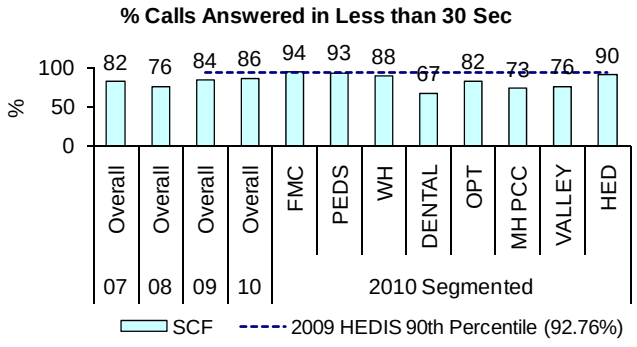
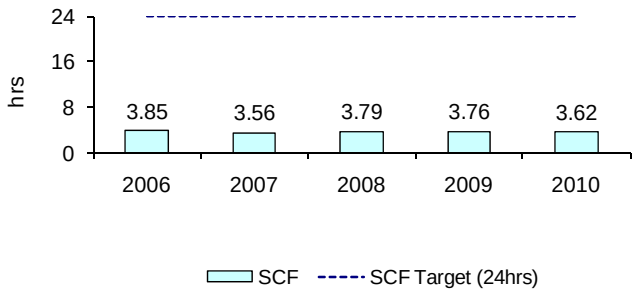
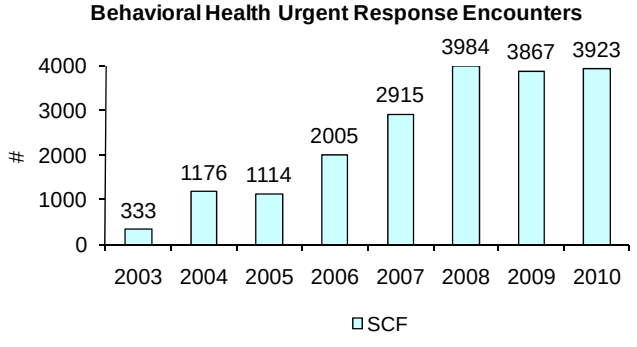


Figure 7.1-29: Behavioral Urgent Response Team

CQ2 | Fast Response Times with Increased Encounters | ▼Better ▲Better





Figs. 7.1-27 through 7.1-29 demonstrate other aspects of access to care. ED Fast Track [Fig. 7.1-27] "left without being seen" metrics allows SCF to keep a pulse on C-O wait times in an emergent care area. Call answer times [Fig. 7.1-28] allow SCF to monitor access through telephonics. The ability to meet C-O needs in a behavioral health crisis, after hours (24/7), is reflected in the BURT metric [Fig. 7.1-29]. This service was identified as a need in 2003. Capacity has since increased ten-fold to meet needs, and is now expanding to other geographical locations in the state. Despite large increases in encounters, BURT response times remain stable.

Continuity of Care: Figure 7.1-30

Benchmark: C-O expectation to see provider when health care needs arise and establish a relationship. Compare with Military Health System (empanels to a named provider).

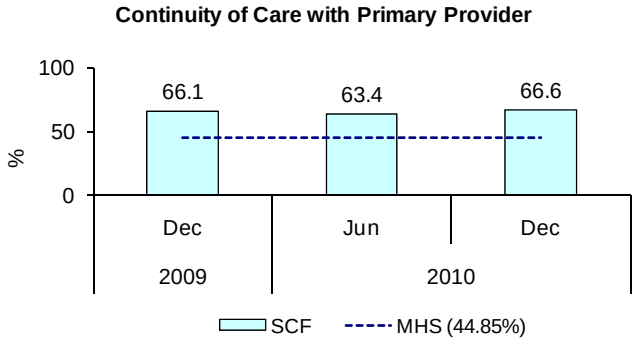
Trends: SCF reviews data over time to understand trends and patterns. Additional years of data are available on-site.

Segmentation: Organization-Clinic-Team-Provider. Detailed segmentation data is available on-site. SCF segments data to the individual PCP level allowing the PCP and subsequent ICT to take responsibility for C-O care.

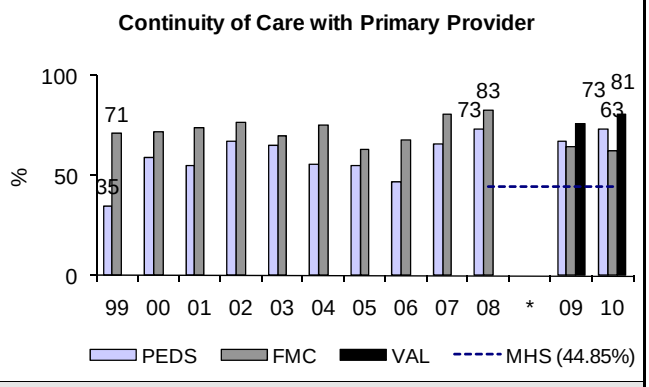
Integration: Empanelment to a named provider, policy and procedures, appointment booking guidelines, staff education and training, accountability and performance measurement based on providers empanelled population, provider "action lists" that facilitate proactive and preventive care, relationship and trust building with C-O.

Figure 7.1-30: Continuity of Care with Provider

CQ2 | Exceeds Benchmark | ▲Better



* Method Change in 2009 *(tighter definition – provider vacation or other unavailability is not excluded. New method is combination of availability and continuity. Metric will never be 100 %.)*



Shared responsibility with C-O, increased confidence in self care, and the ability to see your chosen PCP are important aspects in having RELATIONSHIP-based care. Even with a rapid increase in empanelled C-O over the years, SCF continues to improve and sustain high continuity of care with C-O seeing their chosen empanelled provider over two-thirds of the time for primary care visits.

Information Systems: Figures 7.1-31 through 7.1-32

Benchmark: Internal customer expectations and industry best. Population Health Turnaround is compared to TRICARE's Military Health System (MHS), because they empanel to a named provider and use similar action lists.

Trends: Population Health Information Turnaround Time [Fig. 7.1-32] has been trending in a positive direction.

Segmentation: Not required below Organizational Level. Reports generated from Data Mall provide information from organizational to provider level.

Integration: Main form of communication is through the computer network; the Data Mall is central repository for health information; data from Data Mall is used by all empanelled health care teams to manage and improve their population's health; training, education, and work processes are built around Data Mall and ability to get timely, accurate data; performance action plans from organization to individuals available through network; wireless capability across organization; information obtained is used to evaluate performance at all levels of the organization.

Figure 7.1-31: Computer Network Status

CQ2 | Approaching Industry Best | ▲Better

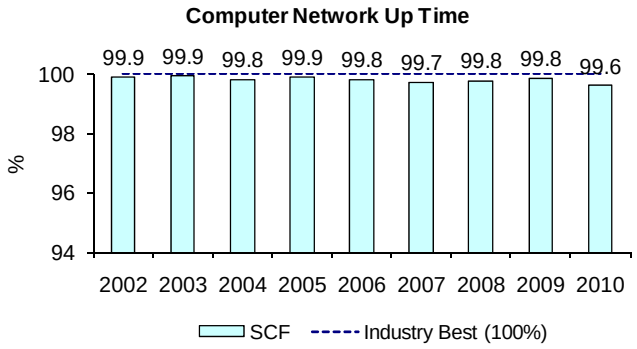
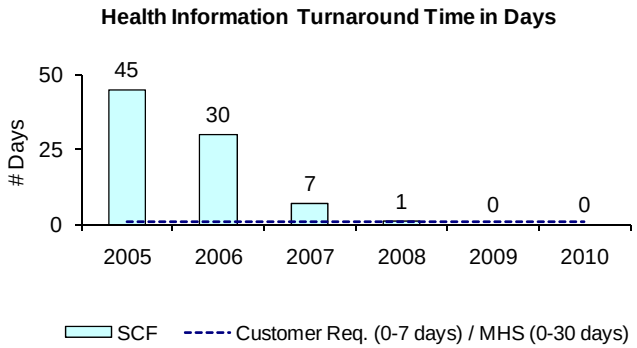


Figure 7.1-32: Population Health Info. Turnaround Time

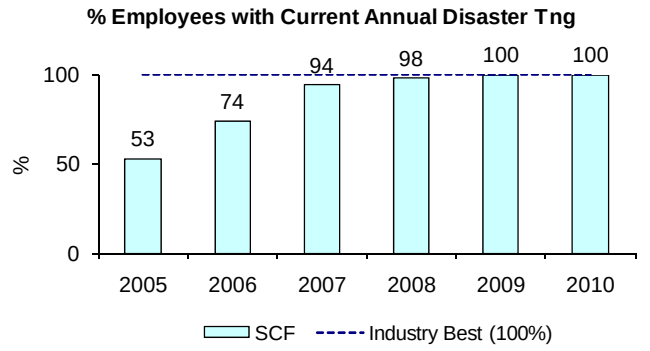
CQ2 | Exceeds Requirement | ▼Better



In 2007, SCF focused on an improvement effort to increase the number of employees completing emergency training [Fig. 7.1-33].

Figure 7.1-33: Employee Disaster/Emergency Training

CQ2	100% Trained	▲Better



7.1c Strategy Implementation Figures 7.1-34 to 7.1-36

Benchmarks: Governance Institute and SCF-defined goals

Trends: SCF reviews data over time to understand trends and patterns. Additional years of data are available on-site. Scorecard data and tracking is color coded: Blue=above target; Green=at target; Red=below target and an improvement plan is in place.

Segmentation: Additional segmentation and aggregate data are available on-site for most measures.

Integration: Action plans are developed to address results and opportunities are integrated into system-wide strategies (via the FCS).

SCF's key indicator of success towards achieving MVKP is found in the BSC. Fig. 7.1-34 lists a sample of 2010 BSC measures that support SCF's four perspectives [4.1a(1)].

Figure 7.1-34: Balance Scorecard Sample

FY10-Q1/Target	Below Min.	Meets	Exceeds

Measures by Perspective	Figure Ref.	Score
Customer-Owner		
Overall Rating of Care	7.2-1	91.0%
Culturally Respectful	7-2-3	94.0%
Financial & Workload		
Operating Margin %	7.5-1	
Third Party Rev. (Mil $)	7.5-4	
Operational Effectiveness		
Child Immunization %	7.1-12	80.1%
Breast Ca Screen %	7.1-11	57.5%
Cervical Ca Screen %	7.1-10	75.6%
Colorectal Ca Screen %	7.1-9	59.5%
Diabetes: LDL < 100 %	7.1-3	51.0%
Diabetes: Ann. HbA1C %	7.1-1	92.0%
Diabetes: Poor Ctrl % ▼	7.1-2	20.2%
CVD: LDL < 100 %	7.1-7	48.4%
Access: 3rd Next Avail ▼	7.1-26	<1 day
Continuity of Care %	7.1-30	66%
ER Visits per 1000 ▼	7.1-20	48.78
Wellness Care Plan BHC Visit %	7.1-14	77.6%
Workforce Development		
AN/AI Workforce %	7.3-15	55%
Workforce Commitment (0-5)	7.3-1	4.07
AN/AI Turnover % ▼	7.3-13	20.8%

SCF began using the BNQP Criteria for assessment in 2003 but there was little follow-up of identified OFIs after this first assessment. To encourage follow-up, in 2004 SCF began tracking OFI completion from BNQP (and, later, APEX) feedback reports. After reviewing the reports, determinations are made if the OFI relates to application writing or an organizational process or results gap. Gaps are assigned to the appropriate functional committee(s) for follow-up and action. This approach has resulted in steady improvement each year in the SCF OFI Completion Rates [Fig. 7.1-35]. In 2008, SCF shifted focus to support and participate in the APEX state program in their pilot year (no awards or feedback given) and again in 2009, for their first full award cycle, where SCF scored in Band 6 and was selected as an APEX recipient.

Figure 7.1-35: Baldrige/APEX OFI Completion Rate

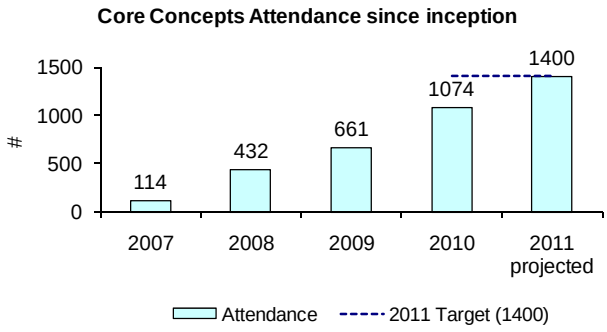
CQ2	100% Complete	▲Better

Score	Below Target < 50%		Minimal Accepted 50-74%		Target or Bett 75-100%	
Category	**04**	**05**	**06**	**07**	**08**	**09- 10**
1	75%	100%	80%	100%	No Application	100%
2	67%	84%	93%	100%		100%
3	34%	67%	100%	100%		100%
4	50%	75%	83%	50%		100%
5	75%	100%	100%	100%		100%
6	0%	100%	81%	100%		100%
7	N/A	N/A	N/A	95%		100%

SCF Leadership is committed to deploying the MVKP/OP to the workforce and set a target of all employees attending the three-day Core Concepts training by 2012.

Figure 7.1-36: Core Concepts Participation

CQ2	Sustained Focus	▲Better



7.2 Customer Focused Outcomes

Benchmarks: Avatar, CAHPS; **2009 US News and World Report Healthcare Rankings (Mayo Clinic, Cleveland Clinic, John Hopkins); Similar Alaska Tribal Org; and NRC Picker.

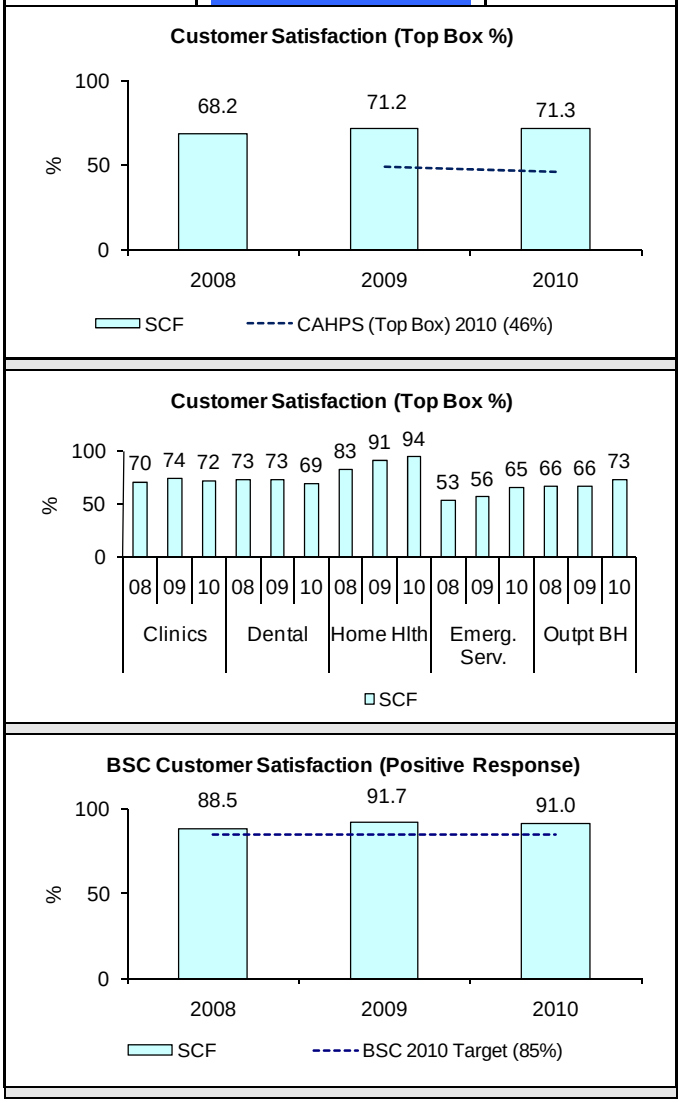
Trends: Historical clinical data is available on-site going back to 2002 for most measures displayed. Overall, trends continue to be improving and demonstrating sustainable results. Method change in 2008, with new vendor, provides ability to evaluate Top Box. Top Box refers to the top box score of SCF's five-point Likert Scale (Strongly Agree).

Segmentation: Segmentation is available down to individual questions at each point of service making C-O service data actionable.

Integration: Outcomes are integrated into planning, training for workforce development, BSC, BOD and reporting, and all processes that impact the C-O experience. Front-line managers access and review the data to identify OFIs. C-O survey results are shared with C-O through multiple media sources. Performance results are integrated into clinic/team work plans and are used in annual employee performance evaluations, which are tied to performance bonuses. C-O satisfaction results are used in planning for future facility expansion efforts and used to determine if current capacity meets demands. Recent expansions to parking and clinic space, and the addition of the SCF Health and Wellness Center, have been made based on C-O feedback. In addition to paper-based and electronic surveys, SCF uses multiple listening posts to gather feedback from C-O.

Figure 7.2-1: Customer Satisfaction (Top Box)

SR2 | Exceeds Benchmark | ▲Better



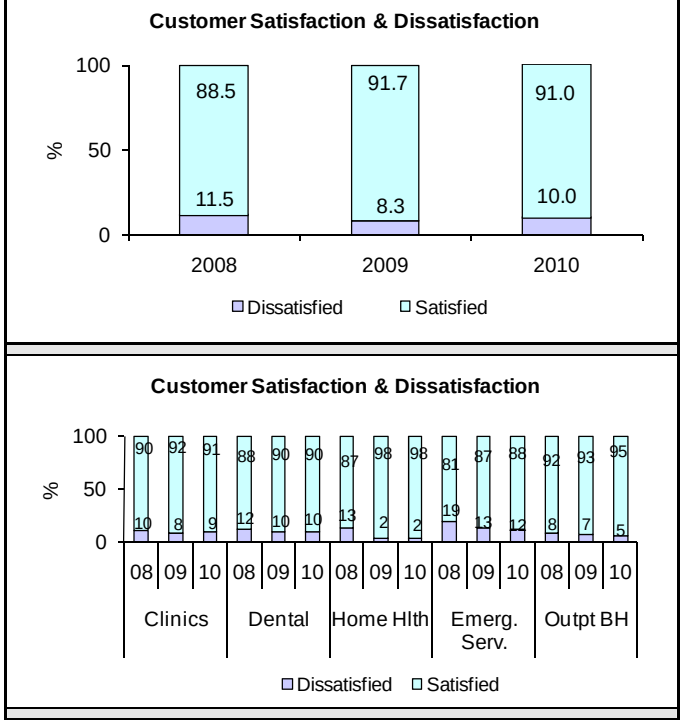
In 2008, SCF deployed a new customer survey vendor, Avatar International LLC with advanced capabilities to provide SCF with a viable approach to meet common and unique information needs. The decision to change was based on (1) continuous improvements to data collection efforts; (2) new strategies to improve response rates; (3) the ability to customize survey questions; and, (4) distribution techniques, acquiescent to SCF's unique C-O population and culture. Surveys utilize a specific set of eleven core questions, with additional questions tailored to location, program, or clinic. Questions are organized into key "factor" categories of Appointment, Education, Environment, General Care, Key Results, Leaving, Office Staff, Patient Safety, Problem Resolution, Provider Care and Test & Procedures.

Results from the survey question, "Overall, the services I received at SCF met my needs," are reported on the BSC. Top Box scores [Fig. 7.2-1] outperform leading health care industry leaders and results reveal consistency in achieving and exceeding expectations, essential to building positive, strong and lasting relationships in alignment with OP.

Data in Fig. 7.2-2 reflects the ratio of C-O responses, where "satisfied" is an aggregate of neutral, agree, and strongly agree; "dissatisfied" is the aggregate of disagree and strongly disagree. Dissatisfaction results reflect OFIs in (1) problem resolution skills; (2) good communications in regard to the manner in which tests and procedures are explained; and, (3) understanding care requirements after leaving the appointment. These analyses are incorporated in the SID.

Figure 7.2-2: Customer Dissatisfaction

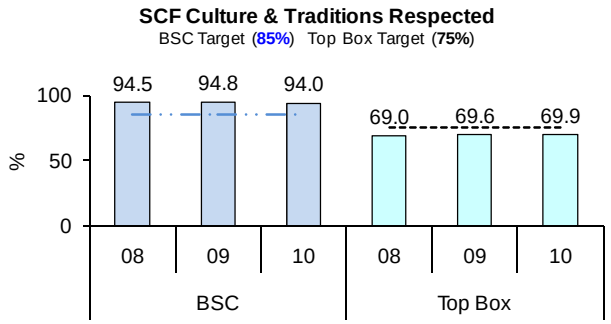
SR2 | Stable | ▼Better



SCF uses a "customized" non-benchmark survey question to track performance in cultural sensitivity and respect for AN/AI concerns, values, and traditions [Fig. 7.2-3]. The results are reported on SCF's corporate BSC. SCF has received positive responses and is now working on improving Top Box Scores. SCF set the Top Box target at 75% to drive even more improvement in this innovated measure that is unique to C-O and their culture. OFI related to courtesy were identified when C-O feedback results were segmented in 2007.

Figure 7.2-3: Culture & Traditions Respected

SR1 | Exceeds BSC Target | ▲Better



Historical (Different Method)	04	05	06	07
Mean Score	na	66	69	69

Similar Alaska Tribal Organization: 2010 (Top Box) = 56.0%

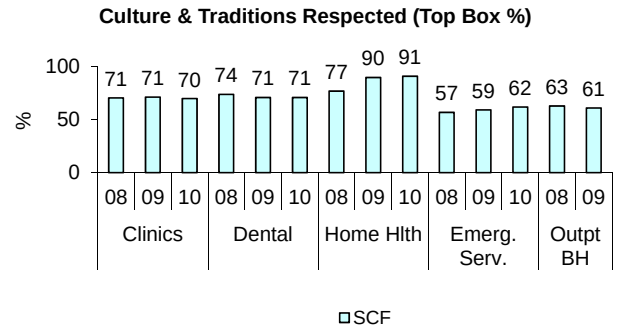
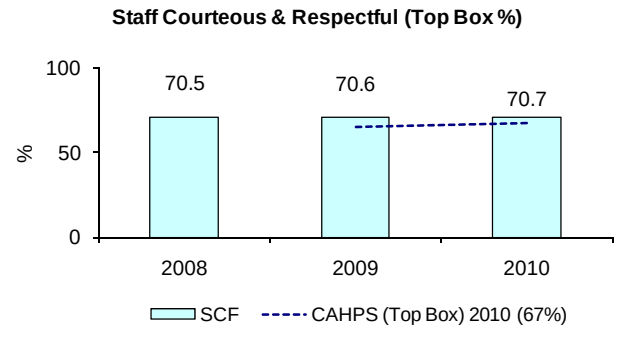
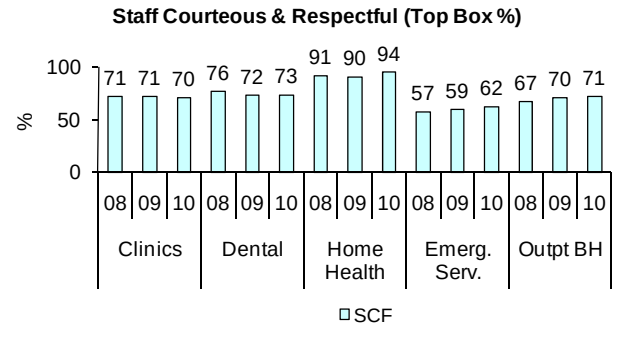


Figure 7.2-4: Staff Courteous & Respectful

SR1 | Exceeds Benchmark | ▲Better

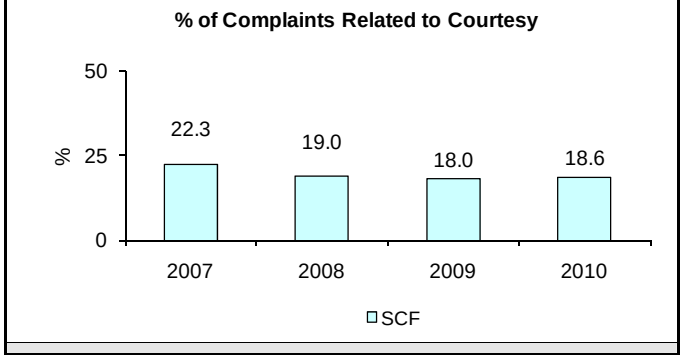




SCF responded to C-O desires for improved C-O service by developing defined behavioral expectations for all employees [3.1b(2), Fig. 7.2-4]. The identified OFI was incorporated into 2008 annual work plans with improved results through 2010 [Fig. 7.2-5].

Figure 7.2-5: % Complaints Related to Courtesy

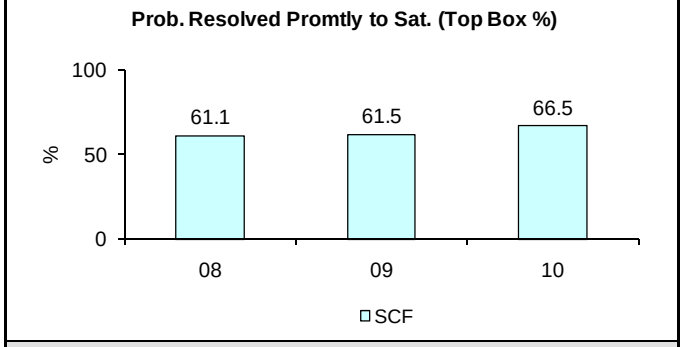
SR1 | Improved Results since 2007 | ▼Better

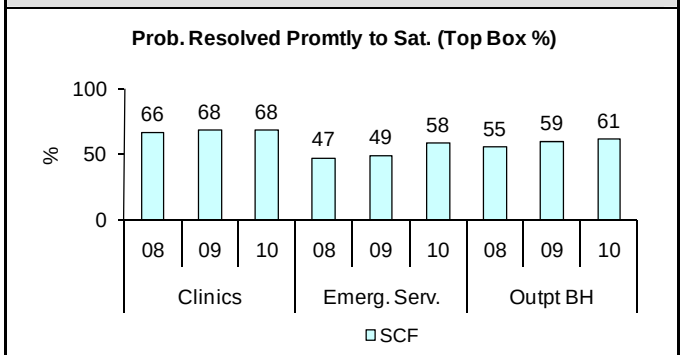


To address C-O dissatisfaction [Fig.7.2-2], SCF began improvement efforts in 2008, including tracking "problem resolved promptly" [Fig. 7.2-6].

Figure 7.2-6: Problem Resolved Promptly to Sat.

SR2 | Improving Trend | ▲Better

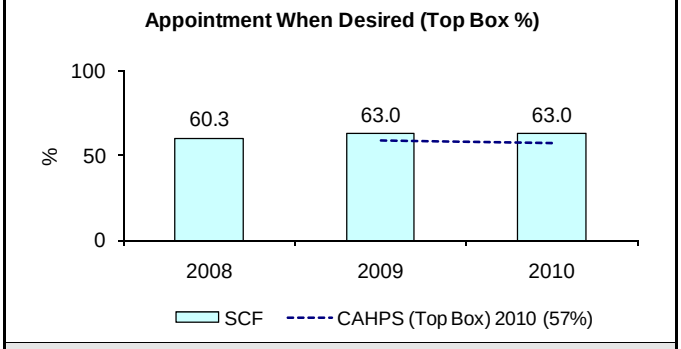




The CAHPS Top Box benchmark for "Appointment When Desired" is based on an appointment type and if a C-O "needs" an appointment. Need is typically defined by the health care system providing care and different appointment types typically have different access standards. SCF Scores [Fig. 7.2-7] are reflective of all appointment types and ask if an appointment was available when the C-O "desired," not when the health care system determined it was needed. SCF's *higher* standard scores for appointment satisfaction are innovative and are outperforming the "need" national benchmark. Appointments Available at 0800 [Fig. 7.1-25] is the innovative higher benchmark SCF uses to ensure, on a daily basis, we meet C-O desires for an appointment.

Figure 7.2-7: Appointment When Desired

SR2 | Exceeds Benchmark | ▲Better



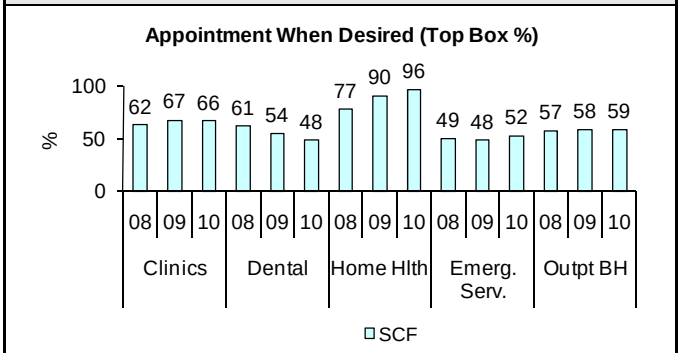
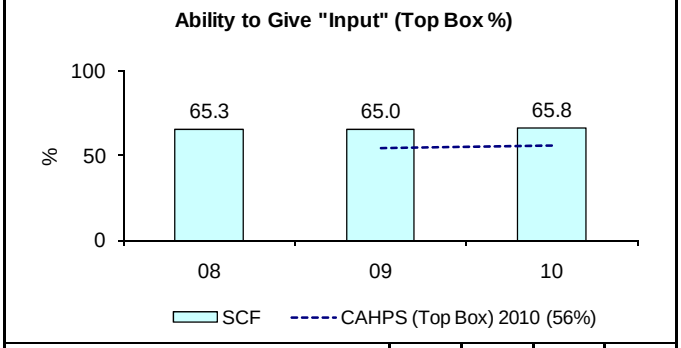


Figure 7.2-8: Ability to Give Input in Decisions

SR2 | Exceeds Benchmark | ▲Better



Historical (Different Method)	04	05	06	07
Mean Score	na	71	73	73

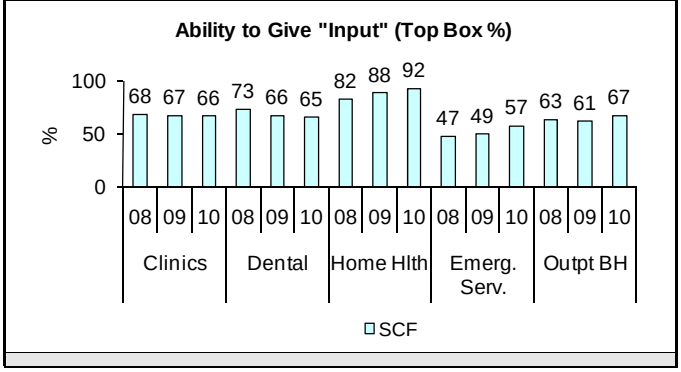
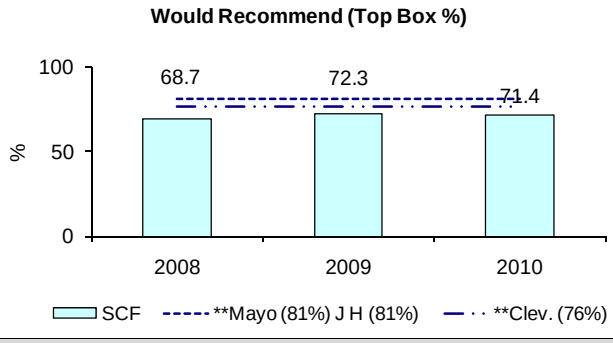


Fig. 7.2-8, demonstrates SCF's shared responsibility with C-O. C-O are not just asked, but also encouraged to participate in making decisions related to their health care and journey to wellness. C-O recommendations of SCF services reflect a perception of loyalty and value. CAHPS comparisons are not available for this item, so SCF chose to benchmark against nationally recognized leaders in health care. In 2009, the "U.S. News and World Report Health Care Rankings" recognized the Mayo Clinic, Cleveland Clinic and John Hopkins in the top 0.5% of all health care facilities in the U.S. SCF's overall performance for "would recommend" is slightly below these world-class performers and stable. Segmented data shows SCF performing at very high levels in all areas except Emergency Services. Emergency Services has taken aggressive improvement actions in leadership, succession planning, employee development and retention to improve on the "would recommend" score. An increase of 8% in the ER Top Box Score and results demonstrated in the Emergency Services "Left Without Being Seen" Scores [Fig. 7.1-27] reflect positively on improvement efforts.

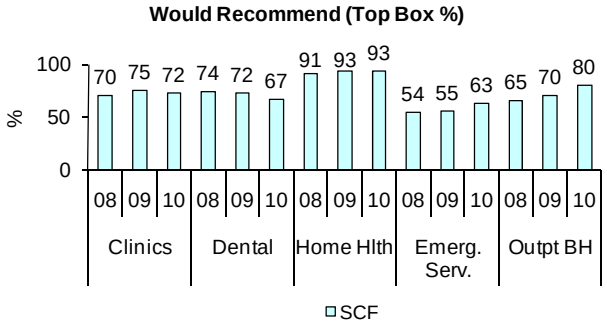
Figure 7.2-9: Would Recommend Services

SR2 | Near Benchmark | ▲Better



**2009 U.S. News & World Report Healthcare Rankings

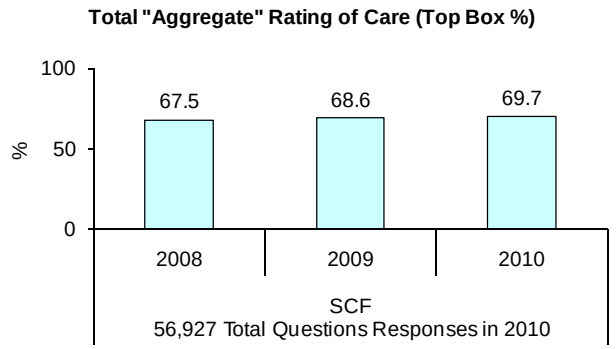
Historical (Different Method)	04	05	06	07
Mean Scores	na	64	66	66



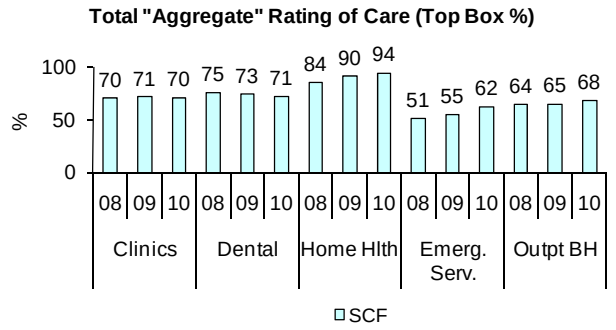
External benchmarks are not available for Fig. 7.2-10, because each health care organization has its own unique set of questions. Therefore, SCF looks to improve on its score over time. C-O "Strongly Agreed" (Top Box) with 69.7% of the customer service questions asked of them in 2010, a Top Box increase from the previous two years. Avatar data allows for segmentation down to the clinic level for each question to identify best practices in C-O satisfaction.

Figure 7.2-10: Aggregate Rating of Care

SR2	Improving Trend	▲Better



Historical (Different Method)	04	05	06	07
Percent	90	88	91	92



7.3 Workforce Focus Outcomes

Benchmarks: Morehead, Saratoga, IHS; Local Competitor

Trends: Historical data is available for most measures displayed. Overall, trends demonstrate sustainable results.

Segmentation: All EOS data can be segmented (available on site) by organization, division, job categories and workforce demographics.

Integration: Action plans are integrated to ensure the whole organization capitalizes on opportunities to engage work-force in integrated care practices and improvement projects.

SCF contracts with Morehead Associates to conduct the annual EOS [5.1a(1)]. The Commitment Indicator score [Fig. 7.3-1] consists of six questions from the EOS as the measure for workforce engagement and satisfaction [Fig. 7.3-3]. The results are segmented, by division [Fig. 7.3-2] and job category [Fig. 7.3-4]. At the department level, managers meet with the workforce to identify OFIs and create action plans to implement into the annual plan. The HRC reviews organizational trends and creates organizational action plans for improvement. These are integrated into the HRC annual plan to improve overall engagement and satisfaction. Fig. 7.3-5 demonstrates SCF's commitment to employee development. The DC determines courses offered through the annual L&D Needs Assessment and ongoing workforce feedback. The DC continues to commit to L&D through increasing DC workforce [Fig. 7.3-7] and shifting from contract trainers to internal trainers for development and delivery of DC courses. SCF and HR collaborated to develop career promotions and progression paths [Fig. 7.3-9]. The workforce understanding of SCF's mission is an indicator of workforce capability. Annually, goals and objectives from the annual plan are implemented into individual PDP. By analyzing EOS data, managers evaluate workforce understanding of SCF's MVKP/OP [Figs. 7.3-10, 7.3-11].

Figure 7.3-1: Workforce Commitment Indicator

CQ1	Improving Trend	▲Better

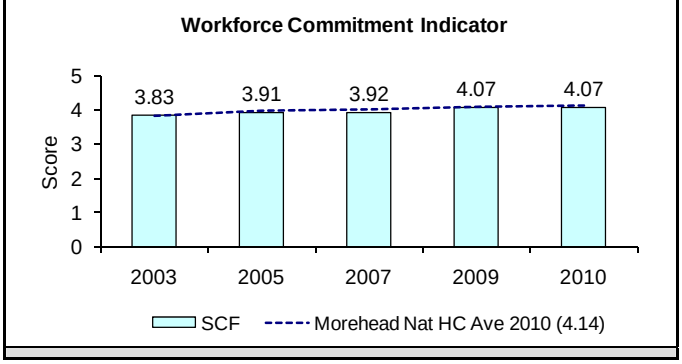


Figure 7.3-2: Commitment Indicator by Division

CQ1	Improving Trend	▲Better

YR	BSD	ETS	FIN	MSD	OTP	ODI	R&D
07	3.72	3.92	3.90	3.88	4.47	4.04	4.06
09	3.96	3.88	4.18	4.04	4.42	4.09	4.26
10	4.03	3.97	4.21	3.98	4.05	4.22	4.37

Figure 7.3-3: Commitment Indicator Questions

CQ1	Overall Sat Improving	▲Better

Item	07	09	10	10 HC Ave
I would recommend this organization as a good place to work	3.82	4.14	4.11	4.16
I am proud to tell people I work for this organization	4.19	4.33	4.26	4.34
I would recommend this organization to family and friends	4.09	4.19	4.14	4.31
I would like to be working at this organization in 3 yrs	4.05	4.24	4.25	4.24
I would stay with this org. if offered similar job/pay elsewhere	3.39	3.58	3.66	3.71
Overall, I'm a satisfied employee	3.82	3.97	3.99	4.06

Figure 7.3-4: Commitment Indicator by Job Cat.

CQ1	Low Variation	▲Better

Job Category	Score		
	07	09	10
Leadership	4.27	4.07	4.11
Clinical Managerial	3.88	4.20	4.24
Healthcare Provider	3.93	4.05	4.14
Healthcare Professional	3.76	4.11	4.00
Healthcare Technician	3.83	4.11	4.07
Non-Clinical Managerial	3.98	3.96	3.91
Non-Healthcare Professional	3.80	3.99	4.17
Non-Exempt\Non-Health\Non-Clerical	4.07	4.26	4.20
Clerical	3.98	4.03	4.04
Other	3.94	4.22	4.08

* In 2007 job categories were redefined

Figure 7.3-5: Number Courses Offered at the DC

CQ1 | Outperform Competitor | ▲Better

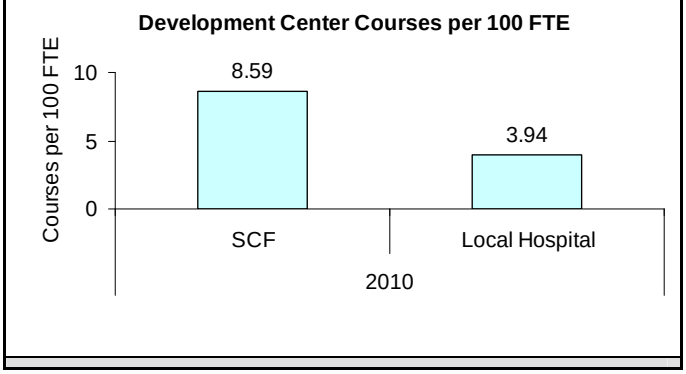


Figure 7.3-6: "I get training to do a good job"

CQ2 | Improving Trend | ▲Better

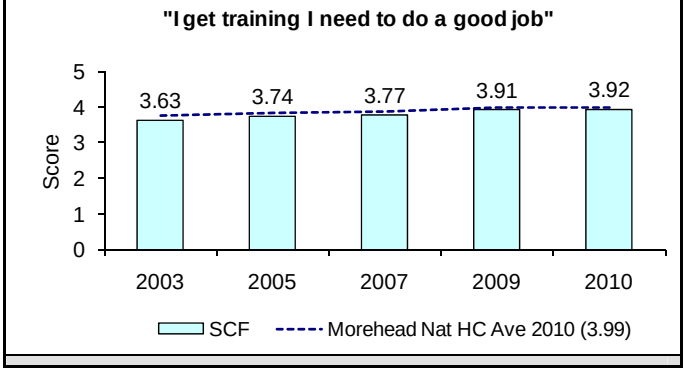


Figure 7.3-7: Employees per Learning & Dev. FTE

CQ1 | Exceeds Benchmark | ▼Better

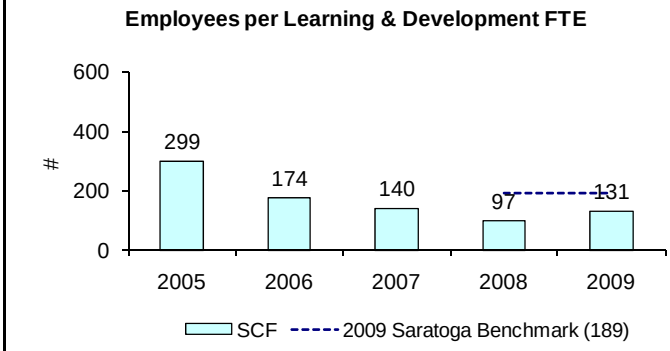


Figure 7.3-9: % AN/AI Workforce Promoted

CQ1 | Above Target | ▲Better

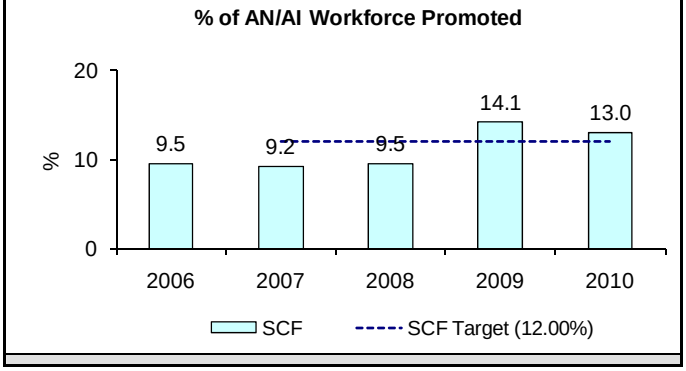


Figure 7.3-10: Understanding Mission & Values

CQ2 | At Target | ▲Better

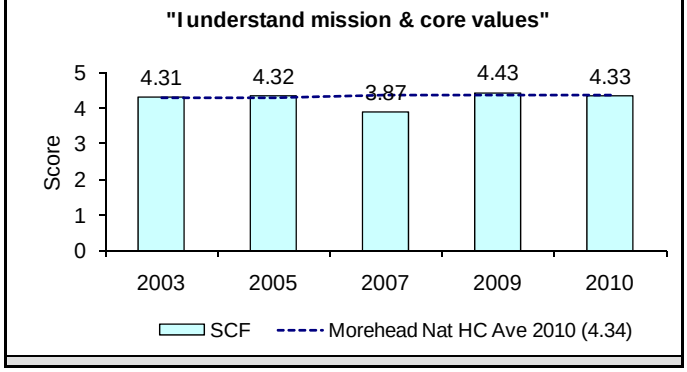


Figure 7.3-11: Understand Job & Mission

CQ2 | Near Target | ▲Better

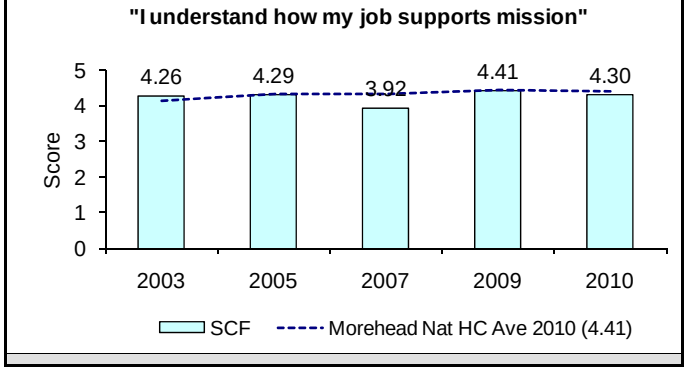


Figure 7.3-12: 90 Day Turnover Rate

Q2 | Near Benchmark | ▼Better

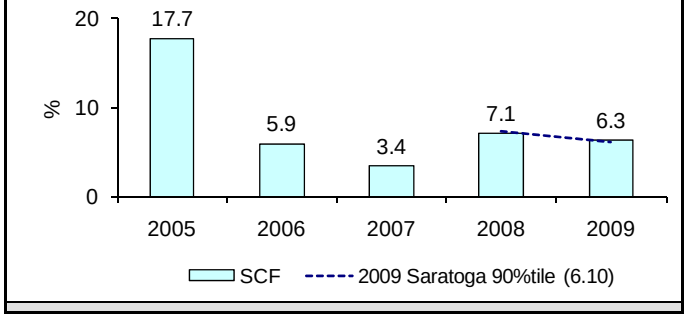


Figure 7.3-13: Total and AN/AI Turnover

CQ1 | Improving Trend | ▼Better

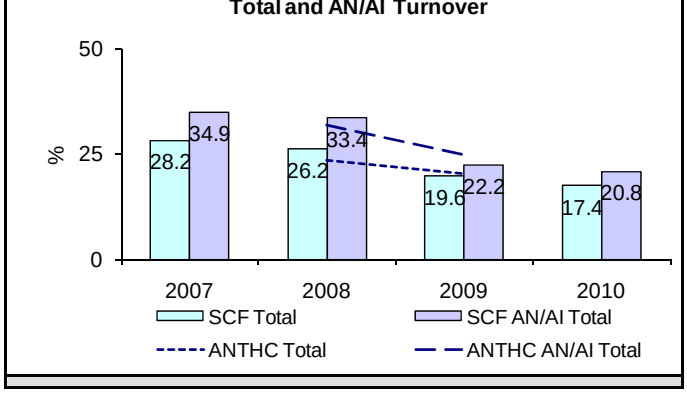
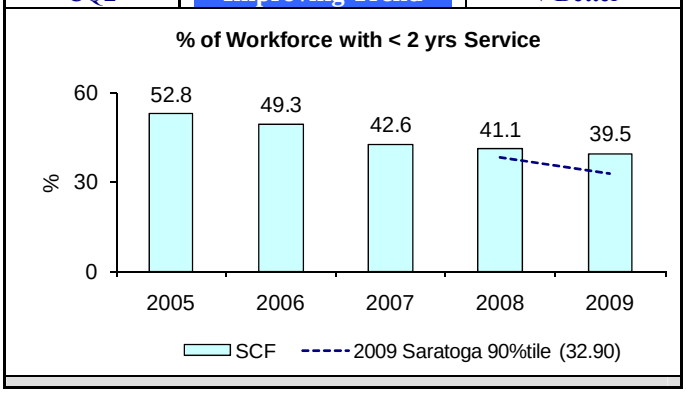


Figure 7.3-14: % Workforce < 2yrs Service

CQ2 | Improving Trend | ▼Better



SCF recognizes turnover as an indicator of meeting capability and capacity needs [Fig. 7.3-12] and measures overall and AN/AI turnover [Fig. 7.3-13, 7.3-14]. In recruitment and selection, SCF is committed to ensuring the "right fit" in every position through a multi-pronged approach including behavioral-based interviewing, increased training opportunities, and structured group interviewing.

Figure 7.3-15: % AN/AI Workforce

CQ3 | Above Target | ▲Better

Divisional Segmentation for 2009

YR	BSD	ETS	FIN	MSD	OTP	*ODI	R&D
09	35%	95%	84%	50%	82%	72%	67%
10	36%	95%	79%	48%	82%	65%	68%

*ODI began Q2/09 prior to that it was OPS

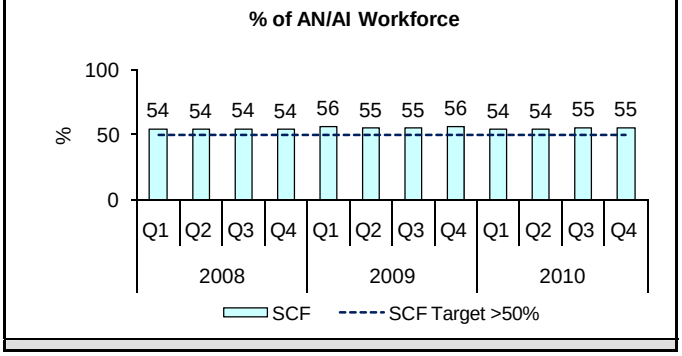
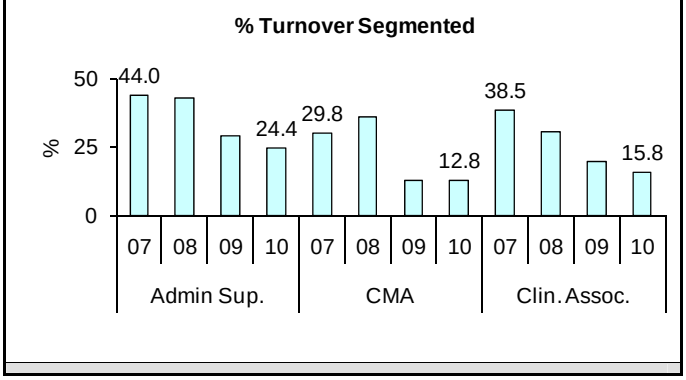


Figure 7.3-16: % Turnover

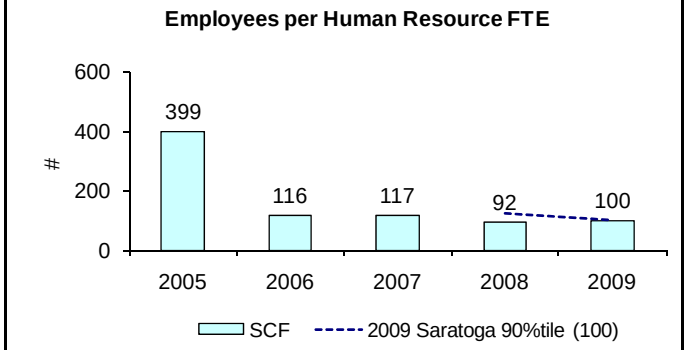
CQ2 | Improving Trend | ▼Better



To address the 90-day turnover rate increase in 2008, HRC implemented a retention workgroup to address issues with turnover and improve overall retention. SCF measures the percentage of AN/AI workforce [Fig. 7.3-15] by division, job category, and overall. SCF has determined turnover for AN/AI employees is high due to a concentration in entry-level positions with expected higher turnover for these job categories. To address this expectation, SCF has developed and delivered training programs for high turnover positions such as Administrative Support, CMA, and Clinical Associate [Fig. 7.3-16].

Figure 7.3-17: Employees per Human Resources

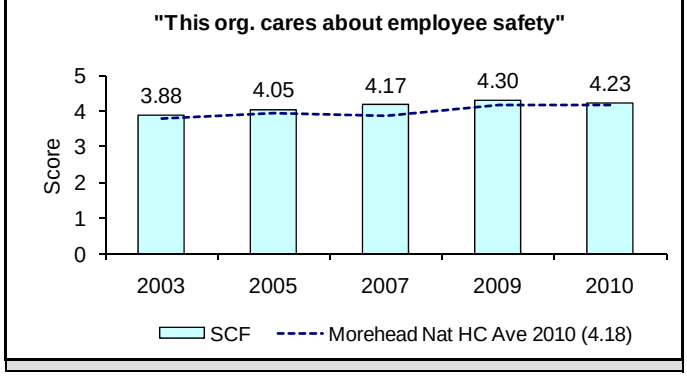
CQ2 | At Target | ▼Better



HR is committed to supporting the workforce and preparing for future growth [Fig. 7.3-17]. As a result, the HR department meets the 90th percentile for hospitals in employees per HR FTE.

Figure 7.3-18: Org. Cares About Employee Safety

CQ2 | Exceeds Benchmark | ▲Better



In 2008, the QA department employed a safety coordinator position and in 2009, added seven security officer positions to improve workforce safety and security. SCF's commitment to safety is measured by the EOS survey [Fig. 7.3-18].

SCF monitors safety and security of the work environment by tracking OSHA Recordable Cases [Fig. 7.3-19], needle sticks/sharps incidents, slips, trips, and falls [Fig. 7.3-20]. Each incident is systematically reported and reviewed at each Safety Committee meeting. The committee determines if changes in processes can be made to minimize risk. In 2010, there were a total of 45 OSHA-recordable cases yielding a rate of 2.9 cases per 100 FTEs (1550 employees). The decrease in the number of recordable injuries can be explained by increased efforts to reduce exposures to bloodborne pathogens and a more active attempt to reduce slips and falls. The addition of heated sidewalks and covered parking has also improved walking conditions in the winter time.

Given the trend of increasing benefits costs, SCF has also realized a significant increase. Although a portion of this increase is passed to the workforce, the overall satisfaction of benefits [Fig.7.3-21] has continued to trend upwards.

Figure 7.3-19: OSHA Recordable Cases

CQ2 | Exceeds Target | ▼Better

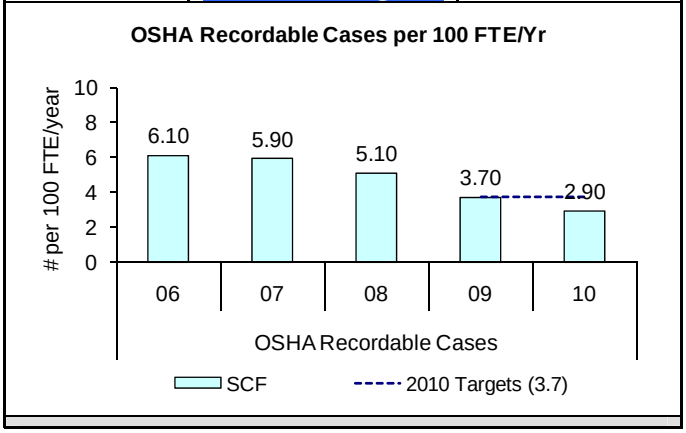


Figure 7.3-20: Sharp Exposures & Slips/Trips/Falls

CQ2 | Exceeds Target | ▼Better

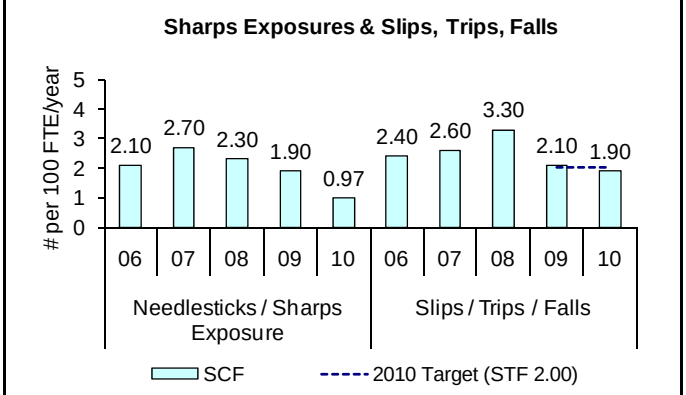


Figure 7.3-21: Benefit Satisfaction & Org Support

CQ1 | Exceeds Benchmark | ▲Better

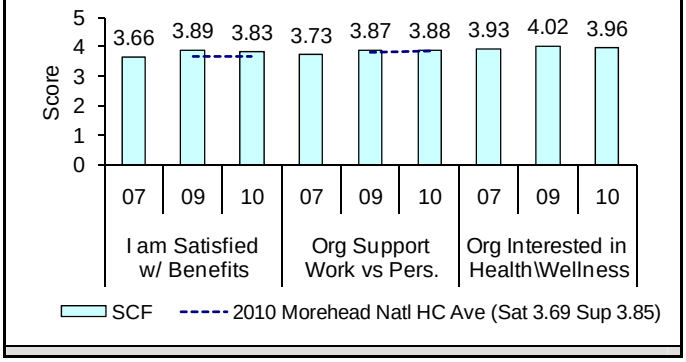
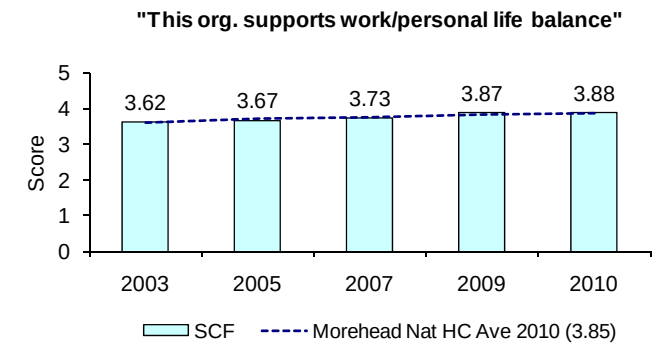


Fig. 7.3-22 shows SCF commitment to supporting work and personal life balance. During the time period displayed on the graph, SCF has added a child care development center for employees and their families and expanded the on-site employee health and wellness center.

Figure 7.3-22: Personal Life Balance

CQ1 | Exceeds Benchmark | ▲Better



7.4 Leadership and Governance Outcomes

Benchmarks: Governance Institute and SCF defined goals

Trends: SCF reviews data over time to understand trends and patterns. Additional years of data are available on-site. Scorecard data and tracking is color coded: Green =above target; Yellow=at or near target; Red=below target and an improvement plan is in place.

Segmentation: Additional segmentation and aggregate data is available on site for most measures.

Integration: Action plans are developed to address results and opportunities are integrated into system-wide strategies (via the FCS).

Figure 7.4-1: Ethical Behavior and Trust Results

CQ2 | Upward Trend | ▲Better

Pulse Survey Quest.	07	09	10	Bench
Ethics (Perf)	3.87	4.04	4.03	4.15
Ethics (%)	72%	78%	78%	N/A
Trust (Perf)	3.28	3.45	3.55	3.56
Trust (%)	47%	53%	60%	N/A

Perf = Mean Performance on 5 pt scale; % Fav = Percentage responding 4 or 5; Bench = 2010 National Healthcare Average

Fig. 7.4-1 represents performance measures that reflect how SCF promotes ethical behavior and stakeholder trust from a workforce perspective. Results from the EOS indicate overall improvement from 2007 to 2010 regarding employee perception that SCF conducts business in an ethical manner, and also reveal a corresponding rise in the perception that SCF has established a "climate of trust." Steady improvements from 2007 thru 2010 bring SCF results in line with the national benchmark. This suggests SCF's expanded Compliance and Ethics training is having a positive effect.

Figure 7.4-2: New Hire Compliance & Ethics Trng 2010

CQ2 | Exceeds Target | ▲Better

Area	% Completed		
	<90	90-94	>=95
Fraud & Abuse			100%
Privacy & Security			100%
Attestation			100%

Fig. 7.4-2 offers indicators of compliance training on the principles and practices required for ethical and legal behavior affecting our compliance outcomes. The content of New Hire

Compliance and Ethics Training is revised or updated annually to stay current with developments in health care compliance and ethics. In 2006, SCF implemented annual reorientation for the entire workforce that contains a Compliance course.

Figure 7.4-3: Fiscal Accountability Results

CQ2	Exceeds Target
Measure	2009 & 2010 Results
Independent external audit	No Findings
Grant Compliance	No Findings

SCF tracks fiscal accountability results in several ways [Fig. 7.4-3] and includes financial measures such as operating margin and overhead [Figs. 7.5-1, 7.5-2] in the BSC.

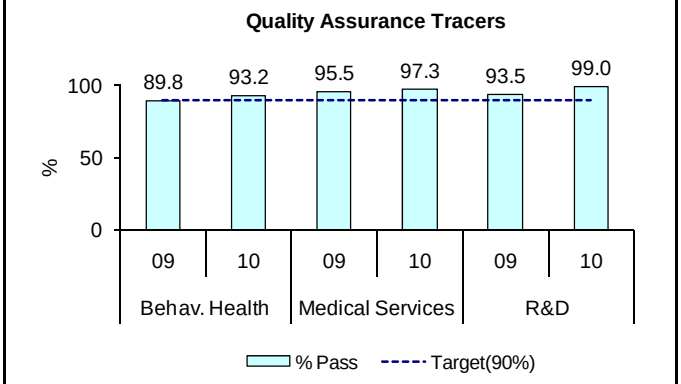
Figure 7.4-4: Accreditation/Compliance Results

CQ2	Full Accreditation
Measure	2009 & 2010 Results
JC	Fully Accredited
CARF	Fully Accredited
CAP	Fully Accredited
Staff Licensure	100 %
Home-Based Service	Fully Accredited

SCF is subject to, and compliant with, regulations and rules of multiple accrediting and regulatory agencies [Fig. 7.4-4].

Figure 7.4-5: Quality Assurance Tracers

CQ2 | Exceeds Target | ▲Better



QA Dept conducts QA Tracers, an internal audit process, to ensure compliance with accreditation agencies [Fig. 7.4-5].

In addition to the Regulatory/Legal Compliance results shown in Fig. 7.4-6, SCF ensures that 100% of employees are screened for criminal background in the systematic new hire process. In response to a 2007 BNQP OFI, the SCF BOD began conducting an assessment every other year. Results from the 2009 Board Assessment are shown in [Fig. 7.4-7].

Figure 7.4-6: Regulatory/Legal Compliance Results

CQ2 | Exceeds Targets

Score | Below Target | Minimal Accepted | Target or Better

Process	Measure	Goal	2009	2010
Compliance Training Orientation	Participation	>=95%	100%	100%
		90-94%		
		<90%		
Compliance Training Annual Re-orientation	Participation	>=95%	100%	99%
		90-94%		
		<90%		
Code of Conduct Training	Participation	>=95%	100%	100%
		90-94%		
		<90%		
Sanctions /adverse actions against SCF for HIPAA violations	Number of sanctions / adverse actions	0	0	0
Annual Employee Tuberculosis Tests	Participation	>=85%	84%	93%
		80-84%		
		<80%		
Accreditation	Tracer Scores	>=90%	92%	96%
		85-89%		
		<=84%		
Environment of Care	Safety Survey Scores	>=90%	95%	98%
		85-89%		
		<=84%		

Figure 7.4-7: Board Assessment Results 2009

CQ2 | Exceeds Benchmark | ▲Better

Measure	SCF	National Avg	Difference
Fiduciary Duties of Care, Loyalty & Obedience	82%	80%	+ 2 %
Financial Oversight	83%	78%	+5%
Quality Oversight	90%	78%	+12%
Setting Strategic Direction	75%	73%	+2%
Self-assessment & Development	67%	61%	+6%
Management Oversight	83%	60%	+23%
Advocacy	88%	59%	+29%
Board Performance	93%	85%	+8%

Elders are important in Alaska Native cultures and represent a key C-O segment for SCF [1.2c]. Launched in 1995, the SCF Elder Program has grown from 570 enrollees in 2001 to over 970 today.

Figure 7.4-8: Support for Elders

CQ2	Ongoing Focus on Relationships
Meals	
Total Meals Served to Elders 2005-2010	86,246 meals
Avg. # Meals Served 2005-2010	1,198 per month
Transportation	
Medical Van Transports 2006-2010	5,887 rides
Avg. # Transports 2006-2010	98 per month

Fig. 7.4-8 reflects growth in the Elder daily meal program. Daily lunch provides nutrition, social interaction, a way to monitor Elders' health, and is a door through which some Elders enter the system. By providing access to transportation to meet essential services, Elders are able to live more independent lives and experience an increase in quality of life. Figs. 7.4-9 and 7.4-10 demonstrate results of SCF's organizational citizenship with employee charitable giving for ECAF and the United Way Campaign. In 2007, the average employee contribution surpassed that of employees from other community businesses with similar workforce sizes. In early 2008, SCF launched ECAF which allows employees, VPLT, and SCF BOD to contribute donations in lieu of or in addition to the United Way fundraising. Fig. 7.4-10 shows ECAF award disbursements for 2009 and 2010 segmented by reason. SCF has been recognized for both organizational and individual excellence and leadership [Fig. 7.4-11].

Figure 7.4-9: Employee Charitable Giving

CQ2	Ongoing Focus on Giving		
CY	ECAF	United Way	Total
2007	N/A	$40,559	$40,559
2008	$23,655	$14,562	$38,218
2009	$34,405	$15,988	$50,393
2010	$26,166	$6,013	$32,179
CY	Total	# Employees Contributing	$ per Contributor
2007	$40,559	120	$338.33
2008	$38,218	148	$258.23
2009	$50,393	157	$320.98
2010	$32,179	153	$210.32

Figure 7.4-10: ECAF Awards

CQ2		Ongoing Focus on Giving		
2009	**%**	**2010**	**%**	**Total**
$32,088	100%	**$34,850**	100	
Breakdown				**Reason**
$4,200	13	$14,015	40	Home Fire
$14,463	45	$6,977	20	Death/Funeral
$2,500	8	$0	0	Child Terminal Ill
$600	2	$0	0	Homeless: Injury
$0	0	$3,975	12	Homeless: Domestic Violence
$430	1	$0	0	Damaged Home
$1,850	6	$1,337	4	Illness Unable to Work
$2,300	7	$3,270	9	Disabled /Losing Home
$3,325	10	$3,566	10	Injured Family Member
$2,170	7	$1,710	5	Other
$250	1	$0	0	Food for Family

Figure 7.4-11: Organizational Recognition – partial list
Complete List Available Onsite including earlier years

CQ2	Sustained Recognition
Year (Level)	**Organizational Awards 2008-2010**
2010 (N)	NCQA Patient Centered Medical Home Level 3
2010 (N)	Best in Show 2009 Public Relations Society of America Aurora Awards
2010 (L)	Bicycle Friendly Business Award
2010 (L)	Anchorage Chamber of Commerce Gold Pan Award Runner up for Distinguished Community Service by a Large Organization
2009, 2010 (N) (S)	Family Wellness Warrior Initiative Awards: National Indian Health Board (2009); Alaska Community Service Award for Health; National Global Community Service Heroes of Health Award; Governor's Shirley Demientieff Award; Mary Byron Project's Celebrating Solutions Award
2009 (N)	Science & Service Award, US Department of Health & Human Services, SAMHSA
2009 (S)	Alaska Performance Excellence (APEX) recognition
2008 (N)	United Way Success By 6 Work Family Award
2003, 2008 (N)	American Nurses Credentialing "Magnet Recognition"
Year (Level)	**Employee Recognition 2008-2010**
2010 (N)	National Indian Health Board Area/Regional Award: James Segura (Board Chair)
2010 (N)	March of Dimes 2010 "Friend of Nursing": Katherine Gottlieb (CEO)
2010 (N)	Enduring Spirit Award: Ileen Sylvester (VP)
2010 (S)	Alaska Meritorious Health Service Award (ALPHA): Katherine Gottlieb (CEO)
2010 (N)	March of Dimes Nurse of the Year for Case Management: Bryen Bartgis
2010 (S)	Alaska's Direct Service Professional Award: Albert Nells, Clinical Associate (The Pathway Home)
2009 (N)	National Indian Health Board's National Impact Award: Kevin Gottlieb (VP)
2009 (N)	National Indian Health Board Youth Leadership Award: RAISE Intern
2009 (S)	Alaska Native Visionary Award: Lisa Dolchok (Traditional Healing)

Key: N = National, S=State, L=Local

7.5 Financial & Market Outcomes

Benchmarks: MGMA; Moody's; SATO; Horizon Health Corporation; Emeritus; national health data; SCF targets.

Trends: Overall, trends continue to demonstrate sustainable results and sound fiscal management.

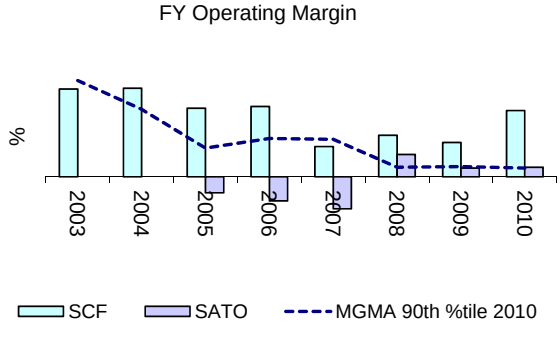
Segmentation: Data is available on site to show segmentation at operational and functional areas.

Integration: Financial results are integrated into every department at SCF. Departments are responsible for annual planning within their budgets. SCF provides budget education and training as well as ongoing fiscal updates with managers during SCF's quarterly LDS and bi-monthly manager meetings. Financial leadership has successfully worked with SCF Data Services to improve on key financial indicator reporting. As a result, key financial indicators are now Web-based and segmented to facilitate more efficient review by finance and program personnel.

Operating Margin [Fig. 7.5-1] and Overhead [Fig. 7.5-2], are tracked quarterly to provide actionable information related to operational efficiency and sound fiscal management.

Figure 7.5-1: Operating Margin

OPE1 and 3	Exceeds Benchmark	▲Better



SCF's Operating Margin goal is set at a level that enables SCF to direct resources toward services while maintaining reserves sufficient to cover contingencies and asset replacement. SCF compares its performance to SATO offering similar services that are comparable in size, revenue and assets. Overhead [Fig. 7.5-2] tracks administrative expenses at the central corporate (e.g., Finance, HR, Employee Development Center) and division levels (e.g., Medical Services and Behavioral Services, Operations, including billing and collection costs). For eight years, SCF has managed overhead expense at or near its established goal, which is below the level of two tribal organizations providing similar services and below the Overhead Percentage of the Alaska Primary Health Clinics (330 Grantees) that provide similar services to Alaska Native people elsewhere in the State. Total revenue received by programs (including grants and entitlements and patient accounts) has increased steadily over the past seven years [Fig. 7.5- 3]. Total revenues continue to exceed expenses [Fig. 7.5-7] and exceed the MGMA 90th percentile and a similar tribal organization.

Figure 7.5-2: Overhead

OPE1 | **Exceeds Benchmark** | ▼Better

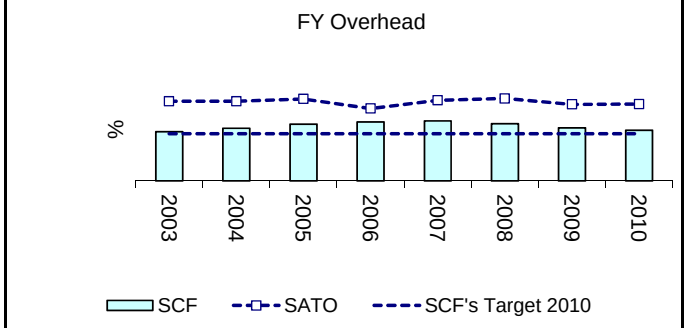


Figure 7.5-3: Total Revenues

OPE3 | **Exceeds Benchmark** | ▲Better

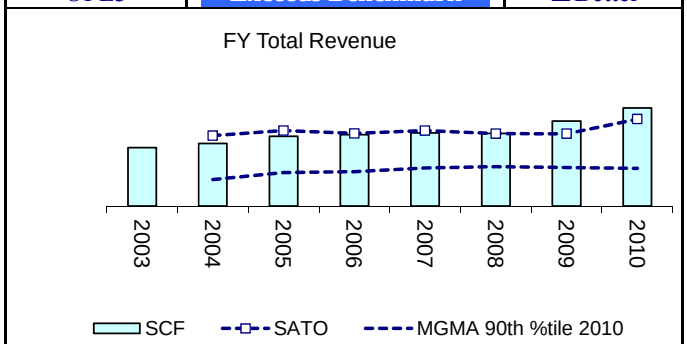
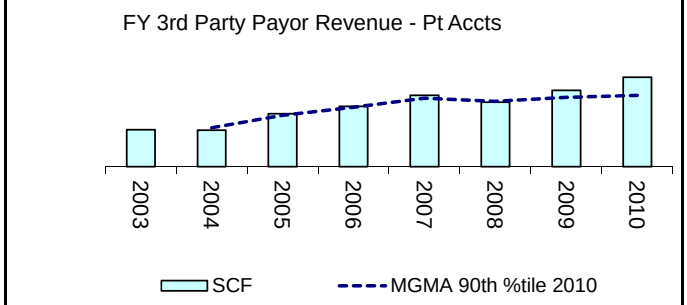


Figure 7.5-4: 3rd Party Payer Revenue (Patient Accts)

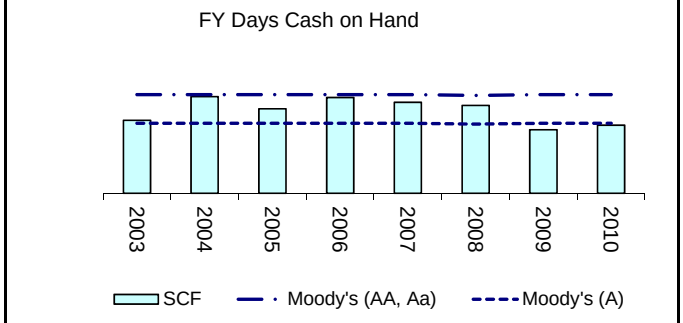
OPE3 | **Exceeds Benchmark** | ▲Better



Revenue specifically from third-party payer billing and collection (e.g., Medicare, Medicaid, commercial insurers) has increased also, exceeding the MGMA 90th percentile in FY 2009 and 2010. These favorable results are important because SCF is mandated under legislative agreements to collect all available third-party revenue and increased third-party revenue represents SCF's primary opportunity to expand revenue**.** Major redesign of SCF's revenue cycle process contributed to the improvement. A multidisciplinary Revenue Team mapped the billing and collection process starting with C-O entry into the system to ensure that people eligible for alternative resources are enrolled and receiving those benefits. Medicaid represents about 55 percent of all third-party revenue. The team standardized procedures, set consistent billing guidelines, centralized staff, and deployed billers across sites to use resources more efficiently. On-site training in clinics was used to promote troubleshooting, build cooperation, and allow the team to evaluate the new process.

Figure 7.5-5: Days Cash on Hand

OPE1&3 | **"A" Rating** | ▲Better



Days Cash on Hand is a measure of working capital that demonstrates SCF's ability to make funds available for operating costs. Performance for six of eight years has exceeded the level required for Moody's A rating [Fig. 7.5-5].

Figure 7.5-6: Current Ratio

OPE1&3	Exceeds Benchmark	▲Better

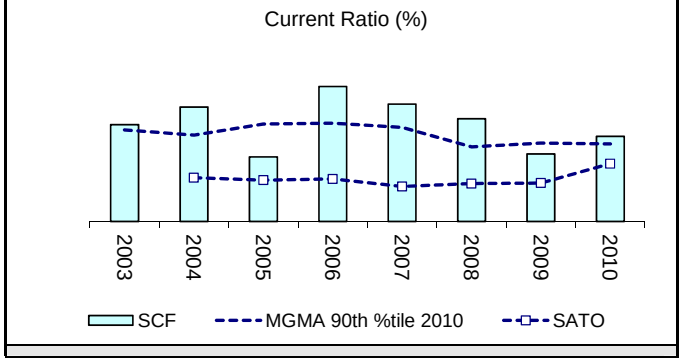
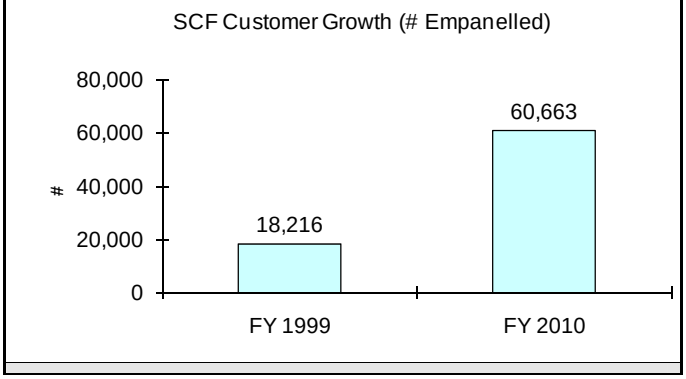


Figure 7.5-8: Customer Growth

SR2 and SR3	233% Growth	▲Better



Current Ratio [Fig. 7.5-6] shows level of liquidity and ability to pay debts when due. While still meeting its obligations SCF deliberately decreased its current ratio from FY 2004 to FY 2005 by utilizing short-term and liquid assets to generate revenue and greater returns. This fiscal shift resulted in a higher current ratio for FY 2006 and 2007 giving SCF a strong position over its competitors. FY 2009 saw a reduction due to investment results reductions and increased asset replacement and construction. FY 2010 saw a recovery and resulting increase above the 90th percentile. SCF benchmarks against Emeritus, Horizon Health Corporation, and a similar tribal health organization.

SCF manages its expenses [Fig. 7.5-7] such that it has met its expense budget for the last eight years. Total SCF revenue [Fig. 7.5-3] has exceeded expenses for the last eight years. SCF benchmarks itself against the MGMA (over the 90th percentile).

SCF changed its practice patterns over time resulting in decreased emergency room visits, specialist visits and hospital days. Costs followed suit [Fig. 7.5-9] and since 2004, SCF has had an increase in C-O growth while the percentage increase in the cost per SCF empanelled C-O remains lower than the percentage increase in national health or MGMA multi-specialty practice spending. SCF reports improved health status while keeping expenditure growth below the national rate of growth.

Figure 7.5-9: Per Capita Expenditures % Change

PE1	Exceeds Benchmark	▼Better

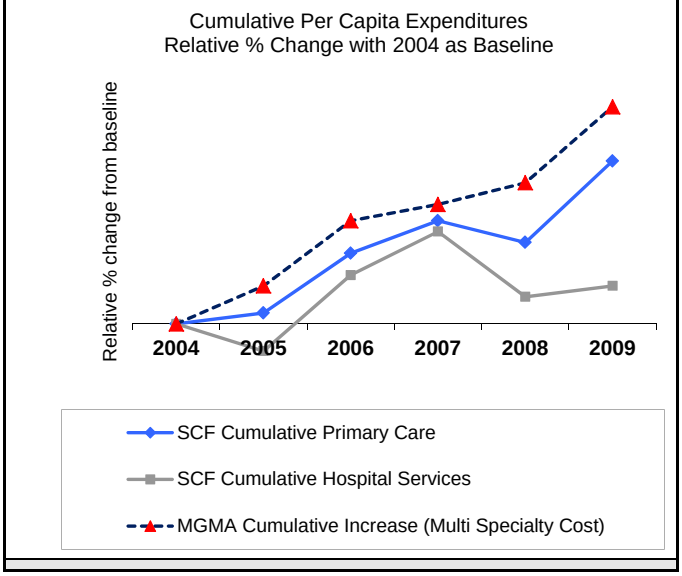


Figure 7.5-7: Expenses

OPE1	At Target	▼Better