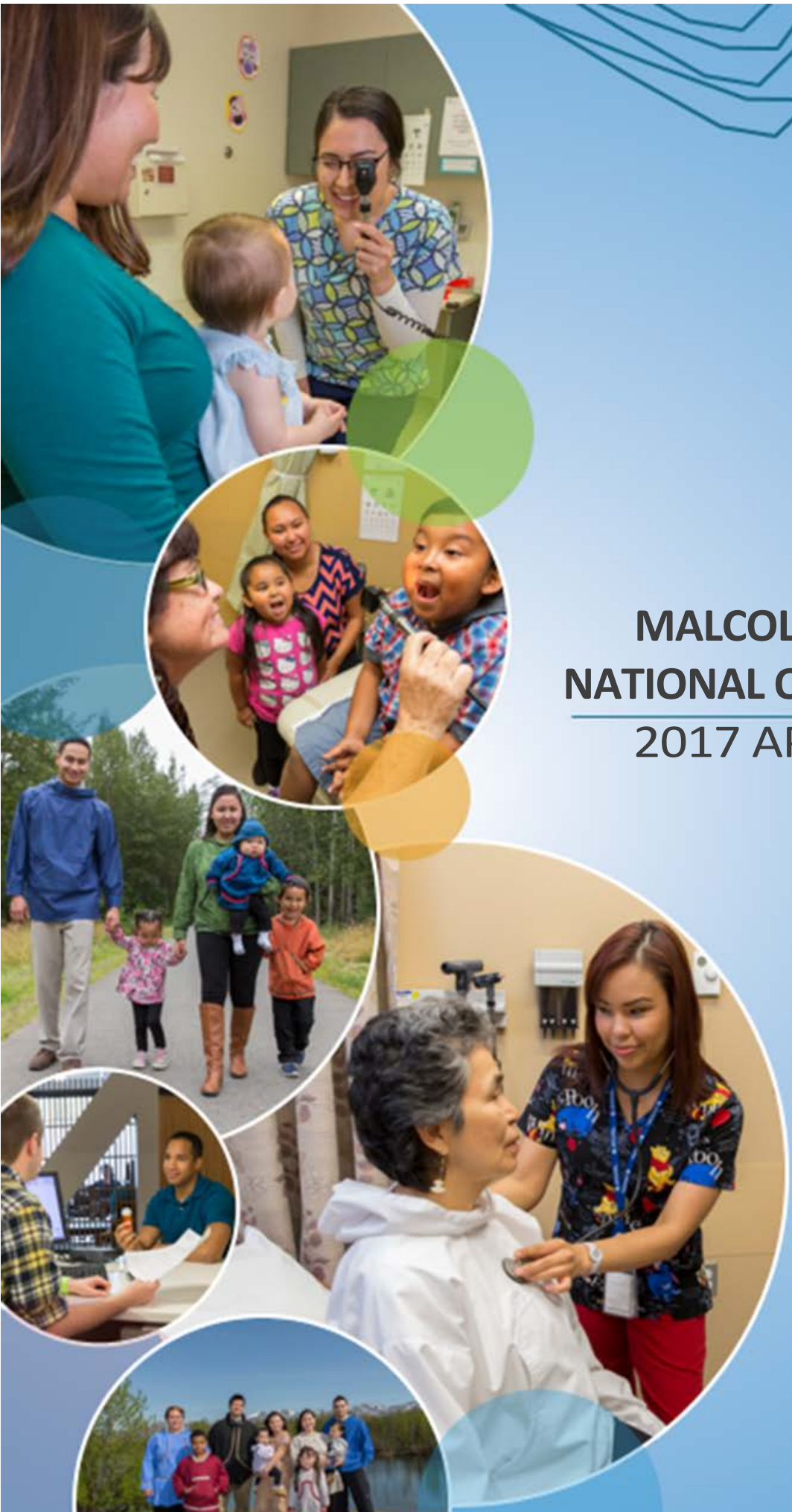


MALCOLM BALDRIGE NATIONAL QUALITY AWARD

2017 APPLICATION

Southcentral Foundation

Table of Contents

Glossary of Terms and Abbreviations

Term	Meaning
<	less than
>	greater than
▲	upward or higher results is better
▼	downward or lower results is better
A1c	Laboratory test that measures average control level of blood glucose or blood sugar over a period of approximately three months
AAAHC	Accreditation Association for Ambulatory Health Care
AAPT	Automated Annual Planning Tool
AFN	Alaska Federation of Natives
AN	Alaska Native
AI	American Indian
ALET	Advanced Leadership Education
ANHB	Alaska Native Health Board
ANHC	Alaska Native Heritage Center
ANMC	Alaska Native Medical Center
ANPCC	Anchorage Native Primary Care Center
ANTHC	Alaska Native Tribal Health Consortium
AP	Annual Plans
APQR	Annual Plan Quarterly Report
APU	Alaska Pacific University
ARO	Annual Reorientation
ASTP	Administrative Support Training Program
ASU	Anchorage Service Unit and Training
BFA	Beauty for Ashes
BHC	Behavioral Health Consultant
BOD	Board of Directors (SCF's seven-member board)
BSC	Balanced Scorecard
BSD	Behavioral Services Division
BURT	Behavioral Urgent Response Team
CAP	College of American Pathologists
CARF	Commission on Accreditation of Rehabilitation Facilities
Cat	Category
CBG	Core Business Group
CC	Core Competencies
CDC	Centers for Disease Control and Prevention
CDR	Character Driver Risk
CEC	Customer Experience Committee
CEO	Chief Executive Officer
CFRS	Customer Feedback Reporting System (Quantros)
CG	Corporate Goals
CHC CI	Community Health Center Corporate Initiatives
CIHA	Cook Inlet Housing Authority
CIRI	Cook Inlet Region, Inc.
CITC	Cook Inlet Tribal Council

Term	Meaning
CM	Committee Manager - a web-based tool used to document committee agendas and minutes and disseminate committee specific information
CMA	Certified Medical Assistant
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Service
CNM	Certified Nurse Midwife
CO	Corporate Objective
C-O	Customer-Owner, the SCF term used instead of patient or client
COMC	Communications Committee
COMP	Comparison or Competitor
CPA	Certified Public Accountant
CQ	Commitment to Quality (one of SCF's Corporate Goals)
CSS	Customer Satisfaction Survey
DATC	Data Analysis & Tracking Committee
DB	Dashboard
DBMS	Database Management System
DC	Development Center
DEA	Drug Enforcement Agency
DM	Data Mall
DNKA	Did Not Keep Appointment
ECAF	Employee & Community Assistance Fund
EH	Employee/Environmental Health
Elder	Seniors ages 55 years old or older
ELE	Executive Leadership Experience
EMP	Emergency Management Plan
EMT	Executive Management Team
EOS	Employee Opinion Survey
EPA	Environmental Protection Agency
ER	Emergency Room
ETS	Executive and Tribal Services
EWC	Employee Wellness Committee
FASD	Fetal Alcohol Spectrum Disorders
FCS	Functional Committee Structure
FDA	Food and Drug Administration
Fig	Figure
FMW	Family Wellness (one of SCF's Corporate
FOM	Foundations of Management, an L&D program for mid-level management
FTE	Full-time Equivalent
FWWI	Family Wellness Warriors Initiative
FY	Fiscal Year (October 1 to September 30)
GPRA	Government Performance and Results Act
HC	Health Care
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HR	Human Resources

Term	Meaning
HRC	Human Resources Committee
HRSA	Health Resources and Services Administration
HVA	Hazard Vulnerability Analysis
ICT	Integrated Care Team
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
ISMP	Information Security Management Program
IT	Information Technology
ITS	Information Technology Services
JOB	Joint Operating Board
KWP	Key Work Processes
LDL	Low Density Lipoprotein
LDS	Leadership Development Sessions
L&D	Learning and Development
LMS	Learning Management System
LPN	Licensed Practical Nurse
Mat-Su	Matanuska-Susitna Borough, part of SCF's Service Area
MGMA	Medical Group Management Association
MM	Managers Meeting
MRT	Measurement Rules Template
MSD	Medical Services Division
MVCG	Mission, Vision, Corporate Goals
NCQA	National Committee for Quality Assurance
NHO	New Hire Orientation
NIST	National Institute of Standards and Technology
Nuka	best practice ideas from around the world.
System of Care	The term includes all aspects of the system from service delivery to the systems that support that delivery.
OBGYN	Obstetrician-Gynecology
OC	Oversight Committee
ODI	Organizational Development and Innovation
OFI	Opportunity for Improvement
OP	Operational Principles
OPE	Operational Excellence
OPS	Operations Committee
Org	Organization
OSHA	Occupational Safety and Health Administration
P&P	Policy and Procedure
P/CEO	President/Chief Executive Officer
PCP	Primary Care Provider
PDP	Performance Development Plan
PDSA	Plan-Do-Study-Act Rapid Cycle Improvement Model
PEDS	Pediatric Clinic
PHI	Protected Health Information
PI	Process Improvement
PIC	Process Improvement Committee
POS	Point of Service
PR	Public Relations
PTC	Project Team Charter
QA	Quality Assurance
QAC	Quality Assurance Committee
QI	Quality Improvement
QIC	Quality Improvement Committee
QMC	Quality Management Courses
RAISE	SCF program developing AN/AI youth with workplace skills and experience
RCC	Revenue Cycle Committee
RD	Registered Dietician
RELATE	Respond, Engage, Listen, Advocate, Thank, Encourage
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAN	Storage Area Network
SBIRT	Screening, Brief Intervention, Referral, Treatment
SCF	Southcentral Foundation
SharePoint	Business collaboration platform that facilitates communication and sharing work-related information
SID	Strategic Input Document
SL	Senior Leader
SME	Subject Matter Expert
SPC	Strategic Planning Cycle
SPP	Strategic Planning Process
SR	Shared Responsibility (one of SCF's Corporate Goals)
SWOT	Strengths, Weaknesses, Opportunities, Threats
TJC	The Joint Commission
VA	Veterans Administration
VNPCC	Valley Native Primary Care Center
VOC	Voice of the Customer
VP	Vice President
VPLT	Vice President Leadership Team - the P/CEO and her team of VPs (Senior Leaders)
WCP	Wellness Care Plan

Organization Profile

P.1 Organizational Description

Southcentral Foundation (SCF) is an Alaska Native nonprofit health care system that was established in 1982 under the tribal authority of Cook Inlet Region Inc. (CIRI) to provide health care and related services to Alaska Native and American Indian people (AN/AI) in southcentral Alaska. CIRI is one of 13 Alaska Native regional corporations created by Congress in 1971 under the terms of the Alaska Native Claims Settlement Act. Once established, SCF began contracting with the federal government to provide services, with its role expanding throughout the late 1980s and 1990s. In 1998, SCF took ownership of primary care services from the Indian Health Service (IHS) and changed everything.

After spending a year listening to feedback from the Alaska Native Community (who, at long last, had local control of the system), the health care system was completely overhauled to focus on two major elements: customer-ownership and relationships. SCF does not use the passive term "patients" as it does not reflect the level of engagement for which SCF strives. Rather, since the AN/AI people served are both the customers and the owners of the health care system, they are referred to as customer-owners (C-O). At SCF, C-Os work in relationship with their care providers to achieve overall wellness. SCF recognizes that each individual has more control over his or her own health outcomes than providers, and that when providers build strong, long-term relationships with C-Os, it helps providers understand C-Os and the health issues they may be facing. It also builds trust between them, which allows providers to more effectively support C-Os in achieving wellness.

Today, SCF has grown from fewer than 100 to approximately 2,200 employees, with an operating budget that has grown from $3 million to $349 million. SCF operates the Nuka System of Care, a customer-driven, relationship-based health care system. "Nuka" is an Alaska Native word for strong, giant structures and living things.

SCF's Nuka System of Care has distinguished itself as one of the nation's leading health care systems. SCF regularly hosts visitors from around the world who come to learn about the Nuka System of Care and seek help in reforming their own health care systems, including representatives from the National Health Service (U.K.), the Veterans Health Administration (U.S.), the Institute for Healthcare Improvement (U.S.), and many other organizations. While SCF utilizes best practice ideas, the entire system of care is designed and driven by C-Os.

P.1a(1) Health Care Service Offerings. SCF's Nuka System of Care provides a broad spectrum of health and health-related services to support C-Os on their journey to wellness, including primary medical care, dentistry, optometry, audiology, behavioral health (includes residential and day treatment programs), complementary medicine, traditional healing, physical therapy, Elder and youth programs, health education, chronic pain management, and home-based services. SCF considers each service offering critical for achieving whole- person wellness. The approach SCF uses to provide these 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 reviews derived from C-O input, SCF's delivery systems are continually evolving to best meet C-O needs and requests. This feedback is also used to determine the importance of each service in the system.

SCF works with its partner, the Alaska Native Tribal Health Consortium (ANTHC), to ensure a seamless continuum of care. Services at the Alaska Native Medical Center (ANMC) are provided through SCF's collaboration with ANTHC's tertiary and specialty services. Most SCF C-Os live in and around Anchorage, though some C-Os 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 a team approach to ambulatory office visits (individual, group, peer), home visits, learning circles, email and telephone visits, health information and education (classes, paper, web), outpatient services, behavioral services (including psychiatric consultation, brief intervention, and group therapy), day and residential treatment, detoxification services, and consultation with and referral to higher levels of care. SCF's clinical teams regularly travel to rural villages to deliver family

medicine, dentistry, pediatrics, OBGYN, audiology and behavioral services. In areas where village clinics are staffed by local village health aides, SCF clinicians 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 C-Os from rural villages to Anchorage.

P.1a(2) Vision, Mission, and Values. As an Alaska Native customer-owned system, SCF believes that effective relationships are key to improving the overall health of the community. SCF's values and commitment to C-Os are embedded in its Mission, Vision, and Corporate Goals (MVCG) [Fig. P.1-1], its Core Concepts [Fig. P.1-2]; Operational Principles (OP) [Fig. P.1-3]; and its Core Competencies (CC) [Fig. P.1-4].

These are not statements that reside only in promotional materials; rather, they shape every aspect of organizational life. The OP defines characteristics of the RELATIONSHIP-based Nuka System of Care and guide process and system design/redesign, as well as employee actions and behaviors, throughout the organization. SCF has also defined its Core Concepts [5.2b(1)], the key characteristics of its organizational culture.

In 2007, SCF added an annual Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis process to determine the CC, resulting in integration of CC determination into the Strategic Planning Cycle (SPC) [2.1a(1)]. The CC relate to the Corporate Goals (CG), which keep SCF's performance evaluation, planning and improvement efforts focused on achievement of the vision and mission. CG create the framework for Corporate Objectives (CO) [Fig. 2.1-1].

Figure P.1-1: Vision, Mission and Corporate Goals

MVCG	Explanation
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.
Corporate Goal 1: 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.
Corporate Goal 2: Commitment to Quality	We strive to provide the best services for the Native Community. We employ fully qualified employees 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 employees.
Corporate Goal 3: 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.
Corporate Goal 4: Operational Excellence	We develop and improve our operations that support delivery of services to customer-owners.

Figure P-1-2: Core Concepts (WELLNESS)

W	Work together in relationship to learn and grow
E	Encourage understanding
L	Listen with an open mind
L	Laugh and enjoy humor throughout the day
N	Notice the dignity and value of ourselves and others
E	Engage others with compassion
S	Share our stories and our hearts
S	Strive to honor and respect ourselves and others

Figure P-1-3: Operational Principles (RELATIONSHIPS)

R	Relationships between the customer-owner, the family, and provider must be fostered and supported
E	Emphasis on wellness of the whole person, family, and community including physical, mental, emotional, and spiritual wellness
L	Locations that are convenient for the customer-owner and create minimal stops for the customer-owner
A	Access is optimized and waiting times are limited
T	Together with the customer-owner as an active partner
I	Intentional whole system design to maximize coordination and minimize duplication
O	Outcome and process measures to continuously evaluate and improve
N	Not complicated but simple and easy to use
S	Services are financially sustainable and viable
H	Hub of the system is the family
I	Interests of the customer-owner drive the system to determine what we do and how we do it
P	Population-based systems and services
S	Services and systems build on the strengths of Alaska Native cultures

Figure P-1-4: Core Competencies

Customer Care & Relationships
Communication & Teamwork
Improvement & Innovation
Workforce Development, Skills & Abilities

P.1a(3) Workforce Profile. SCF's diverse workforce population [Fig. P.1-5] is approximately 2,200 and all staff, including physicians, are considered employees. The workforce has grown recently based on an increase in the number of C-Os we serve and their needs, as well as the addition of new specialties and services. The medical staff is privileged according to Medical Staff Bylaws. Unlike other health care systems, all groups and segments of employees are subject to the same SCF personnel policies and practices, such as the SCF Code of Conduct & Ethics, performance evaluations, and action planning.

Figure P-1-5: Workforce profile as of FY16

Workforce Category	Percentage
Alaska Native/American Indian	53.89%
Non-Native	46.11%
Female	73.77%
Male	26.23%
Under 21 years	2.38%
21-30 years	25.32%
31-40 years	28.28%
41-50 years	20.27%
51-60 years	15.36%
61-70 years	7.63%
Over 70 years	0.76%
Full-time	89.46%
Part-time	1.81%
Temporary	2.1%
Intermittent	6.63%
Clerical	24.08%
Clinical Managerial	1.57%
Health Care (HC) Professional	15.5%
HC Provider	20.79%
HC Technical	14.83%
Leadership	2.81%
Non-Clinical Managerial	9.2%
Non-Exempt Non-Clerical Non-HC	3.86%
Non-HC Professional	7.34%

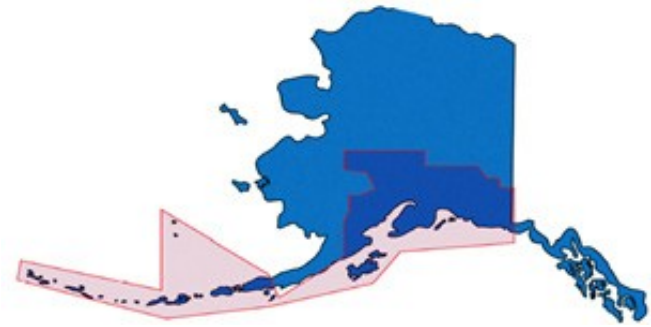
The medical staff is not managed differently from other employees. There are no organized bargaining units within SCF. The Indian Self-Determination Act allows SCF to give AN/AI applicants preference in hiring and supports CO focused on recruitment and development of AN/AI staff [5.1a(2)].

Educational requirements for different employee groups and segments are defined as components of a job description and/ or Performance Development Plan (PDP). Special health and safety requirements are defined by job descriptions or SCF policy and procedures (P&Ps). 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.

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. AN/AI people make up 54 percent of the workforce overall, including 61 percent of management/leadership and 98 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. SCF also has dental and medical clinics in several villages. These settings present various health and safety risks, including equipment use, exposure to bloodborne pathogens and hazardous materials, and travel.

P.1a(4) Assets. SCF owns 33 facilities. These facilities include a 173,000-square-foot clinical space in the Anchorage Native Primary Care Center (ANPCC); a clinic building for dentistry, optometry, and behavioral health; facilities for residential, day treatment, and transitional living; an Elder program in Anchorage; as well as an 85,000-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 the 150-bed ANMC hospital in Anchorage, 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, to display and/or sell arts and crafts, and to visit relatives and friends. The requirement to capture the essence of respect and culture of the Native Community is included in every building project.

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



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-Os and employees.

SCF's Information Technology Services (ITS) Department supports all programs. SCF operates primarily in a Windows environment with full active directory services deployed, and that system is fully routed in all locations. Primary applications are Microsoft Exchange, Serenic Navigator, Kronos, TIER, and other clinical applications. SCF's ITS department is actively involved in developing web-based tools that are customized to SCF in order to continually improve workflow. Examples of these web-based tools include Committee Manager (CM), Balanced Scorecard and Dashboard (BSC/DB), Annual Planning Tool (APT), and Employee Development Center (DC) 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 and is subject to federal, state, and local laws applicable to the services provided (e.g., CMS Conditions of Participation, Professional Licensing laws, DEA, FDA), reimbursement requirements (e.g., Medicare & Medicaid), health and safety (e.g., OSHA), privacy and information security (e.g., Health Insurance Portability and Accountability Act, or HIPAA), environmental protection (e.g., EPA), Indian Health Service (IHS) agreements, and labor laws (e.g., Americans with Disabilities Act, Civil Rights Act), to name a few. SCF voluntarily meets The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF) Standards. ANMC has also earned Magnet Recognition for Nursing Excellence. In addition, SCF is subject to requirements placed on it by grant funding sources (e.g., NIH).

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

P.1b(2) Patients, Other Customers, and Stakeholders. SCF's C-O groups have access to different services depending on their geographic location [Fig. P.1-7]. From C-O input, SCF has learned that despite differences in geographic location and service level, all C-Os share a common set of requirements, shaped by cultural values and preferences. The requirements were initially shared during the period of whole-system transformation. SCF translated these requirements into its OP [Fig. P.1-2], creating a set of design specifications to drive improvement and innovation.

P.1b(3) Suppliers and Partners. SCF works with diverse partners to deliver health care services, support, education, and training for Alaska Native people, and to secure funding for SCF programs and staff [Fig. P.1-7]. SCF also partners with the U.S. Department of Veterans Affairs to provide care for approximately 1,200 military veterans at the Benteh Nuutah Valley Native Primary Care Center (VNPCC).

Figure P-1-7: C-O Group/Services as of 12/31/16

C-O Group	Service/Support
Anchorage and Mat-Su: SCF provides primary health and related services to C-Os empaneled to named providers in Anchorage and the Mat-Su Valley.	Full access to all SCF services.
Cook Inlet Region Inc. (CIRI): SCF supports CIRI 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 [Fig. P.1-5]: 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.	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.

SCF leverages the potential of partnerships to drive improvement and innovations by involving SCF BOD and senior leaders (SL) in committees with partner leadership, as well as by engaging employees from both SCF and partner organizations in committees and improvement teams. To provide seamless care to C-Os, many SCF employees participate in ANTHC committees and work groups. SCF shares and evaluates a number of specific measures with ANTHC, since many SCF C-Os use their services. Suppliers support service delivery to C-Os, 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 interactions, 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.1-8].

Figure P-1-8: Partial List of Key Partners

Partner	Role	Relationship
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, two-way communication
CITC	Educational services and substance abuse counseling	Grant sub-awards & reporting, committees, two-way communication
U.S. Dept. of Veteran's Affairs	Contract for SCF to provide primary care and other medical, behavioral, and support services	Contract for services, committees, two-way communication.
The CIRI Foundation	Scholarships for Alaska Native students	Committees, two-way communication
ANHC	Educational services on Alaska Native cultures	Committees, two-way communication
UAA; APU; University of Washington; Alaska Career College; SUNY (Lutheran Medical Center); University of Colorado Denver	Education and training for employees and future employees	Contracts, two-way communication
IHS; CDC; CMS; HRSA; SAMHSA; NIH; PCORI; ACF; State of Alaska; Denali Commission; Rasmuson Foundation	Funding for SCF programs and staff	Grant reporting, two- way communication

P.2 Organizational Situation

P.2a(1) Competitive Position. SCF is the primary provider of care for AN/AI people in the ASU [Fig. P.1-5]. As of February 2017, SCF had 65,838 empaneled C-Os from the ASU. 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 based on legislative agreements and funding requirements. However, more than half could pay or use insurance to get services elsewhere, so SCF must provide services in a way that attracts C-Os 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. Since almost all AN/AI people

in the Cook Inlet region choose to use SCF for health care services, 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 ANTHC, with whom it jointly owns and operates ANMC, to identify needed services and to develop plans for closing gaps in providing these services. SCF identifies potential service gaps as part of its strategic planning process (SPP) [2.1a(1)]. SCF's 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 Input Document (SID) [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 Engagement	Press Ganey	External (National)
Human Resources, Learning and Development	Saratoga-Price Waterhouse	External (National)
Financial	MGMA & Other Healthcare Organizations	External (National & State)
Regulatory	TJC, CMS, CARF	External (National)

Internal sources, such as comparison charts, allow SCF to evaluate variability in health service delivery between clinics, teams, and providers. This information helps clinic managers identify best practices for improvement efforts. External data sources, such as Healthcare Effectiveness Data and Information Set (HEDIS), allow SCF to compare its performance to national top performers. SCF has established the HEDIS 75th percentile (within nation's top 25 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 (within nation's top 10 percent) as a goal for its financial measures when like measures exist. 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, and SCF uses their health care benchmarks for comparison. Press Ganey is a nationally recognized group that works with more than 26,000 health care organizations, providing them with employee satisfaction data and metric benchmarks. SCF administers a custom survey to C-Os on mobile tablet devices [3.1a(1)] where C-Os receive the customer satisfaction survey (CSS) at the place of service, immediately following their experience. The CSS results, available to all employees via the vendor tool, highlight and provide feedback about the relationship between providers and C-Os.

Occasionally, SCF develops performance measures that do not have national comparison data, but use 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 TJC, CMS, and CARF.

P.2b Strategic Context. [Fig. P.2-2] outlines SCF's key strategic challenges and advantages as they relate to SCF's five key work systems: medical, dental, behavioral, tribal, and health care support. Sustainability depends on SCF's ability to balance, align, and integrate its responses to key strategic challenges and advantages. Simultaneously, SCF must maintain and enhance the funding stream it needs to support growth capacity as demand increases, yet still achieve high performance.

P.2c Performance Improvement System. SCF's approach to maintaining and supporting the organization's focus on improvement includes implementing PDSAs, balanced scorecards (BSC), annual planning, reviewing high-performing organizations, and utilizing the health care criteria of the Baldrige National 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.

SCF has a linked system of BSC (strategic measures) and DB (operational measures) to track performance quarterly. Defined thresholds and goals help identify improvement priorities. Annual Plans (AP) at all levels link to these key measures. Reviewing a comparison of performance against the AP promotes learning and allows for adjustment. Also, 25 percent of an employee's performance evaluation is based on improvement and innovation, integrating all employees into the improvement process [5.1a(4)].

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 visits to other sites, all of which allow SCF to benchmark processes and results. In 2002, SCF adopted the Baldrige Criteria for Performance Excellence as its framework for organization-wide review of its key processes and performance. In 2009, SCF was the recipient of Alaska's APEX Award for Performance Excellence. In 2011, SCF was awarded the Malcolm Baldrige National Quality Award. As a result of learning from Baldrige and APEX, SCF implemented a Functional Committee Structure (FCS) to promote communication and broaden involvement in decision-making [Fig. 1.1-2]; BSC/DB to support planning and performance review [4.1a(1), 4.1b]; directed our focus to seeking comparative data to evaluate performance [Cat. 7]; and created a web-based planning tool to deploy the strategic planning cycle [2.1a(1)].

P.2-2: Strategic Advantages and Strategic Challenges

Category	Key Work System(s)	Strategic Advantages	Strategic Challenges
Health Care Services	Medical, Behavioral, Dental	Engaged C-O	Understanding and responding to C-O expectations
Operations	HC Support	Longevity in leadership and governance that provides consistency in direction and focus	Maintaining and improving our future funding stream to meet growth and C-O needs and expectations
Societal Responsibilities	Tribal	Relationships as the driver of all interactions	Strategic partnerships within community
Workforce	HC Support	Organizational commitment to learning	Recruiting to meet short- and long-term needs

Category 1: Leadership

1.1 Senior Leadership

1.1a(1) Setting Vision and Values. SCF's MVCG were created with input from C-O focus groups, surveys, and formal/informal group processes. The feedback was translated into simple, memorable, and culturally significant statements that are systematically evaluated, reaffirmed, and updated as needed during the SPC [2.1a(1)] by SCF's senior leaders (P/ CEO, VPLT) and the BOD. The CG/CO, reviewed annually by SLs/BOD and reaffirmed/modified as necessary, are derived from and support the MV. The OPs were developed [Fig. P.1-2] as a framework translating the MVCG into actionable language for the workforce.

SCF uses several approaches to deploy the MVCG to key stakeholders [Fig. 1.1-1]. For example, SCF deploys MVCG to new hires by including them in a letter in the new-hire packet from HR. SLs also present a corporate overview, including MVCG/OP, at bi-weekly NHOs as well as community events (e.g., Annual Gathering). The MVCG are consistently threaded through all corporate communications [Fig. 1.1-3]. Improvement PTCs articulate the relationship to the MVCG, and all improvement activities are measured against the OP to ensure alignment.

SLs demonstrate commitment to SCF values in many ways. For example, the P/CEO commits three days, quarterly, to facilitate Core Concepts training. Other SLs also share their stories during Core Concepts. The P/CEO also donated personal funds for the start-up construction of a Health Education & Wellness Center. In addition, personal contributions were made by SLs and BOD to Family Wellness Warriors Initiative (FWWI) (an SCF program to end domestic violence, child sexual abuse, and child neglect) and to develop SCF's ECAF [5.1b(2)].

1.1a(2) Promoting Legal and Ethical Behavior. SLs foster a commitment to legal/ethical behavior by contributing to the SCF Code of Conduct and reinforcing its importance. SLs require all new staff attend NHO, and all established staff revisit the Code of Conduct during ARO and reaffirm, by their signature, their commitment to it.

Figure 1.1- 1: Deployment Approaches of MVCG

Approaches	Workforce
Anchorage Native News (SCF newsletter)	Workforce, Suppliers, Partners, C-Os
Annual Reorientation	Workforce
FWWI's BFA/Arrigah House/ALET	Workforce, Partners, C-Os
Brochures	Workforce, Suppliers, Partners, C-Os
Code of Conduct	Workforce, Suppliers, Partners, C-Os
Communicator (employee newsletter)	Workforce
Core Concepts	Workforce, Partners, C-Os
Annual Gathering	Workforce, Suppliers, Partners, C-Os
Employee Recognition/Celebration Gifts	Workforce, Suppliers, Partners, C-Os
ECAF	Workforce, Partners, C-Os
Internet	Workforce, Suppliers, Partners, C-Os
SCF Intranet	Workforce
Living Our Values Recognition Program	Workforce
Nuka Presentations	Workforce, Suppliers, Partners, C-Os
New Hire Orientation	Workforce
Performance Evaluations	Workforce
Posters/Signage	Workforce, Suppliers, Partners, C-Os
PR Campaigns	Workforce, Suppliers, Partners, C-Os
Passive Education Panels (digital)	Workforce, Suppliers, Partners, C-Os
Strategic Planning Committee	Workforce, C-Os

SLs provide direction and allocate resources to foster a Commitment to Quality (CQ), integrity, ethics, and compliance. The BOD and SLs regularly monitor ethics/compliance [Fig. 1.2-1] through bi-monthly reviews of QA reports, approval of related P&Ps, scheduled audits and monitoring, and periodic compliance report reviews to ensure action is taken on all reported compliance incidents.

The BOD and the Research Oversight Committee, which includes three VP members, review research proposals to ensure all initiatives/resulting

publications conform not only to legal and ethical standards, but also to AN values.

1.1b Communication. SLs promote team building and open communication by role modeling Core Concepts skills/ principles, and attending MMs, learning events, and department meetings to discuss current issues, outcomes, and lessons learned. All levels of leadership have an open-door policy. Office areas, including the office of the P/CEO and BOD meeting room, were redesigned to "bring down the walls" and create a welcoming/transparent environment. All managers/ supervisors have cell phones/remote access to the network for email to ensure their availability/accessibility. SCF uses regularly scheduled events, frequent meetings, and other face-to-face interactions to encourage frank two-way communication [Fig. 1.1-3]. SLs also stay connected to the workforce through all-staff and all-division email communications and SharePoint (intranet) messages. SLs/managers visit SCF's remote sites, often joined by others from HR, Facilities, QA, BSD, and MSD. These visits offer SLs opportunities to communicate key decisions and information with C-Os and staff. For example, when SCF assumed management for St. Paul Island's health clinic, SCF managers/leaders spent weeks at a time assisting with the transition, meeting with the remote staff, talking about MVCG, documenting workflows, facilitating meetings, and otherwise integrating SCF culture into the clinic.

Key decisions & two-way communication: In response to staff feedback, SLs use various approaches for internal communications and visibility [Fig. 1.1-3]. For example, the MM underwent a PDSA in 2009 based on manager feedback. The meeting had been an opportunity to update mid-level management on key decisions/topics. After reviewing several cycles of satisfaction surveys, changes were implemented to allow opportunities to contribute to strategic planning, decision making and improvement, as well as to network and connect across departments/divisions. Standard agendas now include Q&A sessions with P/CEO and VPLT. Also, in 2007, SCF's Communications Committee piloted use of electronic tools to communicate more effectively. Today, based on results of the PDSA, SCF publishes its employee newsletter on SharePoint, utilizes an "SCF Insider" news feed on its home intranet page, and sends a weekly all-staff email with the week's highlights/headlines to ensure important information is quickly disseminated to the workforce.

Motivating the workforce: SLs interact with a diverse group of staff across all divisions by taking part in committees, as well as in employee celebrations (e.g., P/CEO holds periodic recognition luncheons for high performing teams such as facilities/campus security and clinical teams). SLs personally participate in the Employee Recognition Program [5.2a(4)], which emphasizes high performance and actions that support the MVCG/OP, by participating in nomination, selection, and presentation of SCF's higher-level awards; supporting on-the-spot awards through special budget allocation; and hand-delivering celebration packages to departments three times a year.

1.1c(1) Creating an Environment for Success. SCF creates an environment for current success (i.e., to make a daily impact on C-O health and wellness), but also focuses on performance improvement and learning. SCF leaders design/deploy/integrate multiple approaches [Fig. 1.1-1], and continually review them, for achievement of SCF's MV. Examples include job progressions (explicit in job descriptions and PDPs), annual planning, and AP reporting that occurs at all levels of SCF [Fig. 2.2-1]. The BSC supports systematic performance review; helping to monitor results and proactively identify improvement needs [4.1b].

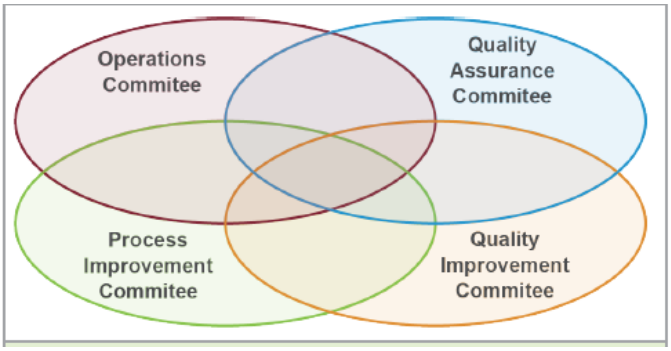
Agility: Based on staff feedback and SCF's first Baldrige assessment, the Functional Committee Structure (FCS) [Fig. 1.1-2] was launched in 2004, redistributing responsibility for decision making from SLs to four Oversight Committees (OCs) and their subcommittees. The four OCs are:

- **Operations Committee**: Focused on ensuring the effective day-to-day operations of programs. Provides ongoing evaluation of individual and department performance.

- **Quality Assurance Committee**: Ensures compliance with standards, regulations, ongoing evaluation of clinical standards and practices, credentialing and licensure, and risk management.
- **Process Improvement Committee**: Focused on improving the performance of systems and processes that support SCF's operations, includes developing, piloting, deploying and integrating improved or enhanced systems and processes.
- **Quality Improvement Committee**: Focused on improving clinical or education quality. Includes developing, piloting, deploying, and integrating targeted clinical or systems improvements, and education on best practices. Provides oversight to Clinical Core Business Groups.

The FCS provides a mechanism for ongoing feedback across the organization. There is intentional overlap within these areas and it is essential that all four functional areas be in balance and alignment to achieve business excellence.

Figure 1.1-2: Functional Committee Structure



Restructuring has enabled SLs to take a more strategic, and less operations- focused approach. This structure speeds the pace for innovation/improvement and allows further agility with respect to decisions, organizational knowledge transfer, cross- departmental/ disciplinary planning and action, and increased system integration. The AP progress of the OCs is reviewed at least twice annually with SLs, who also serve as committee executive sponsors. All committees have charters that outline their purpose relative to the four OCs, meet regularly, and include representatives from various levels of SCF, an intentional design that promotes communication/ collaboration between internal customers.

In 2009 and 2014, the PI Committee, under the direction of VPLT, conducted reviews of the FCS to identify OFIs related to EOS scores on communication. As a result, SCF redefined FCS membership, and executive sponsors replaced outdated subcommittees with the Strategic Planning Committee and Expenditure Reduction Committee. This review has now become part of the SPC.

Organizational & workforce learning: Numerous approaches are used to maintain SCF as a learning organization. SLs support SCF-wide competency in the use of the Improvement Process [Fig. 6.1-2]. In addition, they allocate resources to support learning/sharing. SCF's intranet is one of its most important tools for high performance, as it makes goals/objectives/plans/data available to all staff. SLs further demonstrate their commitment to organizational learning by teaching LDS and QMC [6.1b(4)]; presenting at MM, Core Concepts, NHO, and Nuka Conferences; participating and facilitating at learning events; and using Baldrige Feedback Reports to facilitate discussions with the BOD during the SPC.

Innovation: To cultivate innovation, SCF integrates C-O/ staff feedback into the SID; benchmarks and visits sites to study ideas that can be adapted; and uses the SPC to prioritize, plan for, and implement technological or organizational advances. A specific example of using benchmarking research is the implementation of videoconferencing for psychiatric care. This technology allows C-Os in rural areas to connect with a psychiatrist on a regular basis. In many cases, the result is access to care that was not previously available.

Intelligent risk taking: SLs create an environment for intelligent risk taking by involving everyone in cultivating innovation within the boundaries of the approved AP and budget. SCF has built a SWOT analysis into the SPC/SID to aid leadership in making educated decisions about organizational direction given its current position. All four OCs complete a SWOT analysis, ensuring BOD, SLs, and staff driving change are all clear on the direction.

Responding to C-O desire for improved access to behavioral health, SLs participated in the planning/ implementation of the Behavioral Services Redesign project. They defined the vision/ goals and identified key concepts for innovation/change in how C-Os enter behavioral services and other service options. SLs chartered a team of key staff and an improvement advisor [2.1a(2)] to develop specific processes, supporting strategies, and an implementation plan. SLs continue to participate in quarterly reviews to assess the impact of the changes on C-Os, staff, budgets, and organizational goals. Lessons learned are identified, with intentional knowledge transfer to make immediate improvements, for annual planning, and to inform next phases in other programs.

Customer engagement: SCF creates a culture that delivers a consistently positive C-O experience. Job candidates are selected for their relationship-building skills; these skills are expanded/reinforced in NHO with RELATE training, ARO, and other L&D opportunities. All staff also attend Core Concepts, which provides guiding principles for use in every interaction (with C-Os, peers, and other stakeholders) in order to create healthy relationships and encourage engagement.

Customer Care and Relationships is one of four identified Workforce Competencies [5.2a(4)]. Staff are evaluated annually on how well they create/develop/nurture culturally appropriate interactions with each other, C-Os, and the community. Monthly, the CEC reviews CSS data from across SCF to ensure each department is meeting its goals.

Development of future leaders: SCF uses the following principles (acronym: "OWNERSHIP") to guide leadership:

- Operate from the strength of Alaska Native cultures and traditions of leadership.
- Will stand in the gap to align and achieve the mission and vision.
- Nurture an environment of trust that encourages buy-in, systematic growth, and change.
- Encourage ownership of responsible, calculated risk taking.
- Respect and grow the skills of future generations to drive initiatives and improvements.
- Share and listen to personal life stories in order to be transparent and accountable.
- Hedge people in by creating a safe environment where spiritual, ethical, and personal beliefs are honored.
- Improve for the future by learning from the past, giving away credit, and celebrating achievements.
- Practice and encourage self-improvement; believing there is good in every person.

The P/CEO has structured formal leadership development opportunities. The P/CEO selects, and mentors into their roles, SCF's VPs. The VPs attend structured VPLT meetings where corporate decisions are made by consensus of the VPLT group. VPs also attend, and are expected to participate in, the bi-monthly BOD meetings. VPs have alternating opportunities to lead SCF as Acting CEO while the P/CEO is out of the office and also represent the CEO during meetings requiring executive presence/ participation (e.g., IHS negotiations, JOB/ ANTHC BOD/legislative/other health care meetings). Two VPs are AN, consistent with the organizational goal of developing AN/AI staff at all levels.

The designation of senior director is used by the P/CEO to identify and develop future VP and/or CEO successors. The designation invites participation in expanded activities (e.g., JOB or legislative meetings with the P/CEO and/or their VP) and training to further develop their leadership abilities. SCF currently has six senior directors, with a mix of clinical or administrative roles. They are mentored by the P/CEO (and the VP they report to) and participate/ observe in VPLT and BOD meetings periodically. They are also given the opportunity to lead as Acting VP when the VP is out of the office.

Figure 1.1-3: Internal Communication Approaches

What/How	Frequency	Audience	Purpose
SCF BOD Retreat (Two-Way Communication)	Annual	SCF BOD, P/CEO, VPLT	Review/affirm MVCG; strategic planning
LDS (Two-Way Communication)	Quarterly	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 Communication)	Bi-Monthly	P/CEO, VPLT, Directors, Administrators, IA, Managers	For communication with P/CEO, VPLT and OCs, and for strategic planning
Annual Learning Event (Two-Way Communication)	Annual	SCF BOD, P/CEO, VPLT, Workforce	Highlights SCF programs, projects
NHO (Two-Way Communication)	Bi-Weekly	New Hires	Deploy MVCG/OP; introduce SCF P&Ps and other tools
Annual Gathering (Two-Way Communication)	Annual	SCF BOD, P/CEO, VPLT, Workforce, C-O, Partners, Community	Highlights SCF programs; gathers C-O feedback and input on needs
Functional Committee Meetings (Two-Way Communication)	Monthly	P/CEO, VPLT, Workforce	Strategic planning and monitor AP status
Core Concepts (Two-Way Communication)	Multiple Times Annually	P/CEO, VPLT, Workforce	Deploy MVCG/OP; build relationships
SCF Intranet	Daily	Workforce	SCF information, upcoming events, tools (AAPT, BSC, DM, Evaluation Tool, Improvement tools) Strategic planning and monitor AP status
Employee Satisfaction Survey	Annual	Workforce	Monitor staff satisfaction and engagement; strategic planning for improvement
QMC (Two-Way Communication)	Ongoing	Workforce	Educational offerings through the DC related to improvement
Department Meetings (Two-Way Communication Communication)	Ongoing	Department employees	Communicate key decisions and issues
Communicator (Two-Way Communication)	Ongoing	Workforce	Communicate key decisions and information; provide recognition
SCF Weekly	Weekly	Workforce	Issues staff reminders; shares key highlights from Communicator

Regardless of current position, all staff with an interest in gaining an executive leadership perspective are encouraged to apply for Executive Leadership Experience (ELE), a two- year program that further develops SCF's internal leadership capabilities. ELE participants are selected by the P/CEO, who then mentors them and offers opportunities for job shadowing and observation. This leadership experience is built upon SCF's "OWNERSHIP" principles and includes elements such as learning from SCF governance, participating in events/ conferences with key SMEs, completing an assigned project, and receiving additional learning and development support.

The Special Assistant Program is another P/CEO initiative to help staff progress and grow in their leadership capabilities. This program assigns special project work from VPLT to emerging AN leaders. It was reviewed and restructured in 2009 to ensure trainees experience more formal management training.

SCF has acted on an OFI by incorporating leadership development into the comprehensive system for how SCF hires, trains, and supports the workforce. For example, SLs actively participate in FOM, which was created in response to the need for manager mentoring/development [5.2b(3)].

FOM covers the fundamentals of leadership through a series of courses available in a non-sequential order. New leaders enter FOM through an initial orientation process where they learn from select departments such as Compliance and HR.

VPs and directors are also responsible for mentoring and developing their division management team, committee leaders, and workforce, respectively [5.2b(1)].

Additionally, through a partnership with APU, SCF has had 12 staff complete the Alaska Native Executive Leadership Program, resulting in L&D and nine graduate-level credits.

Culture of patient safety: SLs create and promote a culture of safety through resources for PI, a focus on National Patient Safety Goals, an automated patient tracer data tool, programs to improve medication safety, standardized code designations in alignment with state/national initiatives, and defined safety responsibilities for the QA Committee. C-Os and staff are encouraged to use a confidential 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, as well as standardized clinical practices, and safe C-O care environments. As the BOD and eligible SLs/staff use SCF services, their personal stake helps drive the focus on safety.

1.1c(2) Creating a Focus on Action. SCF's focus on action to achieve objectives, improve performance, and attain the mission, begins with the BOD, which constantly raises the bar and holds management accountable for measurable improvement, supported by the BSC [4.1a]. The BOD uses a subset of measures as key indicators to evaluate the P/CEO's performance. This action and its results are further reflected in SCF's cascading system of plans, performance measures, and BSC. SLs review BSC measures quarterly and take action based on their findings [4.1b]. To focus on actions for improvement, SCF uses the SPC [2.1a(1)] with metrics/timelines that are tied to the CG/CO and are defined in four BSC perspectives [4.1a(1)]. This tool helps ensure SCF examines and sets expectations; addresses multiple, and sometimes competing, stakeholder priorities; and creates balanced value for C-Os and other stakeholders. All PDPs, including those for SLs, are aligned with CG. SLs demonstrate personal accountability by leading the focuses on transparency, information sharing, and accessibility.

1.2 Governance and Societal Responsibilities

1.2a(1) Governance System. Through their oversight, review, and feedback, the BOD ensures accountability and transparency in operations and governance.

Accountability for SL actions: The BOD holds the P/CEO accountable through the BSC, SP and budgets, as well as operational performance reviews. The BOD establishes goals/ targets and annually evaluates P/CEO performance. Other SLs also take responsibility for specific CG/CI during the SPC and are evaluated on their achievement.

Accountability in SPs: To ensure accountability, SCF cascades initiatives and work plans to specific committees, and then departments and individual PDPs, thus creating a checks and balances system. For example, primary care providers/ medical directors have expectations such as cancer screening rates linked to CI in their PDPs.

Fiscal accountability: SLs/managers review financial statements, budget to actual reports, and key ratios via the DM. The Finance Committee [Fig. 1.1-2] analyzes financial performance and reports to OPS regularly on improvement activities related to expenditure control. Grants management and 3rd party reimbursement are two areas in which SCF must also demonstrate accountability. Reimbursement is reviewed monthly by SLs/managers and the RCC. Evaluators work with the Planning & Grants Department to support managers in meeting grantor requirements. Grant compliance reports are shared with the VPLT. An internal auditor periodically reviews compliance

with financial P&Ps and practices, and the BOD/ SLs review bi-monthly.

Transparency in operations: SCF ensures transparency by making P&Ps, financial data, CSS and EOS data, APs, and the P/CEO report to the BOD available on the intranet to all staff. The process for P&P approval includes review by appropriate committees [Fig. 1.1-2], managers, and staff for input. VPLT meeting minutes are available to all staff via the CM. SCF's public events provide opportunities for anyone to access SCF staff and ask questions.

Selection of BOD & disclosure policies: The CIRI Board, comprised of elected tribal members, appoints the SCF BOD (seven members) for terms of three years. Board members are evaluated annually and reappointed at CIRI's discretion. Board longevity has contributed to the strength of SCF's organizational governance. P&Ps are in place to identify and address conflicts of interest, and the BOD is required to read and abide by SCF's Code of Conduct [1.2b(2)], including conflict of interest disclosures.

Independence & effectiveness of audits: External audits are performed annually as required for government-funded programs. An independent CPA firm performs the audits, and the Board Audit Committee and SLs receive the reports. SLs review and update financial reporting and internal controls following best practice measures. SCF Corporate Compliance [1.2b(1)] sets internal audit priorities using a risk-based plan, which draws from an annual risk assessment that includes input from the FCS/BOD/VPLT. Special issues may require contracting with outside auditors. The internal audit activity brings a systematic approach to evaluating and improving the effectiveness of governance, risk management, and control processes. Results are formally reported to the BOD. P&Ps outline procedural steps for internal audits and risk assessments, including providing for any incidences where SLs would be unable to resolve issues, in which case they would be taken to the BOD.

Protection of stakeholder interests: All BOD members are also C-Os invested in SCF's sustainability for their care and the care of their families/future generations. The BOD has a key role in the SPC, with oversight to help ensure that actions have been effectively implemented to protect C-O interests (in the case of audit findings, etc.). The BOD also evaluates the performance of the P/CEO.

Succession planning for SLs: Succession planning is a key responsibility of the P/CEO. While SCF has many ways to develop staff, the P/CEO spends additional time focused on developing future leadership. SCF's succession planning process involves structured and ongoing preparation in career/ leadership planning, development, and assessment; retention; and performance management. Assessments include CDR assessment, leadership readiness self-assessment, manager assessment, and 360-degree assessment from subordinates and peers.

1.2a(2) Performance Evaluation. SCF's approach to performance evaluation is based on achievement of goals developed through the SPC, which aligns CG/CO with individual PDPs at every level [5.2a(4)]. All staff, including SLs, use the same PDP tool. SLs engage in leadership evaluations through processes such as CDR assessments. They use the findings to improve skills by means of leadership development plans that are part of their PDPs.

The CIRI Board annually evaluates the SCF BOD [1.2a(1)]. Using 2007 Baldrige feedback, the BOD determined the need for a self-assessment tool that provided national comparative data from other health care boards. SCF benchmarked The Governance Institute as a source to assess performance through tools/resources and other services. As a result, BOD agendas are more strategic, discussions have been expanded to include succession planning, and further BOD educational opportunities have been identified. Members of the BOD come from diverse backgrounds, but all are AN C-Os. The BOD annually elects, and also evaluates, the P/CEO. Pay is incentivized based on goal achievement, 360-degree feedback and, since 2005, quantitative results from BSC measures. The P/CEO, in turn, evaluates the VPs based on 360-degree review from direct reports, other VPs, and the P/CEO. SLs use Baldrige assessments, CSS, and EOS results to

evaluate their effectiveness as a leadership system. The FCS, implemented in 2004, is a system improvement [Fig. 1.1-2].

1.2b(1) Legal, Regulatory, and Accreditation Compliance. SCF participates in health care committees/organizations (e.g., TJC) that maintain listening/learning sensors attuned to changes in accreditation, regulatory, and legal matters [Fig. 1.2-1] affecting health care. Through participation in workshops/ meetings/webcasts, SCF has access to information that enables 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/ requirements related to accreditation and compliance. The CBG reviews information on public concerns and changing requirements to help determine SCF's approach for addressing changes for services and operations.

Anticipate/prepare for public concerns: SLs participate in committees, and serve on boards of various organizations, to keep abreast of concerns and to integrate community feedback into service improvement strategies and the SPC. SCF utilizes various communications tools, including its newsletter and proactive media relations with local, state, and national news sources, to communicate key issues and address potential concerns. Through ongoing communications and community relations, SCF maintains a bank of goodwill with its targeted audience. 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/refillable water bottles/paper products instead of disposables in meetings/ gatherings. SCF also participates in "green" action planning with other U-Med Green District members.

Key processes/measures/goals to achieve and exceed regulatory/ legal/accreditation requirements: [Fig. 1.2-1] summarizes examples of SCF's overall integrated system, processes, practices, measures, and goals, deployed to comply with the range of accreditation/regulatory/legal requirements. The SCF Compliance and QA departments collaborate to monitor/track measures that support accountability. These measures are collected/reported through the Compliance and QA committee structure and reported quarterly to SLs/BOD.

SCF Compliance provides guidance 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 that programs continue to be vigilant.

Addressing risk: The Compliance Committee chartered the Auditing & Monitoring Subcommittee to proactively provide support and advice using a risk-based approach to auditing and monitoring activities. The subcommittee provides input in risk assessment, audit planning, and reporting processes. The Compliance Committee and its subcommittees meet bi-monthly, report to the QA Committee, and make recommendations directly to SLs.

1.2b(2) Ethical Behavior. SCF promotes a culture of ethical behavior through its robust compliance program, outlined in SCF's Ethics & Compliance Program Policy, and SCF Code of Conduct, which is distributed to every person who provides services at SCF (i.e., staff, contractors, volunteers, residents, etc.). Each person is required to attend training and sign a Code of Conduct acknowledgment, which is kept on file. This training addresses all aspects of ethics, conveys information on how to address and report ethics/compliance concerns, and includes other confidentiality and security expectations. Required ARO includes regulatory updates and specific areas of compliance, and ad hoc training is offered on specific ethics and compliance issues and all related P&Ps. In addition, SCF Compliance reports monthly to SLs and the BOD on regulatory updates; compliance activities, including the volume and type of inquiries; and complaints, audits, and ethics training/ education. Data is tabulated to identify shifts/trends and used to indicate corrective actions. The CSS and EOS also monitor the tone of ethics/compliance across SCF. P&Ps such as the Compliance Issue Reporting and Resolution Procedure are available on the intranet. SCF's in-house counsel/risk management functions are co-located, which facilitates close coordination as they monitor rules and regulations [Fig. 1.2-1].

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

Agency	Compliance Practices	Measure	% Goal
TJC	• Standards for ANPCC: Leadership, Safety, Administration, Medical Staff, Services • Use of restraints, etc. • Disaster/preparedness	TJC Survey & Assessment Scores	100
BME	Medical staff licensing	BME Requirements	100
CARF	Standards for BSD residential programs: Care, Quality, Safety	CARF Requirements	100
AAAHC	Ambulatory Accreditation (Opt, Dental, VNPCC, etc.)	AAAHC Requirements	100
CLIA	Laboratory accuracy and reliability of testing	Current Certificates	100
EPA	Environmental pollution abatement	Agency Standards	100
DOT	Biohazard management practices and medical waste disposal	Vendor Certificates	100
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
DEA	Laws for dispensing medication or abuse of drugs or controlled substances	Provide Required Report on Time	100
CDC	Infection control standards and practices	Provide Required Report on Time	100
DHSS	Infection control reportable diseases	Provide Required Report on Time	100
HIPAA	• Understand and participate in personal health care decisions • Patient privacy, security, transactions and code sets federal regulations	Signed Consents	100
IRB	Ethical standards according to federal and state laws regarding research, investigations and clinical trials	• Follow IRB protocols • OHRP • Audit	100
ICPA	Ensure the protection and safety of C-O	Regulatory Standards	100
Alaska BCU	Ensure the protection and safety of C-O	Regulatory Standards	100
OIG	Ensure the protection and safety of C-O	Exclusion Data Base	0

Key processes for monitoring/enabling ethical behavior & responding to breaches: SCF Compliance is available to staff, managers, SLs, and C-Os during regular business hours, as well as via a 24-hour, 7-days-a-week, toll-free compliance hotline. Through this hotline, the department receives questions/requests for guidance, reports, or allegations of compliance concerns within SCF and with stakeholders, and requests for compliance reviews/audits. All requests are tracked and answered to, and any allegation of wrongdoing is investigated. The findings are used to develop corrective actions that may include education, system modifications, or disciplinary measures. SCF Compliance works closely with HR to ensure corrective actions are implemented in a fair manner, without any real/perceived appearance of retaliation. Also, SCF reports to CIRI quarterly on compliance activity.

1.2c(1) Societal Well-Being. As an AN cultural value, societal/community well-being and benefit are threaded through SCF's MVCG and strategies, and are deployed organization-wide [Fig. 1.1-1]. The MVCG/OP are used in strategic planning, day-to-day operational decisions, and improvement plans. C-Os 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/community wellness. SCF's approach recognizes that wellness is multidimensional. An example of SCF's commitment to societal well-being is found in CO FMW: Reduce the Incidence of Suicide. During SCF's Annual Gathering in 2015, the Denaa Yeets' Program hosted an information booth that drew in more than 600 C-Os for discussion, education, and resources on the topic of suicide [Fig.7.1-12]. Other examples include standardized use of the Improvement Process to continuously improve health and wellness services; ECAF [Fig. 7.4-10]; Green Team; Project Homeless Connect: sponsorship of events such as Heart Run, Citywide Cleanup, SCF Elder Program's Day of Caring and Elder holiday parties; and other community benefit events.

1.2c(2) Community Support. SCF has identified its key communities as C-Os living in its service area with a focus on AN Elders, families, new parents (pre-conception through age 5), and children/youth. The focus areas are determined through two-way communication with C-Os. SCF analyzes the feedback to determine key communities and their needs.

Supporting key communities: SCF's Nuka System of Care has achieved high levels of integration, but it also takes a population-based approach to improving family and community well-being that extends beyond the coordination of care services. For example, programs to eliminate disparities such as SCF's FWWI, which addresses domestic violence, abuse, and neglect across the population through education/ training/community engagement. Also, traditional healing is offered alongside other health care services, and all of SCF's services aim to build on the culture of the AN community.

During the SPC, SCF determines where to focus community health resources based on AN community needs, the MVCG, and ongoing guidance from C-Os. As "key communities," Elders, families, new parents and children/ youth receive special emphasis. To support these communities, SCF aligns/ integrates/ enhances its services with resources provided by staff 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/safety topics; internship and L&D opportunities for youth ages 14-19; car seat education for families; and health education during prenatal screening.

SCF actively supports and strengthens key communities through (1) fulfilling obligations for prepaid health-related services to AN/AI people; (2) seeking grants/collaborative partnerships for innovative programs not covered by government funds or 3rd party payers; (3) recruiting volunteers from workforce/community; (4) being recognized as a model for health care practices; and (5) regular communication/coordination with other CIRI nonprofits.

SCF also promotes health for AN people through its leadership's teaching, mentoring, and advocating. SLs play an important advocacy role in community and governmental activities that are congruent with the MVCG/OP. As faculty at IHI and Nuka conferences, SLs share best practices, including population health management, 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 (e.g., Kotzebue, Fairbanks, Bethel, Kenai, and Southeast Alaska areas) and national indigenous health care organizations, going beyond the range of just influencing SCF's immediate service area.

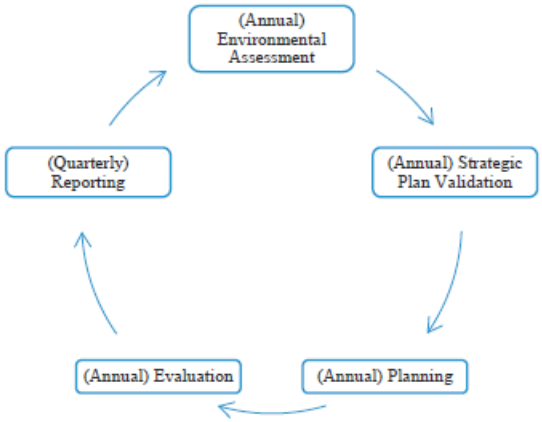
The information sharing and support is evidenced by the frequent site visits to SCF's facilities by other organizations.

Category 2: Strategy

2.1 Strategy Development

2.1a(1) Strategic Planning Process (SPP). SCF's SPP is vital to its focus on whole-system transformation. All staff participate. The approach is aimed at capturing the VOC, ensuring key relationships are created/ maintained, and leveraging the culture of SCF [1.1c(1)] and the community for success. SCF has defined its SPP, also called SPC, as a cycle with these key process steps: (1) Environmental Assessment, (2) Strategic Plan Validation, (3) Annual Planning, (4) Evaluation, and (5) Quarterly Reporting. Each step incorporates a planning horizon, ranging from one quarter to five or more years. The SPP addresses organizational agility, flexibility, and innovation by using the FCS to facilitate review/development of Corporate Objectives (CO), Corporate Initiatives (CI), and Annual Plans (APs).

Figure 2.1-1: Strategic Planning Process/Cycle



1. Environmental Assessment (Jan.–March): Key participants = internal SMEs, including C-Os; considerations include a planning horizon of one to three years; outcome of this step is the SID [4.2b(1)]. An organizational SWOT analysis is conducted annually with input from staff (including C-Os). SMEs provide key information/data, including alignment of CC and potential changes to internal/external environment. A summary of the SWOT and other strategic considerations are documented in the SID, which is vetted by multiple committees. These reviews create an opportunity to develop strategies, incorporate innovation, and address potential blind spots. The SID is then presented to the VPLT and BOD. They review it and identify associated SA, SC, opportunities, and risks. The SID, accessible via the intranet, sets the foundation for all the SPP conversations that follow.

2. Strategic Plan Validation (April–June): Key participants = BOD, VPLT, directors, and managers; includes a planning horizon of one to three years; outcome of this step is a revised Strategic Plan (includes CO and CI). Current strategy and performance is reviewed against the SID. The final plan takes into account innovation, transformational change, and organizational agility. It is shared and reviewed with division leadership and the FCS. All department leaders (i.e., managers) review the plan with their staff, and it can also be accessed from the intranet. Also in this step, managers submit their proposed budgets to VPLT for consideration.

3. Annual Planning (July–Sept.): Key participants = directors, managers and staff; includes a planning horizon of one year; outcomes of this step are multiple APs. Division leadership discuss priorities and agree on which CI will be pushed out to appropriate departments. FCS OCs discuss and agree on which CI will be pushed out to appropriate subcommittees. The receiving groups accept the CI and begin developing APs [2.2a(1)] through a process of team brainstorming with support from improvement staff. They also have the opportunity to pull CI relevant to their department/ committee. VPLT reviews/ approves final budgets for each department, as well as the BSC, consisting of the key performance measures and aligned with CGs.

4. Evaluation (Oct.–Dec.): Key participants = directors, managers, committee leaders, and staff; includes a planning horizon of one year; outcomes of this step are employee PDPs and information gathering for the SWOT analysis. While delivering evaluations of past performance, managers also partner with staff to develop their individual PDPs [5.2a(4)], which are aligned with department APs. The Strategic Planning Committee [Fig. 1.1-1; 2.2a(2)] completes an evaluation of the SPP, using feedback received during the cycle, to identify strengths and OFIs.

5. Quarterly Reporting: Key participants = directors, managers, committee leaders, and staff; includes a planning horizon of three months; outcomes are APQRs and an updated BSC. At the end of each quarter, directors/managers review APs and develop performance reports. The reports and BSC measures are reviewed/discussed by the FCS committees. Strategic opportunities may be identified during this step. Changes to the AP may also occur at this time.

Through the establishment of partnerships with the community, and through mechanisms of capturing real-time C-O feedback, the workforce is empowered to rapidly identify/report on any opportunities/risks as they arise. The FCS can discuss needs for rapid strategic changes during routine meetings and share these with the VPLT/BOD for strategic direction. For example, phishing scams were identified at the employee level. The cybersecurity risk was escalated to IT leadership/VPLT, and a new AP was enacted to address the issue and educate staff on security vulnerability.

2.1a(2) Innovation. SCF identifies strategic opportunities through various approaches, including:

- Collecting C-O feedback [3.1a(1)];
- Including SWOT analysis in SID [2.1a.(1)];
- Reviewing SID with multiple committees [2.1a.(1)];
- Multiple levels of review for CI and APs [2.1a.(1)];
- Incorporating Improvement and Innovation, one of four CC, in job descriptions and PDPs [5.2b(1)];
- Implementing a structured collection and review of conference ideas [4.2b(1)].
- Providing Improvement and Innovation focused workforce training (e.g., NHO, QMC) [5.2b(1)];
- Establishing the Learning Institute and the Nuka Learning and Wellness Center [4.2b(1)];
- Staffing senior business planners to support division
- leaders in developing business plans;
- Establishing/staffing an Org. Development department, including improvement advisors/ specialists [5.2b(1)];

SCF decides on strategic opportunities and intelligent risks to pursue by using the FCS and improvement advisors/ specialists to review and discuss opportunities and risks. Ideas evolve after multiple committee reviews. Organizational Development department has added improvement role capacity to be able to effectively manage workload related to improvement and innovation. Each improvement role partners with and supports division operation leaders in identifying and opportunities and facilitating related work.

Establishing strategic partnerships also stimulates innovation. SCF has partnered with Harvard's Center for Primary Care, IHI and Cerner, among many others. Through these partnerships, new ideas are introduced for consideration in the SPP. Strategic opportunities are listed in [Fig. 2.2-2].

2.1a(3) Strategy Considerations. Collecting meaningful data [4.1a(1)] and transforming it into useful information is an ongoing process. The SID documents relevant strategic data, C-O requirements, etc., and is the foundation for all the SPP decisions that follow. Reviews of the APQR and BSC (by committee to ensure different perspectives) create an opportunity to address blind spots and determine ability to execute the Strategic Plan.

2.1a(4) Work Systems & Core Competencies. Recommendations and decisions on work systems are made at the division level and then vetted by appropriate committees. These decisions are based on SCF's OP and CC.

SCF has five key work systems [Fig. 2.1-2]. Each work system receives input from the FCS. The appropriate committee provides guidance of the accomplishment of objectives and review of work system designs to ensure value-added services for C-Os and stakeholders. When the FCS was implemented, four dimensions of responsibility were identified: QA, QI, PI, and OPS. These dimensions ensure SCF continues its focus on today's work, while balancing resources with future improvement and innovation needs.

Figure 2.1-2: Key Work Systems

Key Work Systems 2.1a(4)	Description of Work Systems	Oversight of Strategic Objectives	Internal or External Service
Behavioral	Clinical delivery of behavioral health services	QIC; QAC	Learning Circles (Internal and External)
Dental	Clinical delivery of dental services	QIC; QAC	Cleft Lip and Palate Clinic (Internal and External)
Medical	Clinical delivery of health care services	QIC; QAC	PEDS FASD Clinic (Internal)
Tribal	Clinical delivery of Alaska Native traditional health care services	QIC; QAC	Community Outreach, Tribal Relations (External)
Health Care Support	Supports all service delivery	OPS; PIC	Learning Institute (Internal and External)

The SPP [2.1a(1)], ongoing performance review [4.1b], and the improvement process [Fig. 6.1-2] determine what work systems are needed. This process includes gathering input from C-Os [Fig. P.1-6], 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, the following factors are considered: (1) alignment with the MVCG/OP, (2) within the scope of CCs (SCF already performs it well), (3) inclusion in funding priorities, (4) best completed internally vs. best completed externally, and (5) cost-effectiveness.

Committee members and/or responsible staff assess suggested work system design/process ideas by using the OP to ensure alignment with C-O requirements and to capitalize on the CC. If the work system is to be outsourced, SCF determines whether the suppliers/ partners/ collaborators have values and processes consistent with the MVCG/OP. For example, the primary care clinics identified chronic pain as an opportunity for improvement. A multidisciplinary team then designed a process to address chronic pain management in-house, with the exception of a few complex cases referred to specialists outside of SCF. Other examples include specialty treatment for allergies, dialysis, and nuclear medicine referrals.

SCF uses input from C-Os and stakeholders to determine key service and process requirements [Fig. 6.1-1]. As requirements are defined, SCF identifies measures to assess whether it is meeting those requirements. These measures are incorporated into various committee and leadership performance review cycles and also maintained on the DM or appropriate BSC.

The majority of improvement related work that is corporate wide (cuts across division and departments), is guided through the FCS. [Fig. 1.1-2]. Most health care organizations rely on “operations” to do PI and clinical quality to do both QA and QI. To drive whole-system transformation and excellence, SCF believes that technical skills and dedicated staffing are needed in all four dimensions: QA, QI, PI and OPS. The four functional/OCs representing these dimensions have members from various disciplines and all divisions. This structure ensures consistency across SCF, and that work system design is driven by both external and internal customers. The four OCs exist at all levels of SCF; the subcommittees evaluate, define, and drive the vast majority of improvement

efforts at SCF. CI, work plans, timelines, and measurement requirements primarily derive from this approach and structure.

2.1b(1) Key Strategic Objectives. From SCF MV [Fig. 2.2-1], the CG are defined as Shared Responsibility, Commitment to Quality, Family Wellness, and Operational Excellence. From CG, SCF strategic objectives are defined as corporate objectives (CO). Key measures aligned with CG/CO are on the BSC and reviewed quarterly by SCF leadership groups. The timetable for each CO is approximately 5+ years. From CO, flow CI. The timetable for each CI is approximately 3-5 years. All associated CI performance measures are reviewed regularly. All CI are assigned to an appropriate committee within the FCS for monitoring. Each committee has an oversight committee and an executive sponsor. The executive sponsor ensures the CI are aligned across appropriate organizational systems. Key changes are identified and documented by all departments/committees with the AAPT.

Each department/committee has an AP. All staff have access to these via the AAPT. The APs contain work plans, and quarterly reports, aligned to CI. This ensures alignment of work and CI, CO, and CG. With this information, along with the SID, VPLT, and BOD are able to identify actionable CO, with the intent to address all of the KWP.

2.1b(2) Strategic Objective Considerations. The review of the SID identifies SA and SC, and generates a wide range of opportunities/risks to consider for balancing competing organizational needs and the needs of all stakeholders. This information then drives the review of the strategic planning horizons. CO and CI are assessed and validated, or updated as necessary, dependent upon organization and division priorities. This ensures an appropriate balance among needs.

In the next layer of consideration, SCF outlines the budget and incorporates the resources needed for the CO/CI, as well as sets aside contingency funds for unforecasted needs if they arise. For example, through SWOT analysis, an SC was identified (related to reviewing regulatory information and changes) and compiled in the SID for VPLT/BOD review.

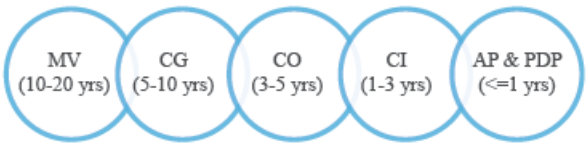
They then acted on the information and approved a new CI.

SCF's strategic objectives are achievable due to its CC, which ensure a solid foundation for success that is integrated throughout SCF by the entire workforce [5.1a(4)]. With the emphasis on the CC and SPP, the workforce is prepared and empowered to accomplish SCF's strategic objectives.

2.2 Strategy Implementation

2.2a(1) Action Plans. SCF's key short-term action plans start with the CI. The CI and work plans (action plans) at SCF are designed as aligned stepping stones that bridge the whole system to reaching the MVCG [Fig. 2.2-1]. Each department/committee develops an AP. APs contain multiple work plans aligned with multiple CI. CO and CI are proposed by the FCS and division/department leadership and approved by the VPLT/BOD. The approved CO, CI, and the SID are then reviewed by committees/departments. This begins the development of potential work plans within APs, defining the specific work that will occur during the course of one year.

Figure 2.2-1: Strategic Planning Linkages



Annually, the APs are developed and proposed in the AAPT. Cycles of leadership approvals occur before implementation. Each AP has an approver. The approver has the ability to provide feedback and return the AP to the owner. This multi- level review ensures discussions about key outcomes and sustainability. Key short- and longer-term action plans are shown in [Fig. 2.2-2].

Figure 2.2-1: Snapshot of SCF Strategic Plan (*detailed version available onsite*)

Strategic Opportunities [2.1a(2)]	SCF Corporate Goals [2.1b(1)]	SCF Corporate Objectives [2.1b(1)]	Corporate Initiatives [2.2a(1)]	Annual Plans/work plans [2.2a(4)]	Annual Plan Key Performance Measures [2.2a(5)]	Action Plan Key Perf Measure Projections [2.2a(6)]
Customer-Owner Experience	Shared Responsibility	3 Customer Focused Objectives	8 CIs (e.g., Improve C-O satisfaction with focus on courtesy, respect, problem solving.)	Customer Experience Committee AP: Develop SCF Customer Care Standards, RELATE.	C-O Satisfaction	Increased C-O Satisfaction Percentage
Workforce Development	Commitment to Quality	3 Workforce Focused Objectives	10 CIs (e.g., Improve SCF leadership and succession planning.)	Development Center AP: Deploy leadership principles, OWNERSHIP.	% of AI/AN in leadership positions	Increased % of AN/AI in leadership positions
Operational Effectiveness	Family Wellness	8 Clinical Focused Objectives	14 CIs (e.g., Improve prevention, screening, and support services for cancer.)	Primary Care Core Business Group AP: Improve screening rates for colorectal and cervical cancer.	Screening rates	Increased % of screening rates Decreased cancer rate
Financial & Workload	Operational Excellence	3 Financial Focused Objectives	11 CIs (e.g., Improve Performance through standardized data management process.)	Data Analysis & Tracking Committee: Transition ad hoc business object reports to Tableau reports within Healthy Intent.	Standardized reports	Increased Standard reports Decreased Ad hoc reporting

2.2a(2) Action Plan Implementation. After the validation phase [2.1a(1)] each spring, the three-month planning phase begins. Key members of departments/committees become AP owners (with set measurements of success, targets, and timelines) and may request work partners from across SCF. AP oversight is designated to committees or leadership teams as appropriate. Large-scale APs typically warrant a PTC. Once all details are provided, approval is attained and the AP owner can proceed as planned. Status updates are reported via the APQR and include progress made, lessons learned, and next steps.

At the end of each quarter, the APQRs are reviewed/approved through the approval chain. This process allows leaders to identify actions and resources needed to sustain or spread the outcomes of the AP. All staff can access and view all APs, associated status updates, and work plans via the intranet.

SCF also shares APs with key external partners [Fig. P.1-7]; for example, with ANTHC (e.g., during meetings of the JOB), enabling primary care and specialty hospital care to work collaboratively across the continuum.

The Strategic Planning Committee is a subcommittee of the PIC responsible for facilitating the SPP. Recent improvements to the AP piece of the SPP include involving committee members early on to review/provide feedback. This includes reviewing APs with AP owners and a division designee to improve awareness of how APs are linked to CI. This review provides another opportunity to capture blind spots.

2.2a(3) Resource Allocation. SCF ensures that financial resources are available by planning/ forecasting, and seeking partnerships/ funding. Revenues for the next FY are forecasted during the assessment phase of the SPP. Forecasts are largely based on results from the last FY and the year-to-date results from the current FY. Any other known or forecastable factors (e.g., significant changes in Medicaid payment methodology, etc.) are also considered. Projections for new business investments are based on market/payor information and include start-up, phase-in, and fully implemented or "mature" budgeted amounts.

If not expected to generate enough revenue to cover expenses, an allocation from corporate reserves can be identified/ designated. In these scenarios, the ROI is more about achieving MVCG. SCF has had success putting the C-O first and investing upfront for downstream savings. Providing the best care/service is the top priority.

Assessment of risk is an ongoing process based largely on financial results from operations, and general knowledge of SCF's marketplace/regulatory environment. SCF formulates long-term financial plans with the knowledge that it is not possible to maintain operating margins at historical levels. Long-term financial planning includes evaluating levels of service that can be supported based on funding projections. The VPLT also monitors the impact of the influx of AN/AI from rural Alaska to the Anchorage area based on SCF's financial position. Because it is understood that this in-migration of C-Os is causing expenditures to grow faster than offsetting revenue, managers are responsible for managing to their department budgets. The finance division tracks and monitors revenue/expenses and identifies deviations from anticipated levels. The RCC monitors and communicates third-party revenue results, addresses OFIs, and makes recommendations to enhance revenue.

SCF manages its costs by involving managers in budget development; developing tools to track costs over time; emphasizing proactive wellness/active management of chronic disease; addressing the C-O family as a unit; eliminating duplication/multiple visits to the greatest extent possible; allowing staff to "work to the limit of their license"; and identifying what type of services complex users of services really need.

SCF takes an active role in its relationship with funding partners, including the IHS, State of Alaska, and Alaska Mental Health Trust Authority, in policy and operational matters. The relationships aid in identifying needs, as well as elements of risk, and working together to resolve them.

To support appropriate workforce planning, SCF uses a comprehensive staffing formula that enables it to project, for every empaneled C-O, the FTE and cost to sustain its action plan changes. Projected staffing needs drive the Corporate Recruitment Plan, which includes strategies for providers, clinical support staff, administrative support, and other staff. These formulas serve to ensure that realistic budgets are set to accomplish long-term staffing needs, along with short-term solutions such as temporary/contract workers.

2.2a(4) Workforce Plans. SCF takes a strategic approach to addressing projected needs for workforce capability and capacity [5.1a(1)]. The organization also capitalizes on its L&D culture. Its DC is dedicated solely to L&D, with the training derived from SCF's CC. There is a notable dedication to professional growth as well as skills/abilities that best serve C-Os.

An uptick in growth in the area's AN/AI population and increased demand for services have significant staffing implications. SCF HR and DC use a combination of formal/ informal feedback to improve or add programs. HR's APs include recruitment to build workforce capability; increasing the percent of AN/AI staff in clinical positions; improving retention; and increasing readiness for the next level of responsibility. Employee engagement is a consideration for every stage of employment, beginning with recruitment. The DC's APs include redesign improvements to onboarding programs such as ASTP, NHO, NMO, CMA/LPN training, and increasing the number of educational offerings with CME and/or university credit. With these plans in place, SCF is able to address the forecasted growth of its C-O base and its implications.

2.2a(5) Performance Measures. All APs are designed with measures and targets [Fig. 2.2-2]. The BSC categorizes the measures by strategic opportunity. With this distribution of the key performance measures, there is a whole-system perspective that allows for appropriate balance. The BSC is reviewed quarterly by VPLT/BOD and is accessible to all staff on the DM [4.1a(1)]. Progress is reviewed quarterly by directors/managers and the OC assigned to each measure. As an extra layer of oversight, the DATC (a PIC subcommittee) oversees data analysis and tracking. The DATC also manages data requests and addresses accessibility issues. The ready access to data enables the identification of potential blind

spots and the ability to modify plans based on performance.

Not only is organizational alignment achieved by the structured approach to the SPP, but it is also reinforced through the CC outlined by the PDP [5.2a(4)]. AP measures are outlined in the AAPT and progress toward these metrics is updated in the APQR. The workforce has access to these APs and metrics, which ensures alignment and minimizes duplication.

2.2a(6) Performance Projections. Several factors are used to set short- and long-term performance targets, including internal/external comparisons of performance and trends [Fig. P.2-1]. Some key performance measures are unique to SCF based on the C-O population. When applicable, projected results are compared to similar organizations and/or national benchmarks. [4.1c(1)] Owners of CI are SMEs who determine appropriate indicators and projections, which are then reviewed by the appropriate OC and/or division leadership.

Progress is reviewed quarterly, and gaps are identified and addressed at the division/committee levels.

2.2b Action Plan Modification. APs can be developed and/ or modified at any time, following the same process as step 4 of SPP. SCF remains flexible to changing circumstances and quickly responds to C-O needs as they arise. All edits to an AP will trigger review/approval through the approval chain. Required APQR and reviews provide leadership with the information needed to make modifications and promote rapid development, deployment, and adjustment of APs. SCF's response to H1N1 (swine flu) in 2009 provides an example of how APs 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 [1.1c(1)].

Category 3: Customers

3.1 Voice of the Customer

3.1a(1) Current Patients and Other Customers. With customer-ownership a key tenet on which the health system is built, multiple avenues for C-O input are central to its design and ongoing functioning. The needs and wants of C-Os are elicited, heard, and integrated into every decision, structure, and process (e.g., strategic planning) within the system. SCF manages and uses listening post data and information to identify changing health care needs and to look for OFIs to become more C-O focused. Listening posts vary for different market segments and stages of relationships with C-Os [Fig. 3.1-1]. Example: Elders Advisory Council is an opportunity to listen, interact with, and observe services for the Elder C-O segment. Information is shared for actionable planning through the SID and AP. P&Ps that outline how key listening posts such as focus groups, social media, and surveys are administered are available to all employees in the organization.

The Customer Feedback Reporting System (CFRS), employee engagement survey [5.2(a)2], and customer satisfaction surveys (CSS) collect detailed information that can be further segmented to different groups; for example: by division, department, department leader, and PCT. Employees have access to this data at varying levels across the organization from different databases. Data is trended over time to identify strengths and OFIs to inform the SPC.

The Learning Institute and PR departments monitor SCF's Twitter, Instagram, and Facebook accounts and ensure feedback from C-Os is responded to and captured in the CFRS so that themes and OFIs can be identified. In the response, the customer hotline number is also provided in the event there are additional incident details the C-O would like to share.

The CSS provide immediate and actionable feedback as a result of a corporate-wide change from mail-out CSS to electronic tablet surveys at the point of service. This idea was piloted and recommended for change through the FCS.

Figure 3.1-1: SCF Listening Posts

Listening Posts	Listening Frequency	C-O	Service Area Segments	Feedback Data	Owner
Personal Interactions	Ongoing	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative	All Employees
Comment Cards	Ongoing	Current C-O	Anchorage & Mat-Su Valley	Qualitative	All Employees
Customer Satisfaction Surveys	Ongoing	Current C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit	Quantitative	Organizational Development
Survey Monkey	Special Purpose	Current C-O	Anchorage Service Unit	Qualitative, Quantitative	Organizational Development
24-hour Hotlines	Ongoing	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members M	Qualitative	Corporate Compliance
Web-generated email to P/CEO	Ongoing	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative	Organizational Development
Nuka Conference	Periodic	Current C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative, Quantitative	Learning Institute
Site Visits	Ongoing	Current C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative, Quantitative	Learning Institute
Governing Board	Periodic	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages	Qualitative	Vice President Leadership Team
Advisory Committee	Periodic	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, Anchorage Service Unit, State Tribal Members	Qualitative	Vice President Leadership Team
Community Leadership	Periodic	Current, Potential, and Former C-O	Anchorage Service Unit, STM	Qualitative	Vice President Leadership Team
Social Media (Facebook, Twitter, Instagram)	Ongoing	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative, Quantitative	Public Relations, Learning Institute
Focus Groups	Special Purpose	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley	Qualitative	All Employees
Service Agreements	Special Purpose	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit	Qualitative	Quality Assurance
Patient Portal/myANMC	Ongoing	Current C-O	Anchorage & Mat-Su Valley	Qualitative	Medical Services Division
Annual Gatherings	Periodic	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley	Qualitative	All Employees
Population Surveys	Periodic	Current, Potential, and Former C-O	Anchorage & Mat-Su Valley, CIRI Villages, Anchorage Service Unit, State Tribal Members	Qualitative, Quantitative	Organizational Development
CMS Regulated Satisfaction Surveys	Ongoing	Current C-O	Anchorage & Mat-Su Valley	Qualitative, Quantitative	Home Health, Organizational Development
Staff Huddles	Ongoing	Current C-O	Anchorage & Mat-Su Valley	Qualitative	All Employees

As part of the FCS, the Customer Experience Committee (CEC)—its membership comprised of employees who are all eligible for services—uses listening post feedback from employees, C-Os, and other stakeholders to measure the performance of the services provided. The CEC reviewed the mail-out survey response and utilized the low response measurement as a form of feedback. Through brainstorming sessions and researching best practices used by other organizations, including Baldrige award recipients, the CEC piloted the electronic tablet CSS. The success of the pilot was measured using department-specific monthly targets, based on the number of C-Os served. The intention was to avoid survey fatigue while capturing a statistically significant amount of feedback. The results were reported at each CEC monthly meeting. After several revisions, the process was deployed throughout the organization. The improved process increased survey response rates, reduced vendor costs, increased accessibility to actionable data, and helped to resolve concerns in a timelier manner. It also furthered SCF's ability to identify larger trends, including successes and OFIs.

The CEC provides the FCS with recommendations and OFIs regarding the way SCF listens to, interacts with, and observes C-Os. Based on conversations in the FCS, progress, recommendations, and SWOT analyses are provided in the SID annually as part of the SPC, which sets the organizational direction for listening to the VOC. The SID [2.1(a)1] is reviewed by the BOD annually. Quarterly reports are submitted by the CEC to share AP progress, suggest improvements based on OFIs or best practices, and request guidance and approval for corporate-wide changes by CEC's oversight, the OPS committee. The CEC and OPS committees work with leadership to embed updated C-O satisfaction and feedback measures into the manager PDP template [5.1(a)4], which further influences all employee PDPs.

Deployment of corporate-wide customer service standards ensure that the entire workforce is capable of listening to and meeting C-O requirements and expectations at all stages of involvement with the health system. SCF begins modeling customer service best practices early for employees in NHO. All employee PDPs, including department leaderships', include a competency and measure associated with customer care [5.2(a)4].

In 2015, the CEC recognized an opportunity to improve the customer service delivery standards. Previous standards were purchased through a vendor, a "one-size fits most" approach that did not allow for optimal alignment with SCF's OP. Data trends demonstrated elevated concerns regarding rudeness despite the use of the standard. As a result, the CEC developed culturally relevant and relationship-based customer service standards: Respect, Engage, Listen, Advocate, Thank, Encourage (RELATE). RELATE was deployed to current employees and integrated into NHO training. Additional training was developed for front-line staff. The change in approach increased customer satisfaction results and decreased occurrences of perceived rudeness.

3.1a(2) Potential Patients and Other Customers. SCF uses listening posts [Fig. 3.1-1] such as face-to-face interactions at community events; web and social media generated inquiries; and surveys to listen to former, potential, and competitors' C-Os.

For example, the annual Gathering event provides opportunities for the wider community, including potential and former C-Os, to share feedback with department staff and SCF leadership. The event offers engagement with 140 or more booths staffed by SCF departments/programs, community vendors, and AN/AI artists. The CEC and SCF PR Department host booths each year to engage C-Os and the community. If a work plan can be supported by additional feedback, the CEC uses this opportunity to gather data from current, former, and potential C-O groups through custom surveys.

The PR department helps find new opportunities to invite involvement with the health system. For example, on Facebook, the messaging option has become very popular and provides a way for C-Os to ask questions privately. Additionally, the SCF website offers a menu of options (e.g., general comments, concerns, job application inquiries, program information) for anyone who would like to make contact, for any reason. The web-generated

comments are monitored daily, entered into the CFRS, and responded to accordingly.

Qualitative feedback is entered into the CFRS that allows SCF to turn the feedback into quantitative data and identify trends. Feedback data is aggregated into actionable information and reviewed at least quarterly by the CEC, FCS, division and department leaders, and during the SPC. Feedback is also included in the BOD reports, with lessons learned and recommendations for improvement. Recent improvements based on former, potential, and competitors' feedback include changes to maternal child health access, improving referral process from primary care to behavioral health, improving access in the behavioral health redesign and integration, and improved health care access by partnering with community health centers across Alaska.

3.1b(1) Satisfaction, Dissatisfaction, and Engagement. SCF's listening posts [Fig. 3.1-1] are used to determine C-O satisfaction, dissatisfaction, and engagement. SCF leaders and committees systematically review C-O feedback data during monthly and quarterly review meetings. The satisfaction data is retrieved at a department/clinic level.

Qualitative data from listening posts are entered into the CFRS. A standardized process is deployed to all departments via the Customer Feedback Reporting Procedure. Concern data is classified by issue type at submission so the CEC can review trends and patterns and identify OFIs.

Every department engages in the CSS process, and the results are available to all employees on DM. As for variations in methods, SCF recognizes that among its Elder C-O segment, the ability to use the tablet device for data collection might be limited. SCF coordinates with its Elder Program to collect surveys at their various events and lunches. Also, some survey questions may vary between the departments due to the different services provided, but the core questions asked of all customer groups are the same. Relational 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 requirements. Even with some variance at the department level accessible on DM, the results are able to be reported by "question group" when looking at the aggregate data.

SCF's data from programs on the shared campus is forwarded to ANTHC and combined with their hospital data, to be reviewed by the EMT and JOB. The CEC analyzes C-O data to develop a committee plan and APQR, and presents updates and improvement recommendations to OPS and VPLT. The segmented results are used to identify targeted program improvements or may be blended for system-wide improvements. The aggregation and analysis data is a key input to the SID and is used in SPC. The types of recommendations can vary from improvements to workforce education, performance expectations, or even technologies utilized.

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.

An example of how C-O feedback leads to improvement, in 2014 the CEC identified an OFI in the telephone-appointment- making process based on increased C-O concerns. Another arose when a panel of C-Os had increased problems getting in touch with their assigned CMS. Members from the CEC worked with primary care to pilot a new process that allowed C-Os to decide if they wanted to leave a message with their CMS first or move on in the telephone queue to reach another CMS who could schedule an appointment. Not long after the change was implemented in all primary care clinics, the CEC observed a decrease in concerns related to the appointment- making process.

3.1b(2) Satisfaction Relative to Competitors. SCF obtains comparative satisfaction information and benchmarks through surveys, public CAHPS database, IHS, VA, employee feedback, and in-person interactions.

While surveys are ongoing, review of data happens at least quarterly. In this review, the CEC, OPS, and division and department leaders determine

satisfaction of C-Os by analyzing internal and external benchmarks.

Benchmarking and target scores are identified by the CEC through research and review of best practices identified from Quest Conferences, the public CAHPS database, other IHS customer satisfaction data, and historical trend data that is segmented within SCF by division, department, and teams.

Annually, a SWOT analysis is completed by the CEC and included in the SID as part of the SPC.

3.2 Customer Engagement

3.2a(1) Service Offerings. 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 [Fig. P.1-6].

The VOC helps SCF determine health care service offerings and plan for future projects at SCF by utilizing the FCS and the SPC. Key listening posts (e.g., tribal relations, advisory councils), as well as state population market research studies (e.g., Craciun Research), help inform the FCS by identifying patterns in emerging health care service needs. When emerging data trends arise, the CEC may use additional measuring tools such as internal or external surveys, focus groups, or social media polls (e.g., Facebook).

SCF is committed to innovating services [Fig. 3.2-1] to meet and exceed C-O expectations.

C-O expectations are defined in the SCF OP [Fig. P.1-2] and improvements are continually reassessed by the CEC based on current feedback.

Figure 3.2-1:Examples of Improvements/Innovations

Facility	Renovations, PCCIII, Elder Program, FWWI, VNPCC, Parking, Walkways, PEDS Building
Program	ICT, Wellness Center, BSD CM, Family Support Groups
Service	Tobacco Free Campus, ECAF, PEP, Satellite Pharmacy

An example: C-O feedback in satisfaction surveys and other listening posts, as well as rates of appointments not kept, pointed to the need for a rethinking of SCF's approach to behavioral health. Focus groups identified that the stigma and long wait times were barriers to meeting the requirements and expectations of C-Os. With the goal of improving the C-O experience, SCF set out to create a new concept model (affecting intake process, work flows, relationship building, etc.) capable of connecting C-Os to same-day services and offerings that better matched C-O needs and values. The launch plan was deployed over four phases with C-O feedback collected continually. Elements were tested and piloted using the Plan Do Study Act (PDSA) process with ongoing data tracking/analysis and check-ins. Staggered rollout in each of the clinics allowed organizational learning and ramping up to changes while still serving C-Os. Behavioral health is now more accessible and user-friendly, meeting people where they are at. Additionally, learning circles, which expanded as a service option under this new approach, have established supportive relationships among small communities of C-Os, which is aligned with C-Os' relational orientation as AN/ AI people. Learning circles also expanded SCF's C-O engagement in churches/gathering places and correctional facilities.

SCF has engaged C-Os as active partners by making it easy to access care and by providing support of a consistent and trusted team. SCF has rebuilt the system around what the C-O (vs. the provider) wants and needs. A robust ability to partner with people over time has helped providers get to know C-Os, including their priorities and motivations, to influence their health habits and choices. As a result, health status has improved, along with individual, family, and community satisfaction with the health care experience.

3.2a(2) Patient and Other Customer Support. Because SCF is customer driven, the delivery of all care and support takes place in the setting that is most acceptable to the C-O, with the goal being to meet the C-Os where they are and provide immediate services for a range of needs. SCF offers C-Os the option of information and support by same-day appointment or even a phone call with their PCT for case management, navigating through primary care, and scheduling. For other needs and support,

C-Os have call-in and in-person access to customer service representatives, as well as 24-hour access to the SCF website, social media (Facebook, Twitter, etc.), and 24-hour hotline. MyANMC, an online health management tool, has provided C-Os with additional opportunities for two- way communication with their PCTs, as well as medication refills through secure messaging and viewing lab results and appointments. Future plans with MyANMC include direct scheduling.

C-Os have expressed the importance of involving family, and thus have the option of allowing their families to accompany and support them during visits. Nearly half the clinical spaces have been "de-medicalized" (i.e., comfortable talking rooms with no exam tables), creating a power-neutral and culturally respectful environment.

For support beyond what the PCT can provide, other health professionals are integrated into the primary care setting. For example, if a C-O needs to see a nutritionist, pharmacist, or behavioral health consultant, these individuals are located in the same shared PCT space to offer additional support. As part of BH Redesign, Psychiatrists were co-located. Other medical specialists, such as cardiologists, are available on referral the same day at ANMC. SCF collaborates with ANTHC to support shared C-Os with a care plan continuum.

Information and support mechanisms for C-Os are determined by reviewing data relative to other like-departments and benchmarking targets set by the CEC. Every employee has a role in and is held accountable for C-O support, as detailed in their PDP under the "Customer Care & Relationships" CC. To ensure the workforce understands the cultural sensitivity expectations of C-Os, SCF integrates cultural requirements into selection, orientation, and ongoing education and training. In addition, SCF surveys C-Os using a set of cultural questions to monitor performance and anticipate future requirements and expectations. The OP and customer standards are based on the cultural values of the AN/AI community.

QMC support organizational learning including analyzing and implementing changes in C-O requirements. Curriculum includes Survey Design, VOC, and PDSA [2.1(a)2].

For rural communities' (usually only accessible by air travel) C-O groups, the process for connecting includes SCF leaders traveling to meet with village councils and tribal boards, attendance at tribal gatherings, leadership retreats, and governmental conferences.

3.2a(3) Patient and Other Customer Segmentation. SCF uses listening posts to determine C-O groups and changing market requirements. Formal methods of listening to current, potential, and future C-O segments include BOD, advisory committees, Alaska Federation of Natives, and informal face-to-face interactions. Determining C-O groups and market segments is done across the organization annually, during the SPC and at leadership's annual review of the SID.

The data is reviewed and analyzed by the FCS for best practices and OFIs for developing work plans. As the customer groups expand, the ability to gather and analyze data also expands. Example: VA services and expanded services to rural Alaska. The data displayed in the DM is segmented into these additional market segments.

These approaches for gathering and using C-O data, and the subsequent analysis, use, and segmentation of the data in the SP process help SCF identify future directions and services necessary to meet C-O needs.

3.2b(1) Relationship Management. SCF's Nuka System of Care is based on what C-Os have said they want: a primary focus on relationships. Relationship building is the core priority for how SCF designs services, improves flow, decreases waste, designs facilities, measures success, and recognizes and rewards excellence. A process for empanelment in primary care where C-Os are matched, by self-selection, to an ICT is one entry point for retaining C-Os, meeting their requirements, and exceeding their expectations. Trusting relationships with their ICTs, built and maintained over time, allow providers and C-Os to work together to address health in the context of their families' lives, values, and beliefs. Providers are primarily in a partnering, coaching, mentoring role. Under this model, not only are C-Os treated with more respect, they are also taking a more active role in their health care. They are involved in

decision making, including asking questions and providing input. This involvement is critical in achieving whole-person wellness and managing chronic conditions such as diabetes.

One C-O shared: "My experience is much better, because I feel like I'm talking to someone who has an investment in my health outcomes. Since I will be seeing this person the next time I have any health issues, I feel like she cares about my overall wellness."

The relationship focus has helped SCF enhance its brand image and increase engagement. SCF is even assuming the health care responsibility for some outlying villages because of its reputation.

SCF has made major investments in employee training and development to create this relationship-based culture. The fundamental importance of relationship building is introduced at NHO and modeled by leadership. The culture is reinforced through employee communications/publications, Core Concepts [5.2(b)1], ongoing staff meetings, and team huddles using "check-ins". SCF builds relationships utilizing the Core Concepts (with a special focus on articulating and responding to story, a C-O requirement) and RELATE customer service standards. Both are deployed through NHO, ARO, ICTs and a variety of listening posts. C-Os experience the primacy of relationships through empanelment, ICTs, PR publications and social marketing campaigns, community events, and listening posts, all of which help SCF build its market share.

SCF manages and enhances brand image through engaged C-Os, employees, and leadership as its brand ambassadors, as well as collaboration between its PR department and Learning Institute. They work together to establish community outreach, targeted marketing campaigns, and a web and media presence. PR also works to engage C-Os while they are at SCF facilities. Copies of the Anchorage Native News—SCF's corporate newsletter—are available in all the waiting areas (and are also distributed by mail and available online). The themes of the newsletter are aligned with the MVCG and the OP. It celebrates progress toward the CG and offers success stories, information on how to access services (a frequently trending C-O question and area of interest), announcements on new/ expanded offerings, and health education tips. Posters and signage in all the waiting areas are also updated monthly by the PR department. The messages invite C-Os to take part in upcoming activities and/or raise awareness of a priority health issue, tied to CIs, and promote behavior change. Also, a new digital communication "billboard," RiseVision, is currently being installed in all the waiting areas. This will allow for themes and messages to be tailored to C-Os of each clinic and delivered while they are waiting for services. For example, it will enable C-Os waiting in OBGYN to learn more about the services they can receive after childbirth.

To expand its network of relationships, boost its brand, and engage in conversation with C-Os as well as prospective Learning Institute customers, SCF utilizes social media in its PR and marketing strategies. Facebook, Instagram, and Twitter accounts are monitored by the Learning Institute and PR department [3.1a(1)]. Requests and inquiries into the Nuka System of Care, via social media, by other organizations are tracked by the Learning Institute to determine needs of that customer group and to plan for upcoming site visits and consultations.

The PR department provides monthly reports on its relationship building and customer engagement at the ETS managers meetings. Metrics used to monitor how online content is performing are provided in these reports, as well as reports for the FCS and SPC.

3.2b(2) Complaint Management. SCF uses the CFRS to manage concerns, compliments, suggestions, and questions. To ensure that concerns are resolved promptly, the workforce is trained and empowered to accept and enter direct feedback into the CFRS at the point of service.

The CFRS does two things: it follows regulatory bodies' guidelines for C-O concern resolution, and it classifies and trends themes in C-O feedback for identifying best practices and OFIs. Two procedures, the Customer Feedback Procedure and the Customer Satisfaction Survey Procedure, assist the workforce in consistently managing concerns.

The CEC reviews trends in C-O satisfaction survey data and in CFRS feedback data quarterly, with the ability to monitor more frequently as needed. Feedback data is integrated as part of the SPC for identifying OFIs and best practices for future action planning, including addressing concerns.

The list of listening posts [Fig. 3.1-1] describes which method can accept concerns and who owns/monitors and manages listening posts. SCF has also deployed supporting P&Ps that encourage and hold managers accountable for responding to concerns.

The CFRS tracks concerns through resolution. To recover C-O confidence, and enhance satisfaction and engagement, the CFRS also assesses C-O satisfaction with the resolution. Themes are classified and analyzed for OFIs and best practices to influence improvements in the organization. The ongoing reporting to leadership of themes, action plans, and updates through the SPC, SWOT, and SID help to avoid similar concerns in the future.

Category 4: Measurement, Analysis, and Knowledge Management

4.1 Measurement, Analysis, and Improvement of Organizational Performance

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 Balanced Scorecard (BSC). Measures are balanced among four perspectives: C-O, Workforce Development, Organizational Effectiveness, and Financial and Workload [Fig. 6.1-1]. The BSC and other aggregate performance measures can be reviewed 24 hours a day on the Data Mall (DM) with access through the intranet. 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. While the BSC is updated quarterly, clinical metrics are updated daily.

To complement the BSC, SCF also tracks and evaluates operational measures with a short-term focus on operational objectives. These assist management in decision making and support improvement of day-to-day work processes.

Operational measures are available on the DM and are segmented to the appropriate level to take action. Data points are updated daily and can also be reviewed 24 hours a day via the intranet. SCF makes data available to those without intranet access via publications such as the Nuka System of Care: Data Book, case studies, research publications, and articles in the SCF newsletter.

SCF is developing an active monitoring system to monitor performance of initiatives to ensure they are effective in achieving their related objectives. Currently, BSC measures are selected (or reaffirmed) during the annual SPC [2.1a(1)] when the leaders verify that each corporate objective (CO) and supporting initiatives has a BSC measure to track progress. Every initiative is supported by at least one work plan with multiple action items. Each work plan, with its corresponding performance measures, has a scheduled timeline [Fig. 2.2-1] 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 those that would be expected for a hospital. However, SCF reviews hospital-based performance metrics quarterly with its external partner, ANTHC. 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 committee structures, 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 DM 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-Os. 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. The DM 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 DM and elsewhere serves as input for the SID used in the SPC [2.1.a(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 Measurement Rules Template (MRT) that identifies the strategic objective measured, measurement owner, comparative data source, measurement targets, and reporting frequency. The appropriate oversight committee reviews the completed MRT for verification and approval. Part of the approval process includes searching for comparative data sources with similar methodologies. These comparative data sources may be at national, state, or local levels. When comparative data does not exist, internal performance targets may be used. In these instances, internal performance targets are determined based on literature reviews of best practices (when available) or on a percentage increase over baseline. In all cases, 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]. This process is repeated for non-BSC metrics where key SMEs within each division work with the SCF Data Services Department to identify appropriate comparative data, benchmarks, and targets. SCF's performance against recognized benchmarks is part of the SID. 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. Examples of external comparative sources utilized by SCF include HEDIS, HCCA, CMS, UDS, HDA, Saratoga, Gartner, and MGMA.

4.1a(3) Patient and Other Customer Data. As a customer- driven, customer-owned organization, SCF collects VOC data and information from a variety of key sources [3.1a(1)] and using several methods [Fig. 3.1-1]. SCF's approach to data collection and the questions asked are based on SCF's MVCG/ OP. Social media is one of the newer listening posts. VOC feedback via social media is responded to and captured in the CFRS so that themes and OFIs can be identified.

Once collected and aggregated, C-O and stakeholder data is segmented and trended and 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. An example is the use of results and feedback in planning for future facility expansion efforts. SCF

used VOC data to determine the demand for additional exam rooms, increase health care offerings in complementary medicine, and expand Fast Track services.

4.1a(4) Measurement Agility. The VPLT, FCS, and departments annually evaluate the performance measurement system for relevance to CG and CO, internal and external requirements, and to ensure the system remains agile and current. SCF 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. SCF works collectively with our EHR vender, Cerner, to expand data analysis capabilities. Lastly, SCF maintains 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 using related process and outcome 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. The goal is to remain constantly proactive, quickly identifying changing trends, and responding accordingly. All data is updated daily, weekly, monthly, or quarterly as appropriate via the SCF intranet for ongoing review and action as needed. Finally, metrics are developed or revised based on real-time feedback from SMEs within each division.

4.1b Performance Analysis and Review. SCF uses various forums to review organizational performance and capabilities [Fig. 4.1-1] to help set priorities for resource use and improvement work. Reviews are linked and aligned by means of the FCS [Fig.1.1-2]. The analyses look at all four perspectives (i.e., C-O, Workforce Development, Organizational Effectiveness, and Financial & Workload). The VPLT and BOD reviews the BSC (i.e., key performance measures showing progress toward strategic objectives) regularly on a schedule aligned with quarterly reporting. The BOD also receives formal reports on work plan progress and movement toward achieving the objectives from the P/CEO, which includes updates from all SCF divisions. The four oversight committees report to the VPLT at least twice annually. The committees provide an assessment of progress on the AP and an analysis of performance results, as well as identify OFIs. Each functional committee reviews performance 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 to the division, and then on to the VPLT. Performance targets, performance comparisons, trends and projections, and variation and progress on quarterly AP are reviewed at every level to assess progress toward accomplishing CO. 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.

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 Managers	BSC, EPE, DM
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, DM
P/CEO Board Reports	Bi-Monthly	SCF, BOD, P/ CEO, VPLT	BSC, AP, PDSA

4.1c(1) Future Performance. SCF annually reviews and selects best practices benchmarks related to SCF's CO. Many of these measurement benchmarks are dynamic, with performance measurement goals increasing each year. When applicable, SCF targets future performance to be in the top decile

of nationally recognized benchmarks. Individual departments may have both a goal and a stretch target for their metrics. Performance targets are made visible and displayed with all applicable performance measures. Key action plans are developed to address future performance strategies within the SPC.

4.1c(2) Continuous Improvement and Innovation. Translation of data review findings into improvement and 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 gaps and the need for improvement and/or innovation. 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 obtain input about priorities and options. A recommendation for improvement is then designed and implemented, 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, such as the monthly EMT committee meetings or face-to-face interactions.

When a BSC measure is recognized as below measurement target, the measurement owner takes action by developing a work plan to improve performance. The measurement owner ensures that 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. Benchmarking plays a major role. It is used to redesign a poorly performing process, as well as to proactively drive innovation. SCF identifies high performers with whom to benchmark processes and results through participation in professional associations and conferences, such as IHI and Quest for Excellence.

4.2 Information and Knowledge Management

4.2a(1) Quality. SCF utilizes a number of tools and techniques to both validate and monitor the quality of data and information. Division data workgroups work with SCF Data Services to define processes for data collection and then collectively work to validate data reports. Every SCF employee that utilizes data, and especially reports on the DM, is encouraged to look at the results with an eye toward quality. If discrepancies are noted, Data Services is contacted and a systematic review is undertaken to address the issue — making corrections to reports as needed. Data Services also collaborates directly with Health Information Technology (HIT) staff to ensure DM reports are updated based on changes to the EHR systems or data collection processes. Internal audits, chart reviews, and other manual reviews are also routinely used to ensure data quality and validity.

The majority of applications that are in place at SCF use traditional Database Management System (DBMS) tools, such as Oracle, Microsoft SQL Server, and Inter Systems Cache' database platforms. The use of these industry standard systems provides 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 to share this 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.

SCF's information security officer and designees undertake regular security risk analysis activities and, together with IT, work to ensure all systems incorporate robust checks of validity, integrity, and security without impacting usability.

Lastly, SCF has deployed and integrated the following approaches to facilitate data reliability: standardized data and information collection and

reporting tools, such as the Automated Annual Planning Tool (AAPT) and BSC; 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 such as Cerner and ANTHC to ensure that information systems are easy to use, taking into account the number of screens and key strokes required, etc.

4.2a(2) Availability. SCF systematically makes needed data and information available to employees, C-Os, suppliers and partners. SCF utilizes its EHR systems to manage clinical, business, and administrative information. These electronic systems facilitate standardized and structured health care data and information. At SCF, structured data from multiple EHR are consolidated and queried to build pre-established reports. These reports provide managers and end-users valuable information from a systems perspective, which promotes safe, evidence-based C-O care, efficient operations, and performance improvement. Having information in a centralized electronic format makes data analysis more robust; decisions are based on population parameters and not on sample statistics.

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 P&Ps, 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-Os to help them manage their health. For example, SCF offers C-Os 24/7 access to myANMC, an online health management tool and patient portal [3.2a(2)]. Additionally, SCF provides a user-friendly Health Education section of the website, online access to the SCF newsletter and other publications/communications, print materials and digital signage in the clinic waiting areas, classes and group visits, personal appointments, and phone calls or emails with the PCP and/or RN/Case Manager. In addition to access mechanisms, HR enables the public to seek employment using SCF's online application process. Committee meetings, informal interactions, SCF's website, and print communications are also ways SCF shares data and information with suppliers/partners.

An example of an ongoing improvement project to ensure additional data availability is the SCF Initiative Scorecard (IS). Designed to partially mirror BSC, the IS will both provide not only a means to monitor performance on metrics related to corporate initiatives, but also for additional data such as research publications and program evaluation reports, that relate to those initiatives.

User-friendliness of data and information technology systems is constantly monitored. When reports are in development, Data Services works directly with SMEs within each department to design the format for maximum usability. Modifications are routinely made to their design based on user feedback. Similarly, end users are involved in the evaluation and selection process of any new HIT system or program. User-friendliness is a key criterion for selection. User feedback groups and IT department customer surveys are utilized to monitor satisfaction with IT systems and identify OFIs. Modifications made based on feedback from these tools include expanding the use of a single login across more programs, implementing dictation options vs. typing, developing pictorial guides, and increasing IT training options through the SCF DC.

4.2b(1) Knowledge Management. Collection and transfer of workforce knowledge: SCF's team-based approach allows for routine transfers of knowledge. Team sharing, coaching, and mentoring (even departing staff mentoring their replacements, when possible) is a SR. Departmental shared drives are used as a central location to share, store, and research documents. This also allows for transfer of knowledge to future workforce. However, the primary vehicle to capture and share workforce knowledge is the intranet, which is available to all staff in all locations. The intranet contains a wide range of data/information, including links to corporate P&Ps for all divisions and departments; SharePoint sites for teams and work groups to store/share information; annual safety goals; an employee

newsletter/blog; the DM; and the C-O feedback, safety/risk management, case manager, AP, and CM tools. The AP and CM tools are used to document decision-making history for use by new/current/ future workforce. CM supports the FCS and provides all staff with full access to committee activities, including rosters and meeting minutes.

An annual manager's 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, newsletters, one-on-one huddles, and retreats. SCF uses these active approaches to manage and share organizational knowledge.

The Annual SCF Learning Event supports peer learning and teaching. The PI committee identifies critical learning opportunities that merit broad participation and executive sponsorship. Attendance is required for all SCF staff with exceptions made for critical staff (who then receive individual training at later dates). Feedback from staff is collected during and after the event to assist in designing the following year's training.

Blend and correlate data from different sources to build new knowledge: All staff who attend external conferences complete feedback reports upon return and share key lessons learned or potential opportunities to explore. 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 collaborative efforts, such as those sponsored by the IHI. Lessons learned are tested in the SCF environment of care using the improvement process [Fig. 6.1-2]. The behavioral-based interviewing process is an example that has been implemented to improve hiring and reduce turnover.

C-O data is blended and correlated from sources such as the CSS and CFRS [3.2b(2), 3.1b(1)].

Transfer of knowledge from and to customers, partners, collaborators, and other stakeholders: SCF's key C-O listening posts [Fig. 3.1-1] are the principal methods for gathering relevant knowledge from C-Os 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-Os and their families, as well as the general public, by means of the Internet, printed communications/publications, various news media, and community reports, and through the SCF Learning Institute. The SCF Board of Directors established the SCF Learning Institute to accomplish the following objectives: Ensure sustainability of Southcentral Foundation including succession planning; Raise the honor, pride and sense of accomplishment of the Alaska Native people; Attract and retain the best/ brightest/most talented people; Reinforce the core organization with revenue/profit streams; Learn from the experiences of others and feedback external learning and findings; Infuse the passion of SCF within the Institute; and Transform global and US healthcare. The Learning Institute partners with programs across SCF to share and expand the core competencies of staff.

The SCF Learning Institute shares best practices about SCF's Nuka System of Care to help customers and partners transform their systems. The Learning Institute provides site visits, trainings, and opportunities for in-depth learning, including student experiences over an extended period of time. The SCF Learning Institute also manages SCF's new Nuka Learning and Wellness Center for Anchorage-based trainings for internal and external customers and partners.

The SCF Nuka Learning and Wellness Center (NLWC) started operations in spring of 2016, the

building features state-of-the-art equipment. Simulation labs that are designed to mirror SCF's clinical and talking rooms are available for training purposes. All of the rooms have recording capability and have the potential to be upgraded further with full webcasting functionality and one large room has cameras and microphones for recording and streaming video. The NLWC also houses six SCF departments and the building has hosted several large events for SCF over the last year.

Several sessions of SCF's Core Concepts training [1.1a(1)], the training that teaches SCF employees how to build the strong relationships that are the core of SCF's Nuka System of Care, were held at the NLWC. SCF hosted multiple sessions of Beauty for Ashes [Fig 1.1-1], its training program to educate and train Natural Helpers to use culturally appropriate means to work with individuals and communities impacted by violence, at the NLWC, including its largest session ever with approximately 80 participants. SCF also hosted its annual Learning Event at the NLWC, an all-employee gathering where SCF leadership provides information about the state and direction of the organization.

With key service delivery partners, SCF participates in formal committees, boards, and processes to share relevant knowledge. With ANTHC, for example, SCF representatives participate in JOB, MET, CQC, and various SCF-ANTHC committees. The ANMC intranet, managed by ANTHC, contains information relevant and accessible to the SCF workforce, such as infection control data and laboratory results. Informal interactions and personal relationships of leaders complement formal committees, boards, and processes.

Knowledge is also shared with the general public via research publications, social media, case studies, news articles, and presentations.

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. [2.1a (1)]

The SID brings together qualitative and quantitative data from internal and external sources to support the SPC.

Information is gathered throughout the year by data owners, and is organized by ODI to facilitate use by SPC participants.

SMEs across the organization routinely review industry publications and events to both monitor current events and changes in innovations in health care and other sectors that may benefit C-Os.

4.2b(2) Best Practices. Performance variation is tracked and monitored on the DM using innovated comparison charts that identify significant performance. 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, mentors include focus on best practices in their discussions with mentees.

4.2b(3) Organizational Learning. SCF invests heavily in building and sharing knowledge; it is part of Alaska Native culture and SCF's organizational culture. SCF uses multiple approaches to operationalize knowledge sharing and resources. For example, the DC provides training using SCF SMEs as instructors and facilitators. The learning curriculum uses SCF data, information, and process examples for application of learning. Another example of organizational learning is the culture of mentoring and coaching for staff development within teams, committees, and work systems.

Category 5: Workforce

5.1 Workforce Environment

5.1a(1) Capability and Capacity. As part of the SPC [2.1a(1)], SCF annually determines workforce capability and capacity needs by means of the Annual L&D Plan (capability) and the Corporate Recruitment Plan (capacity).

Skills: SCF determines its workforce capability needs through an annual L&D assessment as part of the SPC. The DC is organized into integrated L&D teams, with each team having either a divisional or topical focus. The DC teams collaborate with key

partners to identify, prioritize and provide comprehensive L&D support. This process ensures that SCF's workforce has the combination of knowledge/skills/abilities/ competencies required to address short- and long-term organizational needs. L&D needs identified during the year outside of the SPC are prioritized with other organizational and division needs. The DC tracks the breadth and depth of knowledge/skills/abilities developed through the L&D system using a combination of pre- and post-evaluation surveys for all courses. These methods enable SCF to compare current workforce capabilities against the anticipated requirements of initiatives in the SP and AP, addressing them through plans such as the Corporate Recruitment Plan and Annual L&D Plan.

Competencies: Competency is demonstrated by staff meeting established benchmarks outlined for their positions, including targets captured in staff PDPs for training, certification, demonstrated skills, and task completion. Documentation is collected during the year in individual competency folders and maintained by department managers.

Certifications: Job descriptions are developed by managers and SMEs to ensure the requirements, including certifications, meet or exceed industry practice, including state and federal laws. These job descriptions are approved by HR to ensure continuity of certifications throughout the organization.

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/budget impact for the next year and the future. SCF 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. Recruiting: SCF uses a network-based approach to recruiting, with data to support that many candidates learn about openings from family members/ friends. Open positions are advertised internally, allowing staff to apply or share with others. SCF also fills positions through partnerships with local trade/technical schools, AN 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: online job postings left open, talking to every applicant whether there is an opening or not, and keeping an applicant database for when positions do come available. SCF also uses lifestyle-based recruitment for these positions, nationally targeting applicants interested in living in AK. Display booths/mailers/marketing materials are designed to capture the attention of applicants drawn to the scenery and abundant recreational opportunities in AK. For national recruitment of some positions, SCF invites family members to take part in the interview process and, if they are also qualified for an SCF position, encourages them to apply. Building relationships with the family unit improves the chances of long-term fit, which helps facilitate relationships between C-Os and providers.

Through specific outreach and educational programs, SCF also recruits for the future. For example, SCF's RAISE internship program is dedicated to developing future workforce by employing AN/AI youth. SCF also partners with the Alaska Native Cultural Charter School to begin building relationships with children in elementary school.

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 a fit with SCF is based primarily on behaviors vs. skills. During a behavioral- based interview, the applicant shares stories about past performance. The ability to share/respond to story is aligned with AN cultural traditions and is a C-O requirement for the health care system. After the initial pilot, behavioral-based interviewing was implemented for all positions to improve fit, and thereby retention. In 2009, the CC [Fig. P.1-3] were integrated into the interview questions allowing SCF to evaluate candidates' behaviors in alignment with the MVCG/ OP and CC.

HR also 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. If a good fit for the organization is determined, the interview group then recommends the best department for the candidate based on education/experience/ interests. This approach is now used for many jobs with openings in multiple departments/locations, including CMA/LPNs, clinical associates, mental health workers, administrative support, and management.

Retention: The HRC examines retention data and conducts tests of change to improve retention rates. For example, SCF benchmarked Baldrige recipients and developed a training program for new administrative support (a position with historically high turnover) staff. The training program consists of formal and on-the-job training, and has been effective in improving retention. Similar new-hire training programs have been implemented to address retention for CMA/LPNs, case management support, and RN/Case Managers.

Diverse ideas/cultures: SCF is committed to Native preference hire [P.1a(3)] and, in alignment with SCF's CQ, staff must be fully qualified for their positions. To achieve a workforce representative of the C-Os served, managers are required to screen/take action on qualified AN/AI applicants first [Fig. 7.3-3]. HR, recognizing not all positions can be filled with AN/AI candidates, also encourages others to apply, enhancing diversity of ideas/cultures that enrich the workplace.

As part of NHO, SCF sets the stage to ensure it is inclusive of every employee's culture/ideas/ thinking. A cultural orientation component provides opportunities for all new-hires to share. The value of diversity is reinforced in Core Concepts and customer service training.

5.1a(3) Workforce Change Management. As part of the SPC [2.1a(1)], SCF annually determines workforce needs by means of the Corporate Recruitment Plan and Annual L&D Plan. This process ensures SCF is prepared to manage workforce growth or reductions. SCF prepares for changes in capacity, organizational structure, and work systems through division and department planning meetings; openly sharing organizational direction, strategy, key initiatives, and performance; and by encouraging personal/ professional growth and L&D. One example is SCF's Annual Learning Event. SCF leaders review all the survey comments to ensure the next year's event focuses not only on CI, but also on topics/programs/ updates the workforce has expressed an interest in. One-on-one conversations, including guidance on career progression [Fig. 7.3-8] and support with the PDP process, also helps prepare staff for capacity changes. Scholarships are available to eligible staff and academic leave programs offer opportunities to attend college classes during work hours.

Changes in grant funding and project scope can create need for workforce reduction. The Access to Recovery (ATR) program ended in April 2015 due to our proposal not be awarded by SAMHSA. There is a limited number of native entities provided with this funding and Southcentral Foundation (SCF) had received the funding multiple times over the previous years. The approach that SCF took to assist staff was for the manager to meet with the human resources department to find out what openings other departments had available and then work with staff to see if any of the positions were of interest to them. We started this process a few months prior to the ATR end date to have sufficient time for staff to be interviewed and if needed possibly shadow in the new department. As a result, 100% of staff were offered new positions within SCF.

5.1a(4) Work Accomplishment. Accomplish work: Leaders manage, organize, and reinforce 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.1-3], establishing criteria expected of the entire workforce. For example, Customer Care &

Relationships reinforces the overarching importance of C-Os, stakeholder, and health care service focus. The four workforce competencies are integrated into all HR functions, including the interview process [5.1a(2)], job descriptions, performance evaluations, and performance management. Workforce competencies are also utilized in developing L&D offerings and development plans.

Reinforce focus on C-O, customers, and health care: SCF's workforce has achieved the highest level of Patient Centered Medical Home™ recognition from NCQA. NCQA emphasizes the use of systematic, patient-centered coordinated care that supports access, communication, and patient involvement. SCF's workforce is committed to going beyond these standards by focusing on the C-O and his/her family driving the system rather than the professionals; services that are woven into C-Os' lives, built around them, rather than the medical office; and an approach that addresses the whole person/family in a well-coordinated and personal way. The organization of the multidisciplinary ICT, which consists of a provider, RN/Case Manager, CMA/LPN, case management support, BHC, and RD, reinforces these focuses. C-Os select their teams. SCF and C-Os capitalize on each provider's unique set of skills, while a shared set of CC unify them and keep the key messages consistent. 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. The DC, Finance, and PR departments use a similar team-based model, with each team becoming intimately involved with their assigned departments/ divisions, programs, and priorities.

Exceed performance expectations: SCF keeps the workforce focused on exceeding expectations using the SPC and PDP processes. Through the organizational structure, teams are empowered/equipped to improve/innovate. BSC measures are created and, through the AP process, plans are disseminated as part of the FCS and individual PDPs. PDPs outline goals, accountabilities, and ways to achieve "exceeds performance expectations" scores on annual evaluations, 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. Primary care clinics incorporate real-time data to serve as a report card on panel management via the DM. Providers know how they are doing compared to peers and can seek ways to be leaders in terms of performance/outcomes. Administrative departments also have measures readily available on the DM.

5.1b(1) Workplace Environment. SCF maintains and improves [Fig. 7.3-6; 7.3-7] workplace health, security, and accessibility in a proactive manner by ensuring the workforce (1) understands related P&Ps and performance expectations, (2) acquires and systematically updates the knowledge/skills needed to promote safety/health, and (3) participates with workforce experts in minimizing risks and addressing improvement opportunities. SCF complies with all ADA, state and municipality regulations on accessibility. The QA committee manages and monitors processes related to employee health, safety, security, and accessibility. As part of the SPC, the committee reviews data by various segmentations, including position and department. The data is then used to drive work plans for improvement. A recent improvement was the installation of safety flags at some crosswalks to help increase visibility of pedestrians.

A safe work environment is maintained by conducting assessments at various levels of the organization and at various frequencies. Annually, the QA department conducts at least one multidisciplinary assessment in non-clinical programs and at least two in all clinical programs. The department also conducts monthly tracers in all clinical programs. Within BSD, assessments are conducted on a monthly basis by collateral- duty safety officers in each program. Safety issues identified in any of these assessments are addressed by management to ensure identified hazards are corrected. The status of this follow-up is shared monthly with division leadership via the QA Gap Analysis. This report also identifies trends

that can be addressed by division leadership and management to improve worker safety. Staff receive initial, annual, and impromptu safety training that is tailored to identified trends. Post-injury inquiries help identify injury causation and preventive measures for reducing re-occurrence of similar incidents. These processes have helped decrease the number of OSHA- recordable cases [Fig. 7.1-23] and incidence of needlesticks injuries [Fig. 7.1-24].

5.1b(2) Workforce Benefits and Policies. Services: SCF's Health Education & Wellness Center (EWC) was created to integrate wellness into the workplace. It uses workforce input to identify/ prioritize classes and activities (e.g., Lose to Win for weight loss).

SCF's EWC, available to C-Os and staff, offers a full range of health education programs, learning circles, fitness equipment, and group classes.

To support SCF's vision for whole-person wellness (i.e., emotional, physical, mental, and spiritual), a licensed professional position was created to assist staff after a traumatic event in the workforce or community. SCF also offers an employee assistance program with access to trained counselors and other family resources. Additionally, SCF created ECAF [Fig. 1.1-1] to provide temporary financial assistance to staff and community members who have encountered financial hardship. It is supported by monetary donations from the workforce, BOD, and community members.

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 [Fig. 7.3-7]. SCF uses the Hay Point Method to evaluate job descriptions using three categories: know-how, problem solving, and accountability. This system, alongside market data, allows HR to systematically evaluate SCF's compensation structures in order to remain competitive in the changing labor market. SCF recognizes that the rural (village-based) workforce is unique in its recruitment/retention challenges. SCF utilizes creative options to meet those 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 funds for CMEs, and a trip to Anchorage each year to support work/life balance for targeted positions.

Additional market reviews and employee feedback have led to changes in the benefits package. For example, SCF began offering medical, dental, and vision insurance separately. This approach allows for a variety of coverage options, thereby meeting both health and financial needs. Also, the EWC and HR implemented an hour of wellness leave per week (in addition to accrued paid time off). To accommodate this, a provider's weekly schedule can be blocked off for an hour. SCF also offers nonstandard workday and workweek schedules when efficiency and productivity can be ensured or enhanced.

A robust leave package is provided to meet cultural needs of the workforce, including participation in the AN/AI subsistence tradition (e.g., fish camp in the summer). SCF has also established educational services to encourage professional and personal development [P.1a(3)].

Policies: New policies are developed based on organizational need, employee feedback, and regulatory compliance. Each P&P is reviewed through a designated committee(s) to ensure feedback from staff from different workforce groups/segments. To ensure existing P&Ps are up-to-date and reliable, they are modified and reviewed every three years. A P&P manager (1 FTE) coordinates and supports this effort organization-wide.

5.2 Workforce Engagement

5.2a(1) Organizational culture. SCF has an SA in terms of organizational culture and work environment, identified in its SP as "an employee and workforce development focus, a learning organization. Internalized passion for the mission that results in willingness to continually change and innovate." SCF uses multiple methods to foster this culture of open communication, high performance, and an engaged workforce.

Intentional work design [1.1b] encourages collaboration and passion for the mission; accessible information, via the intranet, engages the workforce in continual learning; and

educational opportunities help maintain the workforce development focus, enhancing knowledge and skills needed for high performance. SCF annually assesses these factors through the EOS.

Open communication: SCF communicates through face-to-face interactions, electronic communications, formal and informal meetings, and events such as the Annual Learning Event [Fig. 1.1-3]. Open work design fosters open communication between managers, workforce, and C-Os and allows for visibility and accessibility. The CM tool, another method for encouraging communication, enables the workforce to stay current with committee work. Intranet, Skype for Business, and emails link staff 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 CG/CO is a shared responsibility. SCF fosters high performance beginning with the SPC [2.1a(1), Fig. 2.1-1]. All of the resources (e.g., AP, AAPT, SID) used in the SPC are shared with staff during orientations and trainings, and are accessible for review at any time via the intranet.

Workforce PDPs are developed from the AP process [2.2a(1)]. Staff are evaluated/compensated annually based on PDP achievement and high performance. Managers meet with their direct reports throughout the year to evaluate and discuss progress toward targets in the individualized PDPs. This process aligns goals/ actions with organizational needs and the AP, while supporting and setting mutual expectations [Fig. 7.3-12, 7.3-13].

The DM allows for access to performance data with comparative sources, giving feedback on high-performance work and promoting discussion on best practices among peers.

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, including interdisciplinary committees and project teams. Core Concepts and RELATE trainings build relationships, common language, and effective dialogue for the entire workforce, including senior leaders. This ensures all staff are engaged in supporting SCF's MVCG/OP. SCF places emphasis on the wellness of its workforce, most of whom are also C-Os, by providing a full range of classes and activities for whole- person wellness [5.1b(2)].

Diverse ideas, cultures, and thinking: This foundation of SR is reinforced in NHO, Core Concepts, department orientation, and ARO, and is threaded through all work settings by empowering staff to share their stories/ perspectives. All staff are able to have their voices heard and are reminded of their value. Sharing stories helps staff gain a better understanding of one another and provides an opportunity to connect on a more authentic level. SCF also expresses its strong relationship focus and commitment to SR in its widespread use of team/ committees. These structures further encourage and ensure diverse ideas in support of SCF's forward-thinking culture.

Empower: SCF's CC help drive a culture of engagement and empowerment for high performance. One of the competencies, Improvement & Innovation, empowers the workforce to continuously seek OFIs. Staff are held accountable for this through their PDPs and annual evaluations. The development of a PDP is an empowering process in itself: a partnership between the employee and his/ her manager that captures employee input, strengths, and L&D interests. Each employee is trained on improvement tools/methods and strategic planning in NHO and ARO, with additional support and reinforcement provided through their manager and/or supervisor and ODI.

5.2a(2) Drivers of Engagement. SCF uses Press Ganey's EOS [P.2a(3)] to determine drivers of workforce engagement across three domains: colleagues and job, organization, and manager. The Press Ganey Engagement Indicator Score measures workforce engagement and satisfaction in response to six key items across the domains. The EOS results and Engagement Indicator Score are segmented by job classification, position, work groups, divisions, and various demographics to allow for focused analysis.

5.2a(3) Assessment of Engagement. SCF assesses workforce engagement through the annual EOS, online surveys, and daily face-to-face interactions. Feedback from committees and scheduled reviews of PDPs and competency folders also play a role. Results within the EOS are segmented in a variety of ways, including by division and job category [Fig. 7.3-9, 7.3-11], to explore differences among workforce segments and provide comparisons to other data in Press Ganey'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. As part of the SPC, the HRC reviews the EOS and identifies organizational improvements for the AP. At the division/department level, managers share results with their teams to identify actions needed and to understand the key elements (e.g., respect, effective communication, recognition, and fair compensation) related to engagement and satisfaction.

Throughout the year, online surveys at the corporate and department levels target and gauge workforce engagement and satisfaction and measure tests of change. In response to low feedback on exit interviews, the HRC recommended piloting open-ended questions via the EOS. The result was a significant amount of feedback on engagement, strengths, and OFIs. The data is reviewed by HRC annually to develop work plans as part of the committee AP.

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, employee readiness, succession planning, and increasing AN/AIs in clinical positions.

5.2a(4) Performance Management. SCF's performance management system is designed to (1) communicate individual performance expectations, (2) provide meaningful feedback to staff so they are able to learn and grow (with progression opportunities built into job descriptions and PDPs), and (3) align the work of each employee with the SPP. The PDP is the tool used to communicate performance expectations that are specific to a position and to each employee for the upcoming evaluation cycle. HR provides managers across SCF with guidelines and support for developing the PDPs with their staff. PDP templates may be developed for specific positions— in partnership with a representative group of staff—and then modified for each employee. After reviewing Baldrige feedback, SCF benchmarked approaches to better identify workforce competencies with tools to drive performance. The following four workforce competencies have since been integrated into PDPs: (1) Customer Care & Relationships (reinforce C-O/stakeholder focus); (2) Communications & Teamwork; (3) Improvement & Innovation (intelligent risk taking); and (4) Workforce Development, Skills & Abilities (reinforce health care focus). As part of the SPC, individual APs (for the PDPs) are defined to support each competency, including metrics to evaluate performance and deadlines for completion. Quantitative data can be retrieved from a variety of sources including BSC, DB, DM, CSS, and EOS results. The performance standards are linked to annual compensation changes and progressions along the employee's career ladder of choice.

In 2005, EOS feedback drove the redesign of the employee recognition program. Leader's benchmarked Baldrige recipients and replaced loosely coordinated programs with an organization-wide, three-part program that rewards both individual and team achievements. The highest honor, Living Our Values, is awarded annually to honor exceptional contributions to CG and CO, customer service, improvement, or innovation. Nomination stories come from within the organization and senior leaders participate in selecting the honorees and presenting the awards [1.1b]. 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, staff 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) Learning and Development System. The DC was established in 2001 to support workforce learning and development [Fig. 7.3-7].

Core competencies, strategic challenges, and action plans: SCF's four workforce competencies are aligned with SCF's CC. SC are reviewed annually in the SPC. SCF's Annual Learning Event (an all-staff meeting) is designed to address the SC and APs. Each year, as part of the SPC, the DC partners with leadership from across the organization, as well as the HRC, to develop curriculum around identified challenges. In support of the MVCG/OP, and as an approach to address the strategic challenge of growing AN/AI leaders and increasing the AN/AI workforce [Fig. 7.3-3], SCF has launched innovative training and mentoring programs. For example, the administrative support training program, case management support, CMA/LPN, and RN/Case Manager training programs, to name a few. These programs onboard, orient, and train the workforce in high-turnover and/or hard-to- fill positions, as well as reinforce CC and address SC.

Performance improvement & innovation: The workforce is introduced to the PI model during NHO and receives a refresher training annually on innovation and improvement though ARO. 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 & business practices: Beginning in NHO and continuing through ARO, the workforce receives training on the Code of Conduct and False Claims Act from the compliance department [1.1a(2), 1.2b(2)]. 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 DC courses. As part of the year-long FOM [1.1c(1)] program for new managers, additional training is through offered on ethical health care and business practices.

C-O & stakeholder focus: In support of the MVCG/OP, an emphasis is placed on growing AN/AI leaders and increasing the AN/AI workforce [Fig. 7.3-16]. The DC ensures L&D's approach for the entire workforce [Fig. 7.3-5] is designed, delivered, evaluated, and improved systematically to promote high performance, service to C-Os, and leadership development [1.1a(3)]. For example, when SCF identified an opportunity to improve workforce understanding of the MVCG/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-Os [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) learn how to align your aspirations, intentions, and behaviors; and (4) learn methods for good dialogue and productive conversations.

All staff attend this three-day workshop, which is facilitated by the P/CEO and members of the VPLT [1.1a(1)]. In 2016, SCF piloted new customer service standards. The deployment included integration with NHO, expanded training with all front-line staff, and comprehensive manager-led training within departments. The training is reinforced during ARO, and through an intranet scenario campaign and promotional materials distributed to staff.

Workforce desires: The DC and HR departments gather and analyze feedback through a variety of mechanisms to identify L&D needs and desires. The delivery methods (e.g., classroom training, online options, on-the-job-training, on- site job-shadowing, mentoring [Fig. 7.3-15]) and content are guided by working closely with the workforce, managers, and committees, and reviewing data from course evaluations and the annual L&D Needs Assessment [5.2c(1)]. The assessment is conducted annually to determine current and future needs as identified by the workforce. Throughout the year, feedback is also gathered from trainer-workforce

interaction, post- training evaluations, manager feedback, and a DC training tool "suggestion box" available on the intranet. Additionally, HR conducts an annual face-to-face needs assessment with department managers. The DC and HR blend and correlate the data to inform the improvement of existing offerings as well as decisions to add new ones. The two departments work together to develop the year's schedule of offerings (i.e., trainings, workshops, presentations, and other learning initiatives).

Methods to develop SCF leaders, and respond to leadership aspirations include initiatives such as NMO, quarterly LDS, bi-monthly manager meetings, Leadership Readiness Assessments, and CDR. Formal training, mentoring, and coaching have also been implemented in a variety of positions, including physician, nurse, pharmacist, and clinical associate roles, and through FWWI's Advanced Leadership Education and Training.

Reinforcement on the job: Following NHO, departments orient new staff for up to 45 days to reinforce knowledge/ skills needed on the job. New managers attend the 12-month FOM [1.1c(1)] program, consisting of learning modules facilitated by various SCF leaders and SMEs. Other methods used in the L&D system are job shadowing, coaching, and specific competency demonstration. After the initial training period, reinforcement continues with mentors. For example, physicians, RN/Case Managers, BHCs, and pharmacists have peer-mentor coaches to reinforce clinical skills.

5.2b(2) Learning and Development Effectiveness. The DC systematically evaluates the effectiveness and efficiency of its learning systems. Staff evaluate each course they take. The DC team gathers and analyzes the feedback to identify OFIs and to revise courses when needed. In 2009, the DC recognized an OFI in the evaluation process and revised it to create a multi-faceted survey tool. The tool 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.

The DC also conducts 90-day post-evaluation surveys for the NHO and ASTP programs. These surveys assess the value of the programs, as well as provide for learning transfer and retention on the job. Learner feedback is used by managers and SMEs to review and revise curriculum/delivery methods. Satisfaction scores for DC courses, NHO, and ASTP are made accessible to all SCF staff by quarterly postings to the DM.

5.2b(3) Career Progression. Growing leaders from within the organization, including future generations of AN leadership, is important to SCF and its C-Os. As such, SCF is intentional in its design of systems to support, train, promote, and progress internal candidates into leadership positions [Fig. 7.3-19, 7.3-20].

Career development: 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/skills needed to succeed/ progress. During the PDP process, managers engage their direct reports in discussions about job/career goals. In this context, their professional development and L&D needs are integrated into their PDPs 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. These provide the workforce with a clear path, allowing SCF to grow its own workforce into leadership positions [Fig. 7.3-19, 7.3-20].

SCF has a number of training programs designed to facilitate career and leadership development. Some focus on professional development starting at the paraprofessional/ entry-level, such as ASTP and Dental Assistant Training Program, while others, such as ELE and the Special Assistant Program, prepare AN/AI staff further along career pathways for leadership roles. Academic programs, coaching/mentoring, and assessment tools, such as 5-Dynamics and CDR, help further identify and develop employee potential.

An example of one of SCF's newest academic programs is the CMA scholarship program. In 2016, the DC partnered with MSD and piloted this program for staff to pursue education and on-the-

job training while still earning their salary. As a result of the very successful pilot, it has since been fully deployed and implemented.

Succession planning: Ongoing succession planning is a CI linked to CQ, with OPS oversight. SCF is committed to growing leaders from within, in both clinical and operational roles. A broad portfolio of programming and work plans, covering entry-level to senior positions, supports this initiative. The RAISE youth internship program, Special Assistant Program, senior director positions, Leadership Development Sessions, and ELE are all a part of the strategy. The ELE was piloted in 2012 as an experiential training program for AN/ AI emerging leaders. The program includes working closely with P/CEO, VPLT, BOD, and managers [1.1a(3)]. Leadership, C-O, and employee feedback continues to drive program improvements.

Category 6: Operations

6.1 Work Processes

6.1a(1) Determination of service and process requirements. Driven by the MVCG/OP, SCF listens extensively and continually to C-O and stakeholder input [Fig. 3.1-1] to determine KWP requirements [Fig. 6.1-1]. Based on the feedback, BOD/VPLT, have determined, and regularly review via the SPP [2.1a(1)], a system of services that must be provided, aligned, and integrated in order to address C-O wellness needs.

6.1a(2) Key work processes (KWP). KWP categories and their subsequent processes [Fig. 6.1-1] are determined and reviewed through the SPP [2.1a(1)]. Alignment with SCF's OP is the fundamental requirement for the KWP.

6.1a(3) Design Concepts. SCF uses its Improvement Process [Fig. 6.1-2] to incorporate new technology, organizational knowledge, evidence-based medicine, service excellence, C-O value and the potential need for agility in design/redesign. This process is taught during NHO and deployed SCF-wide.

1. Design/redesign projects are guided by the FCS. When a design/redesign need is identified, and approved, in alignment with OP, a project team (typically multidisciplinary, interdepartmental, and associated with an existing committee) is established for process design and implementation.
2. The PTC defines the project aim, change concepts, key metrics, measures of success, and alignment with MVCG/ OP and CO. It also helps identify the need for internal SMEs who may bring critical data/information about key requirements, including regulatory. SMEs may also contribute critical organizational knowledge to help the team succeed and align its work with SCF P&Ps and practices. The team designs its process, usually including multiple tests of change.
3. The team implements, standardizes, and disseminates the process or redesign across the organization, where applicable. Standardization occurs through the development, redesign, and deployment of P&Ps and training.
4. Progress is tracked/reported on appropriate APs/APQRs, including corresponding BSC/DB data, to relevant committees and in real-time on the intranet for all staff.

Example: In response to stakeholder feedback, SCF identified the need to design a process to standardize data requests. Using the improvement process and organizational knowledge via the FCS, the process that identifies, prioritizes, and tracks a requested measure through its lifecycle, was standardized and deployed across SCF. Incorporating new technology allowed for automation of the process. The Data/Information Request Tool was created in-house and is accessible to all staff via the intranet. It facilitates all phases of the request process. In a cycle of learning, the DATC approved improvements to the tool that have resulted in higher stakeholder satisfaction.

SCF uses guidelines/benchmarks, and allows high-performing outcomes to shape/guide the processes (vs. the processes guiding the outcomes). Example: an ICT with a high- performing process and outcome is spread to other teams. Focusing more on the outcome (vs. the process) allows for innovation and agility.

6.1b(1) Process Implementation. SCF uses several performance measures, linked to KWP and C-O

requirements, to control and improve the work of the organization [Fig. 6.1-1]. KWP and their subsequent measures, many of which are segmented, benchmarked, and displayed on DM, relate to the quality of outcomes and the performance of services that allow SCF to meet CG. KWP are systematically reviewed and acted upon by the FCS as part of the SPC. The VOC is gathered and used to improve in-process measures and KWP where needed. KWP that support the day-to-day focus on the C-O, financial, workforce development, and operational effectiveness perspectives are systematically reviewed by leadership and the FCS to determine OFIs. The goal is performance excellence.

6.1b(2) Patient Expectations and Preferences. SCF's C-O driven system of care requires information/techniques/skills to be readily available to act on C-O expectations/preferences. Training/retraining on customer service standards (i.e., RELATE [3.1a(1)]) is crucial, as is deploying various methods to intentionally engage C-Os [Fig. 3.1-1] and gather feedback. In primary care, C-Os decide which PCP (and thus ICT) they will partner with, enabling care based on their personal values and goals [3.2b(1)]. This approach has influenced expanded opportunities for deeper knowledge of expectations/ preferences and trust in the long-term relationship with the ICT. Other examples include C-Os and providers co-creating written treatment plans in BSD, aftercare instructions in Fast Track, and Wellness Care Plans in primary care.

Figure 6.1-1: Key Health Care Services, Processes, Requirements, Measures and Results

Key Work Process Categories & Examples	Key Requirements	Sample Key Measure and Result
Customer Perspective • Customer Survey • Customer Feedback	Relationship fostered and supported Locations that are convenient Access optimized Simple and easy to use Family is the hub of the system Interests of C-O first Culturally appropriate Together with C-O as active partner	Staff Courteous & Respectful-Fig. 7.2-4 SBIRT Screening-Fig. 7.1-11 Appointment When Desired-Fig. 7.2-6 Primary Care Access to Care-Fig. 7.1-26 Would Recommend Services-Fig. 7.2-8 Continuity of Care with Provider-Fig. 7.1-20 Culture & Traditions Respected-Fig. 7.2-3 Ability to Give Input to Decisions-Fig. 7.2-7
Financial and Workload Perspective • Budget Planning • Budget Review	Services are financially sustainable Whole system design Interests of C-O first	Operating Margin-Fig 7.5-1 Overhead-Fig. 7.5-2 Days Cash on Hand-Fig. 7.5-5
Operational Effectiveness Perspective • Strategic Planning • Operational Review	Measures for continuous improvement Whole system design Services are financially sustainable Population based Working together in relationship with each other and our C-Os	Organizational Recognition-Fig. 7.4-16 Balanced Scorecard-Fig. 7.4-4 Board Assessment Results-Fig. 7.4-3 Core Concepts Participation-Fig. 7.1-30
Workforce Development Perspective • PDP • Annual Reorientation	Whole system design Emphasis on whole person wellness Working together in relationships to learn and grow	Balanced Scorecard-Fig. 7.4-4 Benefit Satisfaction & Org Support-Fig. 7.3-7 Employee per L&D FTE-Fig. 7.3-17 Career Development Opportunities-Fig. 7.1-29

6.1b(3) Support Processes. SCF serves C-O needs and expectations/requirements while working toward achieving MVCG/OP. This strategic focus begins at the process- thinking level and relies on defined KWP to provide day- to-day operations. First, key health care processes [Fig.6.1-1] are identified in FCS and leadership discussions, and SPP and improvement team meetings. A process owner or team is identified to define the process and recommend an implementation plan in pertinent functional work groups or specific programs/departments. This step also requires defining measures to help SCF assess if process requirements are met and in alignment with OP, organizational targets, and goals.

Next, key support processes are identified that are necessary to support the functional work and initiatives, including interactions with C-Os and the workforce. KWP are created as either a process map or protocol, or defined as P&Ps. Some examples include Behavioral Based Interviewing, purchasing materials and supplies through the Concur online system, reporting incidents in the Quantros system tool, Instructional Design Process for in-house L&D, DC course signups, and the PDSA process for making improvements. Day-to-day process management is the responsibility of SCF staff that utilizes the processes. Throughout SCF's key work systems, staff are expected to define and implement process steps, review process performance, and make improvements when needed. A dedicated team of improvement staff is available to assist at all stages. Improvement staff are trained to manage change. The improvement staff are assigned to key work systems and partner closely with operational management. SCF's emphasis on performance improvement includes review of processes, continual focus on innovation and improvement with PDSA cycles, and integration of these methods and process discussions into relevant FCS and work group meetings. In the FCS, the PI and QI Committees discuss KWP to identify areas for innovation and to increase the focus, if needed, on processes within SCF. These approaches ensure the consistent and systematic provision of high-performing services across SCF.

Figure 6.1-2: SCF Improvement Process (*detailed version available onsite*)

1.	A need for design, or redesign, improvement is identified and is checked for alignment with the OP.
2.	Complete Project Team Charter 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.

6.1b(4) Service and Process Improvement. At a system level, the use of the Baldrige framework helps SCF achieve its CQ through an ongoing focus on keeping KWP current with service needs/directions. SCF utilizes input from C-Os, collaborators, and internal customers and aligns all KWP to MVCG/OP and CO. SCF has used the framework since 2003, including teaching it at NHO and through a DC QMC.

SCF's improvement approach begins at the department level. Departments assess progress and performance of APs [2.2a (2)] through extensive use of performance data. 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. The OP are considered before improvement ideas are acted upon.

The Improvement Process [Fig. 6.1-2] balances removing undesirable variation with continual innovation and the spread of evolving best practices. To ensure there is a systematic evaluation and improvement of KWP, the PI, and QI Committees provide oversight. With interdisciplinary membership, the committees provide opportunities for sharing improvements and innovations, as well as lessons learned across SCF. The PI and QI Committees develop APs with improvement initiatives that are cross-departmental. The QI Committee oversees four CBGs: Primary Care, Dental, Behavioral Services, and Family Wellness Warriors Initiative. These groups include clinical leaders, front-line clinical staff, and strong improvement support, ensuring involvement from all levels of SCF and consistent application of data and quality while supporting innovation and spread.

In addition, to drive organizational learning and innovation, SCF encourages extensive external learning opportunities such as conferences, collaborative learning events, and benchmarking visits to seek knowledge about changing health care services, standards, and technology, and to identify best practices. Internal approaches for learning and innovation include posting departmental and committee improvement plans on the intranet as part of the AAPT, and fostering a culture of sharing that encourages the spread of improvement and innovative ideas. The workforce is encouraged to mentor and coach others in all areas of learning, as well as share knowledge as a method for spreading organizational best practices and accelerating organization-wide change.

6.1c Supply-Chain Management. Supply chain management is embedded in the day-to-day assessment of the effectiveness of SCF's work. Suppliers are selected with Native preference, utilizing other AN/AI nonprofits in the management of the supply chain when possible. For example, SCF partners in a regional supply center with ANTHC for critical hospital supplies. To ensure suppliers are qualified and positioned to enhance SCF's performance and C-O satisfaction, all vendors must complete a vendor packet that includes key terms.

Performance is evaluated through feedback from end users. SCF strives to develop relationships/two-way communication with vendors, resolve any ongoing issues, and give reasonable time to make corrections. In the event of poor performance, SCF first corrects contributing factors and then allows the vendor to make adjustments or improve. If issues cannot be resolved, then alternative vendors are sought. The procurement of goods/services is guided by Uniform Grant P&Ps to ensure federal funds expended are allowable under federal cost principles and in compliance with Uniform Grant guidelines.

6.1d Innovation Management. The SID provides a summary of the strategic considerations that are used to develop and revise the SP. In the SPC, the BOD uses the SID to determine and validate strategic direction, including strategic opportunities (e.g., new services) that are identified as intelligent risks. Strategic opportunities and initiatives are cascaded to the appropriate committee or department where they are addressed and tracked via the AAPT. The FCS provides oversight and direction. Once strategic opportunities are addressed (e.g., through resource allocation to designs or redesigns), and targets are achieved, they are monitored to maintain performance. Conversations, usually within the FCS and leadership, are used to determine a course of action (e.g., discontinuation of a pursued opportunity if evidence suggests it). An example is when SCF was looking to implement an EHR. Conversations about resource allocation to assist with the implementation began at the EHR committee and, through the FCS, elevated to VPLT. There, it was determined a high percentage of the improvement workforce would temporarily put improvement projects on hold and focus on the EHR implementation. The decision to reallocate improvement resources was deployed across the organization by the OD director. Under the direction of the EHR committee, the improvement workforce assisted in the successful implementation of the EHR.

6.2 Operational Effectiveness

6.2a Process Efficiency and Effectiveness. SCF often fundamentally rethinks and redesigns entire systems with the goals of minimized hand-offs, direct and immediate responsiveness, and co-location of team members. For example, the entire primary care system guarantees C-Os same-day access, locates all team members in the same ICT space, and uses workflow analysis to minimize waste.

SCF also focuses on bringing all services to the C-O, "max- packing" every visit, and having every service provider "work at the top of their license." Such approaches have radically reduced total cost and dramatically improved performance of required clinical interventions.

To prevent rework and errors, SCF uses the Improvement Process [Fig. 6.1-2] to pilot, learn, and refine before fully implementing changes. SCF also emphasizes implementing best practices and

systems of continual learning and spread to reduce undesirable variation while continually supporting innovation. For example, BSD implemented the role of BHC's at the front end of the specialty BH clinic. It was first tested on a small scale, then deployed to all C-Os calling or arriving for a behavioral services appointment. This process resulted in a structure greatly improving access while reducing cost. Another example is when the SCF ITS Department implemented standardized help desk scripting and troubleshooting guides to provide a consistent response and efficiently resolve customer issues.

To minimize costs of inspections, tests, and audits, SCF ensures all work teams have access to data to monitor and manage their efficiency and effectiveness. For example, SCF uses a comprehensive medical error reporting system. The workforce reporting is supported by the QA team and an error evaluation process. This approach has been fully deployed throughout SCF, resulting in reduced error rates. The QA team also runs tracers to test process conformance. Measures are tracked and accessible to staff on the DM. This approach has minimized the need for unnecessary testing and inspection, thus reducing cost. A Green Team committee also engages the workforce in stewardship of resources and reducing organizational waste.

The MVCG, OP and Core Concepts [Fig. P.1-1; Fig. P.1-2] are utilized to balance the need for cost control with the needs of our C-Os and other customers when they differ. An example of this is the creation of the SCF Elders Program [P.1a(4)], one of SCFs key communities, where the decision to start this non-revenue generating program was driven by MVCG, OP and Core Concepts rather than cost.

6.2b(1) Reliability. As part of its CQ, SCF strives for secure/ confidential information systems that deliver accurate and reliable information in a timely and efficient manner.

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 counts, and internal auditing procedures ensure accurate coding for medical care. The SCF Data Services Department works closely with providers, auditors, and HR to ensure accurate data collection/reporting. Data Services has integrated a number of proactive tools into its information systems to facilitate accuracy. For example, diabetes action lists used for population health purposes identify how and when each diabetic was identified. Any coding discrepancy can be quickly resolved by knowing the date and location and the codes used to identify the diabetic. These proactive tools have improved accuracy and provider confidence in screening and condition management registries. Data Services also conducts training and education with end users, as requested by department managers, to ensure the workforce understands the approach/methodologies. Lessons learned and guidance on resolving discrepancies have been integrated into the DM for dissemination and easy access. The standardized MRT [4.1a(2)] is also easily accessible via the intranet for all staff. The MRT ensures the metrics and data used are thoroughly planned and accurately defined.

Integrity and reliability: Most applications that are in place at SCF use traditional DBMS tools, such as Oracle, Microsoft SQL Server, and Inter Systems Caché 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 per industry standards to ensure data integrity. Data reliability is managed by ensuring that multiple information systems have the ability to collect information in a centralized and standardized format, and to share this information among them. Example: SCF's integrated use of a centralized master patient index to track C-O information across different information systems. SCF has also deployed and integrated standardized data/information collection and reporting tools, such as the AAPT and BSC; limited access for data entry or modification, such as authorizing specific individuals to enter BSC data; training employees in the use of IT to ensure adequate knowledge/skills; and working with key IT partners to ensure that systems are easy to use, taking into account the number of screens and key strokes required, etc.

Recent PI efforts around reliability also led to the development of an SCF ITS template to standardize database requests. The template has facilitated improved communications when developing databases.

Timeliness: SCF's approach to timeliness involves understanding how the data/information will be used. Data systems used for point of service (POS) with C-Os require real-time data to ensure safe and effective care, while population management and reporting tools may not require updates as frequently [Fig. 4.1-1]. To ensure timeliness, SCF ITS monitors the performance of its critical information systems, utilizes intranet and cloud-based monitoring tools, and has implemented technologies such as Enterprise Mobility Management and Office365. These strategies facilitate timely, secure, and non-duplicative information sharing. POS tools used in direct C-O care are updated as soon as information is entered. Tools that are not as time sensitive are updated daily or weekly, based on analysis and reporting requirements. These tools/reports are available via the intranet and DM. From an organizational performance perspective, BSC reporting frequency requirements are part of the MRT associated with each measure. These are reviewed by multidisciplinary teams for accuracy. SCF's intranet provides the workforce with 24/7 access to AAPT, LMS, P&Ps, Evaluation Tool, and organizational forms.

Data/information availability: SCF systematically makes data/information available to staff, C-Os, and suppliers/ partners, as appropriate. SCF utilizes its EHR systems to manage clinical, business, and administrative information. These systems facilitate standardized and structured health care data and information. At SCF, structured data from multiple EHRs are consolidated and queried to build pre-established reports. These reports provide managers and end-users valuable information from a systems perspective, which promotes safe, evidence-based C-O care, and efficient operations and performance improvement. 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).

Staff have broad access to data by means of the FCS. All staff can access the intranet to view committee meeting minutes and plans (via the CM tool), P&Ps, BSC results, and other data/information needed to perform their jobs.

SCF's commitment to SR involves making data/information available to C-Os to help them manage their health. For example, SCF offers 24/7 access to myANMC, a patient portal and online health management tool [3.2a(2)], as well as My AK Wellness, a fitness tracking/wellness resource that links to the EHR. SCF also offers classes/group visits, personal appointments, phone calls/emails with the PCP and/or RN/ Case Manager, and Health Information Stations in primary care lobbies with computer access/videos/print materials. HR enables the public to seek employment using an online application process. Committee meetings, SCF's website, informal interactions, and print communications are other ways SCF shares data/information with suppliers, partners, and C-Os.

Hardware/software reliability: SCF has built strong relationships with its major IT vendors. Each work closely with SCF ITS to ensure standardization and consistency. An integrated solution enables SCF to store, deliver, and manage data with three-tier redundancy. This allows SCF to roll back systems quickly and efficiently with minimal service interruptions.

To keep up with rapid changes in technology, SCF has substantially invested in ITS staff training (e.g., training on systems/call centers). Operationally, SCF promotes reliability by ensuring staff have a standard process/catalog of items available for purchase through SCF Procurement.

User-friendliness & feedback: To develop user-friendly IT systems, feedback from staff/end users is incorporated through the FCS via the IT Committee, SPP, and special work groups that plan for and deploy new systems. SCF ITS proactively solicits input on needs and preferences, provides training, and tracks user problems to be addressed immediately or in future design and/or purchasing.

The IT Service Desk, which is available to teach, answer questions, and troubleshoot, sends surveys to internal customers with each closed-service ticket to get feedback on the user-friendliness/effectiveness of the services.

6.2b(2) Security and Cybersecurity. Confidentiality as an all-staff responsibility is introduced at NHO and is part of the SCF Code of Conduct and ARO. SCF proactively manages security and fulfills regulatory responsibilities in support of HIPAA and CMS EHR meaningful-use requirements. EHRs and other information systems are secured through the AAA methodology: Authentication requires users to identify themselves by a unique username/password; Authorization is determined by the data author/manager; and Accounting provides an access audit trail.

SCF's Information Security & Privacy Committee was formed in 2015 as part of the FCS. It provides organization- wide input to jointly shape the direction of security practices. This is an industry best-practice and also aligns with SCF's CQ and SR.

The focus of SCF's Information Security Management Program (ISMP) is to evaluate emerging threats, improve employee awareness, and facilitate urgent responses through a formal Security Incident Response team.

The ISMP's risk assessment processes have been developed in conjunction with the NIST Risk Management Framework. SCF approaches information security management as a process of continuous improvement (vs. a point-in-time review-and- remediate approach) with automated vulnerability scanning, penetration testing, and administrative reviews throughout the year. The identified areas of risk are documented within a registry for tracking and systematic remediation planning, including evaluation and rapid prioritization of initiatives to reduce risks. In the event of a potential breach, mitigation and communication plans are in place. SCF ensures an open and easy reporting structure through its IT Service Desk, Quantros, and ITS security officer. A standard security incident form is completed for every incident. It includes notification, actions, evaluation, and follow up.

SCF deploys administrative safeguards such as assessments of potential risks, and P&Ps on confidentiality and use of technological resources. The ITS security officer is responsible for oversight and implementation, including looking for vulnerabilities to electronic protected health information (PHI). Examples of SCF's physical safeguards include storing PHI in locked, secured locations, and controlling/monitoring them by a badge-access system. SCF has also implemented physical safeguards related to data backup [6.2c(2)]. SCF's technical safeguards include unique identifiers and access to information based on an employee's role/responsibility. Username/ password access has been integrated into all IT systems where restricted access is required. Other technical safeguards include automatic computer log-off after a predetermined time of inactivity and encryption of email and electronic PHI. To protect email and file communication accessed by staff mobile phones, SCF requires version control of operating systems, encryption, and automatic lock with a PIN. Data and information shared between SCF and ANTHC are on a closed- network infrastructure. To ensure confidentiality of PHI, SCF uses an email encryption/content scanning utility.

Hardware/software security: SCF has implemented physical security mechanisms so only authorized staff can enter SCF's data centers. SCF also uses video surveillance.

Most SCF facilities have security alarm systems. SCF security officers also provide routine patrols of the facilities 24/7. The officers audit SCF's badge-access logs, both successful and attempted entries, to review the effectiveness of the access controls. The photo ID badges serve the purpose of identifying staff and providing access to only those areas appropriate to their role. The employee's manager grants access to common entrances and departmental resources, but only IT and Facilities provide access to more restricted areas, including where large depots of hardware/software are stored (e.g., SCF Purchasing maintains an inventory of software media/licenses plus excess hardware being prepared for data destruction and donation).

6.2c(1) Safety. SCF maintains a safety/EH program with a multidisciplinary approach to preventing

injuries, including assessing the work environment for potential hazards. Safety assessments of all programs occur on a rotating schedule and include safety, infection control, accreditation, and risk management SMEs. Identified hazards are uploaded into a database and the report is routed to the appropriate manager for follow-up. All follow-up must be appropriately addressed and the hazard(s) mitigated before the report is closed out.

SCF uses a nurse-staff call-in system for triaging employee injuries. Employees are directed to urgent care, deferred care, or self-care based on information provided to the nurse. Within minutes of completing the triage call, a report is sent to EH. This allows a quick response to injuries and early implementation of control measures to prevent similar injuries. Injuries are reviewed for root causes and prevention methods are implemented when/where appropriate.

6.2c(2) Business Continuity. SCF maintains an Emergency Management Plan addressing continuity and safety. Available via the intranet, the EMP guides the workforce on emergency response. A Hazard Vulnerability Analysis (HVA) is conducted and approved by the safety committee on an annual basis. It rates different types of natural, man-made, and technological disasters that may affect SCF's operations, and is used to identify deficiencies in the EMP. The EMP is routinely reviewed and is updated based on changes in operations and in the community, modifications to the HVA, and lessons learned from drills/exercises.

Prevention: The workforce receives basic training in emergency preparedness during NHO and ARO.

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: SCF is a member of the Anchorage-based Joint Medical Emergency Planning Group, which develops coordinated community plans for disaster drills and training. SCF also works with the State of Alaska on public health and continuity in the event of a mass emergency.

Evacuation: Each SCF facility maintains a building evacuation plan that is exercised at least annually. Each evacuation exercise is critiqued and evaluated to identify any OFIs. 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. 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. This amount is 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.

Emergency availability of IT: SCF ITS is responsible for providing a reliable data-storage platform that allows for rapid expansion to meet changing demands. SCF stores its critical information on an SAN with features that insulate it from hardware failures. It also has software that allows rapid recovery from accidental deletions or overwrites of critical data. In the event of a disaster, this platform has a configuration that allows for complete system recovery. All data is fully replicated off-site at a maximum delay of 24 hours. Most systems are replicated 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 would be lost. SCF also uses a tape archival system that supports a complete disaster recovery back-up daily from the secondary system. 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 early morning of the same business day.

SCF maintains fiber optic connectivity between its buildings on the ANMC campus. All off-campus facilities are connected back to the centralized data center. Remote sites with more than 20 employees have their own local file servers that utilize the main campus as a disaster recovery site.

Category 7: Results

SCF provides primarily outpatient health care [P.1a(1)], and is not a hospital. Thus, the results focus on outpatient, preventative care and not typical "hospital" measures. Aligned COs [Fig. 2.2-2] are indicated at the upper left of each figure.

7.1 Health Care and Process Results

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 identify needed PI initiatives. SCF currently segments HEDIS measure metrics geographically by site and down to the clinic/team/ provider level. In addition, SCF uses Provider Performance Comparison Charts to identify areas of best practice and OFI. (Detailed drill-down charts and graphs are available on site.) Accompanying each HEDIS metric measure is a web-based action list/registry 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/ registries also support forecasting demand for services and ensure current capacity meets demand.

Graphs are grouped into categories (e.g., prevention, screening, disease/condition management, behavioral health integration, utilization, etc.). They summarize SCF's commitment to the population health principles recognized by NCQA. SCF's results demonstrate how empaneling to a named provider and ICT builds a sense of SR that leads to positive health care outcomes. SCF is nationally recognized as a NCQA PPC-Patient Centered Medical Home Level 3 (highest level). The recognition demonstrates the importance of an ongoing relationship with your health care provider/ICT and taking responsibility for C-O care.

7.1a Health Care and Customer-Focused Health Service Results

Benchmarks: HEDIS 75th percentile (when ▲is better) or HEDIS 25th percentile (when ▼is better). When HEDIS percentile metrics are not available, SCF identifies other external world-class performers using similar methods to benchmark against. If external benchmarks are not available, SCF sets internal targets based on performance expectations. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

Trends: Additional historical clinical data is available on-site for most measures displayed. Overall, trends continue to improve and demonstrate sustainable results. SCF continually monitors clinical practice recommendations and adjust performance measures to reflect the most current practice. Because of changes in methods over extended periods of time, we've displayed the last 5 years to reflect current methodologies and information systems.

Segmentation: Provider comparison charts, individual provider performance over time, and clinic-specific measure segmentation are available on-site and via DM. Because methods and process are standardized and we share a common electronic health record platform, we can compare

performance across clinics and geographical locations.

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-Os are empaneled 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 has 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. Our past experiences and lessons learned related to Population Health measurement are being integrated into our electronic health vendors platform through our contractual partnership. Integrated Care Team debriefings, coaching and follow-up are conducted to identify team strengths and team opportunities for improvement. Suggestions are made to teams based on feedback received from high performing teams and lessons learned.

Figure 7.1-1: Diabetes Care: Annual HbA1C

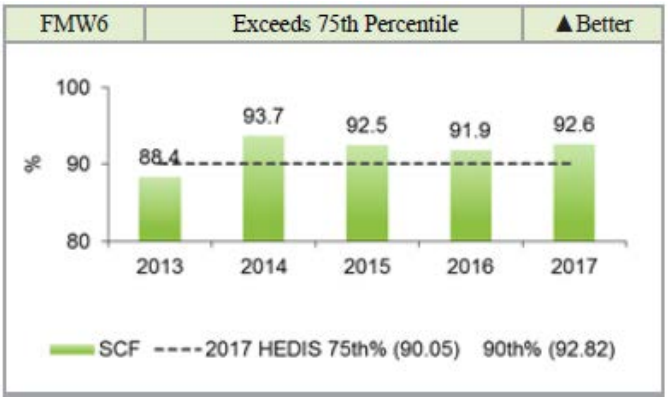


Figure 7.1-2: Annual HbA1C for VA & WCP

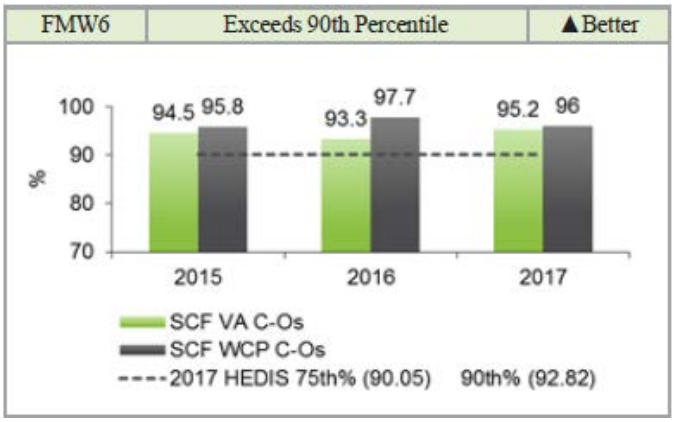


Figure 7.1-3: Diabetes Care: Poor Control

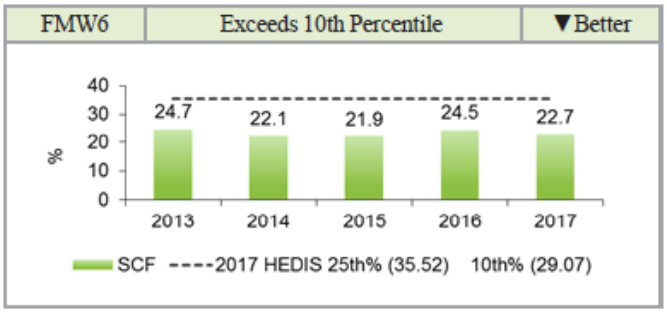
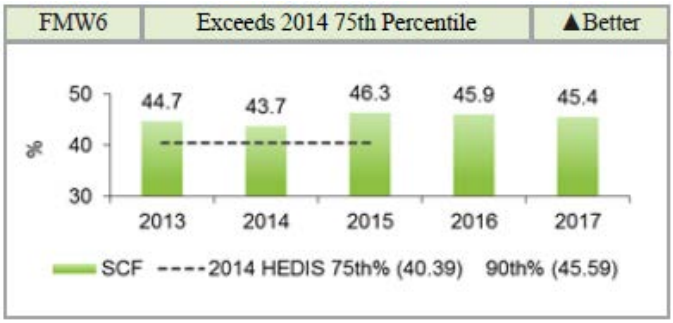


Figure 7.1- 4: Diabetes Care: LDL < 100 mg/dl



Cardiovascular disease and diabetes are two of the most prevalent conditions that SCF works with C-Os to manage. Figs. 7.1-1 through 7.1-4 provide results for SCF's Diabetes Management. 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. SCF's performance for all diabetes measures exceeds established benchmarks. For each clinical measure, SCF has the ability to segment performance by subgroups, such as VA customers (SCF serves veterans at five sites through a VA agreement) and C-Os with complex chronic conditions who choose Wellness Care Plans [Fig. 7.1-2]. Detailed segmentation is available on site. Newly developed measures specific to the Wellness Care Plan Population are available on-site. Initial results show decreases in opioid prescribing and positive changes in utilization patterns.

Figure 7.1-5: Cardiovascular: Annual LDL

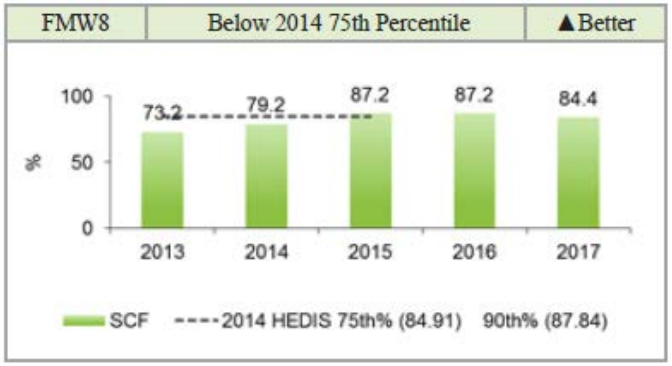
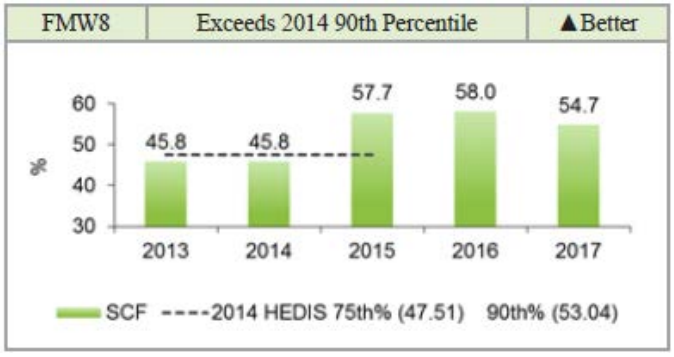


Figure 7.1-6: Cardiovascular: LDL < 100mg/dl



Figs. 7.1-5 through 7.1-6 display SCF's performance related to cardiovascular disease management. The performance measure for cholesterol management of cardiovascular disease for HEDIS benchmarking was discontinued. SCF's performance approaches or exceeds the last established benchmarks, as shown here. Once other measures are developed and become available through the NCQA HEDIS process, those benchmarks will be used.

Figure 7.1-7: Cancer Screening: Breast

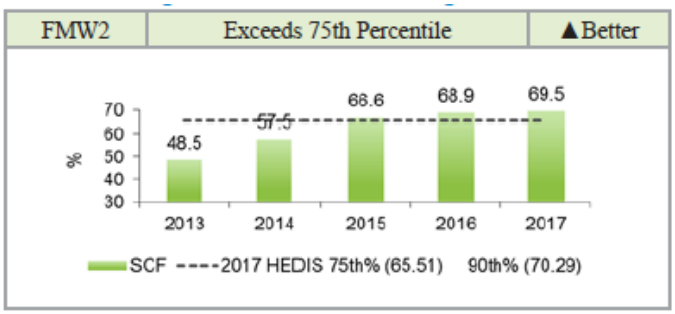
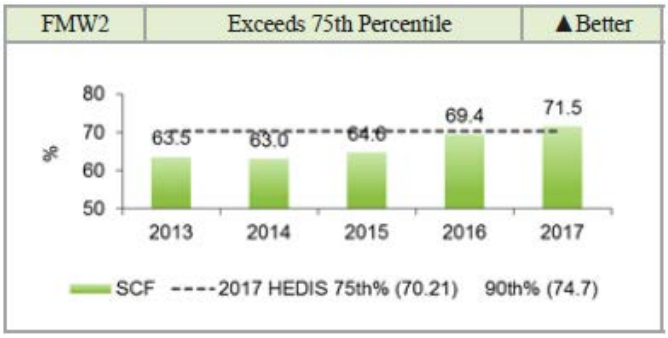


Figure 7.1-8: Cancer Screening: Cervical

Figure 7.1-9: Cancer Screening: Colorectal



Figs. 7.1-7 through 7.1-9 provide results for SCF's cancer screening program. SCF began using a new data warehouse for metric and registry building related to cancer screenings in 2013. Processes were established electronically and automated by the integrated information team to facilitate tracking for each C-O empaneled to an ICT. Performance results exceed benchmarks for breast, cervical and colorectal cancer screenings. Like many of SCF's performance increases, increased performance in cancer screening can be attributed to segmenting team performance, identifying best practices, and sharing that information with others.

Figure 7.1-10: Depression Screening

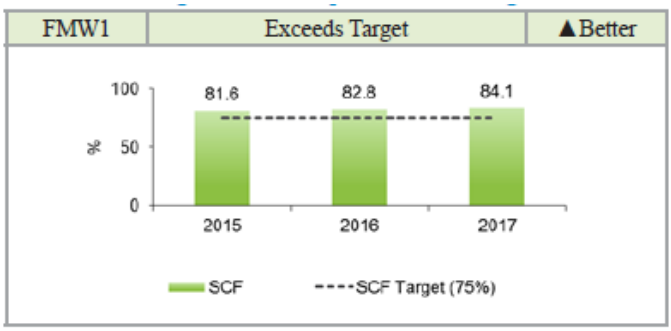
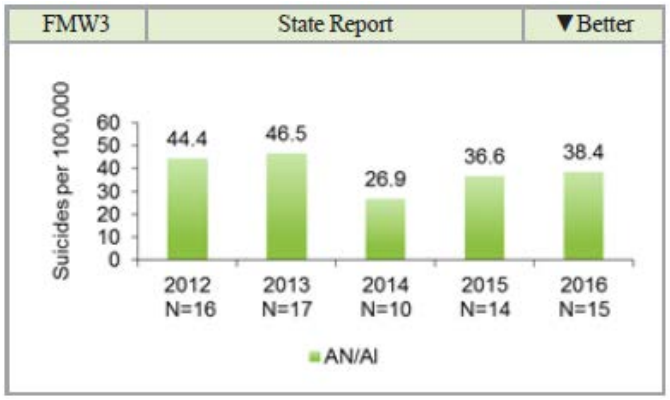


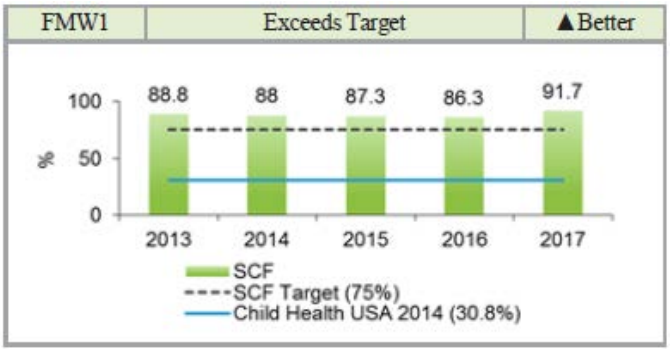
Figure 7.1-11: SBIRT Screening

Figure 7.1-12: AN Suicide Rate Anchorage/Mat-Su



Alaska has one of the highest suicide rates in the country. One of SCF's COs is to impact the rate of suicide among AN people by building healthy relationships with C-Os and providing clinical and behavioral health services, including primary care depression screening and substance- use screening. Figs. 7.1-10 through 7.1-11 display SCF's performance related to measures for depression and substance use. In 2015, screening methods changed and are more targeted. Because of method changes, only performance with similar methods in 2015 through 2017 are displayed. Performance on both measures exceeds benchmarks. Fig. 7.1-12 shows SCF's proxy measure for AN suicides in the Anchorage/ Mat-Su service area. The crude rate for 2014 shows a marked reduction in suicides. As suicide data is collected and recorded at the state level, it is more complete than what organizations would have in a medical record. The data is released annually with a two-year lag.

Figure 7.1-13: Ages & Stages 1st Year



In addition to adult screenings, SCF screens young children for developmental difficulties [Fig. 7.1-13]. SCF has set an internal target of 75% for this important childhood screening. Currently there are no NCQA/ HEDIS benchmarks for this measure. The target benchmark is more than double the national rate of 30.8%, reported by Child Health USA 2014 for developmental screening. SCF consistently performs developmental screening on 86-91% of its child C-Os in the first year of life.

Figure 7.1-14: Childhood Immunizations

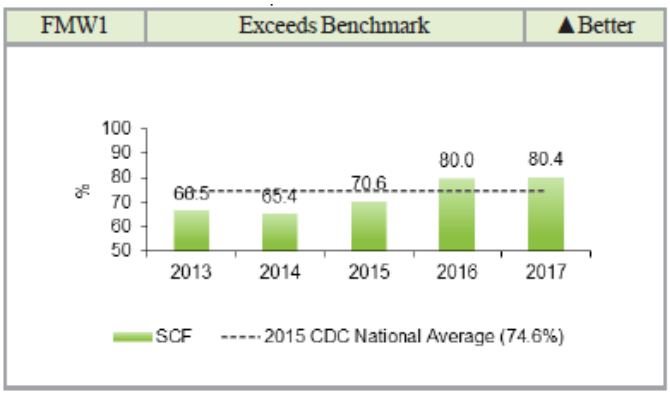


Figure 7.1-15: HPV Vaccinations

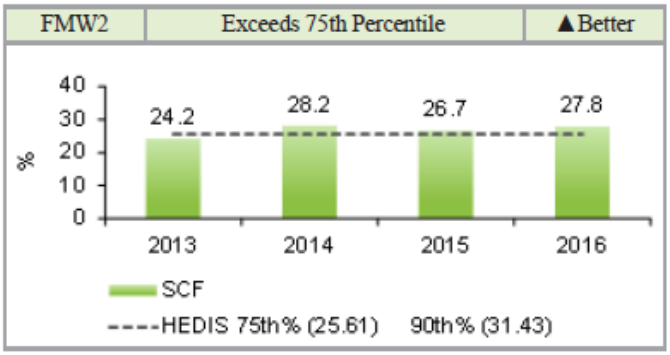


Figure 7.1-16: Adult Pneumococcal Vaccinations

Immunizations can prevent serious illness in all stages of life. Figs. 7.1-14 through 7.1-16 display, in this order, scores for childhood immunization rates on or before a child's third birthday; HPV vaccination rates for female adolescents to prevent cervical cancer; and pneumococcal vaccination rates for adults 65+. SCF is exceeding benchmarks in all immunization metrics. In the case of adult pneumococcal vaccinations, SCF empaneled a large number of VA C-O's whose vaccination data is not yet available. However, SCF is working with the VA to integrate this information.

Figure 7.1-17: ER Visits/1000 Member Months

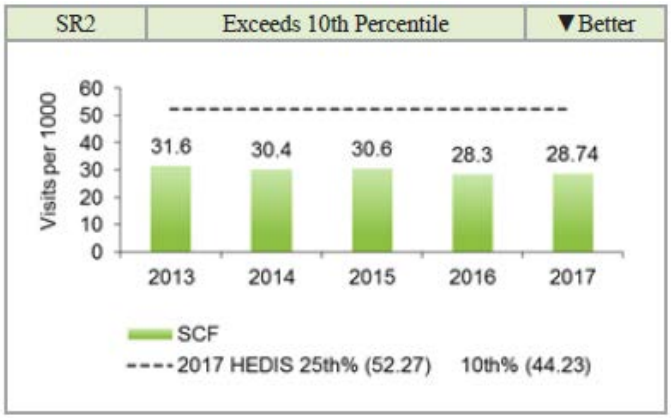


Figure 7.1-18: Outpatient Visits/1000 Member Months

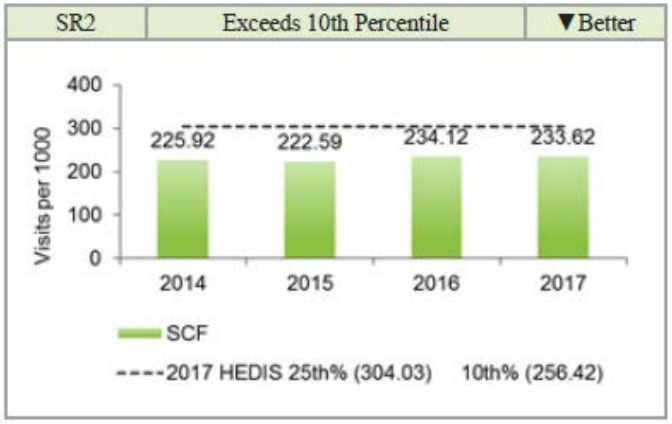
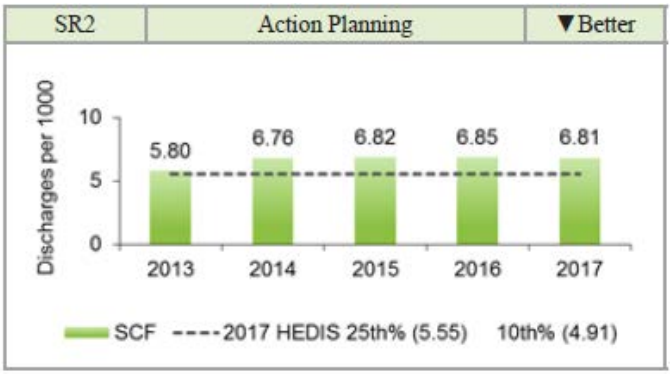


Figure 7.1-19: Inpatient Discharges/1000 Member Months



Figs. 7.1-17 through 7.1-19 reflect utilization of services rates to the emergency department, outpatient care, and inpatient discharges. Fig. 7.1-17 reflects SCF's low (lower is better) emergency department utilization. Low rates are attributed to having appropriate access to primary care and urgent care services for non-emergent care after hours. Fig. 7.1-18 reflects SCF's low outpatient utilization rate. ICTs encourage relationship building and work to communicate and partner with C-Os in their care. Proactive management of those empaneled [3.2b(1)] includes interactions with C-Os outside face-to-face clinic visits. Integrated care also encourages more comprehensive care (behavioral health, pharmacological management, etc.), allowing the C-O to get more services within a single visit. Fig. 7.1-19 shows inpatient discharges for SCF C-Os. Inpatient discharges are slightly higher than the HEDIS benchmark. Although SCF doesn't provide all inpatient services, it does monitor utilization. (ANMC is a regional facility that cares for more complex conditions. The geographical region covered is far larger than what most facilities in the U.S. are responsible. Many C-Os travel long distances to get there and may require longer stays).

7.1b Work Process Effectiveness Results

Benchmarks: Regulatory Compliance, Accreditation and Certifications that reflect criteria SCF has successfully met nationally recognized standards for quality, safety, and processes. TRICARE's Military Health System (MHS), because they empanel to a named provider and have similar continuity of care metrics. 2016 Adult Medicaid CAHPS Results, for customer perspective. If external benchmarks are not available; SCF sets

internal targets based on performance expectations.

Trends: Improved and sustained performance against benchmarks.

Segmentation: Segmentation at the service level of analysis.

Integration: Work processes are integrated into clinic and personal development plans to ensure sustainability. Monitoring results and tracers are reviewed within the committee structure and action plans developed as needed. Results are periodically discussed at managers meeting to ensure consistent communication throughout the organization. Results related to OSHA hazard metrics are used to drive changes with occupational controls (administrative, engineering and personal protective equipment) to improve safety.

Figure 7.1-20: Continuity of Care with Provider

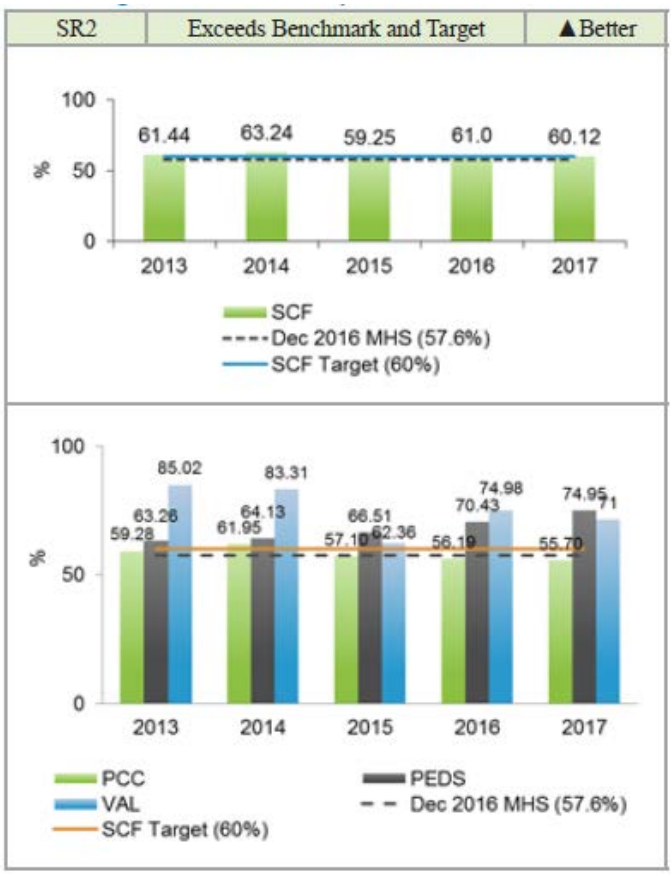


Figure 7.1-21: OBGYN Match Rate

Empaneling C-Os to a named provider of their choice, and seeing that provider during each visit, is a primary means of building strong relationships in health care. Figs. 7.1-20 through 7.1-21 show measures of continuity (match) with a C-O's empaneled provider for primary care and OBGYN. OBGYN match rate is for C-Os who have an empaneled provider for prenatal, pregnancy, and postpartum care. Having a 100% continuity of care rate is not operationally feasible with providers requiring ongoing training, not available 24/7, and taking scheduled vacations. SCF sought an organization that empanels and publishes their continuity of care metrics, and found the Military Health System's TRICARE. SCF then chose a benchmark internally that exceeds what is believed to be an industry best comparison. SCF is consistently exceeding its 60% benchmark overall and in OBGYN care. The VOC is a valued and important way for SCF to measure its work process effectiveness results. Customer experience survey results that exceed the 2016 Adult Medicaid CAHPS results are displayed in section 7.2. The results show positive outcomes related to work process effectiveness perceived by the C-O.

Figure 7.1-22:Employee Disaster/Emergency Training

Figure 7.1-23: OSHA Recordable Events

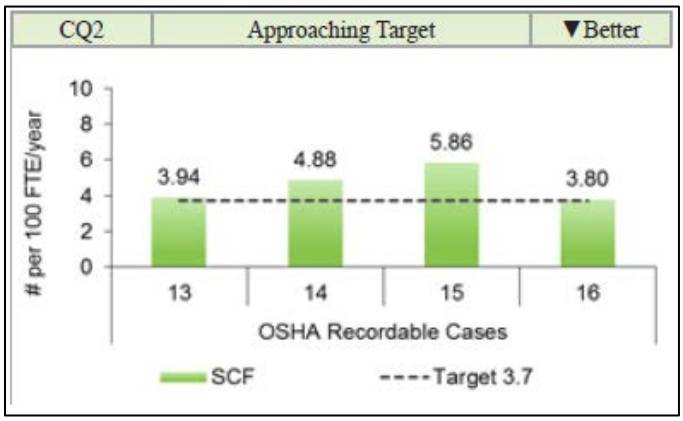
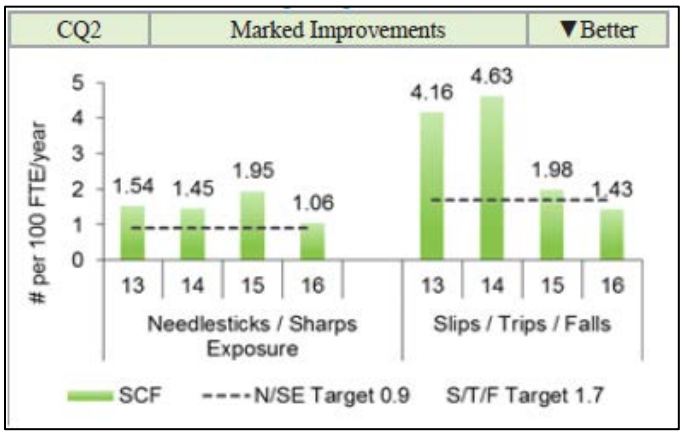


Figure 7.1-24: Needlesticks/ Sharps Exposures & Slips/Trips/Falls



Figs. 7.1-22 through 7.1-24 display results related to occupational health and safety. Emergency preparedness training is included in ARO and includes an overview of responses to local emergencies (e.g., fires) and large-scale disasters (e.g., earthquakes). Additionally, staff receives information on creating family disaster plans/kits so they can ensure they are prepared for a variety of emergency situations at home. 100% of the workforce is trained in emergency preparedness.

Workforce injuries requiring more than first-aid medical attention are captured as OSHA-recordable events in the depicted table. This table provides some insight in determining the severity of employee injuries. After a slight increase in the OSHA-recordable rate in 2014 and 2015, the rate in 2016 decreased to just slightly above the SCF goal of 3.7 OSHA- recordable events per 100 FTEs. When the OSHA-recordable rate is calculated as a Total Case Incidence Rate (using employee hours worked vs. FTE), the SCF rate (5.03) is below the median score (5.9) for other health care entities in the U.S.

Slip/trip/fall injuries generally occur in parking lots in winter as a result of snow and ice. The rates of these injuries have been significantly reduced as a result of installing heated sidewalks around several buildings and improving snow removal/gravel application processes by SCF Facilities and contractors. SCF also offers discounted ice grippers to staff.

Although needlestick injuries have decreased over time, the rate is still above the SCF goal. The majority of needlesticks occur in SCF Dental where sharps with safety-engineered sharps protections are limited or not commercially available. All needlestick injuries are reviewed for causative factors and the brand, type, and model of sharp involved is tracked so any trends with a specific device can be reviewed.

Managers are empowered to review employee injuries and determine causative factors to help prevent future occurrences. Proactively, SCF maintains a full-time safety manager who conducts regular audits of work environments to prevent unsafe conditions and provides regular staff training on specific safety topics. The SCF Quality Assurance Department also conducts regular tracers in programs to help identify potential hazards and ensure established procedures are followed.

Work process effectiveness result outcomes are demonstrated by SCF's accreditation, regulatory and compliance results shown in Figs. 7.4-5 through 7.4-7.

7.1c Supply Chain Management Results

Benchmarks: 2014 Merritt Hawkins & Associates Survey of Physician Appointment Wait Times. Military Health System Review – Final Report (29 Aug 2014). 2016 Adult Medicaid CAHPS Results. Merritt Hawkins' 2014 Survey of Physician Appointment Wait Times is a survey examining the time needed to schedule a new patient appointment with a physician in 15 major metropolitan markets

Trends: Overall, trends continue to be stable or improved meeting goals. 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.

Access to care and appointment availability are critical supply components in delivering the right care, to the right person, at the right time. Having trained ICTs that can meet more of a C-O's needs in a single interaction (both in-person and outside a visit) helps maintain this access in a way that is convenient to the C-O. Figs. 7.1-25 through 7.1-27 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.

SCF's OB/GYN clinic advanced access measure is displayed in Fig. 7.1-25. SCF access to OB/GYN specialty care is well below the national average of 17.3 days for the 15 major metropolitan areas surveyed in the 2014 Merritt Hawkins & Associates Survey.

Figure 7.1-25: 3rd Next Available Appointment

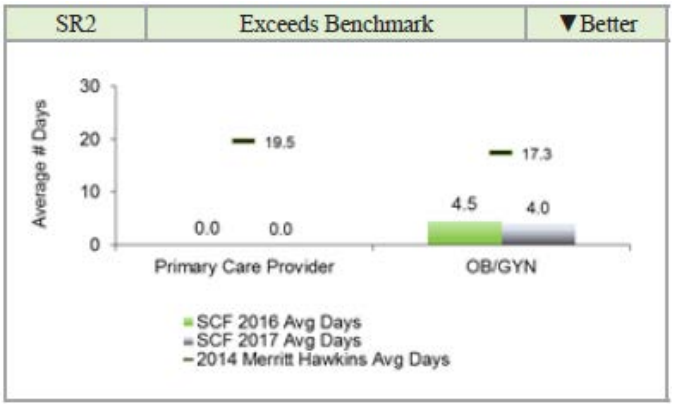


Figure 7.1-26: Primary Care Access to Care

Fig. 7.1-26 demonstrates SCF's ability to meet same-day access requests. Of all primary care appointments, 24- 40% are available for booking the same day. The percent of appointments at 0800 for primary care became the new standard for SCF Primary Care access after consistently having a 3rd next available appointment the same day. This innovative measure pushes the limits on measuring what C-Os really want. Comparing SCF to industry benchmarks in this instance doesn't correspond with what C-Os want or expect. For example, the 2014 Merritt Hawkins & Associates Survey of Physician Appointment Wait Times (1,399 medical offices surveyed) offers a snapshot of physician availability in the 15 major

metropolitan areas. Despite having some of the highest physician-to-population ratios in the country, many of these markets are experiencing appointment wait times that average 19.5 days or longer. In family practice, average wait times ranged from five to 66 days.

SCF provides same-day access for those who desire it. Other organizations, such as the Military Health System, establish access to care standards and measure success based on appointment type: 24 hours for acute, 7 days for routine, and 28 days for specialty appointments. The average wait time (MHS Review - Final Report, 29 Aug 2014) for an appointment within MHS Primary Care is: Acute 1.4 days, Routine 6.22 days, and Specialty 12.4 days.

Figure 7.1-27: Telephone Encounters

Figure 7.1-28: FY Provider Turnover

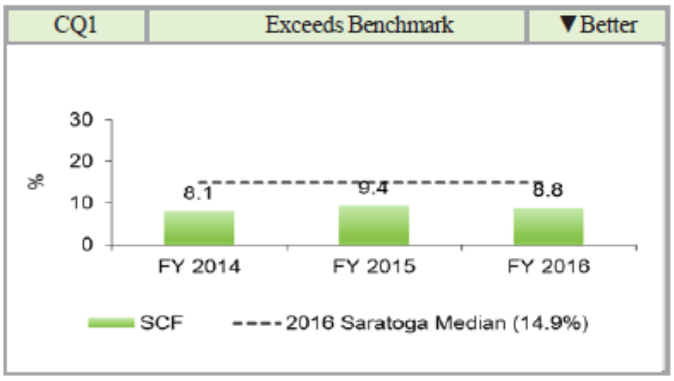
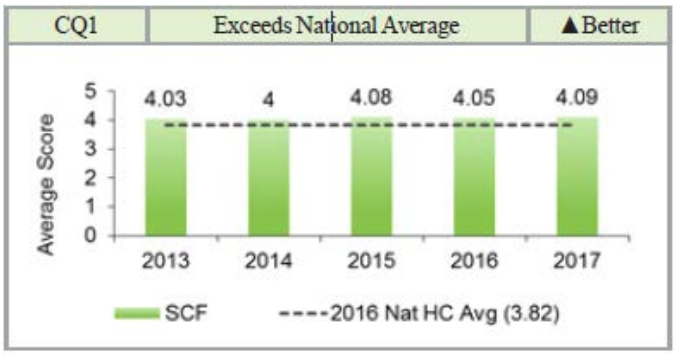


Figure 7.1-29: Career Development Opportunities



SCF Primary Care has same-day access for all types of care. SCF Primary Care doesn't categorize types of appointments, because C-Os believe they should be seen the same day regardless of appointment type. SCF measures success based on its ability to meet this C-O expectation. (While other organizations classify appointments based on what they feel is the urgency to be seen, this is not necessarily what the C-O wants/desires.)

Fig. 7.1-27 displays SCF's growing commitment to meeting C-O needs outside of a face-to-face office visit, when appropriate and convenient to the customer. SCF began tracking this metric three years ago. Results show teams are increasing their utilization of telecommunications with C-Os to manage their health needs.

All results for primary care access are segmented down to the ICTs to evaluate variation and performance. Telecommunications are segmented down to the clinic level for analysis.

Fig. 7.2-6 demonstrates customer satisfaction (exceeding benchmarks) with obtaining care when desired.

Directly related to the supply of appointments to meet advanced access needs, is the supply of providers available and trained to deliver care. Fig. 7.1-28 displays SCF FY Annual Provider Turnover Rate. The provider rate has remained below benchmark. (Overall turnover, and segmentation by other positions, is available on-site.)

How staff feel about their career development opportunities within the organization is a prime driver of SCF's retention rates. Fig. 7.1-29 shows positive responses toward career development exceeding the national benchmark.

Figure 7.1-30: Core Concepts Participation

Fig. 7.1-30 displays SCF core commitment to training all employees to meet the needs of our C-O's through the integration of the core concepts of FWWI throughout the organization.

7.2 Customer Results

7.2a Patient and Other Customer-Focused Results

Benchmarks: Adult Medicaid 2016 CAHPS, Quantros, internal benchmarks.

Trends: Historical data is available on-site for most measures displayed. Overall, trends continue to be improving and demonstrating sustainable results. CSS administration method transitioned from mail-out surveys to electronic tablet surveys in 2013, which increased the CSS response rate for reliable trending analysis.

Segmentation: Segmentation is available by department, provider team, age, and gender with ability to modify the electronic tablet survey to gather additional segmentation, as needed. Additional segmentation is available on-site.

Integration: Survey administration and listening post results are integrated into planning, training, BSC, SID, CI, and APs, including the manager PDP templates. Managers can access the data, identify OFIs and create work plans. Results are shared with C-Os through a multitude of outlets including SCF newsletter, Gathering, and intranet. C-O satisfaction results are used in planning and future facility expansion efforts to determine if current capacity needs are met, including parking and clinic space.

In response to manager and C-O feedback, the CEC piloted (2013) and deployed (2014) the electronic tablet survey [3.1a(1)]. Survey items are grouped into key themes that align with the VOC through the MVCG/OP. Survey item groups allow for survey customization for individual programs, including capturing the voice of youth and Elders [7.2-11], allowing for flexibility within a program but also ability to report aggregate data, such as overall satisfaction and dissatisfaction [7.2-1].

Figure 7.2-1: Customer Satisfaction (Top Box)

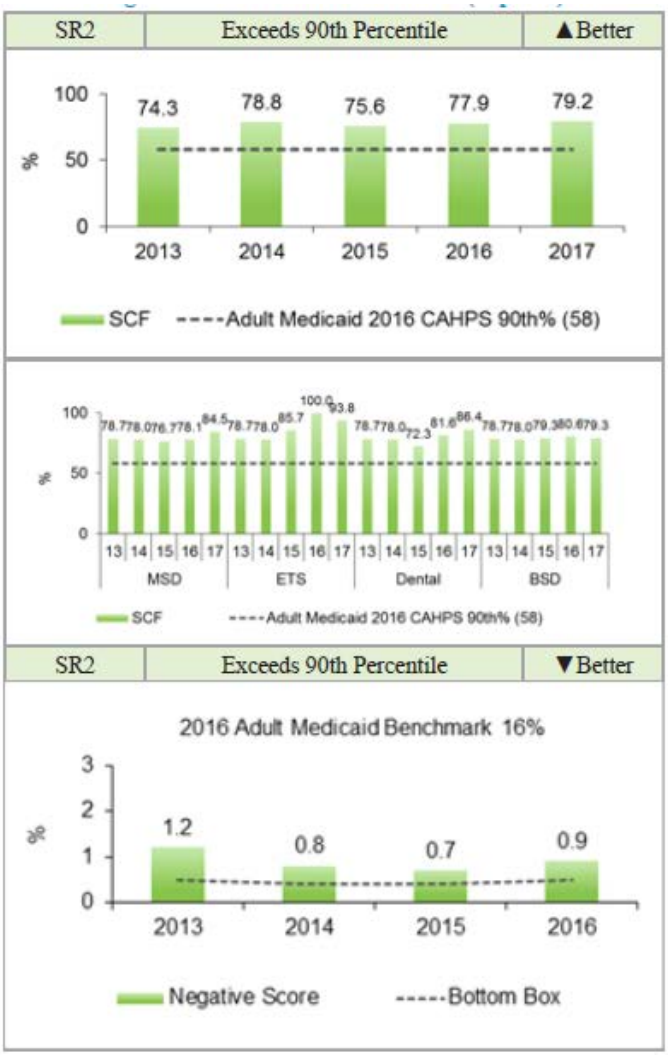


Figure 7.2-2: Customer Satisfaction Survey n Sizes

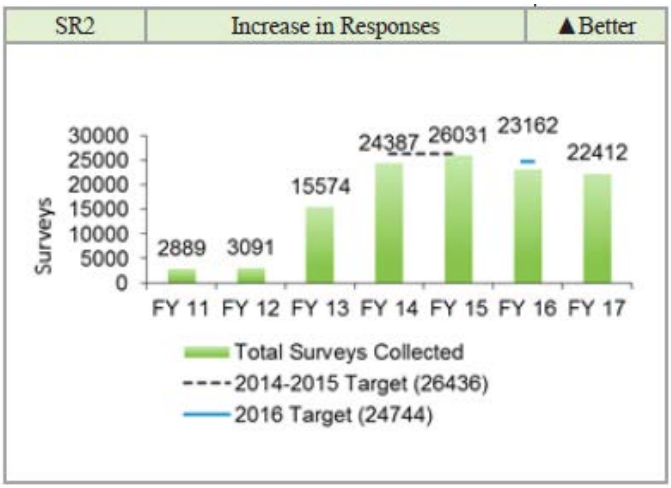
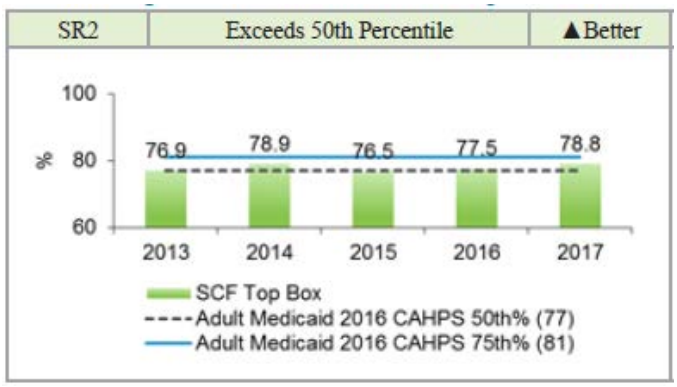


Figure 7.2-3: Culture & Traditions Respected

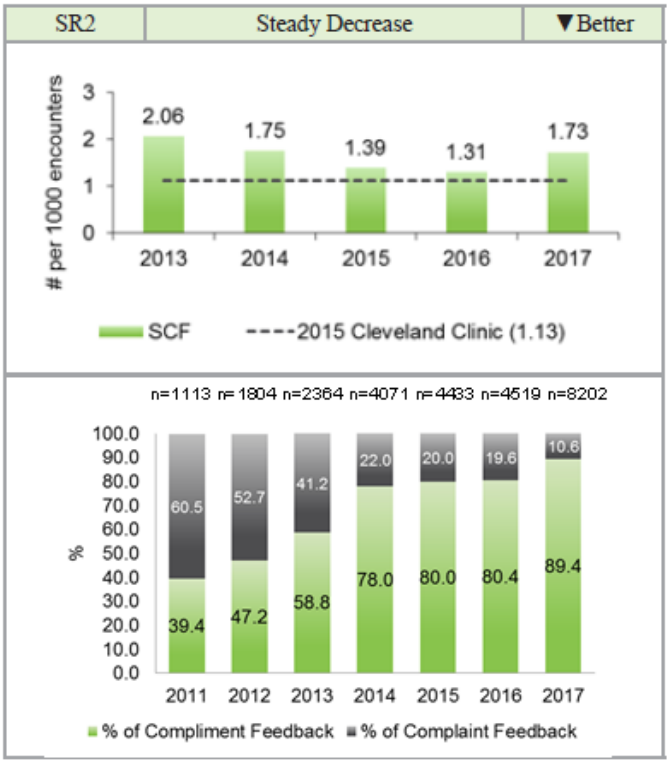
Figure 7.2-4: Staff Courteous & Respectful



Department specific and aggregate data are reported in DM and transparent to all staff for action planning. Key measures are identified and reported. BSC measures include overall customer satisfaction [7.1-1], culture and traditions [7.2-3], involved in care [7.2-7] and likelihood of recommending services [7.2-8]. When possible, external benchmarks are used for BSC measures, including CAHPS. When comparable external benchmarks are not available, internal benchmarks are developed; for example, the measure for culture and traditions [7.2-3]. All benchmarks are reviewed annually through FCS and BSC. Data is viewable in DM and aggregated monthly, quarterly, annually, and ad hoc.

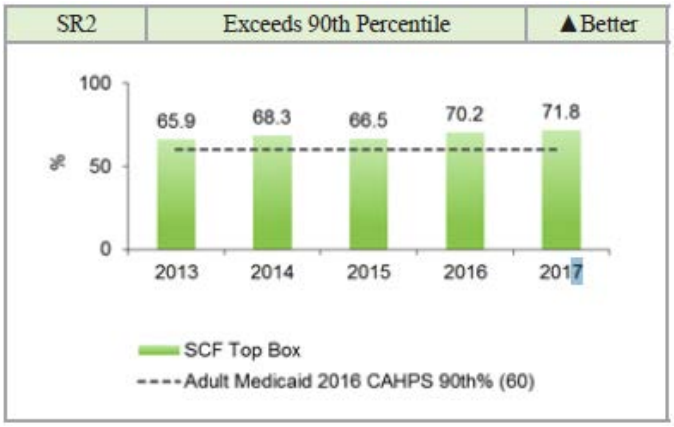
Prior to the electronic tablet survey, SCF Data Services and ODI partnered to determine each department's monthly response rate targets for reliable and actionable data. After implementation of the electronic tablet survey, survey response rates significantly increased [7.2-2]. To ensure each department meets the target, weekly response rate reports are sent to managers. Response rates are reviewed quarterly by the CEC and OPS to ensure reliable and actionable data as well as OFIs. Example: When C-O feedback indicated survey fatigue, Data Services and OD re-examined, with response rates and historical trending, and adjusted department response rate goals. As a result, SCF gathered nearly 3,000 less surveys in 2016 and still maintained excellent satisfaction ratings.

Figure 7.2-5: Concerns per 1000 Encounters & C-O Feedback Rates



SCF recognizes the increase in C-O population has resulted in increased C-O encounters. SCF listens and responds to the VOC using behavioral standards for all staff. In response to concerns regarding courtesy and respect, SCF launched culturally relevant and relationship-based customer service standards, known as RELATE [7.2-4], resulting in an increase in top box scores. Qualitative feedback (e.g., received in the CSS, received by SCF's customer service representatives, etc.) is also entered into Quantros for quantitative reporting. Following the RELATE implementation, the percentage of complimentary feedback significantly increased. Best practices are shared with similar teams and information connects back to the C-O through outlets such as the SCF newsletter [7.2-5].

Figure 7.2-6: Appointment When Desired



The CAHPS benchmark for "appointment when needed" is based on appointment type and if a C-O "needs" an appointment. "Need" is typically defined by the health care system and different appointment types typically have different standards. SCF scores are reflective of all appointment types and ask if an appointment was available when the C-O desired. SCF's higher standards for appointment satisfaction are innovative and outperforming the "need" national benchmark [7.2-6]. Appointment available at 0800 [7.1-26] is the innovative higher benchmark SCF uses to ensure, on a daily basis, we meet C-O desires for an appointment in primary care. For specialty services, third next available indicator is used to meet C-O needs [7.1-25]. Managers review data on the DM to monitor appointment desirability and availability, and identify OFIs.

As a CG, SR with C-Os is measured through a variety of customer satisfaction measures. C-Os 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 services reflect a perception of loyalty and value, including involvement in care, trust, information provided, and recommendation of care [7.2-7, 7.9, 7.2.10, 7.2-8]. Each of these measures exceeds the CAHPS 75th percentile or greater, and supports SR and relationship building.

Figure 7.2-7: Involved in Decisions About My Care

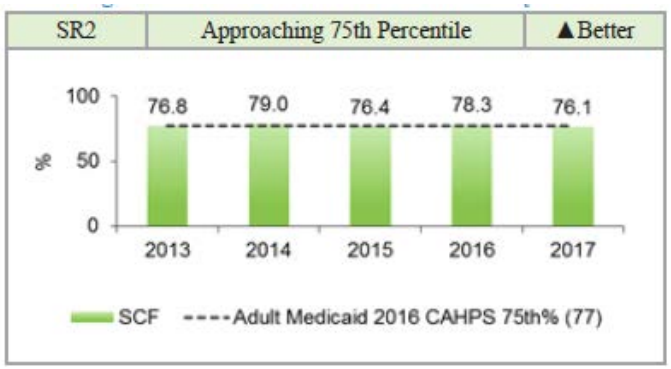


Figure 7.2-8: Would Recommend Services

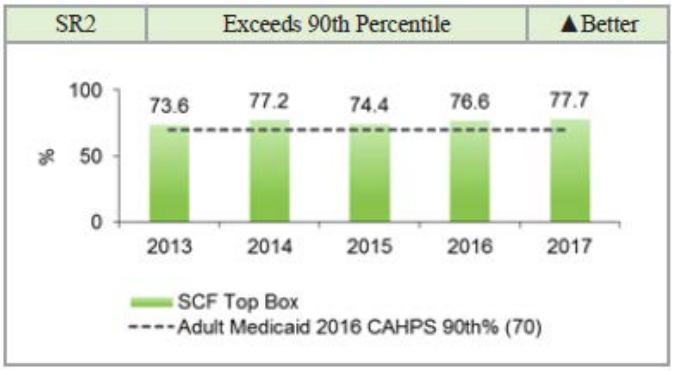


Figure 7.2-9: Trust in Care

Figure 7.2-10: Information Provided in Care

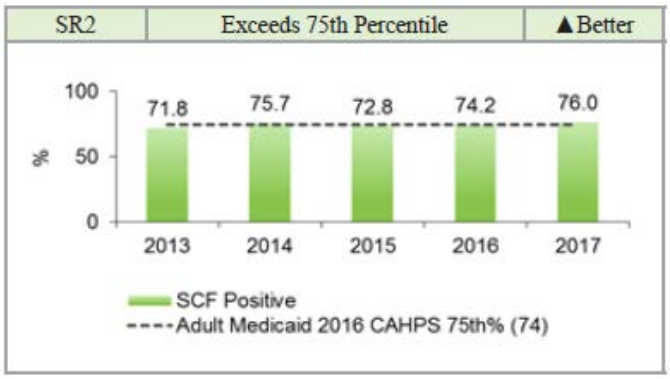
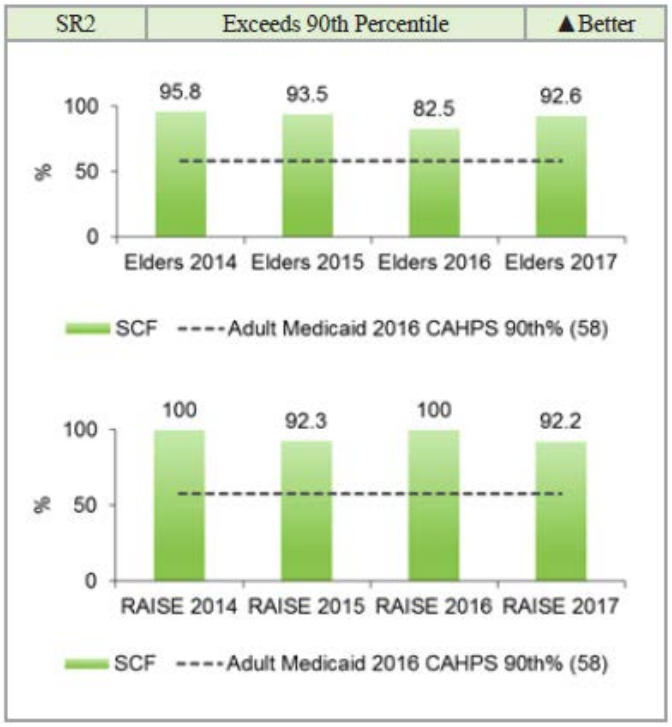


Figure 7.2-11: Elders and RAISE Overall Positive Satisfaction



7.3 Workforce Results

7.3a Workforce-Focused Results

Benchmarks: Press Ganey, Saratoga, Association for Talent Development (ATD), ANTHC. Press Ganey's mission is to support health care providers in understanding and improving the entire patient experience. As a strategic business partner to more than 26,000 health care organizations, they lead the industry in helping clients transform the patient experience and create continuous, sustainable improvement. Saratoga Institute database provides global metrics and benchmarking. The metrics cover industry sectors worldwide with more than 300 metrics relating to workforce productivity, span of control, succession, recruiting costs and efficiency, quality of hire, labor costs, turnover, diversity, human resource department cost, and organizational structures.

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

Segmentation: Available on site. All EOS data can be segmented by organization, division, job categories, and workforce demographics. Additional measures are segmented as appropriate.

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

Figure 7.3-1: 90-Day Turnover Rate

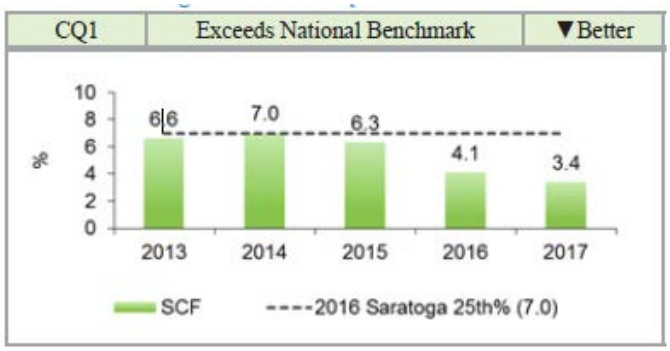
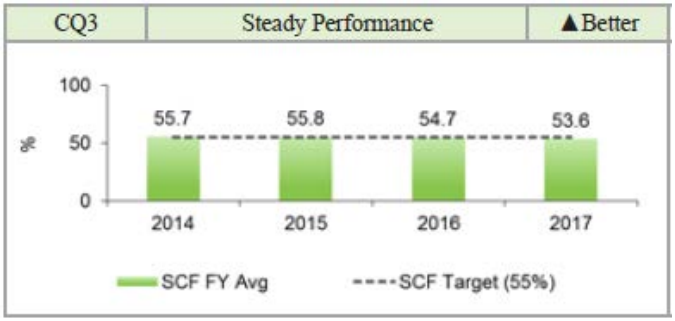


Figure 7.3-2: Total and AN/AI Turnover

Figure 7.3-3: Percentage of AN/AI Workforce



SCF turnover as an indicator of meeting capability/capacity needs. Both overall and AN/AI turnover [Fig. 7.3-2] are measured. SCF has determined that AN/AI turnover is high due to a concentration in entry-level positions with expected higher turnover for these job categories. To address this, SCF measures the total percentage of AN/AI employees [Fig. 7.3-3] to be reflective of SCF's C-O culture. When a performance gap is identified, improvement may be addressed through division- specific initiatives (such as re-categorizing clinical associates to behavioral health technicians in 2016) or through HRC. SCF is

committed to "right fit" hiring through a multi-pronged approach (e.g., behavioral-based interviewing); as a result, 90-day turnover is far below the Saratoga 90th percentile [Fig. 7.3-1].

Figure 7.3-4: Scholarship Amounts per FTE

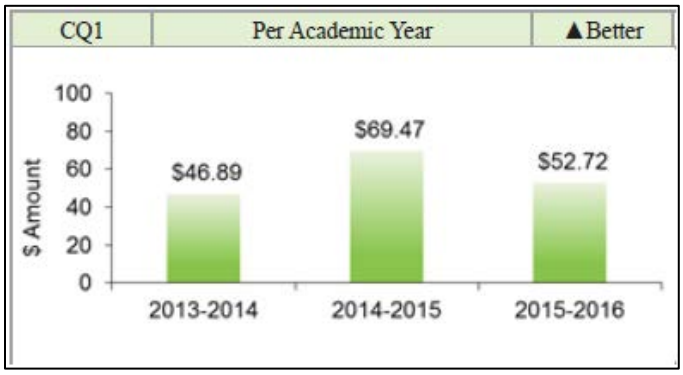


Figure 7.3- 5: Academic Leave Hours per FTE

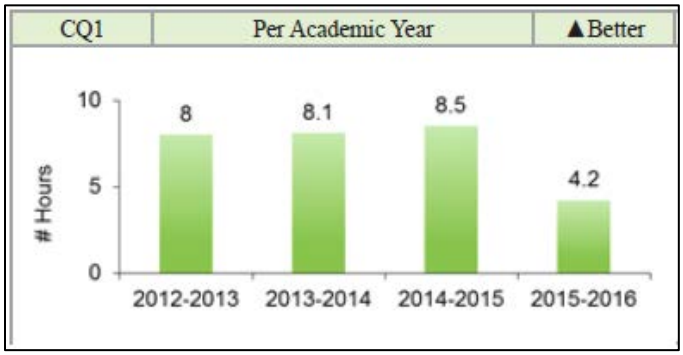
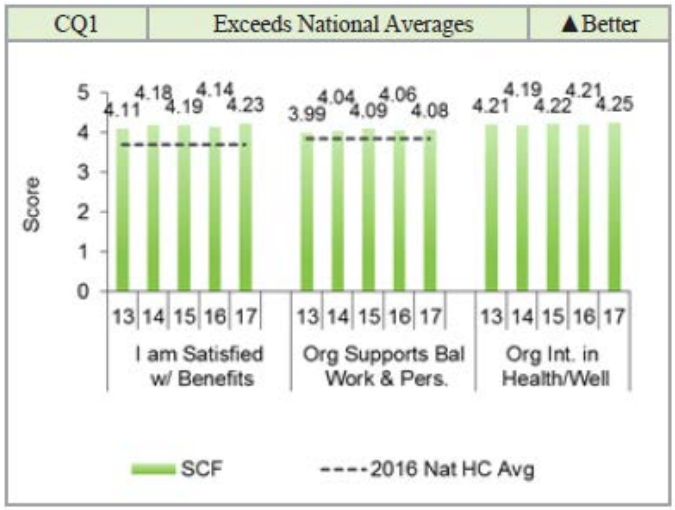


Figure 7.3-6: Organization Cares about Employee Safety

Additionally, SCF assesses workforce capability/capacity through the EOS. The QA Committee manages and monitors processes related to workforce health/safety to ensure that employees feel supported and safe [Fig. 7.3-6]. SCF also provides support by way of health, dental and vision insurance, paid time off, wellness leave, and many other benefits. The EOS results show employees are satisfied with the benefits/ support offered, with scores higher than the national average [Fig. 7.3-7].

Figure 7.3-7: Benefit Satisfaction & Organizational Support



An emphasis on personal/professional development is embedded in SCF's culture. SCF promotes development by encouraging staff to take advantage of academic program benefits, including scholarships for AN/AI employees, tuition reimbursement, and paid academic leave. SCF awarded an average $52.72 in scholarships per FTE during the 2015-2016 academic year [Fig. 7.3-4]. Paid academic leave [Fig. 7.3-5] is offered based on level of education sought, with an average 4.2 hours per FTE during the 2015-2016 academic year. Data by division for scholarships and academic leave is available on site.

SCF contracts with Press Ganey to conduct the annual EOS [5.2a(2)]. The Engagement Indicator score [Fig. 7.3- 8] consists of six questions from the EOS as the measure for workforce engagement [Fig. 7.3-10]. These data can be segmented from organization to work unit level and by various workforce demographics [Fig. 7.3-9]. The data can also be segmented by how engaged employees are depending on their job category [Fig. 7.3-11]. These categories were updated in 2016.

At the department level, managers meet with the workforce to identify OFIs and create work plans to implement in the AP. The HRC reviews organizational trends and creates organizational work plans that are integrated into the manager PDP template [5.2a(4)]. EOS results indicate steady performance with the workforce understanding SCF's MV [Fig. 7.3-12] and the connection between MV and their jobs [Fig. 7.3-13]. EOS results also indicate SCF has consistently met workforce L&D

needs, remaining steady [Fig. 7.3- 15] with external benchmarks. Position-specific trainings exceed the internal benchmarks [Fig. 7.3-14], created when comparable external benchmarks are not available.

Figure 7.3-8: Workforce Engagement Indicator

Figure 7.3-9: Workforce Engagement Indicator by Division

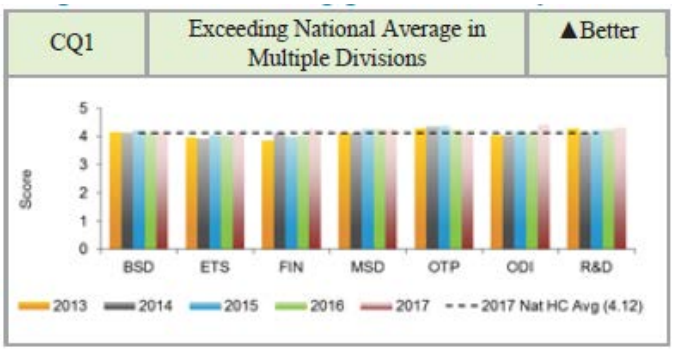


Figure 7.3-10: Engagement Indicator Questions

Figure 7.3-11: Workforce Engagement Indicator by Job Category

CQ1	Excellent					▲Better
Job Category*	2012	2013	2014	2015	2016	2017
Healthcare Provider	4.11	4.07	4.05	4.23	4.2	4.14
Healthcare Professional	4.1	4.23	4.23	4.27	4.2	4.34
Healthcare Technician	4.26	4.19	4.08	4.24	4.25	4.22
Non-Clinical Managerial	4.33	4.19	4.15	4.32	4.25	4.18
Non-Healthcare Professional	4.13	4	3.94	4.13	4.02	4.15
Non-Exempt\Non-Health\Non-Clerical	4.09	4.15	3.94	3.87	4.09	4.08

Figure 7.3-12: Understanding Mission & Values

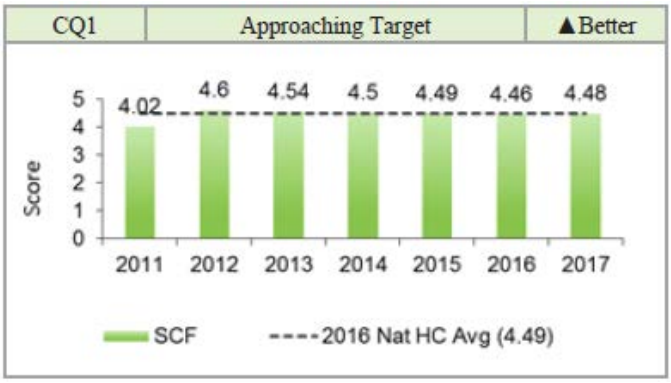


Figure 7.3-13: Understanding Job and Mission

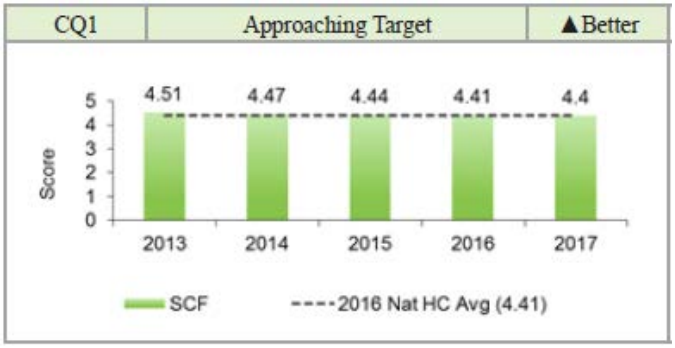


Figure 7.3-14: ASTP Satisfaction Rating

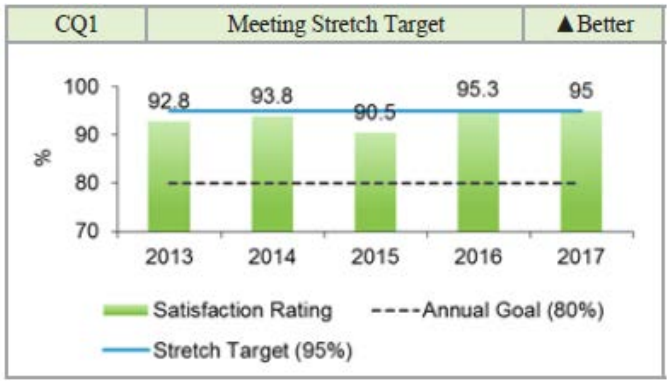


Figure 7.3-15: "I get the training I need to do a good job."

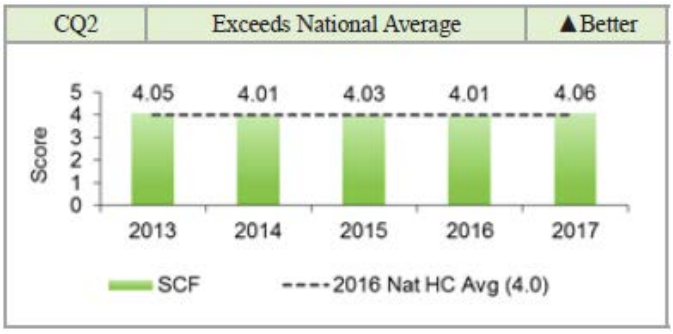


Figure 7.3-16: L&D Hours per Employee

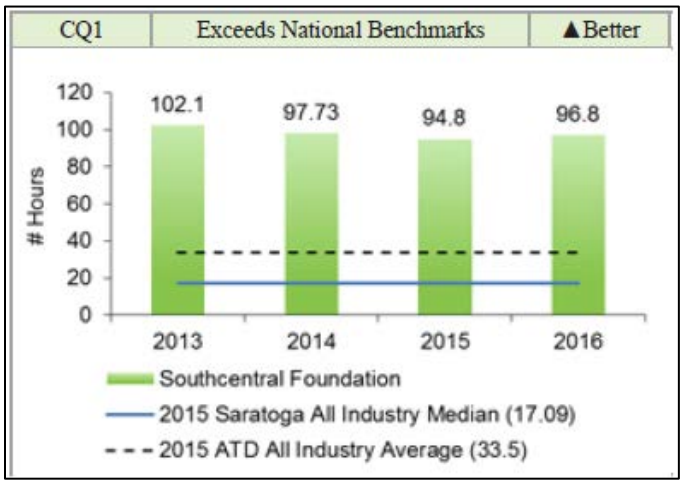


Figure 7.3-17: Employees per L&D FTE

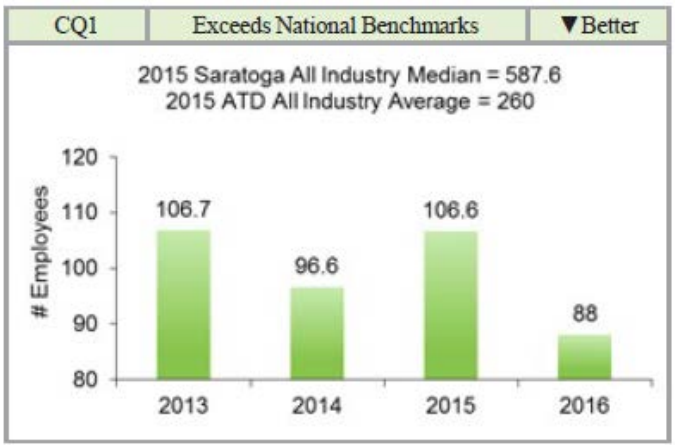
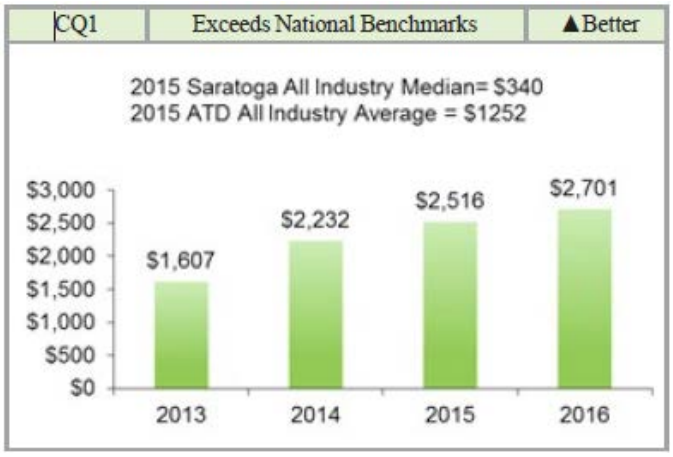


Figure 7.3-18: L&D Investment per Employee



SCF utilizes Saratoga and ATD to compare with national workforce development benchmarking. SCF's commitment and investment in workforce development is demonstrated by consistently exceeding Saratoga and ATD national benchmarks [Figs. 7.3-16, 7.3-17, 7.3-18]. Workforce engagement in training continues to meet or exceed Press Ganey's national average [Fig. 7.3-15]. FOM provides educational support for managers and others in positions of leadership, offering monthly training topics such as Improvement and Innovation, Teams at SCF, etc. Participant feedback consistently indicates high levels of satisfaction and confidence in their knowledge of the topics covered [Figs. 7.3-19, 7.3-20].

Figure 7.3-19: FOM Average % Positive Knowledge/ Confidence with Class Content

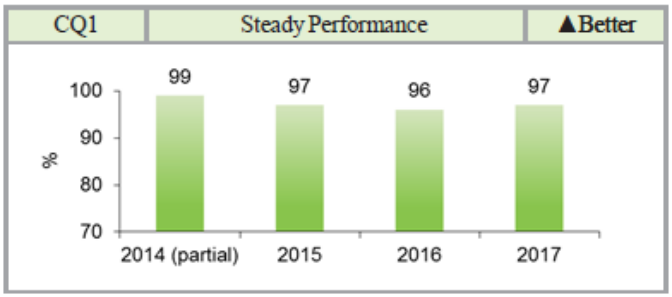


Figure 7.3-20: FOM Average % Positive Satisfaction

7.4 Leadership and Governance Results

7.4a. Leadership, Governance, and Societal Responsibility

Benchmarks: Press Ganey, regulatory benchmark (The Joint Commission), Commission on Accreditation of Rehabilitation Facilities (CARF), CAP and SCF defined targets. The Joint Commission is an independent, not-for-profit organization, which accredits and certifies nearly 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

CARF provides accreditation services worldwide at the request of health and human service providers. Whether you are seeking rehabilitation for a disability, treatment for addiction and substance

abuse, home and community services, retirement living, or other health and human services, you can have confidence in your choice. Providers that meet standards have demonstrated their commitment to being among the best available. CARF accreditation signals a service provider's commitment to continually improving services, encouraging feedback, and serving the community.

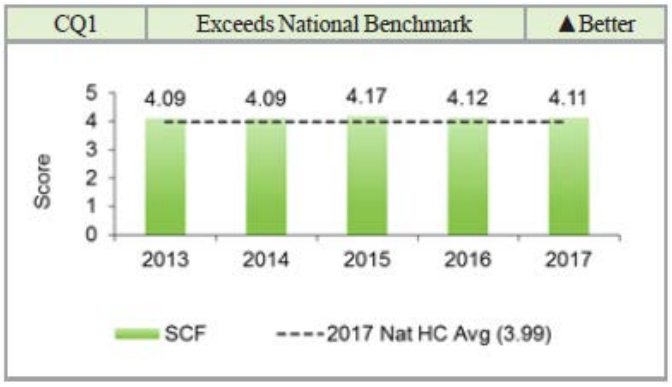
The College of American Pathologists (CAP) is widely considered the leader in laboratory quality assurance and advocates for high-quality and cost-effective medical care. The CAP inspects and accredits medical laboratories under deemed authority of the Centers for Medicare & Medicaid Services (CMS).

Trends: SCF reviews data over time to understand trends and patterns.

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: EOS Statement on SL Actions



Figs. 7.4-1 and 7.4-2 are the results for SLs' communication and engagement with the workforce. SCF's EOS results for "Senior management's actions support this organization's mission and values" [Fig.7.4-1] consistently exceed the National HC Average from Press Ganey. The EOS allows SCF to drill down from organization level to specific work unit, offering opportunities to determine appropriate APs.

SLs are responsible for leading the Annual Learning Event. Staff rate their satisfaction with the event consistently between 80-90%, and their feedback is used in planning efforts for each subsequent event.

Figure 7.4-2: Annual Learning Event Overall Satisfaction

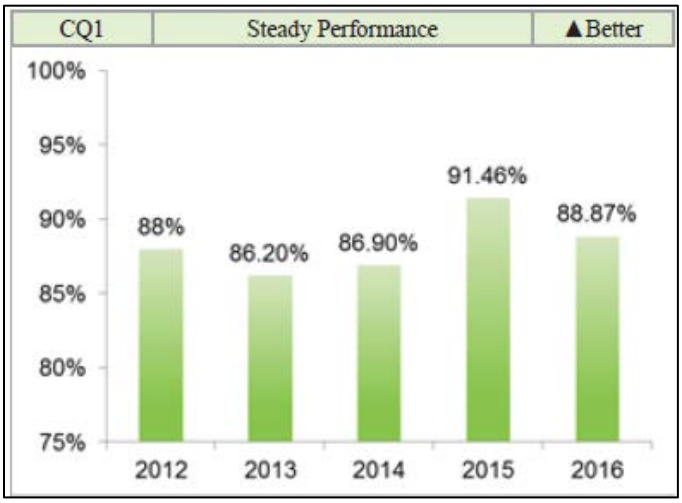
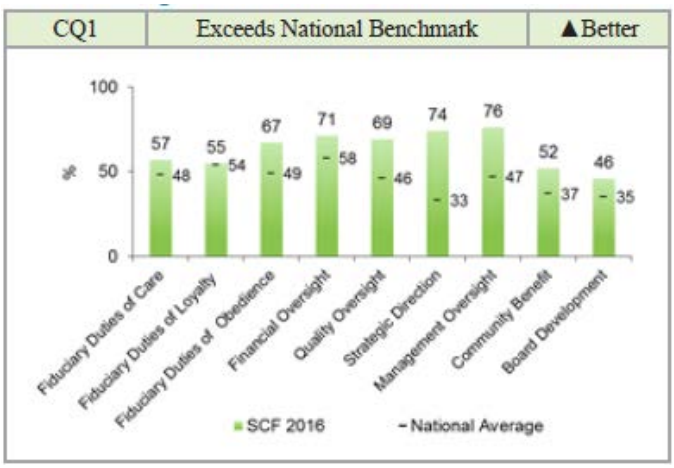


Figure 7.4-3: Board Assessment Results



SCF regularly conducts a BOD governance assessment. Fig. 7.4-3 shows the 2016 results exceeding national benchmarks across indicators, demonstrating accountability in areas of fiduciary concerns, quality, strategy, oversight, community and board development. SCF measures fiscal accountability in multiple ways and includes financial measures in the BSC [Figs. 7.4-4, 7.4-5].

Figure 7.4-4: Balanced Scorecard Sample

2017-Q4	Below Min.	Meets	Exceeds
Measure by Perspective		**Figure**	**Score**
Customer-Owner			
Culturally Respectful		7.2-3	94.9
Recommended Provider		7.2-8	77.7
Input into my Care Decisions		7.2-7	76.1
Financial & Workload			
Operating Margin (FY)		7.5-1	12.7
Operational Effectiveness			
Pediatric Immunization Combo 2		7.1-14	80.4
Breast Cancer Screening Rate		7.1-7	69.5
Cervical Cancer Screening Rate		7.1-8	71.7
Colorectal Cancer Screening Rate		7.1-9	71.5
PrimeMD Depression Screening Rate		7.1-10	84.1
SBIRT Screening Rate		7.1-11	80.1
Diabetics with A1C in Poor Control (▼= Better)		7.1-3	22.7
Diabetics Annual HbA1C Screening Rate		7.1-1	92.6
Adult Pneumovac (Age 65+)		7.1-16	78.1
Visits/1,000 Member Months to ER for Empanelled (▼= Better)		7.1-17	28.74
Percent of Time you see your PCP		7.1-20	60.12
Workforce Development			
Percent of AN/AI Employees		7.3-3	53.6
Total Turnover Rate (▼= Better)		7.3-2	14.9

Figure 7.4-5: Fiscal Accountability Results

OPE1	Exceeds Target	0 = Better
Measure by Perspective	*2012-2017 Results*	
Independent external audit	No Findings	
Grant Compliance	No Findings	

Figs. 7.4-6 and 7.4-7 show SCF performance in meeting accreditation requirements. SCF consistently performs above target for multiple divisions. Over time, SCF has demonstrated full accreditation [P.1a(5), 1.2b(1), Fig. 1.2-1]. SCF's QA department performs QA tracers [5.1b(1)], an internal audit process, to ensure compliance with the standards associated with the accrediting bodies. The tracers are also used as education for staff as part of the continual improvement process.

SCF continues to strive to improve workforce TB testing rates [Fig. 7.4-8]. The trend in the rate of compliance over the past four years can be attributed to the Employee Health process of engaging staff in their work units and instituting an electronic system for improved monitoring and reporting (e.g., email notification sent automatically to staff and their direct supervisors if requirements have not been met). Feedback from 2016-17 has reflected staff preference for shortening Employee Health's annual compliance period to one month, and having standardized Employee Health encounter areas within the clinical space. These suggested improvements will be considered for 2017-18.

Figure 7.4-6: Quality Assurance Tracer

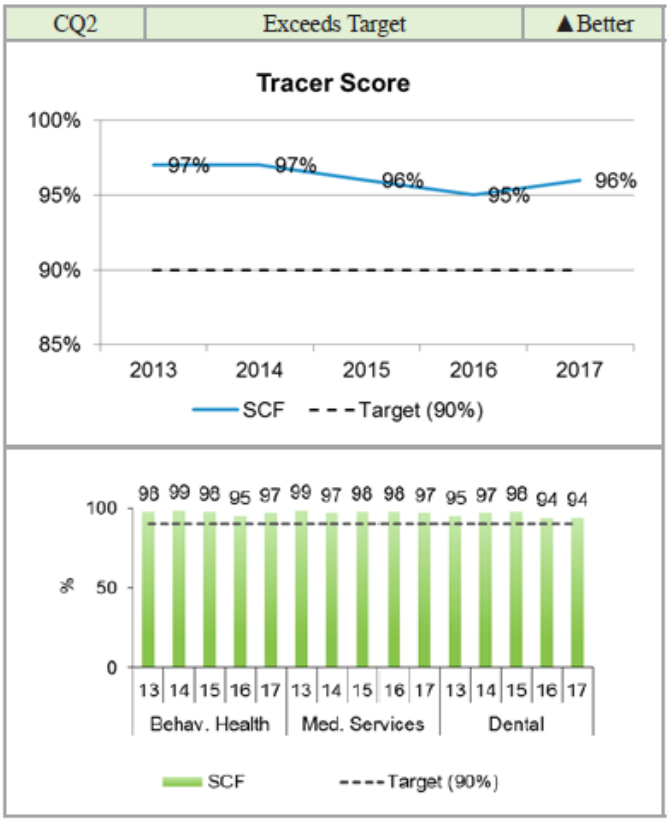


Figure 7.4-7: Accreditation Compliance Results

CQ2	Full Accreditation	▲Better
Measure	*2012-2017 Results*	
TJC	Fully Accredited	
CARF	Fully Accredited	
CAP	Fully Accredited	
Staff Licensure	100%	
Child Care Licensure (TPH)	100%	

Figure 7.4-8: Regulatory Compliance Results

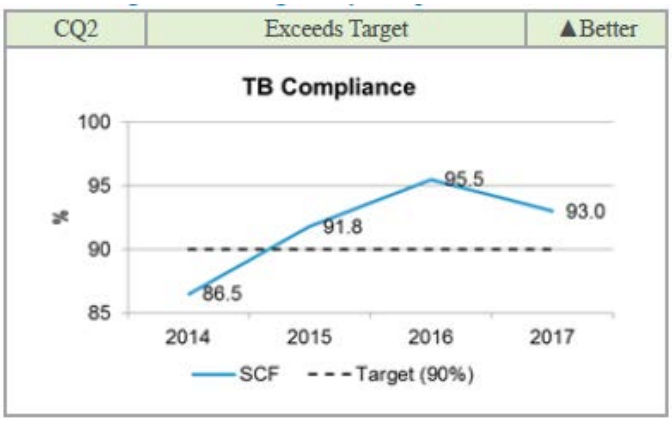


Figure 7.4-9: Ethical Behavior & Trust Results

CQ2	Exceeds Targets					▲Better	
	'12	'13	'14	'15	'16	'17	Bench
Ethics (Perf)	4.13	4.11	4.12	4.14	4.14	4.17	4.16
Trust	3.81	3.72	3.7	3.84	3.76	3.81	3.79

Fig. 7.4-9 shows EOS results for ethical behavior and stakeholder trust [1.1a(2), 1.2b(2), Fig. 1.2-1]. The results indicate steady performance around the benchmark.

Figure 7.4-10: New Hire Compliance & Ethics Training

CQ2	Exceeds Target (95%)	▲Better
Measure	*2012-2017 Results*	
Fraud & Abuse	100%	
Privacy & Security	100%	
Attestation	100%	
Annual Reorientation (ARO)	100%	

Fig. 7.4-10 shows completion rates of 2011-2017 New Hire staff compliance and ethics trainings [5.2b(1)]. All staff are required to complete ARO.

Figure 7.4-11: Support for Elders

SR1	Ongoing Focus on Relationships					▲Better
Meals	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17
Total Meals Served	19261	20924	20461	21066	27756	29418
Average # meals Served per month	1605	1743	1705	1755	2314	2452
Transportation						
Medical Van Transports	1005	990	878	1622	6823	9775
Avg. # Transports per month	83	82	73	135	568	815

SCF is committed to innovating services to support relationships with its key communities, including Elders, [1.2c(2)] for example, medical transports for Elders [Fig. 7.4-11] were increased with the institution of a new bus route in fall 2015. Contributing to the health of the community, this route provides access to all of the main clinical buildings on the campus 8x/day.

[Fig. 7.4-12] Under SCF's CI "Improve our Environmental Friendliness," SCF's Green Team identifies opportunities to implement green approaches. The EOS measures whether staff believe SCF is environmentally responsible [1.2b(1), 1.2c(1)]. Internal targets (i.e., 3% annual increase) were met three of the previous five years. The Green Team is responsible for monitoring feedback, piloting and implementing changes for SCFs environmental sustainability. As a result, SCF continues to increase the percentage of positive scores on the EOS. Additionally, the Green Team recognizes that environmental sustainability is accomplished through improvements that do not always impact employee perceptions, as a result GT is in the process of developing metrics that will measure greenhouse gas emissions for SCF's building portfolio that will enable SCF to track and measure improvements that reduce overall consumption of fossil fuel. This approach to measurement will allow SCF to benchmark against buildings nationwide and statewide using two databases, the Environmental Protection Agencies Portfolio Manager, and Alaska Housing Finance Corporation's Alaska Retrofit Information System.

Figure 7.4-12: Environmentally Responsible

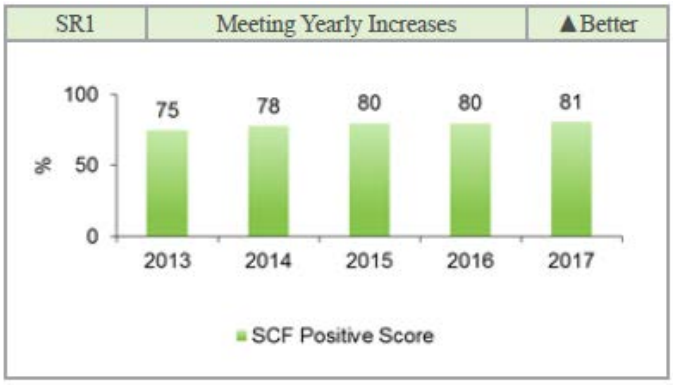
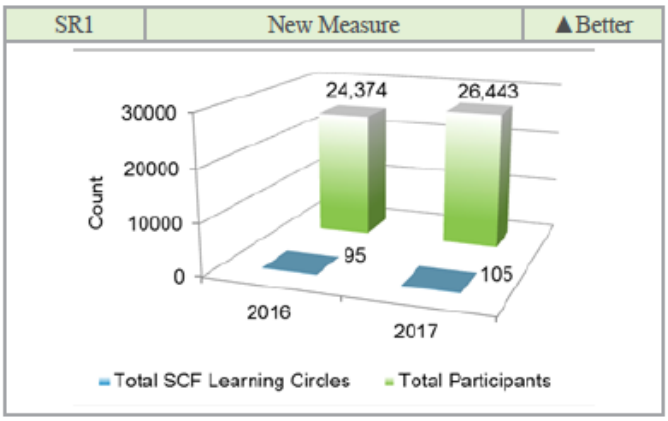


Figure 7.4-13: Learning Circles 2016



Learning circles [Fig.7.4-13] establish supportive relationships among small communities of C-Os [3.2a(1)]. Through listening to the VOC, topic areas aligned with SCF's focus on relationship building were identified and offered in Behavioral Health, Health Education and FWWI.

Figure 7.4-14: Employee Charitable Giving

CY	Employee and Community Assistance Fund (ECAF)
2012	$6,505.74
2013	$15,421.47
2014	$9,965.90
2015	$5,280.00
2016	$30,461.00

Figure 7.4-15: ECAF Awards

Figs. 7.4-14 and 7.4-15 reflect ways in which SCF helps fulfill societal responsibilities through increased giving and through support of staff and community members who have encountered financial hardship [5.1b(2), Fig. 1.1-1].

SCF has been recognized for both organizational and individual excellence and leadership [Fig. 7.4-16 & 7.4-17]. A complete listing is available on site.

Figure 7.4-16: Organizational Recognition

Year (Level)	Organizational Recognition 2013-2016
2016 National	Monroe E. Trout Premier Cares Award finalist ($25,000 prize as a finalist) for creative, replicable solutions to health status improvement
2016 State	Alaska Public Health Association Health Equity Award for impact on families through Nutaqsiivik Nurse-FamilyPartnership
2015	Level III, Patient Centered Medical Home™ three-year recognition (2015-2018) – from the National Committee for Quality Assurance for SCF's Anchorage Native Primary Care Center (2009-2012, 2012-2015, 2015-2018), Benteh Nuutah Valley Native Primary Care Center (2015-2018), McGrath Regional Health Center (2015-2018) and Nilavena Subregional Clinic (2015-2018).The Patient Centered Medical Home standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement.
2015 National	CARF three-year accreditation 2015 for all Behavioral Health Services outpatient programs (Fireweed Behavioral Health, Anchorage Native Primary Care Center Behavioral Health, Benteh Nuutah Valley Native Primary Care Center Behavioral Health and McGrath Behavioral Health)
2014 National	CARF three-year accreditation 2014 (The Pathway Home, Dena A Coy, Quyana Clubhouse and Four Directions)
2014 National	League of American Bicyclists' Gold Bicycle Friendly Business Award
2014 State	Yukon-Kuskokwim Health Corporation recognition to SCF Board of Directors, SCF President/CEO, and VP of Finance for significant contributions and partnership with YKHC resulting in a favorable settlement of YKHC's contract support cost lawsuit with the Indian Health Service.
2014 State	Anchorage School District Spirit of Tomorrow Award: SCF's work with Alaska Native Cultural Charter School
2013 National	Level III Patient Centered Medical Home 3-Year Recognition 2013-2016

Figure 7.4-17: Employee Recognition

Year (Level)	Employee Recognition 2013-2016
2016 State	Alaska Information Technology Award
2016 Individual	Ray Helfer Award
2016 Individual	Honorary Doctor of Humane Letters: Katherine Gottlieb (President/CEO)
2016 State	March of Dimes Nurse of the Year – Education and Research Award
2016 State	March of Dimes Nurse of the Year – Direct Care, Community Based Award
2016 National	National Alliance of State Pharmacy Association Excellence in Innovation Award
2015 National	Harry S. Hertz Leadership Award (Baldrige Foundation): Katherine Gottlieb (President/CEO)
2015 National	Office of the Secretary of Defense, Employer Support of the Guard and Reserve Award
2015 State	Hospice of Anchorage Heroes of Health Care Lifetime of Service Award

Year (Level)	Employee Recognition 2013-2016
2015 State	March of Dimes Nurse of the Year – Case Management/Care Coordination Award
2014 Leadership	Cook Inlet Region, Inc. Elder of the Year Award
2014 State	March of Dimes Nurse of the Year – Mentoring Award
2014 State	March of Dimes Nurse of the Year – Case Management/Care Coordination Award
2014 National	National Indian Health Board – National Impact Award
2014 National	National Indian Health Board – Area/Regional Impact Award
2014 Individual	Hot Key Books Young Writers Prize
2014 State	Alaska Pharmacists Association Pharmacy Technician Award
2014 Leadership	UAA Martin Luther King Student Appreciation Award
2014 National	Save the Children's The REAL Award
2014 State	Hospice of Anchorage Heroes of Health Care Award
2013 National	National Association for Home Care and Hospice's Top 50 Home Care and Hospice Nurses/ Top 10 Finalist for Nurse of the Year
2013 National	Bridge Builders of Anchorage "Excellence in Community Service Award": Katherine Gottlieb (CEO)
2013 National	National Indian Health Board Area/Regional Health Awards: Terry Simpson (board)and Katherine Gottlieb (CEO)
2013 State	Alaska Federation of Natives President's Health Award: Charles Akers (Board)
2013 National	Indian Health Service Pharmacy Technician of the Year
2013 State	Alaska Journal of Commerce Top Forty Under 40 Awards
2013 National	Minnigerode Award for Nursing Excellence Hanzel Award for Administrative Activities

7.4b Strategy Implementation

Benchmarks: SCF defined targets.

Trends: SCF reviews data over time to understand trends and patterns.

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).

Results for key measures of achievement of organizational strategy (e.g., CO) are demonstrated by the BSC [Fig. 7.4-4]. Achievement of SCF strategy and action plans is indicated through various tools [Fig. 7.4-18]. These tools are reviewed regularly, by multiple levels of staff to BOD, to inform on progress of strategy and plans. All staff have access to the tools listed.

Results for building and strengthening CC are captured in SCF's PDP [5.1a(4)] completion rates [Fig. 7.4-19], which are at 95% or higher. SCF also maintains a 97% completion rate for Annual Performance Evaluations. The high rate of completion can be attributed to the following process steps: 1) the expectation that PDPs/Evaluations are completed on time is incorporated into each manager's PDP; 2) electronic system reminders for PDPs are sent to managers two weeks prior to the due date and daily after the due date; 3) during the evaluation completion cycle, reports are sent weekly to SCF leadership reporting on complete/incomplete rates; and 4) merits are calculated for every eligible employee based on performance evaluation results.

Results for managing risk and taking intelligent risks are demonstrated through SCF's SPP [1.1c(1)]. Specifically, SCF captures strategic considerations in the SID and determines appropriate changes to the strategic plan. This creates an opportunity to review and determine appropriate consideration and response to risks identified. Also during the year, the committees in the FCS review and discuss results for managing risk and taking intelligent risks as necessary.

SCF's business planners (a new position in 2015) partner with division leaders to determine a strategic response to opportunities and associated risks. SCF has increased its business plan workload [Fig. 7.4-20] it completes each year to meet the challenges of changes in the service environment.

SCF staffed one business planner in 2015, two in 2016, and three in 2017, accounting for the sharp increase in completed business plans.

Figure 7.4-18: SCF Tools

Organizational Strategy	Tools	Review	Indicators	2013-2017
Corporate Objectives	BSC, PCEO Report	Quarterly, Annually	Completion rates; FCS reviews	100%
Corporate Initiatives	AP, DM	Monthly, Quarterly, Annually	Completion rates; FCS reviews	100%
Annual Plans	AAPT, DM, CM, Employee Evaluation Tool, SID	Daily, Monthly, Quarterly, Annually	Completion rates; FCS approval	100%

Figure 7.4-19: PDP & Evaluation Rates

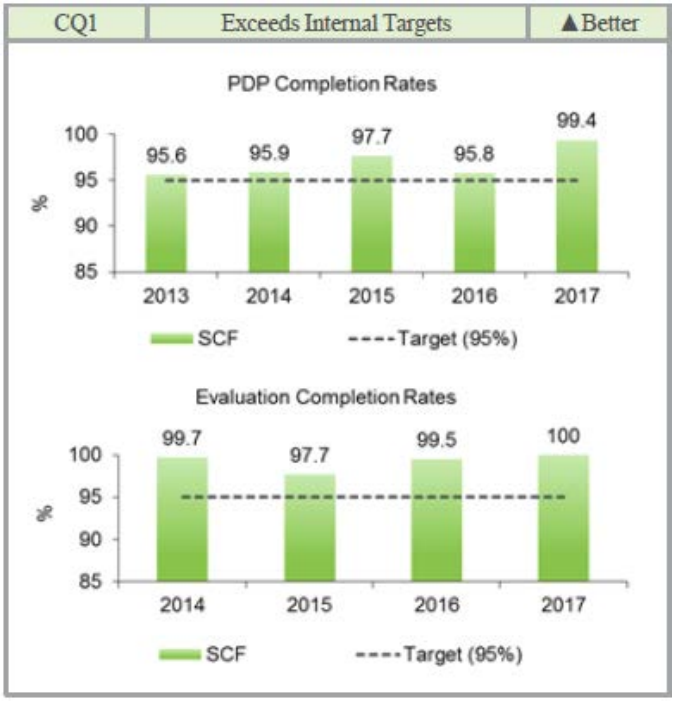
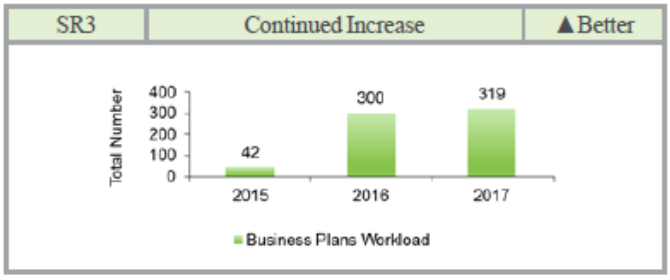


Figure 7.4-20: Business Plans



7.5 Financial and Market Results

7.5a Financial and Market Results

Benchmarks: MGMA; Moody's; SATO; National Health Data; SCF Targets. MGMA represents more than 33,000 administrators and executives in 18,000 healthcare organizations in which 385,000 physicians practice. MGMA applies rigor and sophisticated data-capture methods to produce a wide selection of robust expense, physician and staff compensation benchmarking data to measure and improve the performance of medical group practices nationwide. Moody's is an essential component of the global capital markets, providing credit ratings, research, tools and analysis that contribute to transparent and integrated financial markets.

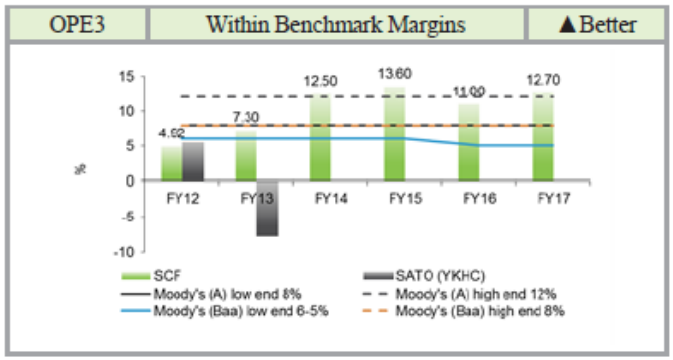
Trends: Historical data is available for most measures displayed. Overall, trends demonstrate sustainable results.

Segmentation: Data are 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 during SCF's MM. Financial leadership has successfully worked with SCF Data Services to improve in key

financial indicator reporting. As a result, web-based key financial indicators, segmented to facilitate more efficient review by finance and program personnel, are available.

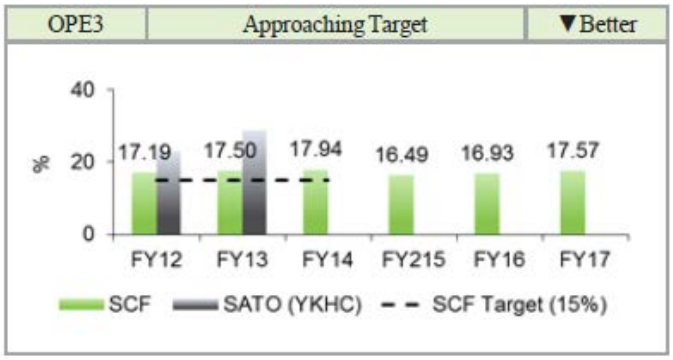
Figure 7.5-1: Operating Margin



Operating Margin [Fig. 7.5-1] is tracked quarterly on the BSC and both operating margin and Overhead are tracked in SCF's monthly financial statements to provide actionable information related to operational efficiency and sound fiscal management.

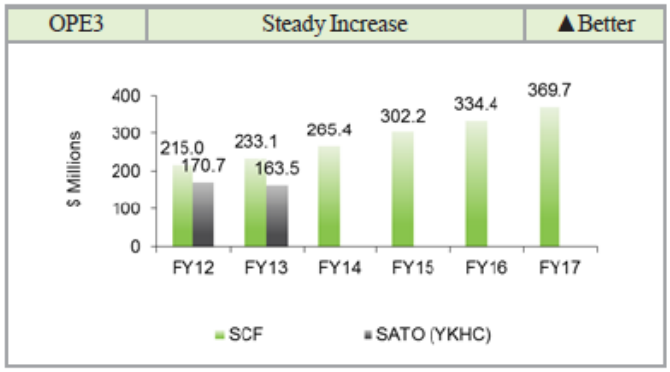
SCF's operating margin goal is set at a level that enables SCF to direct resources toward services while maintaining reserves sufficient to cover contingencies and asset replacement. SCF has compared its performance to SATO, offering similar services comparable in size, revenue, and assets.

Figure 7.5-2: Overhead



Overhead [Fig. 7.5-2] tracks administrative expenses at the central corporate (e.g., Finance, HR, DC, etc.) and division levels (e.g., MSD, BSD, etc.), including billing and collection costs. For 12 years, SCF has managed overhead expense at, or near its established goal, which is below the level of the comparable SATO.

Figure 7.5-3: Total Revenue

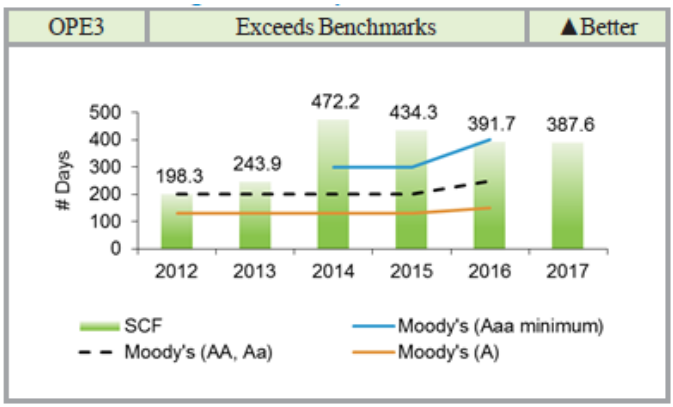


Total revenue [Fig. 7.5-3] received by programs (including grants, entitlements, and patient accounts) has increased steadily over the past 11 years.

Figure 7.5-4: 3rd Party Payor Revenue

FY2017 revenues from 3rd party payors [Fig. 7.5-4] (i.e., Medicaid, Medicare, VA, employer-sponsored health insurance, and marketplace insurance plans) increased 93.2% since FY2014. The primary driver was an increased investment in revenue cycle infrastructure. SCF has standardized complete coding review by SCF-employed certified coders. SCF also implemented multiple processes to improve charge capture and deployed automated insurance verification processes. Within the most recent three-year period, SCF increased efforts to assist C-Os in enrolling and renewing their Medicaid and VA benefits, resulting in significant growth. Medicaid expansion (effective 9/1/2015 in AK) as well as new management responsibilities for multiple rural Tribal clinics have also had a positive impact on revenues.

Figure 7.5-5: Days Cash on Hand



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

Figure 7.5-6: Current Ratio

Current Ratio [Fig. 7.5-6] shows level of liquidity and ability to pay debts when due. SCF benchmarks against a similar tribal health organization.

Figure 7.5-7: Expenses

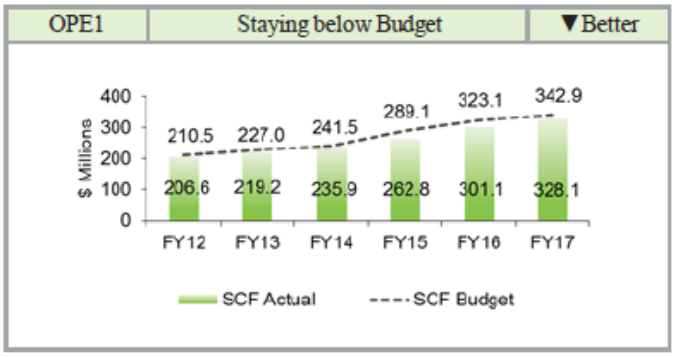
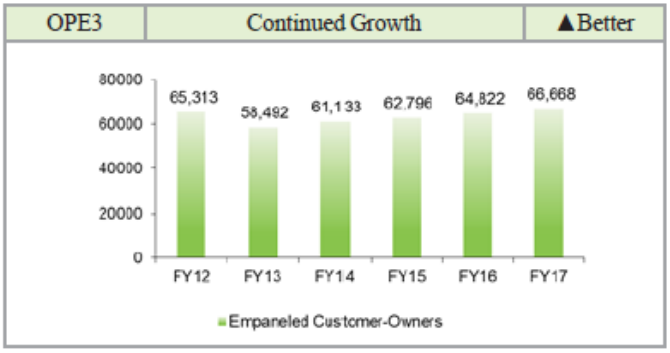


Figure 7.5-8: Customer Growth



SCF manages its expenses [Fig. 7.5-7] such that it has met its expense budget for the last 12 years. Total SCF revenue has exceeded expenses for the last 12 years. SCF changed its practice patterns over time, resulting in decreased ER visits, specialist visits, and hospital days. Costs followed suit. Since 2004, SCF has experienced an increase in C-O population [Fig. 7.5-8]; however, the percentage increase in the cost per empaneled 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.