BALDRIGE
Performance Excellence Program

Arroyo Fresco Community Health Center Case Study

health care

2017

#Baldrige
www.nist.gov/baldrige

2017 ELIGIBILITY CERTIFICATION FORM

2017 Eligibility Certification Form

Malcolm Baldrige National Quality Award

1. Your Organization

Official name	Arroyo Fresco Community Health Center
Other name	n/a
Prior name	*(if changed within the past 5 years)* n/a

Headquarters address: 1345 Desert Bloom Ave.
Yuma, AZ 85364

2. Highest-Ranking Official

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Ramon Gonzalez
Job title	CEO
E-mail	r_gonzalez@af.net
Telephone	(555) ARROYOF (277-6963), ext. 12
Fax	(555) 277-6967

Address: ☒ Same as above

3. Eligibility Contact Point

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

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Roger Sinclair
Job title	Director of Performance Excellence
E-mail	r_sinclair@af.net
Telephone	(555) 487-6235
Fax	(555) 487-6277

Address: ☐ Same as above

2219 Lakeview Blvd
San Luis, AZ 85349

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

4. Alternate Eligibility Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Judy Jackson-Gomez
E-mail	j_gomez@af.net
Telephone	(555) ARROYOF (277-6963), ext. 18
Fax	(555) 277-6967

5. Application History

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

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

Year(s)	2007, 2009, 2015, 2016
Name(s)	

☐ No

☐ Don't know

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

☒ Yes. Did your organization receive the award in 2011 or earlier?

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

☐ No. *If your organization received an award during 2011 and 2015, it is eligible to apply for feedback only. Contact the Baldrige Program at (877) 237-9064, option 3, if you have questions.*

☐ No

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

☒ Yes. Years: 1997, 1998, 1999, 2000, 2002, 2004

☐ No

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

☒ No. *Proceed to question 6.*

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

6. Eligibility Determination

See also Is Your Organization Eligible? (http://www.nist.gov/baldrige/enter/eligible.cfm).

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

☒ Yes ☐ No. *Briefly explain.*

b. Has your organization officially or legally existed for at least one year, or since April 1, 2016?

☒ Yes ☐ No

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

☒ Yes ☐ No

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

☐ Yes ☐ No ☒ Not applicable

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

☒ Yes ☐ No

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

Questions for Subunits Only

f. Is your organization a subunit in education or health care?

☐ Yes. *Check your eligibility by reading* Is Your Organization Eligible? (http://www.nist.gov/baldrige/enter/eligible.cfm). ***Then proceed to item 6k.***

☐ No. *Continue with 6g.*

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

☐ Yes. *Continue with 6h.*

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

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

☐ Yes. *Continue with 6i.*

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

i. Is your subunit in manufacturing or service?

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

☐ Yes. *Your subunit is eligible in the small business category. Attach relevant portions of a supporting official document (e.g., articles of incorporation) to this form.* ***Proceed to item 6k.***

☐ No. *Continue with 6j.*

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

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

☐ Yes. ***Proceed to 6k (table below)***.

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

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

1. My organization has won the Baldrige Award (prior to 2012).	Yes ☒	Your organization is eligible.	No	Continue with statement 2.
2. Between 2012 and 2016, my organization applied for the national Baldrige Award, and the total of the process and results band numbers assigned in the feedback report was 8 or higher.	Yes ☐	Your organization is eligible. Year: Total of band scores:	No	Continue with statement 4.
3. Between 2012 and 2016, my organization applied for the national Baldrige Award and received a site visit.	Yes ☐	Your organization is eligible. Year of site visit:	No	Continue with statement 5.
4. Between 2012 and 2016, my organization received the top award from an award program that is a member of the Alliance for Performance Excellence.	Yes ☐	Your organization is eligible. Award program: Year of top award:	No	Continue with statement 3.
5. More than 25% of my organization's workforce is located outside the organization's home state.	Yes ☐	Your organization is eligible.	No	Continue with statement 6.
6. There is no Alliance for Performance Excellence award program available for my organization.	Yes ☐	Your organization is eligible.	No	Continue with statement 7.
7. My organization will submit additional eligibility screening materials (i.e., a complete Organizational Profile and two results measures for each of the five Criteria results items). The Baldrige Program will use the materials to determine if my organization is eligible to apply for the award this year (as described in the fact sheet at www.nist.gov/baldrige/publications /upload/2015-Baldrige-Eligibility-FAQs.docx).	Yes ☐	The Baldrige Program will review the materials and contact your ECP after determining your eligibility.	No	Call 877-237-9064, option 3, if you have questions.

7. Award Category

a. Award category *(Check one.)*

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

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

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

6214	6211	

8. Organizational Structure

a. For the preceding fiscal year, the organization had

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

in
- ☐ sales
- ☒ revenue
- ☐ budget

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

☒ The chart is attached.

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

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

☐ a subsidiary of	☐ controlled by	☐ administered by	☐ owned by
☐ a division of	☐ a unit of	☐ a school of	☐ other _____

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

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

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

☐ The chart is attached.

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

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

Title | Date

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

☐ Relevant portions of the document are attached.

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

9. Supplemental Sections

The organization has (a) a single performance system that supports all of its product and/or service lines and (b) products or services that are essentially similar in terms of customers/users, technology, workforce or employee types, and planning.

☒ Yes. *Proceed to item 10.*

☐ No. *Your organization may need to submit one or more supplemental sections with its application. Call the Baldrige Program at (877) 237-9064, option 3.*

10. Use of Cell Phones, Cordless Phones, and Voice-over-Internet Protocol (VoIP)

Do you authorize Baldrige examiners to use cell phones, cordless phones, and VoIP to discuss your application? *Your answer will not affect your organization's eligibility. Examiners will hold all your information in strict confidence and will discuss your application only with other assigned examiners and with Baldrige Program representatives as needed.*

☒ Yes ☐ No

11. Site Listing

You may attach or continue your site listing on a separate page as long as you include all the information requested here. You may group sites by function or location (city, state), as appropriate. Please include the total for **each column** (sites, employees/faculty/staff, volunteers, and products/services). See the ABC HealthCare example below.

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

Example

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

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

Your Organization					
	Sites (U.S. and Foreign) *List the city and the state or country.*	**Workforce*** *List the numbers at each site.* *Check one or more.* ☐ Employees ☐ Faculty ☒ Staff	 **Volunteers (no. or N/A)**	*List the % at each site, or use "N/A" (not applicable).* *Check one.* **% of** ☐ Sales ☒ Revenue ☐ Budget	**Relevant Products, Services, and/or Technologies**
	Arroyo Fresco Family Clinic—Somerton, 672 Calle Viejo, Somerton, AZ 85350 (Yuma County)	35	36	9	Medical services (and dental services by mobile van)
	Arroyo Fresco Family Clinic—San Luis, 2219 Plaza Del Oro, Yuma, AZ 85349 (Yuma County)	50	42	20	Medical and dental services
	Arroyo Fresco Community Health Center 1347 Desert Bloom Ave, Yuma, AZ 85364 (Yuma County)	40	0	0	Corporate services such a HR, Accounting, IT, etc.
	Arroyo Fresco Family Clinic—North Yuma, 1345 Desert Bloom Ave, Yuma, AZ 85364 (Yuma County)	32	30	8	Medical and dental services
	Arroyo Fresco Family Clinic—Parker, 4010 Colorado St., Parker, AZ 85344 (La Paz County)	31	26	5	Medical services (and dental services by mobile van)
	Arroyo Fresco Family Clinic—East Yuma, 18137 Fourth Ave, Yuma, AZ 85367 (Yuma County)	38	28	9	Medical services (and dental services by mobile van)
	Arroyo Fresco Family Clinic—Lake Havasu City, 2219 Lakeview Blvd., Lake Havasu City, AZ 85349 (Mohave County)	47	30	11	Medical and dental services
	Arroyo Fresco Family Clinic—Bullhead City, 39675 Fisherman's Way, Bullhead City, AZ 86429 (Mohave County)	41	22	10	Medical and dental services Mobile medical services through Medical Service Van 1, serving towns along Route 8 Mobile dental services through Dental Service Van 1, serving towns along Route 8 and school-based clinics
	Arroyo Fresco Family Clinic—Kingman, 6527 Old Mine Rd., Kingman, AZ 86401 (Mohave County)	36	15	9	Medical and dental services Mobile medical services through Medical Service Van 2, and mobile dental services through Dental Service Van 2—both serving the Parker and Kingman areas on alternate weeks
	Arroyo Fresco Women's Health Center—North Yuma, 3529 El Centro Ave, Yuma, AZ 85365	30	8	9	Obstetrics and gynecology

	San Juan Elementary School, 2058 Plaza del San Juan, Yuma, AZ 85364	19	5	5	Medical services (and dental services by mobile van)
	El Centro High School, 2590 El Centro Ave., Yuma, AZ 85364	20	8	5	Medical services (and dental services by mobile van)
Total		**419**	**250**	**100%**	

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

12. Key Business/Organization Factors

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

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

Ambulatory medical (i.e., obstetric/gynecologic, family medicine, pediatric) and dental services, supported by routine laboratory and X-ray services, vision and hearing screening, behavioral health and substance abuse screening, and pharmacy services. Segments include maternal, infant, and child health; chronic disease; senior care; and dental services. High-quality primary care and preventive services are offered regardless of patients' ability to pay. To increase access to care, Arroyo Fresco also provides "enabling services," such as transportation, translation, case management, health education, and home visitation.

Markets consist of a three-county service area in the state of Arizona: Yuma, La Paz, and Mohave. Services sites are 8 medical/dental clinics, 1 women's health center, 2 school-based clinics, 2 medical service vans, and 2 dental service vans.

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

- Other CHCs in adjacent counties and agencies, such as Pomegranate Health
- Community-based, private, medical, dental, and behavioral health providers in all three counties, but primarily in areas of denser populations
- Indian Health Service (IHS) facilities in all three counties
- Veterans Affairs hospitals
- Providers and facilities in Mexico

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

- Patients needing ambulatory medical and/or dental services, and their families
- Community members who use various screening services through mobile vans that stop at churches, schools, and community centers
- Elementary and high school students at two school-based clinics
- Payors

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

- CactusCom: Telecommunications
- Community hospital in each county: Emergency and inpatient services, as well as some outpatient specialty care
- County governments and community-service organizations (e.g., school boards): Referrals, Services, and Outreach activities
- Desert Data Solutions (DDS): IT, including support for EHR
- Gil's Garage: Vehicle maintenance
- HR Leaders, Inc.: Temporary clinical and office staff
- La Sangre de Vida: Dialysis services
- MedProducts, Inc.: Group purchasing
- National Health Service Corps and other education partners: Recruitment of physicians, dentists, pharmacists, and midlevel providers
- Oates Group: Oates Staff Satisfaction Survey
- Pharmaceutical company: Prescription assistance program
- Saguaro State University (SSU) Schools of Business, Medicine, Dentistry, Nursing, and Public Health: Training and preceptorships
- Service Excellence: Diversity training
- Shiny Clean: Custodial services
- State Association of CHCs: Advocacy at state and national levels
- Talkeetna Medical School and local community colleges: Training
- The Joint Commission (TJC): Survey
- Winding River Casinos: Initiatives related to substance abuse and obesity

e. Financial auditor

	Fiscal year (e.g., October 1–September 30)
Johansen, Simon, and Clark	January 1–December 31

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

N/A	

13. Nomination to the Board of Examiners

If your organization is eligible to apply for the Baldrige Award in 2017, you may nominate one senior member from your organization to the 2017 Board of Examiners.

Nominees are appointed for one year only. Nominees

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

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

Board appointments provide a significant opportunity for your organization to learn about the Criteria and the evaluation process. The time commitment is also substantial: examiners may need to commit more than 200 hours from April through August, including 40–60 hours in April/May to complete self-study training prework, 2.5–3.5 business days in May to attend Examiner Preparation, and 95–120 hours from June through August to complete both Independent Review and Consensus Review. If requested by the program, examiners also participate in a Site Visit Review of approximately 9 days. The nominee or the organization must cover travel and housing expenses incurred for Examiner Preparation.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

E-mail address

from our organization will serve on the 2017 Board of Examiners.

☐ I understand that the nominee or the organization will cover travel and hotel costs associated with participation in Examiner Preparation. I also understand that if my organization is determined to be ineligible to apply for the Baldrige Award in 2017, this examiner nomination will not be considered for the 2017 Board of Examiners.

14. Self-Certification and Signature

I state and attest the following:

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

(2) To the best of my knowledge,

- this package includes no untrue statement of a material fact, and
- no material fact has been omitted.

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

(4) I understand that if the information is found not to support eligibility at any time during the 2017 award process, my organization will no longer receive consideration for the award and will receive only a feedback report.

Signature of highest-ranking official	Printed name	Date
Ramon Gonzalez	Ramon Gonzalez	2/21/17

15. Submission

To be considered for the 2017 award, your complete eligibility certification package must be received no later than February 22, 2017, to

Malcolm Baldrige National Quality Award
c/o ASQ—Baldrige Award Administration
600 North Plankinton Avenue
Milwaukee, WI 53203
(414) 298-8789, ext. 7205

Include proof of the mailing date. Send the package via

- a delivery service (e.g., Airborne Express, Federal Express, United Parcel Service, or the United States Postal Service [USPS] Express Mail) that automatically records the mailing date or
- the USPS (other than Express Mail), with a dated receipt from the post office.

16. Fee

Indicate your method of payment for the $360 eligibility certification fee.

☒ Check (enclosed)	☐ Money order (enclosed)	*Make payable to the **Malcolm Baldrige National Quality Award.***
☐ ACH payment	☐ Wire transfer	Checking ABA routing number: 075-000-022 Checking account number: 182322730397

Before sending an ACH payment or wire transfer, notify the American Society for Quality (ASQ; [414] 298-8789, ext. 7205, or mbnqa@asq.org). Reference the Baldrige Award with your payment.

☐ Visa ☐ MasterCard ☐ American Express

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

W-9 Request: If you require an IRS Form W-9 (Request for Taxpayer Identification Number and Certification), contact ASQ at (414) 298-8789, ext. 7205.

2017 Eligibility Certification Form Checklist

Malcolm Baldrige National Quality Award

OMB Control No. 0693-0006
Expiration Date: 06/30/2019

1. Eligibility Certification Form*

- ☒ I have answered all questions completely.
- ☒ I have included a line-and-box organization chart showing all components of the organization and the name of each unit or division and its leader.
- ☒ The highest-ranking official has signed the form.

For Companies Submitting Additional Eligibility Screening Materials (to meet the new alternative eligibility condition no. 7 for question 6k; see the table on page E-4)

- ☐ I have enclosed a complete Organizational Profile.
- ☐ I have enclosed data for two results measures for each of the five Criteria results items.

For Subunits Only

- ☐ I have included a line-and-box organization chart(s) showing the subunit's relationship to the parent's highest management level, including all intervening levels.
- ☐ I have enclosed copies of relevant portions of an official document clearly defining the subunit as a discrete entity.

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

2. Fee

- ☒ I have indicated my method of payment for the nonrefundable $360 eligibility certification fee.
- ☒ If paying by check or money order, I have made it payable to the **Malcolm Baldrige National Quality Award** and included it in the eligibility certification package.

3. Submission and Examiner Nomination

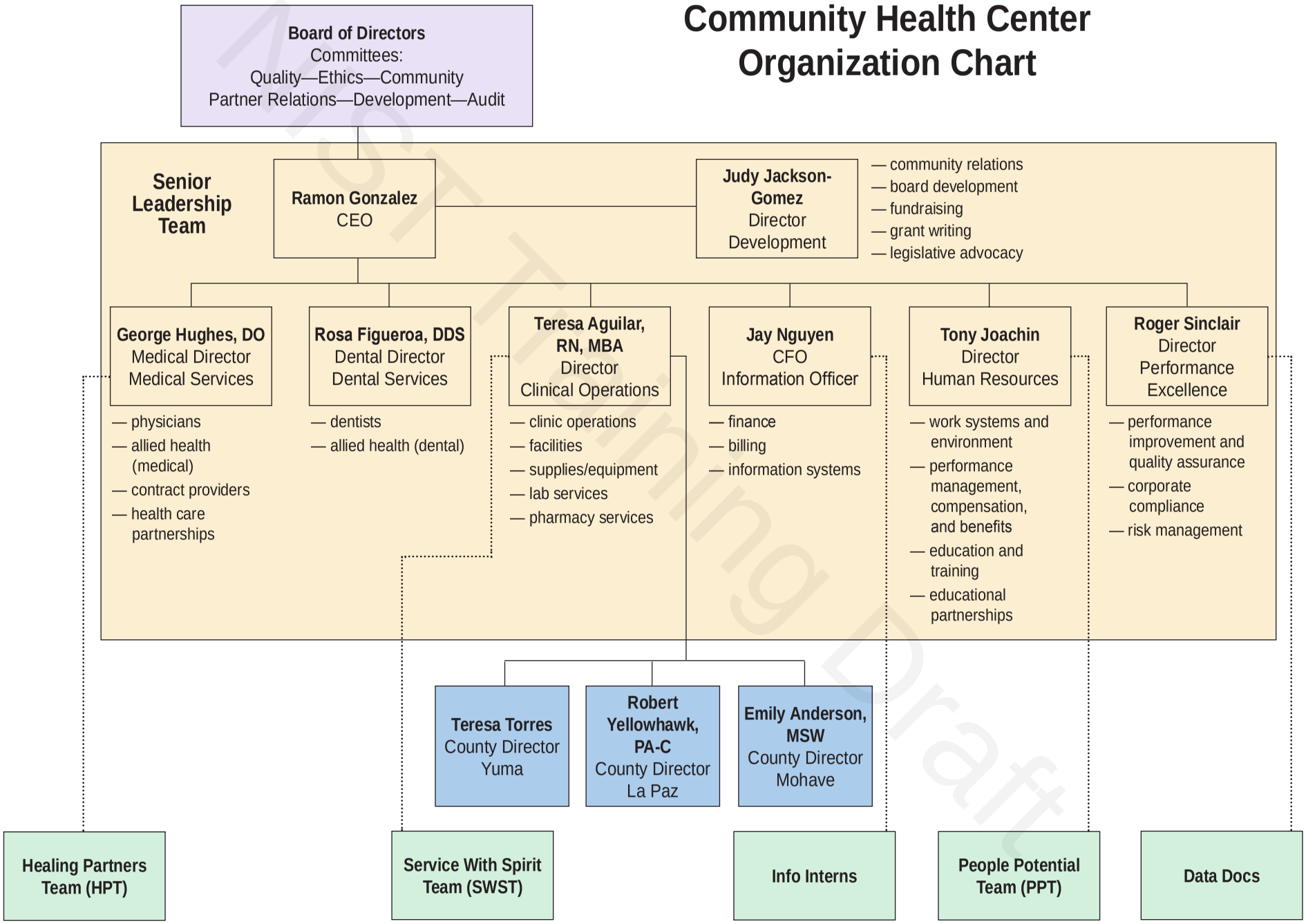
- ☐ I am nominating a senior member of my organization to the 2017 Board of Examiners.
- ☒ I am not nominating a senior member of my organization to the 2017 Board of Examiners.
- ☒ I am sending the complete eligibility certification package to

  Malcolm Baldrige National Quality Award
  c/o ASQ—Baldrige Award Administration
  600 North Plankinton Avenue
  Milwaukee, WI 53203
  (414) 298-8789, ext. 7205

- ☒ I have included proof of the mailing date. (See Application Form and Content instructions at http://www.nist.gov/baldrige/enter/format.cfm/.)

ORGANIZATION CHART

Arroyo Fresco Community Health Center Organization Chart



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OF THE
2017 AWARD
APPLICATION FORM

2017 Award Application Form Checklist

Malcolm Baldrige National Quality Award

OMB Clearance #0693-0006
Expiration Date: 06/30/2019

1. Your Organization

Official name	Arroyo Fresco Community Health Center
Mailing address	1345 Desert Bloom Ave. Yuma, AZ 85364

2. Award Category and Criteria Used

a. Award category *(Check one.)*

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

b. Criteria used *(Check one.)*

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

3. Official Contact Point

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

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name	Roger Sinclair
Title	Director of Performance Excellence
Mailing address	☐ Same as above 2219 Lakeview Blvd San Luis, AZ 85349
Overnight mailing address	☒ Same as above *(Do not use a P.O. box number.)*
Telephone	(555) 487-6235
Fax	(555) 487-6277
E-mail	r_sinclair@af.net

4. Alternate Official Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Judy Jackson-Gomez
Telephone	(555) ARROYOF (277-6963), ext. 18
Fax	(555) 277-6967
E-mail	j_gomez@af.net

5. Release and Ethics Statements

Release Statement

I understand that this application will be reviewed by members of the Board of Examiners.

If my organization is selected for a site visit, I agree that the organization will

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

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

Ethics Statement and Signature of Highest-Ranking Official

I state and attest that

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

(2) To the best of my knowledge,

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

Ramon Gonzalez	5/1/17
Signature	Date

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Printed name	Ramon Gonzalez
Job title	CEO
Applicant name	Arroyo Fresco Community Health Center
Mailing address	☒ Same as above
Telephone	(555) ARROYOF (277-6963), ext. 12
Email	r_gonzalez@af.net
Fax	(555) 277-6967

GLOSSARY OF TERMS AND ABBREVIATIONS

Glossary of Terms and Abbreviations

AAFP.....American Academy of Family Physicians
AAP.....American Academy of Pediatrics
AAR.....after action review
ACA.....Affordable Care Act
ACOG.....American Congress of Obstetricians and Gynecologists
ADA.....Americans with Disabilities Act
AF.....Arroyo Fresco
AHRQ.....Agency for Healthcare Research and Quality
ANOVA.....analysis of variance
AOS.....available on-site
AQA.....Ambulatory Care Quality Alliance
BMI.....body mass index
BPHC.....Bureau of Primary Health Care
BRFSS.....Behavioral Risk Factor Surveillance System
BSN.....bachelor of science in nursing degree
CC.....core competency
CCK.....Care Connection Kiosk
CDC.....Centers for Disease Control and Prevention
CEU.....continuing education unit
CHC.....community health center
CKD.....chronic kidney disease
CMS.....Centers for Medicare/Medicaid Services
CMs.....Clinical Microsystems
CoPs.....communities of practice
CTQ.....critical to quality
DDDI.....Data and Information for Health Care International
DDS.....Desert Data Solutions
DEA.....Drug Enforcement Administration
DMAIC.....define-measure-analyze-improve-control
DOE.....Design of Experiments
ED.....Emergency Department
EEOC.....Equal Employment and Opportunity Commission
EHR.....electronic health record
EOP.....Emergency Operations Plan
EPA.....Environmental Protection Agency
EPSDT.....early and periodic screening, diagnostic, and treatment
FMEA.....failure modes and effects analysis
FOCUS.....Financial performance, Organizational learning, Clinical excellence, Utilization, and Satisfaction
FQHC.....federally qualified health center
H and P.....comprehensive history and physical examination
HCAHPS.....Hospital Consumer Assessment of Healthcare Providers and Systems
HEDIS.....Healthcare Effectiveness Data and Information Set
HIPAA.....Health Insurance Portability and Accountability Act
HP2020.....Healthy People 2020
HPT.....Healing Partners Team
HR.....human resources
HRSA.....Health Resources and Services Administration
IDP.....individual development plan
IHS.....Indian Health Service
IOM.....Institute of Medicine
IT.....information technology
KIC.....Knowledge and Innovation Center
KMP.....Knowledge Management Process
KPIs.....key performance indicators
MAM.....Mothers Aiding Mothers
MSN.....master of nursing
NACHC.....National Association of CHCs
NCQA.....National Committee for Quality Assurance
NHSC.....National Health Service Corps
NIST.....National Institute of Standards and Technology
OASIS.....Opportunity identification, Assess or analyze, Set targets and time lines, Improve, Share and sustain
OSHA.....Occupational Safety and Health Administration
PCMH.....patient-centered medical home
PCT.....Primary Care Team
PDCA.....plan-do-check-adjust
PFABs.....patient-family advisory boards
PHP.....personal health profile
PIF.....Performance Improvement Framework
PPT.....People Potential Team
Promotores/ promotoras....volunteers
QPG.....Quality and Productivity Group
RN.....registered nurse
ROI.....return on investment
RVUs.....relative value units
SAs.....key strategic advantages
SCs.....key strategic challenges
SLT.....Senior Leadership Team
SPC.....statistical process control
SSU.....Saguaro State University
STARs.....Superior Teamwork Achieves Results
SWOT.....strengths, weaknesses, opportunities, threats
SWST.....Service With Spirit Team
TB.....tuberculosis
TJC.....The Joint Commission
URI.....upper respiratory infection
VA.....Veterans Affairs
VMV.....vision, mission, and values
VOC.....voice of the customer
VPN.....virtual private network
YE.....year end

ORGANIZATIONAL PROFILE

Organizational Profile

P.1 Organizational Description

P.1a Organizational Environment

Arroyo Fresco (AF) is a community health center (CHC) serving western Arizona from 11 clinics and 4 mobile service vans. CHCs, established over the past 50 years in underserved areas in all 50 states, are nonprofit, community-owned health care organizations that offer patients high-quality primary care and preventive services regardless of their ability to pay. They also provide "enabling services," such as transportation, translation, health education, and home visitation, which increase access to care. More than 1,200 such centers serve more than 24 million Americans annually. The Health Resources and Services Administration (HRSA) administers the program. A snapshot of AF is shown in Figure P.1-1, and service-area demographics are shown in Figure P.1-2.

AF serves three counties—Yuma, Mohave, and La Paz—with diverse populations and needs. The service area of over 23,000 square miles has fewer than 430,000 people—about 6 percent of the state's overall population. Yuma County borders Mexico.

AF was founded in 1968 by Joe Garcia and Martin Rosales, two Yuma activists committed to providing health care to the underserved. With federal funding through the Migrant Worker Project, they opened their first clinic in a converted gas station in Yuma and called their fledgling operation "Arroyo Fresco," or "cool, flowing stream," to represent a place to be refreshed in a vast, harsh desert. AF grew under their leadership. Operations expanded to full-time, three more facilities opened, and the first mobile van was launched in 1988 with grant funds from the Bureau of Primary Health Care (BPHC). In 1990, AF merged with the Mohave CHC, extending AF's reach along the western Arizona corridor. Ramon Gonzalez, who became the CEO in 1996, saw the importance of reaffirming the organization's heritage and direction set by its founders and developed the vision, mission, and values (VMV). (See Figure P.1-4.)

Communities along the border are among the state's fastest-growing. La Paz, one of the state's most rural counties, is home to the Colorado River Indian tribes, the largest of western Arizona's Native American populations. Mohave County, also sparsely populated, shares with La Paz 400 miles of Lake Havasu coastline and 300 days of sunshine each year, making these counties a destination for "snowbirds" and retirees from across the country.

Barriers to care—whether imposed by geography, culture, income, or other factors—are typically associated with (1) lower levels of prevention screening and (2) less efficient and effective detection and management of chronic disease, with the result that many AF patients—young and old—have poorer health than the general population. Diabetes is a major medical problem throughout the service area, with residents of southern Yuma County experiencing diabetes-related mortality at twice the national rate. Other chronic health problems include asthma, cardiovascular disease, depression, obesity, and substance abuse and other addictive behavior. Specific issues for Yuma County border communities include a higher incidence of communicable diseases (e.g., half of the tuberculosis [TB] cases for all Arizona border counties), including sexually transmitted diseases, and a higher mortality rate for accidents and suicide. AF established a Women's Health Center with obstetrical and gynecological services in North Yuma to address that area's large proportion of younger females in the population and high birth rates, especially among teens.

Figure P.1-1: 2016 Snapshot of Arroyo Fresco

Total revenue	$29.7 million
Total visits	192,403 medical, 61,734 dental
Patients	59,425
Service sites	8 medical/dental clinics, 1 women's health center, 2 school-based clinics, 2 medical service vans, 2 dental service vans
Staff	419 (62% direct patient care)
Volunteers	68

Figure P.1-2: AF's Service-Area Population

Demographics	Yuma	La Paz	Mohave	AZ
Persons per square mile	35.5	4.6	15.0	56.3
Persons below poverty threshold	22.6%	22.8%	20.8%	18.2%
Under 5 years old	7.5%	4.6%	4.6%	6.4%
Under 18 years old	26.2%	17.4%	18.7%	24.1%
65 years old and over	17.4%	36.1%	26.9%	15.9%
White	91.3%	77.1%	92.1%	83.7%
African American	2.7%	1.2%	1.3%	4.7%
Native American	1.6%	12.5%	2.4%	5.0%
Asian/Pacific Islander	2.2%	0.9%	1.2%	3.3%
Two or more races	2.0%	2.9%	2.3%	2.7%
Hispanic heritage*	61.7%	25.7%	15.8%	30.5%
Home language other than English	52.1%	18.6%	11.6%	26.8%
Persons under 65 w/o health insurance	24.0%	27.4%	22.2%	16.0%

*Persons of Hispanic heritage can be of any race.

P.1a(1) AF provides ambulatory medical (i.e., obstetric/gynecologic, family medicine, pediatric) and dental services, supported by routine laboratory and x-ray services, vision and hearing screening, behavioral health and substance abuse screening, and pharmacy services. Its service delivery network includes clinics and mobile service vans that make regularly scheduled stops six days a week at churches, schools, and community centers. AF ensures that patients can access all services required across the continuum of care through partnerships or contractual relationships with hospitals, physicians, and agencies throughout the tricounty area, and these arrangements are spelled out in the annual plan required by BPHC.

AF delivers care through the patient-centered Primary Care Teams (PCTs)—small interdisciplinary teams whose members form ongoing relationships with patients and families and manage the medical and dental care of these various groups, or "populations," of patients. Essential elements of a PCT include the patients, clinicians, and support staff; information technology (IT); and the care processes. AF has 23 PCTs organized according to its key services. For example, each clinic has at least one family medicine PCT.

Figure P.1-3: Relative Importance of each Health Care Service

Patient Population	% of Patient Population	Typical Services
Primary care (not classified elsewhere)	40	Chronic disease management; behavioral health; substance abuse screening; dental, hearing and vision services
Pediatrics	25	Primary care
Women's Services	16	Obstetrics; gynecologic
Geriatrics	19	Medical, rehab, socialization

P.1a(2) The VMV are shown in Figure P.1-4. The core competencies follow:

- (CC1) Culturally competent, patient-centered care
- (CC2) Expertise in the treatment of diseases prevalent within our patient population
- (CC3) Collaborative relationships that increase access to specialty care and other services

The core competencies enable AF to execute its mission successfully.

Figure P.1-4: Vision, Mission, and Values

Vision
Through our leadership in health care design and delivery, education and training, and community involvement, the people of western Arizona will become the healthiest in the state.
Mission
Provide residents of Yuma, La Paz, and Mohave counties easy and timely access to high-quality and safe health care services, responsive to their diverse cultural, and socioeconomic needs, regardless of their ability to pay.
Values
Through our decisions and actions—with our patients and their families, key communities, partners, and each other—we show our commitment to five core values: • **Respect**: We recognize the worth and honor the dignity of every individual. • **Trust**: We build confidence in our integrity by everything we do. • **Relationship**: We believe strong relationships are key to good health and build long-term relationships by honoring patient and family values, preferences, and goals. • **Performance**: We embrace improvement and innovation; we search for and adopt best practices and continually improve our daily work. • **Accountability**: We demonstrate progress toward our vision by sharing our results.

Figure P.1-5: Staff Profile

Gender	Male	38.2%
	Female	62.8%
Race/Ethnicity	White	90.3%
	African American	1.2%
	Native American	5.5%
	Asian/Pacific Islander	0.8%
	Two or more races	2.2%
	Hispanic heritage*	36.1%
Education	Postgraduate	24.7%
	Two–four years of college	38.1%
	High school or equivalent	37.2%

*Persons of Hispanic heritage can be of any race.

P.1a(3) AF has 419 employees (12% of whom are part-time), and the workforce mirrors the race/ethnicity and culture of the population served (Figure P.1-2). Although AF is applying in the health care sector, because of its size, it could apply in the small business category. Clinical providers, who make up 62 percent of the staff, include 29 physicians, 53 medical assistants (who perform outpatient nursing tasks), 12 dentists, 18 dental hygienists/assistants, 4 nurse practitioners, 4 certified nurse midwives, and 15 physician assistants, as well as pharmacists, pharmacy technicians, community educators and social workers, dietitians, podiatrists, and radiology technicians. Administrative, facility, and patient support service staff make up 33 percent of the workforce, and 5 percent of staff members are senior leaders or managers. AF has no organized bargaining units. The key drivers of workforce engagement are shown in Figure P.1-6. The differences in these drivers for workforce groups relate to generational expectations.

Volunteers include patients and patients' family members. Volunteers perform a wide variety of tasks that build relationships with patients and their families and increase the efficiency and effectiveness of care delivery (e.g., providing child care during patient visits, assisting providers' education sessions, and supporting routine administrative tasks). Some have assignments that make use of their professional and technical skills (e.g., participating in grant development), and enabling AF to manage resource gaps.

Health and safety risks in the ambulatory patient care setting include exposure to communicable diseases, exposure to radiation and chemicals, needle sticks, ergonomic injuries, and accidents. Safe driving is a primary requirement for mobile van drivers.

P.1a(4) Clinical facilities include reception areas; examination/treatment rooms equipped for medical or dental services; space for consultation and education; printed materials in English, Spanish, and large print format; and shared provider offices. All facilities are wheelchair-accessible. Medical clinics have machines for audiometric and tympanometric screening and for electronic vision screening, as well as obstetrical ultrasound equipment and dental x-ray machines that reduce radiation exposure. Clinic-based laboratories are equipped with microscopes, blood analyzers, and kits for rapid bacteriologic screening for respiratory and genitourinary

Figure P.1-6: Drivers of Workforce Engagement

Nonmillennials	
(1) Senior management communication	Figure 7.4-1
(2) Job makes good use of my skills and abilities	Figure 7.3-15
(3) Comfortable in reporting errors or unsafe acts without fear of retaliation or disciplinary action	Figure 7.3-15
(4) People on my team are protected from health and safety hazards	Figure 7.3-14
(5) I have a clear idea of what is expected of me	Figure 7.3-15
Millennials	
(1) I have growth opportunities	Figure 7.3-14
(2) I have flexibility in my work schedule	Figure 7.3-15
(3) Fair pay and good benefits	Figure 7.3-14
(4) Personal relationships and partnerships	Figure 7.3-14
(5) I believe strongly in the mission	Figure 7.3-15

diseases. Most clinics are open from 8:00 a.m. to 5:00 p.m. Monday through Friday and on Saturday morning.

School-based clinics are open daily when school is in session and provide basic medical services and behavioral health screening, as well as health education. Laboratory tests and x-rays are performed at the closest AF facility. The Women's Health Center in Yuma has examination rooms equipped for outpatient obstetrics and gynecology services, as well as four labor and delivery suites for routine deliveries. High-risk pregnancies and complicated deliveries are referred to the tertiary care hospital in Yuma, which has specialists on call and a neonatal intensive care unit. AF physicians and midwives also manage routine deliveries at the community hospital in La Paz.

Four mobile service vans provide care to outlying communities and to those unable to access care at clinic sites. Equipped with lifts to accommodate patients in wheelchairs, each van has two examination/treatment rooms outfitted for medical or dental services; x-ray, basic lab, and sterilization equipment; and areas for behavioral health screening, health education, and reception.

AF's IT is managed by Desert Data Solutions (DDS). It includes support for an electronic health record (EHR) integrated with the billing and scheduling system. All staff members have access to computers and the wide array of data and information on the AF intranet. The innovative Care Connection Kiosk (CCK) is a portable, multi-use unit developed in collaboration with CactusCom.

P.1a(5) AF must meet specific federal requirements related to population needs, services provided, fee scale, and governance structure to receive grant funds as a federally qualified health center (FQHC) under section 330 of the Public Health Service Act. AF also received National Committee for Quality Assurance (NCQA) recognition as a patient-centered medical home (PCMH) in 2013. To maintain their federal funding, PCMHs are required by HRSA to be accredited by The Joint Commission (TJC). AF sought accreditation for the first time (then voluntary) in 1996 and has been re-accredited regularly since then, receiving full accreditation and no recommendations for improvement in 2016. AF is required to comply with multiple legal and regulatory requirements at the federal, state, and local levels (Figure 1.2-2).

P.1b Organizational Relationships

P.1b(1) AF is governed by a voluntary 15-member Board of Directors chaired by the founder Joe Garcia (see 1.2a[1]). By-laws and federal program regulations require that at least 51% of voting members be recipients of AF services. The Senior Leadership Team (SLT) members are nonvoting on the board. The board has six standing committees: Quality, Ethics, Community, Partner Relations, Development, and Audit. Five cross-location teams systematically support senior leaders in planning and decision making (see the Organization Chart). They share and integrate data and information across AF and link the SLT and the front line.

Figure P.1-7: Key Requirements of Key Customers and Stakeholders

Requirement	PF	C	PH	S	V	PT	PY
Safety	X	X	X	X	X		X
Effective (high-quality) care	X					X	X
Efficient (cost-effective) care	X	X				X	X
Timely and convenient access (to care and information)	X	X	X	X	X		X
Information/training on current medical technology and procedures			X				
Patient-centered service	X		X	X	X	X	
Equitable (including culturally sensitive) care	X	X	X	X	X		
Reputation as a high-quality health center	X	X	X	X	X	X	X
Knowledge, skills, and tools to do the job			X	X	X		
Personal relationships and partnerships	X		X	X	X	X	
Fair pay and benefits			X	X			
Recognition			X	X	X		
Opportunity to serve and develop job skills					X		

PF = Patients and their Families, C = Community, PH = Physicians, S = Staff, V = Volunteers, PT = Partners, PY = Payors

P.1b(2) AF's key customer groups are patients and their families. AF considers the community, physicians, staff, volunteers, partners, and payors to be stakeholders, and their key requirements are shown in Figure P.1-7. As appropriate, AF segments its key market segments by demographics, health status, location, and other relevant factors. AF acknowledges the many contributions made by its volunteers and considers them a key stakeholder group.

P.1b(3) A diverse set of key partnerships (listed below) enables AF to provide comprehensive care in more innovative ways than it could on its own. The most important supply chain requirements are low cost/high value, on-time delivery, and continuity of operations for providing clinical care. The contributions of suppliers, partners, and collaborators enhance competitiveness.

- **The State Association of CHCs** provides advocacy at state and national levels; group purchasing arrangements for medical and dental supplies and pharmacy and lab services (through MedProducts, Inc.); assistance with grant writing and recruitment/retention initiatives; and educational programs for clinicians, administrators, and board members.
- **Health Care Partners:** AF partners with a community hospital in each county to provide emergency and inpatient services, as well as some outpatient specialty care. AF provides hospital staff members continuing education about high-risk populations and offers learning opportunities for hospital trainees through brief rotational assignments in AF clinics and vans. Also, AF partners with community-based private physicians, who provide most inpatient and specialty care.
- **Education Partners:** AF partners with the Saguaro State University (SSU) Schools of Business, Medicine, Dentistry, Nursing, and Public Health; the Talkeetna Medical School; and local community colleges.
- **Community Partners:** AF partners with a broad array of community groups, including school boards, other leaders, and parents in the two Yuma schools with school-based AF clinics. Other partners include county governments and

community-service organizations that make referrals, promote and participate in services, and contribute to effective outreach activities.

- **Industry Partners:** AF partners with a regional pharmaceutical company on a prescription assistance program. AF has partnered with CactusCom since 1999 for leadership and technology development and training resources. In 2004, AF began a partnership with Winding River Casinos on initiatives related to substance abuse and obesity, as well as Service Excellence training for diverse customers.
- **Strategic Partners and Vendor Partners:** DDS provides IT expertise and support to small, nonprofit organizations. Vendor partners are Packer, for patient satisfaction surveys; Oates, for employee satisfaction surveys; HR Leaders, Inc., for temporary clinical and office staff; Shiny Clean custodial service, for indoor and outdoor maintenance and housekeeping services; and Gil's Garage, for mobile van maintenance services.

The Partners Committee, with representatives from all of AF's key stakeholders, participates actively in the Strategic Planning Process. Members serve as liaisons among the stakeholder groups they represent. AF regularly meets with all suppliers to establish performance expectations and to review performance.

Suppliers, partners, and collaborators play a role in innovation in the organization through their contribution of ideas; replication of best practices; and identification of new products, tools, and technology. They are represented on the Innovation Council.

P.2 Organizational Situation

P.2a Competitive Environment

P.2a(1) As described in P.1a(2), AF has expanded significantly from its humble beginnings. In 2016, AF provided 192,403 medical and 61,734 dental visits to 59,425 patients, accounting for 17% of the market share in the three-county service area, with higher percentages in Yuma (24%) and La Paz (23%) than Mohave (14%). Although AF operates in a high-need service area and guarantees service regardless of patients' ability to pay, it competes for patients and seeks to attract patients from all income strata.

P.2a(2) One of the most significant changes that has occurred in the past two years is the enactment of the Affordable Care Act (ACA). Prior to its enactment, CHCs nationwide had witnessed flat federal grant funding for uninsured patients and reductions in state Medicaid spending and other state funds, while the number of uninsured patients seeking service continued to grow. With ACA and an increasing aging population eligible for Medicare and an increasing percentage of patients below the poverty level who are eligible for Medicaid, AF has begun to be on more stable financial footing. However, increasing demands for care due to increased access and chronic disease conditions continue to place stress on the organization. Figure P.2-1 outlines areas for competition/collaboration in AF's service area. AF also competes for highly qualified staff members across its entire service area (see Figure P.2-3).

P.2a(3) Although AF can access national databases that permit comparison with other health care organizations, including CHC peers, it had difficulty making peer comparisons at the state or local level. In 1999, Ramon Gonzalez led the formation of a Benchmarking Consortium within the State Association of CHCs to create a forum for sharing results, starting with results CHCs already were

Figure P.2-1: Key Areas for Innovation/Collaboration

Area	Innovation/Collaboration
All patients	Other CHCs in adjacent counties and agencies offering access to quality services regardless of patients' ability to pay
Insured patients	Community-based private medical, dental, and behavioral health providers in all three counties but primarily in areas of denser population
Native Americans	Indian Health Service (IHS) facilities in all three counties provide care for those patients living on a reservation. The IHS clinic serving Colorado River Indian Tribes offers an array of Native American rituals and practices as part of its Traditional Healing Center.
Veterans	AF provides outpatient care under contractual arrangements with the Veterans Health Administration, while Veterans Affairs (VA) hospitals provide inpatient care.
Border residents	Providers and facilities in Mexico, where families may have received care previously or may travel for services, depending on cost, accessibility, perceived quality and value, and cultural competence

Figure P.2-2: Key Comparative Data Sources

Comparison Group	Data Sources
National	• Agency for Healthcare Research and Quality (AHRQ) • BPHC/HRSA • Centers for Disease Control and Prevention (CDC) • Centers for Medicare/Medicaid Services (CMS) • Healthy People 2020 • TJC • Health Care Data and Information (HCDI) • Professional Associations (American Academy of Family Physicians [AAFP], American Academy of Pediatrics [AAP], American Congress of Obstetricians and Gynecologists [ACOG]) • Packer Patient Satisfaction Survey • Oates Staff Satisfaction Survey • Quality and Productivity Group (QPG)* • Baldrige Award for Performance Excellence*
State and Local	• Healthy Arizona 2020 • State Association of CHCs • State CHC Benchmarking Consortium • Saguaro State Award for Performance Excellence*

* Indicates sources outside of the health care sector

sharing in a national learning collaborative. Participation is voluntary, and CHCs may protect their identity. With the consortium, AF now can compare its performance on key clinical and patient satisfaction indicators with 25 CHCs across the state.

Limitations on some of the comparative data include the lag in the data, which can be up to 18 months; the reluctance of other local health care providers to share information; and the time and expense involved in obtaining comparisons outside of the health care industry. However, comparisons from outside of the industry are often found by benchmarking with recipients of the Saguaro State Award for Performance Excellence and the Malcolm Baldrige National Quality Award for Performance Excellence.

P.2b Strategic Context

AF identifies its strategic challenges and strategic advantages during its annual Strategic Planning Process and aligns them with five key performance areas (Figure P.2-3). The FOCUS framework establishes performance measures and reports in a series of linked

Figure P.2-3: Key Strategic Challenges and Advantages

Area	Key Strategic Challenges (SCs)
Financial performance (i.e., Operations)	**(SC1)** Balance AF's mission to serve all patients—regardless of their ability to pay—against tight fiscal environments at federal, state, and local level, including • an increasing percentage of uninsured patients (one of the highest in the United States), • no growth in federal grant payments for uninsured patients.
Organizational learning (i.e., Workforce)	**(SC2)** Address workforce gaps, in particular, clinical providers and staff with specific technical skills (e.g., physicians, nurses, pharmacists, pharmacy and radiology technicians).
Clinical excellence (i.e., Health care services)	**(SC3)** Address the low incidence of prevention and screening and the higher incidence of chronic and communicable disease in the service area.
Utilization (i.e., Societal responsibilities)	**(SC4)** Establish and manage mechanisms to provide specialty care and unmet service needs, in particular, to uninsured patients.
Satisfaction (i.e., Workforce)	**(SC5)** Meet staff recruitment and retention challenges related to remote locations; a needy, vulnerable patient population; and a total compensation package.
Area	**Key Strategic Advantages (SAs)**
Financial performance (i.e., Operations)	**(SA1)** Enhanced funding through ACA
Organizational learning (i.e., Workforce)	**(SA2)** Knowledge Management System
Clinical excellence (i.e., Health care services)	**(SA3)** Expertise in treating clinically complex conditions
Utilization (i.e., Societal responsibilities)	**(SA4)** Highly engaged workforce; suppliers, partners, and collaborators; and volunteers in addressing needs beyond patient care in our communities
Satisfaction (i.e., Workforce)	**(SA5)** Flexible approaches to benefits and scheduling that meet the needs of our diverse workforce

and aligned scorecards for the whole organization, its care delivery sites, PCT-based primary care units, and functions (see 4.1a[1]).

Although AF receives federal section 330 grants from the Public Health Service of the U.S. Department of Health and Human Services, these funds have not kept pace with growing needs or economic changes within the health care industry. In 1995, section 330 grant funds represented approximately 46 percent of total operating revenue but two decades later represent just 22 percent of total revenue. Revenue sources are shown in Figure P.2-4. AF accepts most private insurance and many managed care plans in addition to Medicaid and Medicare and offers a sliding fee scale. AF relies heavily on donations to fund special and capital-intensive projects, such as an upgrade and expansion of its fleet of service vans in 2009 and 2015.

P.2c Performance Improvement System

On becoming CEO in 1996, Ramon Gonzales sought to expand the organization's focus on improving access and outreach to achieve organization-wide, patient-centered performance excellence and the highest standard of culturally competent care. After completing the organization's first application for the Saguaro State Award in

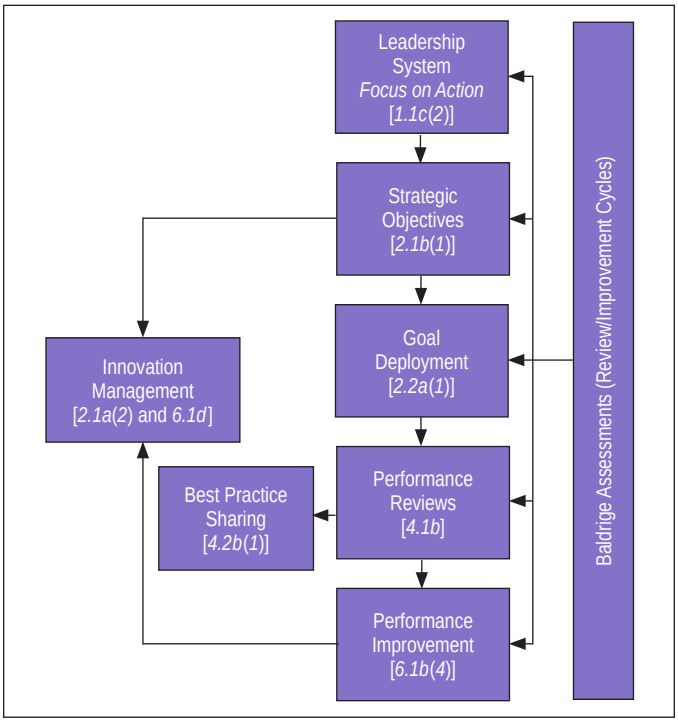
Figure P.2-4: Revenue Sources (2016)

Revenue Source	Percentage of Total Revenue
Medicaid	33%
Grants, donations, annuity	49%
Medicare	6%
Private insurance	6%
Self-pay	6%

1997, the leaders adopted the Baldrige Criteria as their business framework. Since adopting the Baldrige framework, AF's leaders have sharpened their focus on improving efficiency and providing better care for patients. The Performance Improvement Framework (PIF; Figure P.2-5) aligns and integrates all aspects of performance management throughout the organization, starting with leaders setting directions and focusing on action through clearly defined strategies and objectives, followed by regular performance reviews, the sharing and spreading of best practices, and the use of various performance tools. Some of the tools AF uses for performance improvement are plan-do-check-adjust (PDCA), define-measure-analyze-improve-control (DMAIC), and some tools from Lean. This comprehensive and systematic approach drives innovation and improvement in all aspects of the organization. **Some of the results emanating from the PIF are shown at the beginning of each of the Baldrige process categories.**

In 2009, AF was proud to receive the Malcolm Baldrige National Quality Award. Because leaders had integrated the use of the Baldrige framework into the way AF runs its organization, it was natural for AF to follow along with the changes in the Criteria over time and to ensure that any changes in its processes and systems remained current. Senior leaders decided it would be valuable in AF's continued pursuit of excellence to get objective feedback on progress by submitting a Baldrige application in 2017.

Figure P.2-5: AF's Performance Improvement Framework (PIF)



RESPONSES ADDRESSING ALL CRITERIA ITEMS

Category 1 Leadership

Improvements and Innovations

Year	Improvement
2015	Expanded community relations activities by leveraging social media
2014	Improved succession planning process by expanding to key positions beyond senior leaders
2013	Redesigned the AF website to enhance transparency
2012	Implemented 360-degree assessments for all senior leaders
2011	Created the county director position for better communication and more engagement with staff at the clinics
2010	Added the value of "respect" to AF's values

1.1 Senior Leadership

1.1a Vision and Values

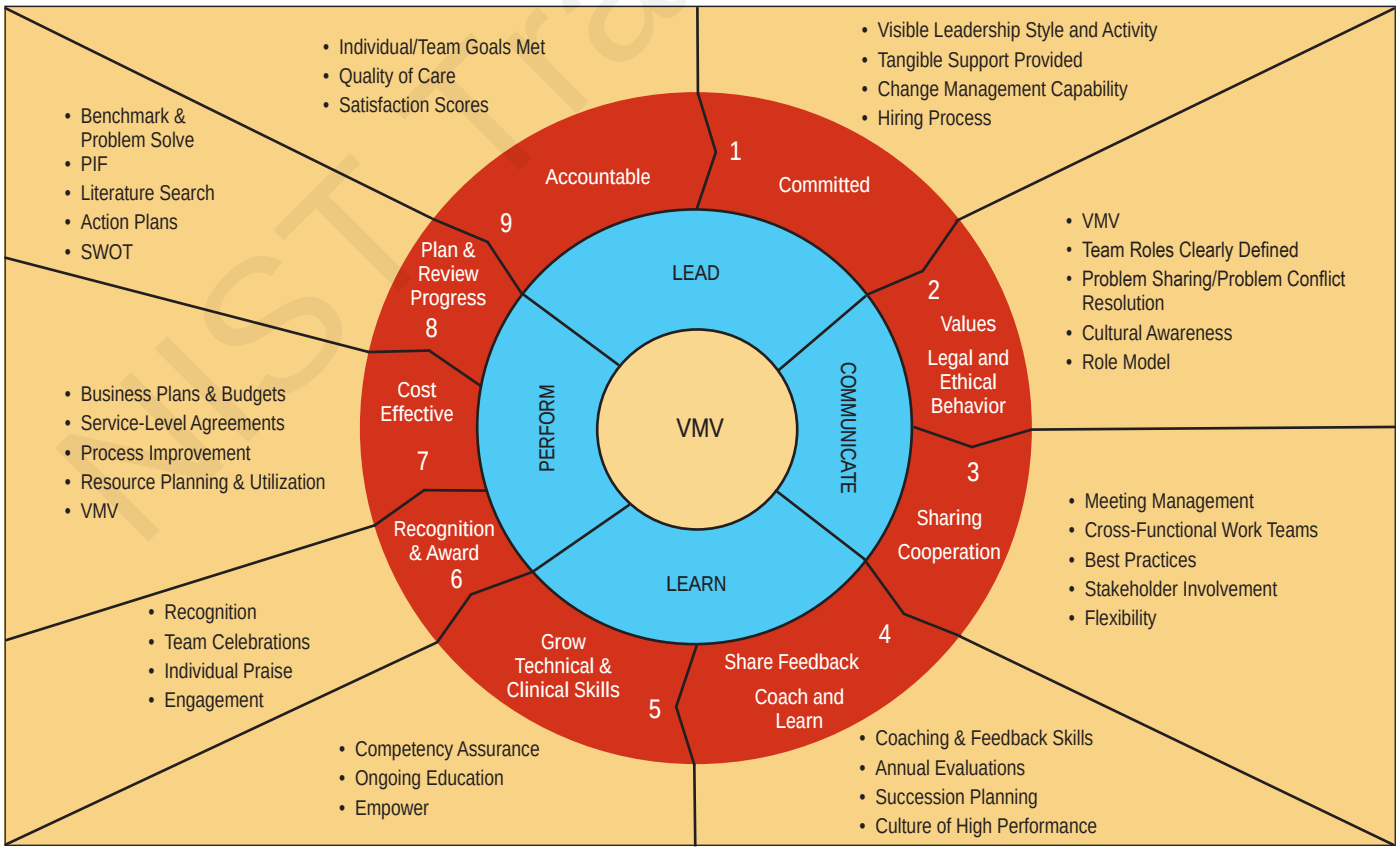
1.1a(1) Ramon Gonzalez and his leadership team review and reaffirm AF's VMV during a leadership meeting in September during the annual Strategic Planning Process (Figure 2.1-1). In 2010, the senior leaders added the value of "respect" to further reflect the culturally competent care that AF provides. The VMV are embedded in the Leadership System (Figure 1.1-1) and deployed to all staff members, patients, partners, suppliers, board members, and the communities served; the Leadership System leverages the communication methods listed in Figure 1.1-2. The VMV are prominently displayed in all locations (even the mobile vans), on AF's Internet and intranet sites, and on all printed materials provided to patients and their families. All displays of the VMV are in English and Spanish. Each quarter, a senior leader champions one of the values, develops a plan for demonstrating that value in everything the organization does, and discusses the value at the quarterly all-staff meetings. The VMV serve as the foundation for the orientation of new staff members, volunteers, and board members and are an integral part of the selection process for staff members, partners, suppliers, and volunteers.

1.1a(2) Senior leaders have created an environment that fosters legal and ethical behavior to reflect all of AF's values. Staff members and the board, as well as partners and volunteers, are required to attend an annual overview of the organization's legal and ethical obligations. Senior leaders present this annual training. In addition, the leadership champion of the value who presents at the quarterly all-staff meeting discusses the relationship between that value and legal and ethical behavior and describes what it means to him or her personally as a way of demonstrating commitment to these behaviors. Ramon Gonzalez conducts the portion of orientation for new staff and volunteers on the VMV and the organization's approaches to ensure legal and ethical behavior.

1.1b Communication

Senior leaders communicate with and engage administrative and clinic staff and volunteers, as well as key customers, through a

Figure 1.1-1: Leadership System



variety of communication mechanisms shown in Figure 1.1-2. Through a systematic process, senior leaders are presented with a need or opportunity to share information. They determine the audience, identify the appropriate media, develop the message, deliver it, and then evaluate it for effectiveness. Senior leaders at AF encourage frank, two-way communication throughout the organization (Figure 1.1-2) and ensure their continuous accessibility to staff, partners, and volunteers despite the challenges of serving such a geographically dispersed population. In addition, they are committed to breaking down some of the traditional barriers to effective communication often present in health care organizations. For example, ten years ago, Tony Joachin introduced what was then an innovative training program called Crew Resource Management, an airline industry safety and error reduction program. Two retired pilots trained all staff and volunteers in skills such as the "two-challenge rule": any staff member or volunteer who disagrees with a colleague's decision is expected to state his or her concerns twice in a professional and constructive manner but seek a supervisor if not satisfied. Similar training is provided to all new staff and volunteers. Since that time, the communication processes have been evaluated and improved to introduce the concept of culturally competent care that focuses on offering the most appropriate method for communication based on the preferences of the member of the workforce or customer (see 3.1a[1], 3.2b[1], and 5.2).

In addition to the more formal programs described in item 5.1b, senior leaders use informal ways to reward and recognize staff and volunteers to reinforce high performance and a patient, other customer, and health care focus. For example, senior leaders spontaneously thank staff members and volunteers for demonstrating the values of the organization. Senior leaders feature staff members and volunteers as AF STARs (Superior Teamwork Achieves Results) for "going the extra mile," and they may receive a small token of appreciation that is linked to the organization's mission. For example, a senior leader may recognize someone who has made a contribution to improved health care services or outcomes with a thank you note and a pedometer. A volunteer who reads to children who are waiting during their parents' appointments may be recognized by a senior leader with a certificate, along with a gift card to a local bookstore.

Figure 1.1-2: Communication Methods

Method	1- or 2-way?	Frequency	Participants	Primary Focus
Staff Orientation	2	As Needed	S, V	Present VMV; discuss ethics and diversity (culturally competent care).
Intranet	1	Daily	S, V	Access online *Staff and Volunteer Handbook*, lessons learned, urgent issues.
Internet (website)	1	Daily	All	Access hours by location, services provided, scheduling of appointments, health care topics, links to other relevant sites, and the Annual Report.
Social Media	2	Daily	All	Receive comments from staff and key customers. Provide responses. Communicate upcoming events and community outreach.
Huddles	2	Daily	S, V	Share time-sensitive information and best practices, address ethical concerns, and identify improvement opportunities. Communicate key decisions. Discuss one of the organization's values.
Senior Leader Rounding	2	Daily	S, V, PF, P, C	Listen and learn. Recognize behaviors consistent with the values of the organization.
Staff Meetings (at each site)	2	Weekly	S, V	Communicate operations for all sites and vans. Communicate key decisions.
County Director Meetings	2	Weekly	S	Work with site managers to do a progress scan.
Communication Boards	1	Weekly	S, V, PF, C	Recognize staff and volunteers; note opportunities. VMV posted.
Champion Messaging	1	Monthly	All	Share progress on strategic initiatives.
Board Meetings	2	Monthly	B, C	Provide oversight of the organization; discuss any issue raised by a member of the community.
Newsletters	1	Monthly	All	Recognize staff and volunteers; share results of Leadership System and board assessments.
All-Staff Meetings	2	Quarterly	S, V	Share progress to plan, discuss values, recognize staff and volunteers, introduce new staff and volunteers, solicit any concerns, and share results of Leadership System and board assessments. Senior leader champions one of the organization's values. Communicate key decisions and the need for any organizational change.
Clinic Visits	2	Quarterly	S, V, PF	Senior leaders rotate across the clinics to conduct face-to-face discussions.
Contract Reviews	2	Annually	PA	Solicit feedback on process improvement opportunities.
Strategic Planning Sessions	2	Annually	S, V, B, P, C	Gather inputs from all stakeholders, conduct a risk assessment, and prioritize needs. Reaffirm the VMV.
Town Hall Meetings (by county)	2	Annually*	All	Listen and learn; celebrate the diversity of the staff, volunteers, and the community; discuss emerging issues in the "big picture" of CHCs.

S = Staff, V = Volunteers, PF = Patients and Their Families, B = Board Members, P = Partners, PA = Payors, C = Community

*Held during National Health Center Week

Figure 1.1-3: Actions to Create a Successful Organization

Area of Focus	Senior Leaders' Actions
Achievement of Mission	Continued commitment to the performance excellence journey through the use of the Baldrige Excellence Framework and addressing OFIs presented in feedback received after applying for the Baldrige Award
Organizational Agility	Maintaining the ability to rapidly respond to changes in the environment (2.2b, 4.1a[4])
Organizational Learning	Benchmarking, and identifying and implementing best practices (4.2b[2])
Learning for the Workforce	Investing in the Learning and Development System (5.2b[1]) and serving as role models as "life-long learners"
Innovation and Intelligent Risk Taking	Use of the Innovation Management System (6.1d)
Workforce Culture that Fosters Customer Engagement	Continuous emphasis on the VMV (1.1a[1]) and deployment of Customer Service Excellence
Succession Planning and Development of Future Organizational Leaders	Personally identifying high-potential members of the workforce for future leadership positions; offering them developmental assignments; serving as mentors (1.2c[2]); and conducting annual board reviews (Figure 1.2-1)
Culture of Patient Safety	Creating a Just Culture (1.2b[1]) and (5.2b[1])

1.1c. Mission and Organizational Performance

1.1c(1) The actions of the senior leaders to build an organization that is successful now and in the future are shown in Figure 1.1-3. Many of these actions are aligned with the use of the FOCUS framework (Figure 2.1-2).

1.1c(2) Senior leaders create and reinforce a focus on action to accomplish the organization's mission through the reviews listed in Figure 4.1-2 that enable them to identify needed actions. Daily Huddles provide real-time reinforcement of the actions needed for the organization to attain its vision. The pervasive use of the PIF model (Figure P.2-5) ensures improvement of the organization's performance. Innovation and intelligent risk taking are supported through the Innovation Management System described in 6.1d. Senior leaders set expectations for organizational performance broadly through the vision and mission and more specifically each year with the deployment of the strategic objectives. These vehicles include input from patients and families, partners, staff, volunteers, payors, and the community, providing a balance across all of the organization's stakeholders. Senior leaders demonstrate personal accountability for the organization's actions by their own individual development plans (IDPs; 5.2a[4]), with oversight by the board in setting compensation.

1.2 Governance and Societal Responsibilities

1.2a Organizational Governance

1.2a(1) AF ensures responsible governance through the Board of Director's Quality, Ethics, Community, Partner Relations, Development, and Audit Committees and other approaches shown in Figure 1.2-1.

In 2003, the senior leaders and the board adopted formal principles of governance. The entire board and SLT completed a four-hour facilitated course on these principles, and new board members receive this training when they join. In addition, two representatives from the board attend the National Association of CHCs (NACHC) meeting, where presentations are made on

Figure 1.2-1: Approaches to Ensure Responsible Governance

Area of Focus	Approaches
Accountability for Senior Leaders' Actions	The board reviews the CEO's performance annually. The CEO reviews the senior leaders' performance annually.
Accountability for Strategic Plans	The CEO reports on the accomplishment of the Strategic Plan annually and presents progress reports quarterly.
Fiscal Accountability	The SLT prepares monthly financial reports and presents them to the board quarterly. The board reviews and approves capital expenditures.
Transparency in Operations	Notices of board meetings, their agendas, and approved minutes are posted to the Internet site for review by any stakeholder. Board members annually disclose conflicts of interest and sign the Code of Ethical Conduct. In addition, although nonprofit organizations are exempt from the regulations of the Sarbanes-Oxley Act, all board members and senior leaders receive training related to its accountability standards, which are incorporated into AF's governance system. Transparency is also one of AF's values.
Selection of Governance Board Members and Disclosure Policies for Them	In compliance with by-laws and federal program regulations, at least 15% of the voting members of the board are recipients of AF services. Other board members are selected for their expertise or ability to represent another stakeholder group. Disclosure policies are outlined in the bylaws and posted to the Internet site.
Independence and Effectiveness of nternal and External Audits	AF has a small internal audit function that reports to the Audit Committee, and audit information is reviewed by the board. This function concentrates on operational practices. AF also employs an accounting firm that specializes in nonprofit organizations to conduct extensive financial audits on an annual basis. Results of these audits are presented to the entire board and published in the Annual Report.
Protection of Stakeholder Interests	Representation from AF's diverse stakeholder groups ensures consideration of and protection of stakeholder interests.
Succession Planning for Senior Leaders	At least annually, the board reviews the succession plan for the CEO and other senior leaders (1.1c[1] and 5.2b[3]).

topics related to effective boards for nonprofit organizations. These representatives share their learnings at the next board meeting. In a cycle of evaluation and improvement in 2015, AF joined BoardWisdom, a national organization focused on strengthening the leadership of nonprofit boards. Through this membership, the board continues to research innovative best practices for nonprofit boards and has implemented several of these practices related to recruiting and mentoring new board members and engaging board members in advocacy for AF.

1.2a(2) The performance of all senior leaders is evaluated at individual levels, as well as at the Leadership System level. The board evaluates the performance of the CEO, and the CEO evaluates the performance of his direct reports (the senior leaders). Each senior leader also receives feedback through an annual 360-degree review process. Feedback for the Leadership System as a whole is derived from the Staff Satisfaction Survey, Community Climate Survey, and Baldrige-based assessments (state or national), all of which are conducted annually. Leadership System opportunities that are identified serve as inputs to the Strategic Planning Process and resulting action plans. Individual feedback and corresponding actions are built into each senior leader's IDP. Progress against these plans is reviewed with the board on a quarterly basis.

The board conducts an annual assessment of its performance using the well-respected Stewart-Hagen model. Results of this assessment are reviewed in the annual "refresher" training conducted with the board and the SLT. Using the PIF model, action plans are developed and worked on throughout the year to improve the board's effectiveness. Assessment results for the Leadership System and the board, along with the action plans, are shared in the quarterly all-staff meeting and published in the monthly community newsletter, which further promotes transparency, one of AF's values.

1.2b Legal and Ethical Behavior

1.2b(1) Key compliance processes, measures, and goals are shown in Figure 1.2-2, and key processes, measures, and goals for addressing risks associated with health care services and other organizational operations are shown in Figure 1.2-3. AF anticipates public concerns with its health care services and operations in multiple ways. One way is during the Strategic Planning Process each May when the community needs assessment is conducted. Another way that AF anticipates public concerns is through the feedback provided by employees and volunteers who are representative of the communities served. The organization also monitors social media and feedback to the Internet site that might identify emerging public concerns. AF addresses any concerns or adverse impacts by identifying potential problems early, determining how to detect them when they occur, and eliminating the risk. A subteam involved in the Strategic Planning Process uses a failure modes and effects analysis (FMEA) to formally document these issues and track them through resolution. For example, needle-sticks are a risk for staff, patients, and their families; especially with the high rate of diabetes among some patients, there was concern about the risk of needle-sticks for family members. A caring staff member worked with a medical supply house to receive an in-kind donation of small, safe, needle-disposal units for patients to use at home. In addition, in the early years of using the FMEA, a risk was identified for patients' personal safety at the clinics. Increased lighting was installed, and a volunteer "escort" system was developed. Another preventive effort is the rigorous background screening conducted for each staff member and volunteer. In addition to the systematic use of FMEA to identify and eliminate potential risks, senior leaders reinforce a "just" culture so that staff and volunteers are encouraged to identify problems or potential problems in the organization and its operations.

Figure 1.2-2: Legal, Regulatory, Accreditation, and Ethical Behavior Requirements

Requirements	Key Processes	Measures	Goals	Results
Corporate Compliance and Ethics	Training in good board governance	Trust in governance	Benchmark	7.4-2
Fiduciary Responsibility	Internal and external audits External audits	Audit results	No irregularities	AOS
Accreditation	TJC survey HRSA	Survey results	No recommendations for improvement	AOS
HIPAA	Training	% Compliance % Staff and volunteers trained	100% compliance 100% trained	7.4-3 7.4-4
Licensure	Licensing for health professionals	Staff licensure	100%	7.4-5
	Licenses for pharmacies	Pharmacies licensure	100%	7.4-5
	Licenses for motor vehicle drivers	Van drivers licensure	100%	7.4-5
	Licenses for outpatient medical facilities and behavioral health facilities	Facilities licensure	100%	7.4-5
Environmental Protection Agency (EPA)	Proper disposal of medical waste	% Staff and volunteers trained % Recycled waste	100% 45%	7.4-6 AOS
Safety	Safety inspections	# OSHA recordables	0	AOS
	Job-specific training for staff and volunteers	% Staff and volunteers trained	100%	AOS
Americans with Disabilities Act (ADA)	Access to facilities and services	Compliance audit results	100% compliance	AOS

Figure 1.2-3: Key Processes, Measures, and Goals Addressing Risks Associated with Health Care Services and Organizational Operations

Risks	Key Processes	Measures	Goals	Results
Patient safety	Medical records management	Accuracy	100%	7.1-28
	Hand washing	Observations	100%	AOS
Environmental impact of waste	Waste management and recycling	% Recycled waste	45%	AOS
	Compliant with DEA regulations for remove of medical waste	Compliance	100%	AOS

AF also focuses on being a good steward of the environment, with an aggressive recycling program in place and efforts to minimize waste. These processes and others related to patient safety are shown in Figure 1.2-3. (Note: Due to space constraints, some results will be available on site [AOS].)

1.2b(2) Senior leaders emphasize the requirement for ethical behavior beginning at orientation. Based on the nature of the work performed and results of a precourse survey, staff, board members, and volunteers are required to complete online, interactive courses with content targeted toward their needs. For example, office staff receive additional training regarding the Health Insurance Portability and Accountability Act (HIPAA) requirements, patient information confidentiality, and related privacy issues. Upon successful completion of the training (100% correct responses on a postcourse survey), each person signs the Code of Ethical Conduct. Suppliers and partners are required to sign a Commitment to Ethical Conduct as part of their contracts. An online *Staff and Volunteer Handbook* provides rapid access for staff members or volunteers with a concern about a specific issue, although everyone is encouraged to ask any of the senior leaders for direction or to contact the Ethics Committee. Key processes and measures or indicators for enabling and monitoring ethical behavior are shown in Figure 1.2-4. Senior leaders explicitly contrast the just "no-blame" environment for identifying problems with a "zero-tolerance" policy for breaches of ethical behavior. All partners and suppliers participate in annual training related to ethics, legal obligations, and AF's VMV. The board's Ethics Committee is charged with investigating any potential breaches of conduct.

1.2c Societal Responsibilities

1.2c(1) AF considers societal well-being as a fundamental underpinning of its vision. As such, it is embedded in strategy and manifest in daily operations. AF contributes to societal well-being with its collaborators and partners through a focus on improving community health, reducing disparities, and expanding access to care. Programs for waste minimization and recycling contribute to a better environment. AF also contributes to the economic systems in the communities in which it operates in several ways. In 2015, AF made a formal commitment to provide a living wage for all employees, with increases tied to local conditions. In addition, AF provides care to those who would otherwise be unable to afford it, and by improving community health, AF is able to keep more people active in the workforce rather than becoming dependent on other sources of aid.

1.2c(2) AF is a nonprofit organization with very challenging resource constraints. Therefore, senior leaders recognize that they cannot commit the financial resources at a level comparable with large corporations. With these limitations, AF defined its key communities as the three counties it serves and related health care organizations at the state and national levels.

AF validates its key communities and determines areas of emphasis for organizational involvement and support as part of the Strategic Planning Process. The Caring Community subteam comprises staff members, volunteers, patients, partners, a board member, and a senior leader. Using a Pugh matrix, team members evaluate and prioritize opportunities within the community against the organization's VMV and identified strategic objectives. In addition, they strive to balance current needs with development for the future. For the past three years, AF has identified the following areas of emphasis: Support for the Body, Support for the Spirit, and Support for the Mind. Each of these areas supports the objective of reducing health disparities by promoting good nutrition, adequate housing, and increased levels of education. Senior leaders demonstrate their support of key communities in two ways. First, they personally serve in key roles on a variety of boards and councils. Second, they provide staff members with three days (paid time) each year to participate in any of the targeted areas for community support, as shown in Figure 1.2-5.

Senior leaders also use the support of key communities as an innovative way to provide developmental opportunities to future leaders. After the Caring Community subteam identifies specific events for the following year, senior leaders approach staff members with the opportunity to lead one of these efforts and commit to serving as their mentors. This effort provides

Figure 1.2-4: Key Processes and Measures for Enabling and Monitoring Ethical Behavior

Key Processes	Measures	Goals	Results
Code of Ethical Conduct training	% Completion for staff, volunteers, and board members	100%	AOS
Job/task-related ethics training	% Completion	100%	AOS
Signing Commitment to Ethical Conduct in contracts	% Signed by suppliers and partners	100%	AOS
Review of potential breach of ethical conduct	% Reviewed by the board's Ethics Committee	100%	AOS

Figure 1.2-5: Key Community Support Areas

Focus Areas	Supporting Activities
Support for the Body	Conduct food drives for local food banks, focusing on low-fat, high-nutrition donations.
	Serve as crew leaders and members for local affordable housing efforts.
	Sponsor a program to provide fans, "swamp coolers," air conditioning, and help in paying utility bills for the elderly and other at-risk members of the community during the hot summer weather.
	Partner with local parks and recreations for Healthy Body, a weight control and fitness program for boys and girls aged 8–13.
	Provide monthly on-site physician and nursing care at area homeless shelters.
	Serve in leadership positions on the Committee on Rural Health Issues, the State Association of CHCs, committees for Healthy Arizona 2020, the Southwest Business Coalition to Reduce Health Care Costs, and the National Association of CHCs.
Support for the Spirit	Provide counseling and child care at Casa de Cuidar (House of Caring), which provides shelter and resources to victims of abuse and domestic violence.
	Promote stronger families with a six-week evening program for parents and older children (sixth grade and up), with fun activities, discussion, and problem solving (child care provided for younger children).
	Offer clinic space and facilitation for support groups for diabetes self-management, caregiver coping strategies, substance abuse, and gambling addiction.
	Serve in leadership positions on the Latino League.
Support for the Mind	Partner with local parks and recreations on a program that provides 13–15-year-olds with valuable job experience (but no monetary compensation) and community service hours in positions matching their interests and capabilities.
	Provide after-school and summer jobs for teens to expose them to opportunities in health care.
	Sponsor the Expect to Succeed program, pairing staff and volunteers with at-risk middle- and high-school students. Mentor and support them through the completion of their education, and help plan a successful transition to college or into the workforce.
	Serve in leadership positions on the SSU Medical School Advisory Board.

Results for some of these activities are shown in Figure 7.4-9.

opportunities for development in leadership, time management, and communication skills, and it also provides these future leaders with visibility within the organization and the community at large. For example, one of the dentists who had recently joined AF was asked to lead the annual food drive for a local food bank. Although she had never led such an effort, she quickly mapped out a project plan with a communication strategy, transportation options, and a logistics approach. With the support of her mentor, colleagues, and key partners (CactusCom, DDS, and the local community college system), she led the effort that became the most successful food drive in the food bank's history.

Category 2 Strategy

Improvements and Innovations

Year	Improvement
2015	Posted the Strategy Map on the website and in all lobbies
2014	Initiated focus groups with volunteers for more robust input to the People Review in May
2013	Created badge tags for employees to identify the most important FOCUS areas for the year
2012	Included outside strategic planning experts to ensure that the impact of changing health care regulations was well understood
2011	Expanded Partners Committee membership, for the second time
2010	Implemented quarterly all-staff meetings to communicate progress to plan

2.1 Strategy Development

2.1a Strategy Development Process

2.1a(1) Formal strategic planning at AF began in 1996 when Ramon Gonzalez became the CEO. Feedback from a 1997 state award assessment confirmed that a more integrated, systematic, planning process was needed. Several senior leaders enrolled in strategic planning seminars sponsored by the State Association of CHCs. With this learning and the guidance of several partner organizations on how they conducted their own strategic planning processes, AF put in place a systematic planning process in early 1998. Space limitations in this application preclude a detailed description of all the elements of the process, but process participants, inputs, and outputs for the major steps are shown in Figure 2.1-1.

Ramon Gonzalez believes that senior leaders have two important roles in the organization—to "manage the present" and to "shape the future." Therefore, senior leaders actively participate in all aspects of the planning process to ensure that

they are engaged in shaping the future. A cross-location team participates in the Strategic Planning Process to ensure that staff in all services and functions at all locations have an opportunity to provide input on how to best serve patients and their family members. County directors, administrative managers from each of the clinics, and a representative from the Caring Community also participate in all steps of the process, ensuring alignment and agility in implementation. Community members also have an opportunity to offer input or comment on the plan through AF's Internet site, social media sites, and CCKs, as well as during the annual Town Hall Meetings.

All key stakeholder groups (P.1b) have direct involvement, with input to and/or review of the plan, including the following:

- patients and their families (through the Patient-Family Advisory Boards [PFABs] at each clinic), who help AF understand the uninsured, underinsured, and vulnerable populations
- AF's physicians, as well as private-practice physicians and dentists from county medical and dental societies in the service area
- AF staff members
- volunteers

Figure 2.1-1: Major Elements in the Strategic Planning Process

Months	Activities	Inputs	Outputs	Who's Involved
Jan.	• Partners Committee meeting	• External trends in technology • Partner feedback, including information on market shifts and changes in the regulatory environment	• Technology assessment • Input for SWOT analysis	• Partners Committee members • The Info Interns (4.2a[1])
March	• Board retreat	• Current strategic plans and short- and long-term actions • Current and projected funding status • Audit report and governance review • FMEA for potential risks • Review of State Association of CHCs' strategic plan	• Governance and sustainability assessment • Financial capability plan	• Board members, senior leadership, and external auditor
April	• Partners Committee meeting	• Scenario exercise • Partner feedback	• Proposals to address blind spots • Input for SWOT analysis	• Partners Committee members
May	• People Review (2.2a[4])	• Staff-related results, recruitment issues, training and credentialing requirements • Community and volunteer needs and requirements • People needs from cross-location teams	• HR strategic challenges, Leadership System improvement opportunities, short- and long-term HR plans (e.g., training and succession plans) • Community involvement areas	• Senior leaders, clinic managers, volunteers • Caring Community subteam • People Potential Team (5.1a[1]) • Service With Spirit Team (3.1a[1]) • Healing Partners Team (6.1a[1])
June	• Partners Committee meeting	• Scenario exercise • Partner feedback	• Proposals to address blind spots • Input for SWOT analysis	• Partners Committee members
July	• SWOT analysis	• Internal/external scans (identified in 2.1a[2]) • Initial inputs on needs from PCTs	• Key improvement opportunities • Key process identification/validation	• All stakeholder groups (via Partners Committee, PFABs, and Internet feedback) • Data Docs (4.1a[1])
August	• Board retreat	• All updated planning inputs • List of current change initiatives	• Draft Strategic Plan around FOCUS objectives	• Board members, senior leadership, and local clinic managers
Sept.	• Partners Committee meeting • Various other stakeholder reviews • VMV review • VMV validation	• External trends in technology; draft Strategic Plan • Partner feedback • Draft Strategic Plan • Draft Strategic Plan • VMV and Strategic Plan	• Technology assessment, revisions to plan • Input for SWOT analysis • Revisions to plan • Pugh matrix • Possible revisions to VMV • Final validation of plan against VMV	• Partners Committee members • The Info Interns • All stakeholder groups through the Partners Committee, PFABs, and CMs • Board members and senior leaders • Board members and all senior leaders
Oct.	• Development of budget	• Strategic Plan and resource requirements • Finalized SWOT analysis	• Annual operating budgets and resource allocation, 5-year capital and funding plans, local action plans • Reprioritization, if applicable, of change initiatives	• Senior leaders and local clinic managers
Nov.	• Communication of plan internally and externally	• Strategic Plan details and objectives	• Communications plan and content	• Senior leaders • All staff and volunteers • All external stakeholders
Dec.	• Aligned personal objectives • Evaluation of the planning process	• Strategic objectives and local action plans • PIF model/AAR	• Personal goals for coming year • Improvement plan for next cycle	• All staff members • All process participants

- representatives from health care and education partners, including the deans of the local community colleges and representatives from the SSU School of Medicine, the State Association of CHCs, and the five community hospitals in the service area
- business partners, including CactusCom; HR Leaders, Inc.; and DDS, through representation on the Partners Committee (see below)
- community representatives, such as state and local health care leadership and officials from each county commissioner's office and county health department, who give input on market shifts and the regulatory environment
- representatives from local church and civic groups assist with community outreach. In addition, since most members of the Board of Directors represent the communities served, their participation reinforces and validates patient and community input obtained through other sources

Additional input for AF's planning process comes from several state- and federal-level initiatives, especially the State Association of CHCs. For example, George Hughes has been active on the Committee for Rural Health Issues, which has developed a comprehensive plan on preventive health issues and for improving health care accessibility and availability in rural areas of the state. The pertinent findings of this group have been incorporated into AF's Strategic Plan.

AF's planning process has two time horizons: a one-year view that has a practical focus on short-term projects, people issues, and resource management ("manage the present") and a three-year time line to address longer-term changes, such as service-area demographics, funding, and technological advances ("shape the future"). The State Association of CHCs develops a statewide strategic plan that identifies the resources needed to meet the health care needs of the unserved and underserved populations in the state over the next three years. AF's long-range horizon matches that time frame, ensuring alignment with the state's objectives and directions for health care delivery. In 2014 during the after action review (AAR), AF recognized the need to change from a five-year, long-term planning horizon to a three-year, long-term planning horizon to address the rapid changes taking place in health care.

Since AF lacks resources and internal expertise in many areas, external partnerships are critical to its success. This approach was formalized in 1998 by establishing the Partners Committee, which meets four times a year to provide input and guidance to AF's planning process. Based on Baldrige application feedback in 1999, the Partners Committee membership was expanded from key business partners to include all external stakeholders, such as payors, volunteers, and representatives from the PFABs, the State Association of CHCs, and local church and civic groups.

The Strategic Planning Process addresses the potential need for transformational change through scenario-planning exercises (2.1a[3]), which cause AF to rethink the status quo. This, in turn, reinforces the need for organizational agility. The wide range and large number of participants throughout the process promote operational flexibility, as the participants gain a deeper understanding of the multiple parts of AF's complex system. At the board retreat in August, the participants review the list of current change initiatives along with their status, resource requirements, and expected outcomes. Based on review of the work done in September, during the budget process in October, senior leaders evaluate the change initiatives against the strategic objectives developed in the five FOCUS areas. If necessary, change initiatives may be reprioritized to maximize the use of limited resources.

The Strategic Planning Process incorporates a review and improvement cycle using the PIF model (Figure P.2-5). All planning participants, including external stakeholders, are asked to provide input on the plan's content and the planning process, either during a November meeting called for this purpose or through an Internet-based survey. A formal AAR is conducted in December after the plan is deployed. AF also captures ideas for improvement through attendance at the Saguaro State Award and Baldrige Quest for Excellence® conferences. All improvement ideas are reviewed by a subset of the senior leaders and board members, and improvements are implemented in the next cycle. A list of improvements to the strategy development and implementation processes is shown at the beginning of this category.

2.1a(2) The Strategic Planning Process stimulates and incorporates innovation in multiple ways. Again, the wide range and large number of participants provide multiple perspectives to generate lively discussion that frequently results in out-of-the-box thinking. The strengths, weaknesses, opportunities, and threats (SWOT) analysis also pushes AF to think beyond current capabilities to address an opportunity or to counter a threat. Scenario-planning exercises that incorporate a "worst-case" scenario will often demonstrate that AF cannot be successful with only continuous improvement. In that case, a focus on innovative solutions that will provide the breakthrough improvement needed may include leading-edge options from the technology assessment.

Strategic opportunities are also identified as part of the SWOT analysis. Strategic opportunities are assessed for being intelligent risks by first evaluating them against the VMV. Alignment with those is the first test. Then the potential benefit of pursuing the strategic opportunity against the possible costs, including the risk of being unsuccessful, is determined. AF's key strategic opportunity currently is developing a partnership with La Sangre de Vida (The Blood of Life) dialysis service. AF's patient population includes an increased prevalence of diabetes and hypertension, which results in a higher incidence rate of chronic kidney disease (CKD). These patients often require dialysis in the later stages of CKD. By partnering with La Sangre de Vida, AF provides a more comprehensive approach to the medical home model.

2.1a(3) Extensive data and information are gathered as inputs for the Strategic Planning Process. Sources of these inputs are the Partners Committee meetings, board retreats, and regular meetings with staff, volunteers, and other partners and stakeholders. These inputs include those shown in Figure 2.1-1.

In addition, AF's strategic challenges and strategic advantages are key elements of the SWOT analysis. These are evaluated in light of the following:

- AF's competitive position in health care outcomes
- performance versus key benchmarks, performance related to key operational and clinical measures, support process performance, and workforce performance and requirements
- critical to quality (CTQ) flow-down analysis of patient satisfaction and complaint results to determine how well AF is meeting patient and market needs compared to its competitors

Potential changes in regulatory requirements are identified by senior leaders and the Partners Committee. Participation in the State Association of CHCs also ensures that AF is kept abreast of changing health care regulations. AF also stays abreast of

- results of benchmarking initiatives, including collaborative participation;
- business continuity and emergency preparedness using FMEA to identify and address potential risks (6.1b); and
- community involvement opportunities.

The Partners Committee provides an external view to help AF identify and address blind spots in three ways. First, external partners actively participate in many steps in the planning process, such as providing feedback on AF's five areas of strategic FOCUS. Second, partners identify and bring innovative concepts and technologies from outside health care, such as the implementation of CCKs (3.1a[1]). Third, the Partners Committee is the venue for two scenario-planning exercises each year to help the organization build agility in addressing possible changing circumstances. For example, the first scenario, "Perfect Storm," conducted in 1999, dealt with a potential funding crisis due to a national recession coupled with federal funding reductions. Learning from the exercise resulted in the establishment of the AF Foundation, which supports improved health care availability in western Arizona—and helped AF weather an actual reduction in funding a few years later. Starting in 2001, the scenario sessions were expanded to take place at two Partners Committee meetings per year and have addressed effective succession planning and shifting demographic and health care needs for an aging population.

AF ensures its ability to execute the Strategic Plan with a systematic approach involving the four factors that affect resource availability: people ("Do we have the right people with the right skills in the right places?"); money ("Can we fund each and all of these initiatives?"); time ("Do we have adequate time to execute these initiatives properly?"); and information ("Do we have all the information we need to achieve these objectives?"). Each of these questions must be answered in the affirmative before the budget is set and the plan approved.

2.1a(4) AF's work systems are ambulatory care services, auxiliary patient services (lab, x-ray, and pharmacy), and community health services (screening, etc.). Work system decisions are made that facilitate the accomplishment of the strategic objectives as part of the SPP. AF intentionally reviews the key processes during the SPP with the objective of determining if those processes can be best accomplished with internal resources or whether external suppliers and partners should be used. That decision is based on whether the process leverages one of AF's core competencies, or if it capitalizes on a core competency of an external party. Senior leaders also consider whether an external party can provide the service (execute the process) more efficiently and more cost-effectively. The need for future core competencies and work systems is discussed as part of the SWOT analysis, which includes an assessment of changing community health needs.

2.1b Strategic Objectives

2.1b(1) AF's short- and long-term strategic objectives are outlined in Figure 2.1-2 along with its most important goals. The currently planned change in health care services, customers and markets, suppliers and partners, and operations is the development of a partnership with La Sangre de Vida.

2.1b(2) As shown in Figure 2.1-2, the FOCUS framework ensures that strategic objectives achieve appropriate balance among varying and potentially competing organizational needs. The figure also shows how strategic objectives address strategic challenges and leverage core competencies and strategic advantages. Both short- and longer-term planning horizons are reflected in the related action plans. Broad participation during the Strategic Planning Process ensures that the needs of all key stakeholders are considered so that objectives balance across those needs.

2.2 Strategy Implementation

2.2a Action Plan Development and Deployment

2.2a(1) Key short- and long-term action plans are shown in Figure 2.1-2. AF develops action plans at four levels: (1) organization-wide (including plans for support processes such as IT and HR), (2) county, (3) point of care, and (4) individual staff members. After the overall Strategic Plan is validated and annual budgets are developed, the SLT and local clinic managers develop specific action plans for deployment to their work units. Senior leaders translate the strategic objectives into action plans through a process of breaking down objectives into measurable and clearly identified goals. Each strategic objective is owned by a senior leader who identifies milestones, resources, and a timetable for accomplishment of the related action plans. Occasionally, board subcommittees also may task other individuals to manage specific action plans. Volunteers also participate in action plan development at the first three levels. Resource allocation for the overall plan occurs as described in 2.1a(3). A similar process is used at each action plan level, including the individual level, to ensure that adequate resources are available across all locations and used most effectively. Once resource availability is validated using the Pugh matrix, the annual plans at the organizational, county, and point-of-care levels are subdivided into 90-day action plans.

2.2a(2) Plan implementation and deployment begins with the involvement of all senior leaders in the Strategic Planning Process. The mechanisms described in 4.1b and Figure 4.1-2 ensure close monitoring of progress at each level and quick intervention if any initiative is lagging. Once these 90-day action plans are developed, senior leaders outline a formal plan to communicate the objectives to all staff members and other

Figure 2.1-2: Strategic Objectives and Most Important Goals

Strategic Objectives CC, SA, SC (P.1a[2], P.2-3)	Key Action Plans ST = Short Term 1 year, LT = Long Term >1 year, WF = Workforce	Goals	Measurements	Projections vs. Competition	Time-tables	Results
Financial Performance Increase net income by decreasing overall cost-to-serve through reductions in administrative and indirect patient cost. SA1, SC1	ST: Improve collection rates.	83%	Overall collection rates	+	YE 2017	7.5-3
	LT: Improve return on assets in clinical units.	16.7	RVUs per net asset value	=	YE 2018	7.5-4
Organizational Learning Take advantage of available internal and external resources to fill workforce gaps. SA2, SC2	WF: Provide current staff with the time and resources to expand their skills. Provide online learning opportunities/paid time off for study.	Benchmark	Staff proficiency rates	+	Ongoing	7.3-21
	WF: Actively recruit and train volunteers, especially retired health professionals in the region, with targeted skills.	Yr/Yr improvement	Volunteer proficiency rates	+	Ongoing	7.3-21
	WF: Promote enrollment in development programs in health care professions.	Yr/Yr improvement	Staff and volunteer enrollment rates	+	Ongoing	7.3-20
Clinical Excellence (1) Increase the overall ratio of patient visits to staff. (2) Develop internal and external resources to address unmet health care needs in the service area to increase the number of new patients served. SA3, SC3 CC1, CC2, CC3	LT: Increase PCT productivity.	Yr/Yr improvement	Office visit cycle time Immunization rates Screening rates Mammograms	+	Ongoing	7.1-27 7.1-9, 7.1-10, 7.1-19, 7.1-20 7.1-3–7.1-8, 7.1-12, 7.1-14 7.1-6
	ST: Pediatrics: Increase immunization rates for children and adolescents. ST: Females: (1) Increase screening rates for domestic abuse, depression, cervical cancer, and colon cancer. (2) Increase mammography services. ST: Males: (1) Increase screening rates for depression. (2) Increase screening rates for colon cancer. ST: Other: (1) Increase screening/support in clinical preventive areas (e.g., smoking cessation, obesity). (2) Increase immunization rates (e.g., for influenza). (3) Increase diabetic screening.			+	Ongoing	See above.
Utilization Expand partnerships and collaborative arrangements with state and local organizations and health care providers to increase the number of new patients served. SA4, SC4 CC3	LT: Increase the number of new patients served through partnering with local community groups, public health departments to identify underserved and unserved populations. Partner with local faith-based organizations to promote health screening services.	TBD	Number of new patients served per month (new measure)	+	Ongoing	TBD
	ST: Increase access.	Yr/Yr improvement	Future capacity Third next available appointment	+	YE 2017	7.1-25 7.1-26
	ST: Reduce the wait times for appointments.	Yr/Yr improvement	Wait times (minutes)	+	YE 2017	7.1-27
Satisfaction (1) Improve satisfaction levels on staff survey "employer of choice" dimensions. (2) Improve satisfaction levels on volunteer survey. (3) Improve external stakeholders' satisfaction. SA5, SC5 CC3	WF: Address lower-scoring issues identified in the most recent Staff Satisfaction Survey.	Oates Top Decile	Staff satisfaction scores	+	YE 2017	7.3-13 through 7.3-14
	ST: Address lower-scoring issues identified in the most recent patient, community, and partner satisfaction surveys.	Oates Top Decile	Satisfaction scores	+	YE 2017	7.2-1 through 7.2-11, 7.3-14, 7.3-16, 7.3-17

CC = Core Competencies; Projections = + better than the projections of comparisons, = at parity, − worse than projections of comparisons

stakeholders, including partners, collaborators, and suppliers. After the county directors and local managers complete this communication, each individual staff member is responsible for developing annual personal improvement objectives (incorporated into the IDP) and an initial 90-day action plan to support implementation (5.1a[1]). Achievement of these action plans and personal objectives links to the performance review process for all staff members (5.2a[4]).

AF ensures that key outcomes of action plans can be sustained through regular monitoring of associated key performance indicators (KPIs) through the reviews shown in Figure 4.1-2.

2.2a(3) Because of the integration of the budgeting process with the Strategic Planning Process, AF ensures that financial resources are available to support the achievement of action plans while meeting current obligations. In addition, the four-part approach to identifying all necessary resources (described in 2.1a[3]) ensures that resources other than financial are also considered and allocated. The use of 90-day action plans and regular review of them help mitigate any risks associated with the plans. If a plan is not making sufficient progress, the cause is determined and either additional resources will be allocated temporarily or the plan may be put on hold.

2.2a(4) Key workforce plans are shown in Figure 2.1-2. Human resource (HR) plans are developed as an integral part of the Strategic Planning Process, in particular during the May meeting or "People Review." All senior leaders and local managers participate in an annual "People Review" that considers all relevant staff issues at AF, including recruitment and retention, factors related to culturally competent services, satisfaction/dissatisfaction indicators, training and credentialing needs, and the use of volunteers. The outcomes of this meeting include identification of current HR challenges (e.g., recruitment, training, and succession planning needs) and drafts of short- and long-range workforce plans. These are later updated and used as input in developing the overall Strategic Plan and then translated into action plans. An example of a HR plan related to AF's strategic objective to increase staff satisfaction is included in Figure 2.1-2. In addition, inputs to the Strategic Planning Process include the assessments or workforce capability and capacity described in 5.1a(1).

2.2a(5) Key performance measures used to track the achievement and effectiveness of action plans are shown in Figure 2.1-2, with results presented throughout category 7. These measures align with AF's overall Performance Measurement System (4.1) and the key measures for health care and support processes (category 6). Organizational alignment begins with the involvement of the county directors, local clinic managers, and the clinical teams in the Strategic Planning Process and continues through 90-day action plan development, finally resulting in aligned personal objectives for all staff members, which are part of the Performance Review Process. Board members and other external stakeholders, such as DDS, participate in validating the Strategic Plan and develop their own objectives based on it. This helps ensure that the needs of all stakeholders have been addressed.

2.2a(6) Projections for AF's short- and long-term performance are provided in Figure 2.1-2. These projections take into account, as available, the performance of local competitors and state and national comparisons. Projections are based on statistical forecasts of AF's performance. Targets for clinical results incorporate the Healthy People 2020 national and state objectives, providing AF with targets to confirm that it is achieving its vision to help make the people of western Arizona the healthiest in the state. Thus, the Strategic Plan is intended first to close local gaps between projected performance and Healthy People 2020 targets and then to exceed the state's long-term targets. Senior leaders identify any gaps in performance against competitors or comparable organizations as part of the Strategic Planning Process. The first step in addressing the gaps is to understand if there are any significant differences between the patient populations of the comparison and AF, such as age-skewed demographics or prevalence of disease condition. The next step is to try to normalize the data to define the true gap. If a gap still exists, action plans are developed to close the gap (2.2a[1]).

2.2b Action Plan Modification

The need to modify action plans may be identified as a result of regular review meetings (4.1b) at either the service entity or the organizational level. For example, the semiannual reviews by process owners (6.2a) may uncover a need to modify action plans to improve process performance. If so, a manager is assigned as the single point of responsibility and is charged with developing revisions to the plan. These proposed revisions are reviewed as soon as possible, either through one-on-one discussions, through e-mail exchanges, or at the next scheduled management review meeting, and they are implemented following approval by the local managers or the SLT. If necessary, priorities may be reset and resources reallocated using the process previously described. Progress against the modified plan continues to be reviewed through the regular management review meetings.

Improvements and Innovations

Year	Improvement
2016	• Partnership with La Sangre de Vida dialysis labs • "Kid-friendly" CCKs deployed
2015	• Monthly Senior Social Hours implemented • School health promotion program revised and deployed
2014	• Staff feedback questions added to all-staff meetings • Service Experience Survey made electronic • Complaint severity index introduced
2013	• Service With Spirit Team (SWST) implemented • Benchmarking customer learning approaches
2012	• Use of portable CCKs expanded system-wide • Partners survey implemented

3.1 Voice of the Customer

3.1a Listening to Patients and Other Customers

3.1a(1) AF uses three key listening and learning methods to determine key patient, family, and other stakeholder requirements (Figure 3.1-1). For patients and families, these methods include satisfaction surveys (3.1b), complaint data (3.2b[2]), and information gathered through staff and volunteer interactions. Each clinic has an eight-member PFAB that meets quarterly with AF staff to give feedback on AF's current services and plans, and its own evolving needs. As a cycle of evaluation and improvement in 2014, each all-staff meeting includes discussion of one question developed by AF senior leaders or the board to obtain feedback on a current issue. All feedback, both quantitative and qualitative, is organized using a standard reporting template and immediately captured in AF's Knowledge Management System (4.2a[1]) for review by senior leaders. Several innovations have been identified as a result of PFAB input; innovations include expansion of mobile services to include a dental lab and partnership with La Sangre de Vida dialysis labs (a current strategic opportunity) to provide seamless service for patients. PFAB members often join design and improvement teams to ensure that patient and family perspectives are incorporated at the front end.

To listen and learn from patients, their families, and from the community at large, AF pioneered the use of innovative, portable CCKs. The kiosks, with attractive graphics and user-friendly touch screen design, are deployed in all facility waiting areas and rotated across the three-county area in shopping malls, recreation centers, and other community locations, often in conjunction with an AF-sponsored health screening event. Thanks to a grant from a local foundation, AF has increased the number of kiosks, improved the user interface, and expanded the content. Users enter an anonymous demographic and health profile, which is entered into a database that provides insights into regional health care needs, users' perceptions of their health status, their preferences, and an assessment of their own needs. This information is aggregated for use in strategic planning (2.1a[3]). Users can evaluate clinical and support services they have received, make side-by-side comparisons, and rank proposed service prototypes. The kiosk is not just a listening post; it also provides access to health information, including health risk appraisals and web links that are selected based on independent rankings of the websites' quality and their relevance for AF's patient population. CCKs also provide information on locations for the mobile units for the next two weeks; insurance program eligibility; food, housing, and transportation assistance; and participation in clinical trials (an effort to expand access and reduce health disparities in treatment). Volunteers trained in the use and content of the CCKs are available in community locations to assist first-time users and also provide demonstrations in waiting rooms for both children and adults. In a cycle of evaluation and improvement in 2015, AF implemented a monthly evening Senior Social Hour targeted at seniors. Second Time Around features an Elders Council member who partners with a content expert to co-teach basic computer use and other topics requested by seniors. Recently in another cycle of evaluation and improvement, AF added a series of "kid-friendly" modules in the CCKs, focusing on exercise and healthy eating.

Patients enrolling for care at AF complete individual profiles, or personal health profiles (PHPs), that include their self-designated race/ethnicity and primary spoken and written language, as well as their preferred medical providers and the name by which patients wish to be called. AF provides assistance in completing these profiles, as needed. To ensure the organization provides culturally competent care, the PHPs are integrated with AF's clinical data system so that clinicians are aware of each patient's preferences (6.1b[1]). Essential individual patient requirements and preferences also are reviewed in Daily Huddles.

To determine and respond to partners' requirements, needs, and expectations, AF's senior leaders meet quarterly with the Partners Committee. At each session, the group discusses current and future needs and trends, as well as opportunities for innovation and greater collaboration. In addition, an annual telephone survey of partners (see Figure 7.2-9) serves as a valuable listening and learning tool, and senior leaders have extensive individual interactions with partner organizations. To determine and address payors' requirements, needs, and expectations, a senior leader serves as the assigned champion for each major payor. Typically, the leader and the payor's representative meet quarterly. Biannually, PCT representatives and other AF staff meet with payors under the auspices of the State Association of CHCs to plan collaborative initiatives and standardize materials, procedures, and requirements across CHCs.

Implemented in 2013, the SWST is a cross-location team led by Teresa Aguilar, with representation from PCTs and functional groups. It is responsible for reviewing and analyzing all market data and customer-related results, identifying cross-organizational improvement priorities, and providing feedback on improving approaches to customer listening/learning and satisfaction. With support from sophisticated analytics tools, each month, team members aggregate, segment, and analyze

these data using time series and conjoint analyses to determine key drivers and trends in satisfaction, loyalty, and positive referral for specific patient, family, and customer groups, and issues a comprehensive report to senior leaders and all managers. The SWST uses CTQ flow down to embed customer requirements into service design and delivery processes (6.1a), translating each requirement into discrete elements of services needed. In addition, the team uses these customer requirements to help PCTs evaluate and develop new service design concepts, using a selection criteria matrix. Using patient survey data and these approaches, the SWST determined that "treated with dignity and respect" (i.e., patient-centered) and "personal relationships" are important predictors of patient loyalty and of satisfaction with quality of care for patients and families in all demographic groups (see Figure 7.2-6).

SWST members also conduct an annual systematic evaluation of the methods and tools used for customer listening and learning to keep them current and relevant to AF's needs. For example, as a result of benchmarking with external organizations and periodic review of the literature, the SWST recommended that AF pilot a national, newly validated, brief questionnaire to capture perceptions of self-management skills among chronically ill patients. Subsequently adopted and deployed across all PCTs caring for patients with chronic disease, this tool gives providers helpful information for use in tailoring care plans to individual patient needs, as well as a national comparative database segmented by race/ethnicity, primary language, and highest level of education attained. This approach has now been adopted by other CHCs in the state.

3.1a(2) The CCKs provide a primary method for listening to potential patients and customers. Additional approaches for reaching potential customers are listed in Figure 3.1-1.

3.1b Determination of Patient and Other Customer Satisfaction and Engagement

3.1b(1) AF has systematically measured patient satisfaction and dissatisfaction for nearly two decades. As it began its Baldrige journey in 1997, AF recognized the need for

Figure 3.1-1: Customer Listening and Learning Approaches

Listening Methods and Relationship Stages	Current Patients								Other Types of Patients			Other Customers		
	Segments				Main Services									
	Primary Care	Pediatrics	Women	Geriatrics	Medical	Dental	Screening	Pharmacy	Former Patients	Potential Patients	Patients of Competitors	Patients' Families	Community	Partners/ Payors
Packer Survey* (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE					
Service Experience Survey* (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE			SDE		
Community Climate Survey* (1,2,3)									SD	SD	SD	SD	SDE	
Partners Survey* (3)														SDE
Complaint Management and Service Recovery Process (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE			SDE	SDE	
Requests to Change Provider (2,3)	D	D	D	D	D	D	D							
CCKs (1,2)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	
PHPs (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE						
Chronic Disease Self-Management Knowledge and Skills Questionnaire (1,2)	E		E	E	E		E		E	E	E		E	
Suggestion Forms (1,2,3)	E	E	E	E	E	E	E	E					E	
Board of Directors Meetings (2,3)													SDE	
PFABs (2,3)	E	E	E	E	E	E						E		
Partners Committee (2,3)														E
Senior Leader Champion (2,3)														E
State-wide Conference of CHCs and Payors (2,3)														E
Website (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	
Social Media (1,2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	
Patients' Personal Letters (2,3)	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE	SDE			SDE		
Post-Treatment Calls (2,3)	SDE	SDE	SDE		SDE	SDE	SDE	SDE				SDE		
Health Fairs and Screenings (1,2,3)	SDE	SDE	SDE	SDE	SDE				SDE	SDE	SDE		SDE	

* = Provides Comparative Information; S = Satisfaction, D = Dissatisfaction, E = Engagement

Relationship Stages: 1 = Beginning, 2 = Building, 3 = Sustaining

benchmarks and peer comparisons. Through the Benchmarking Consortium, Ramon Gonzalez led the State Association of CHCs to craft a group purchase arrangement that enables all CHCs to use the Packer Patient Satisfaction Survey, which has wide acceptance in the health care industry. The vendor mails satisfaction surveys to a random sample of AF patients within two weeks of their service experience. These data are used to identify unique strengths, improve publicity efforts and patient recruitment, pinpoint gaps for system improvement efforts, and plan for changes in markets and services. In addition, AF segments its patient satisfaction data by county and PCT to promote internal benchmarking. By identifying top performers, AF promotes knowledge transfer, often facilitated by staff rotations across sites. Packer makes quantitative satisfaction survey results and transcribed open-ended comments available online within 24 hours of receiving completed surveys from patients. AF also receives a monthly analysis that shows the frequency of particular problems reported and their priority as drivers of loyalty, and it tracks performance over a rolling 36-month period. These problem and priority reports are reviewed by the SWST and senior leaders, and enable AF to target the highest-leverage improvement opportunities, as well as to see the impact of improvement efforts.

AF measures patient satisfaction at the point and time of service through an innovative Service Experience Survey (See Figures 7.2-2 through 7.2-5). Typically, patients (except those too ill or injured) use a tablet to complete a three-question survey at the start of each service experience. It asks patients about their goals for the visit, and it helps the patient and provider link immediate needs with the patient's overall plan for care (6.1b[2]). At the end of the visit, patients use the tablet to evaluate the degree to which their goals were met and rate the experience for access, convenience, timeliness, communication, and respect. The speed and ease of using the survey tool have resulted in a 93% usage rate. Questions correlate with those on Packer's longer, mailed survey. Medical and dental assistants use scripted messages to manage the data collection, capturing it on tablets for immediate integration into the patient database on the intranet. The survey can be tailored with customized questions for a sample of patients or a defined period to enable AF to track progress on specific improvement initiatives in one or more PCTs.

Gathering real-time satisfaction data through the Service Experience Survey enables staff to take immediate action to address patient or family concerns and restore or strengthen the relationship using the Complaint Management and Service Recovery Process (Figure 3.2-3). This process helps PCTs track their progress and get immediate feedback on how they compare with others. PCTs have implemented numerous improvements through use of this feedback, including establishing more effective ways to work with Spanish-speaking patients and their families, improving handwashing compliance, and developing and deploying many new training modules across all sites.

AF measures community satisfaction with the Community Climate Survey (see Figure 7.2-8), which is administered annually through collaboration with the State Association of CHCs and SSU's School of Business. Conducted by telephone and home visits, this survey asks family health decision makers in all counties served by CHCs to compare their most recent health care experience against their expectations, identify their own and their community's unmet needs, prioritize a list of enabling services, and rate and rank providers in their county for outpatient and inpatient care. Using CCKs, AF uses a short version of the same questionnaire to assess the community's pulse in its own service area. Like all satisfaction data and information, these responses are captured in an online database, shared on the intranet, and used by the SWST and senior leaders to improve services. The database permits analysis by county, condition, quality and service characteristics, and demographics. AF compares its results on identical questions with the annual performance of other CHCs.

Since 2003, Partners Committee members annually nominate individuals in their organizations to participate in a 20-minute partner perception telephone interview, conducted by Partners Committee members from other organizations (see Figure 7.2-9). The interview includes a ten-item survey, followed by a series of open-ended questions to explore responses. Committee members use the results to explore ways to clarify and strengthen the partnership within their own organizations, and AF leaders use them as an input to strategic planning—in particular, as input on partner support for new initiatives and greater participation.

Packer continually evaluates and updates its tools and methods. The State Association of CHCs and SSU annually perform a similar function for the Community Climate Survey. In addition, each year, the SWST systematically evaluates AF's tools, methods, and overall approach.

AF determines dissatisfaction from complaints, low scores, and verbatim comments on the Packer Survey and other voice-of-the-customer (VOC) methods.

3.1b(2) The Packer Patient Satisfaction Survey enables AF to compare its performance against that of health care provider organizations nationally and to CHC peers on six dimensions: perception of safety and quality, access, cost effectiveness, equitable, and reputation (see Figure 7.2-6). Packer's research has shown that the survey questions in each of these dimensions focus on what is most important to patients and families about the experience of care. In addition, the state CHCs added two customized questions—for personal relationships and patient-centered—that enable them to track and compare performance on cultural competence. The Community Climate Survey also permits comparison against CHC peers. Volunteers serve as an informal source of information for leaders and staff about patients' satisfaction with AF versus other providers.

3.2 Customer Engagement

3.2a Service Offerings and Patient and Other Customer Support

3.2a(1) Annually during the Strategic Planning Process, senior leaders identify, review, and update the organization's key customer groups and market segments based on the VMV and a comprehensive look at current and projected community needs. The SWST prepares an analysis using information from federal

and state agencies such as the BPHC and the State Association of CHCs, U.S. Census Bureau demographic data (Figure P.1-2), data on the U.S. population's health status and disparities from the CDC, the Behavioral Risk Factor Surveillance System (BRFSS), the BPHC Uniform Data System, Healthy People 2020 data, state and local health department data, and a review of local health care safety net services and utilization, as well as a proactive, systematic literature scan. The team compares the demographics, health status, and service utilization of AF's current enrollees against similar information for the counties that AF serves, the state, and CHCs statewide. By subtracting its own enrollment, AF identifies the needs of potential customers served by others and gauges unmet needs.

3.2a(2) AF offers nineteen access mechanisms for patients, families, and stakeholders to seek information, obtain appointments and services, and make complaints or suggestions for improvement (Figure 3.2-1). These include mail, telephone, online access (Internet-based on a personal computer or through a CCK), social media, and printed materials. For patients enrolled at AF, password-protected online access enables them to make appointments, obtain lab test results, and send/receive messages with their primary care provider. A biannual survey conducted by the State Association of CHCs shows that online access for patients in AF's service area increased from 53% in 2003 to 78% in 2015, through computers in their homes, at the home of a friend, at work or school, or in a public library. To ensure that AF accommodates those patients without online access, AF telephones have after-hours voicemail for routine messages, with a return call guaranteed on the next business day and links to the on-call provider for urgent questions or concerns. All phone systems, online communication, and printed materials provide an option of English or Spanish messaging. Most staff (73%) are bilingual, which facilitates interaction with non-English-speaking patients. For patients with limited reading skills, educational materials are produced as picture-based pamphlets and books, videos, and audiotapes. AF obtains some materials from professional organizations (e.g., from the AAFP and ACOG) and produces other materials with support from AF volunteers. Posters, pamphlets, and storyboards in the clinics provide health tips and information about providers and services. Other enabling services—transportation, for example—are widely advertised in AF facilities, CCKs, and community postings and can be scheduled by telephone or online.

Figure 3.2-1: Customer Support Approaches

Support and Communication Mechanisms	Patients								Other Types of Patients			Other Customers	
	Segments			Main Services									
	Primary Care	Pediatrics	Women	Geriatrics	Medical	Dental	Screening	Pharmacy	Former Patients	Potential Patients	Patients of Competitors	Patients' Families	Community
Website	X	X	X	X	X	X	X	X	X	X	X	X	X
Social media	X	X	X	X	X	X	X	X	X	X	X	X	X
Personal letters	X	X	X	X	X	X	X	X	X	X	X	X	X
Telephone	X	X	X	X	X	X	X	X	X	X	X	X	X
Voice mail	X	X	X	X	X	X	X	X	X	X	X	X	X
On-call provider	X	X	X	X	X	X		X				X	
CCK	X	X	X	X	X	X	X	X	X	X	X	X	X
Face-to-face	X	X	X	X	X	X	X	X	X	X	X	X	X
Print materials	X	X	X	X	X	X	X	X	X	X	X	X	X
Interpreter	X	X	X	X	X	X	X	X				X	X
Insurance eligibility/enrollment	X	X	X	X	X	X	X						
Transportation	X	X	X	X	X	X	X					X	
Child care	X	X	X		X	X							
Leaders' open-door policy	X	X	X	X	X	X	X	X	X	X	X	X	X
Post-treatment calls	X	X	X	X	X	X	X					X	
Health fairs and screenings	X	X	X	X	X	X	X	X	X	X	X	X	X
Complaint Management and Service Recovery Process	X	X	X	X	X	X	X	X				X	
Suggestion forms	X	X	X	X	X	X	X	X	X	X	X	X	X
PFABs	X	X	X	X	X	X		X	X			X	

At the close of every patient interaction, staff members ask what else they can do for the patient and how they can work together to make the next interaction even better. This information then is captured in the patient's PHP to facilitate future visits. Senior leaders are equally receptive; they have an open-door policy for all key stakeholders, and responses to telephone and e-mail inquiries are guaranteed within 24 hours.

The SWST uses data and information from AF's customer listening posts to determine key contact requirements for each mode of access, and it involves customers, as appropriate, in designing and piloting new access mechanisms. For example, members of the Board of Directors and PFABs piloted the prototype CCKs and have been involved in all subsequent updates. Requirements are incorporated into the design of processes and equipment, and they are deployed to all staff and volunteers through orientation, training, and communication channels.

3.2a(3) As part of the Strategic Planning Process, senior leaders use the SWST's analyses (3.2a[1]) to identify current and potential new market segments. These analyses include a comprehensive review of current and projected community health care needs across AF's service area based on population growth and current health trends. Patient demographic and preference data also are aggregated at site, county, and organization levels. Consideration for entering new market segments is based on a match with the VMV. Starting with the launch of AF's first mobile medical services van in 1988, senior leaders have used these analyses to identify and target unmet needs, establishing two school-based clinics for underserved children and adolescents in 1995, adding a dental van in 2000, partnering with local transportation providers in 2010, and continually expanding access to medical and dental services by van and CCKs throughout the service area. More recently, this analysis led to the identification of a strategic opportunity to partner with a dialysis provider. Similarly, because of state rates of diabetes, heart disease, inadequate physical activity among adults (50%), and daily diets with less than five fruits and vegetables (77%), senior leaders allocated resources for the school-based clinics to revise the health promotion program to focus on developing healthy exercise and diet habits and to expand the program to include teachers and staff. A more recent example of the use of this analysis is AF's expansion of services to seniors. The demographic analysis indicated that the population in AF's service area was increasingly aging, due in part to the in-migration of retirees. In 2013, AF hired several new geriatric specialists to serve this growing market segment.

3.2b Patient and Other Customer Relationships

3.2b(1) At AF, relationships are a core value, translated into action through the PCT model and AF's enabling services (Figure 3.2-2). During the enrollment process, AF assesses patient eligibility for various forms of assistance and helps patients complete required forms. Enrollment also includes orientation to AF services and staff. New patients use profiles of AF providers (listing, for example, professional background/medical specialties, interests, and languages spoken fluently) to select a primary provider and PCTs for ongoing care. In addition, PHPs enable the PCT to address each patient's needs and preferences in a personalized fashion, demonstrate respect, enhance communication, and provide culturally competent care. Caregivers systematically review individual profiles in preparation for each encounter and come to know and interact with their patients as individuals, enabling them to tailor care planning and treatment, education, and follow up to the unique needs of that patient and his or her family. AF builds and sustains these relationships through an array of enabling services, including insurance enrollment, transportation to AF facilities (arranged through local partners), child care during appointments, after-hours telephone access to an on-call provider, and on-site pharmacy services.

Figure 3.2-2: Relationship Building Methods

Acquire New Patients and Other Customers	• Website • Social media • Health fairs, classes, and screenings • CCKs • Insurance eligibility/enrollment
Retain Patients and Other Customers	• Complaint Management and Service Recovery Process • Internet/Patient Portal • Post-discharge calls • Social media • Transportation services • Child care
Increase Engagement	• Participation on PFABs • Complaint Management and Service Recovery Process • CCKs • PHPs • Face-to-face interaction • Leaders' open-door policy • Post-treatment follow-up calls
Enhance the Brand	• TV and radio public service announcements • Website • CCKs and social media

Opportunities for active involvement in the AF care experience—through participation in PFABs, on design and improvement teams, and as volunteers—also build and sustain relationships. At two facilities, PFAB input resulted in the addition of Native American healing gardens and the display of Native American artwork and crafts in clinics. PFAB members also serve as "mystery shoppers," exploring ways to reduce noise, improve cultural awareness and confidentiality of patient information, and upgrade signage in clinics. Recognizing the important role played by elders in AF's key communities, PFABs recommended formation of an Elders Council in each county to assist AF leaders and staff with understanding elders' needs and to build relationships. These councils provide input for the design of programs for seniors, review cultural competence training materials, and engage in special projects sponsored by AF. For example, recipes contributed by the Yuma Elders Council were adapted with heart-healthy substitutions by nutritionists at a partner hospital. After taste-testing by the elders, the recipes were posted on CCKs and AF's website.

AF builds relationships with the community, which includes potential patients, through high-visibility activities aligned with specific interests, needs, and preferences of groups. Examples include physical activity and nutrition school programs to combat both adult and childhood obesity; an annual health

fair highlighting self-assessment, prevention, and screening; public service announcements on local TV and radio stations; public recognition of volunteers; a health center peer-to-peer adolescent ambassador program; and expanded presence of CCKs throughout the community. Volunteers carry out public awareness campaigns prior to each event and, for some activities, at key times (e.g., when students return to school, when migrant workers arrive, and during the season for recreational visitors). AF teaches community members to use the PIF and related OASIS improvement tools (Figure 6.1-4). La Paz Elders Council members learned to assess their risk of falling and then developed effective ways to disseminate their tips to other elders in the community.

AF senior leaders participate on the boards of several key partner organizations. George Hughes and Rosa Figueroa serve on two hospital boards, and Tony Joachin serves on the community college board for Mohave County. Through these relationships, AF leaders participate in hospital and community college planning and are proactive in identifying and shaping opportunities for collaboration, with mutually beneficial results. For example, AF collaborated with the community hospitals on establishing a secure phone/fax link that enables AF's partner hospital discharge planners to set up follow-up visits at AF before patients (current or new) leave the Emergency Department or hospital, a practice now used in each county. AF builds relationships with its education partners by delivering training and other learning opportunities that effectively build needed knowledge and skills, including those not readily acquired elsewhere, such as delivery of culturally competent care.

For every patient referred for consultation or special procedures, AF uses a secure survey and suggestion form to systematically gather physician or agency feedback. This listening and learning tool provides useful feedback to enhance AF's relationship with these partners. For example, based on suggestions from several partners, AF worked with all partners to standardize and simplify referral forms and the template to document services and findings.

The SWST annually reviews AF's approaches to building relationships with key customers. The team examines practices across PCTs, considers ideas and lessons learned from AF teams that participate in state and national learning collaboratives, and compares AF practices with others by benchmarking service organizations inside and outside health care. Annually, the team carries out a proactive scan and summary of fresh approaches to serve as an input to strategic planning. This approach has produced several relationship-building strategies, including the STAR recognition program, Mothers Aiding Mothers, Promotores/Promotoras Program, and CCKs.

3.2b(2) AF uses a systematic Complaint Management and Service Recovery Process (Figure 3.2-3). A team of students from SSU's Graduate School of Business completed an action learning project to create this process, based on practices of Baldrige service-sector award recipients and AF's hospitality partner, Winding River Casinos. Starting at orientation, all staff are trained in using the process to resolve complaints from patients, their families, and other stakeholders immediately—to the extent possible. If a complaint cannot be resolved immediately, a clinic leader is notified; he or she contacts the patient or stakeholder within 24 hours to resolve the complaint. A second team of SSU School of Business students later developed additional complaint coding and electronic analytical tools. In 2014, after benchmarking a major defense contractor, AF changed its emphasis to capture all complaints, no matter how trivial, as well as all compliments. Complaints now are ranked by clearly defined type and severity—either 1, 5 or 10—and those with the highest severity are immediately forwarded to Ramon Gonzalez. Repeat complaints are automatically escalated to a higher severity. All complaints are recorded on a short electronic template by the staff person who first hears the complaint and are aggregated by the clinic management team at the relevant site and across all AF facilities. Results are used locally for rapid cycle improvements, as well as rolled up to the AF system for input into the Strategic Planning Process. These results are segmented by severity, site and service type, and stakeholder and cultural group; reviewed monthly by the SWST and executive team; and communicated electronically to staff monthly, along with corrective actions being taken and requests for prevention tips. The top tips are published in the AF newsletter.

Figure 3.2-3: Complaint Management and Service Recovery Process

Step	Actions
L	Listen carefully. Don't interrupt. Get the details
E	Empathize. Feel their pain and tell them you understand.
A	Apologize, even if you feel you have no part in the problem.
R	Resolve. Decide what to do and tell that to the customer.
N	NOW!! Do not delay. Take immediate action.

Improvements and Innovations

Year	Improvement
2016	"Big data" model developed
2015	IT Steering Committee implemented
2014	Knowledge Management Process (KMP) deployed to stakeholders
2013	KMP implemented
2012	Enterprise Portal deployed Enterprise-wide architecture deployed
2011	Cycle time measures added

4.1 Measurement, Analysis, and Improvement of Organizational Performance

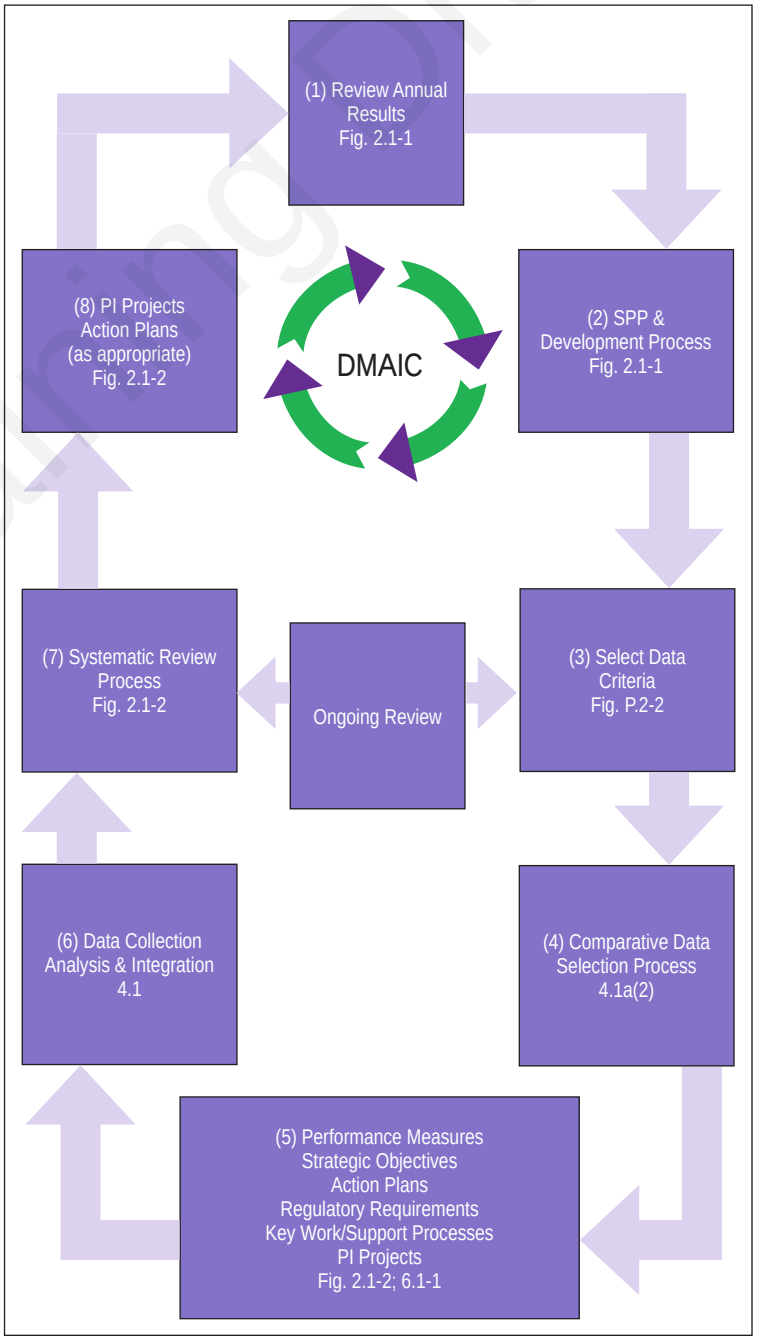
4.1a Performance Measurement

4.1a(1) A key element of AF's measurement, analysis, and improvement of organizational performance is its automated FOCUS scorecard, which uses a commercially available balanced scorecard software application customized to reflect the key measures needed by AF to track daily operations and overall organizational performance. As part of the Strategic Planning Process, a cross-location team (affectionately referred to as the "Data Docs")—representing all the PCTs and functional groups—reviews the performance data from the prior year against AF's VMV and strategic objectives. Roger Sinclair leads the team, which evaluates each measure for its ability to provide timely information, and he helps the team identify any measures required or recommended by a state or national organization; measures include handwashing and other safety measures required by TJC. The cross-functional makeup of the Data Docs ensures that the data collected for the functional groups align with the health care services delivered by the PCTs, and the team's broad representation also results in innovative approaches to measurement. For example, in 2011, some measures associated with Lean were added to track cycle time in several clinical processes, and takt time calculations helped to smooth out appointment scheduling.

The SLT reviews and approves all key organizational performance indicators that will be part of AF's FOCUS scorecard. Each PCT team may add a few customized measures to track performance against the specific services it provides or to reflect the special needs of its patient groups. However, all PCT teams track measures that roll up into system measures, such as performance for congestive heart failure, immunization rates, and preventive health care measures. Figure 2.2-1 lists some of the key organizational performance measures found on the FOCUS scorecard; the default for key measures is monthly, while in-process measures are monitored at least daily. Although not presented in this application due to space limitations, most measures are drilled down into multiple relevant segments, such as age, ethnicity, gender, location, clinical condition, staff category, and PCT team.

4.1a(2) Figure P.2-2 shows the multiple sources of comparative data available to AF, including the highly relevant peer comparisons from the state CHC Benchmarking Consortium. In keeping with its VMV, AF selects the best available comparison from any source to challenge itself to the highest known standard of excellence. These values are included on the FOCUS scorecard (Figure P.2-3). On a quarterly basis, the senior leaders and the leadership teams at each clinic use the comparative data to

Figure 4.1-1: Performance Measurement System



identify gaps in performance and define targets for improvement (see 4.1c[2]). If specific actions for improving the performance are not known, a team will be chartered to identify them using the PIF model. For example, PCTs compared their results for breast cancer screening rates, and high-performing teams shared their approaches to scheduling, patient follow-up, and staff motivation with lower-performing teams to support operational decision making and improve performance organization-wide.

4.1a(3) Senior leaders set the expectation for the use of the voice of the customer (VOC; 3.1a[1]) and market data and information (4.1a[1]), beginning with the Strategic Planning Process (April, May, and July; Figure 2.1-2). VOC data are effectively used by PCTs using the PIF model to improve work processes and to build a more patient-focused culture. Aggregated complaints (3.2b[2]) are reviewed by senior leaders to identify systemic issues across locations and health care service offerings. AF's increased use of social media (1.1b) provides another avenue to communicate with patients and other customers real-time. In addition, the marketing director evaluates trends of topics related to AF found on various social media sites (including those not controlled by AF) for improvement opportunities or enhanced marketing.

4.1a(4) The health care industry is dynamic, and AF's measures and data collection methods must quickly adapt to new trends. For example, with the implementation of the EHR in 2002, data-gathering techniques were rapidly converted to eliminate the need for manual collection of much of the clinical data for the measurement system. In addition, data are integrated into the scorecard automatically, providing a real-time read-out for the workforce, thus improving efficiency and facilitating identification of unfavorable trends or errors. AF works with the State Association of CHCs to re-evaluate measures each year to ensure that operational definitions are updated, and senior leaders stay current with emerging trends through their participation in various associations and health care forums.

Since the Data Docs include both clinical and administrative staff, they can evaluate performance across the breadth of FOCUS measures and recommend changes in multiple dimensions. For example, after reviewing data on infectious diseases, a doctor in La Paz recommended adding a measure for tuberculosis testing for new patients as well as for those who travel frequently to visit families back in Mexico.

4.1b Performance Analysis and Review

Using the FOCUS scorecard posted on the intranet for progress against plan and performance against relevant comparisons, senior leaders review organizational performance monthly. They use a variety of analytical methods to ensure that conclusions are valid. Some of these are listed in Figure 4.1-2, along with some of the reviews they support. Data are presented using statistical process control (SPC), with typical rules applied to indicate when action needs to be taken. Analysis methods include statistical tools such as analysis of variance (ANOVA) and regression analysis. If organizational performance is changing in a statistically significant manner, teams use the PIF model to address the issue. County directors work with managers at each clinic at least monthly to perform a progress scan of the FOCUS scorecard to detect adverse trends before they become major problems. The objectives for various measures, as well as improvement targets, are clearly indicated on the scorecard so that each clinic's managers can quickly assess progress toward goals. In addition, some measures (e.g., diabetes indicators) are plotted on control charts to provide an early indication of adverse trends and to ensure that appropriate intervention is taken. Since PCTs are trained in the interpretation of these charts, they do not overreact to an abrupt but statistically insignificant change. Measures from each PCT are rolled up at the clinic level and aggregated by county and for AF as a whole to assess organizational performance. The FOCUS balanced scorecard software provides the capability to drill down into an aggregated measure simply by clicking on a data point.

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

Approaches	Daily What (who)	Weekly What (who)	Monthly What (who)	Quarterly What (who)	Annual and Biannual What (who)
FOCUS Performance Data	• Daily unit operations assessment (D, F) • Volumes and throughput (C, E) • Staffing (D, C) • Revenues (C, E) • Evidence-based care process (F, D)	• Evidence-based care results (F, D, C, E) • Financial projections (C, E) • Patient experience (D, C, E) • Performance metrics (D, C) • Staffing (E)	Weekly data *plus*: • Financial results (C, E, D) • Turnover (C, E, D) • Composite quality metrics (C, E, D)	Monthly data *plus*: • Charity care (E, B) • Safety and risk metrics (C, E, D) • Patient experience (F, D, C, E, B)	Monthly data *plus*: • Environmental scan (E) • Market share comparison (C, E) • Employee engagement (F, D, C, E, B) • Physician engagement (C, E, B, D)
Analysis	• Variances • Trending	• Variances • Trending • Benchmarks	• Comparison to budget, prior periods, and benchmarks • Trending • Action plan evaluation	• Comparison to budget, prior periods, and benchmarks • Trending • Action plan evaluation	• Gap analysis
Decisions Made/Use	• Operational business development • Service recovery • Safety/regulatory	• Process improvement actions • Action planning (e.g., staffing)	• Resource allocation • Modified action plans • Recognition	• Modified action plans • Evaluation of growth strategies • Recognition	• Strategic Planning Process • Modified action plans • Recognition

F = Frontline staff, D = Directors, C = Clinic Leadership, E = SLT, B = Board

Senior leaders also use these reviews to rapidly respond to changing organizational needs and challenges in AF's operating environment through the early detection of significant trends. For example, when the organization detected an increasing incidence of diabetes leading to CKD, it determined the need to add a dialysis partner to its work systems.

The Board of Directors reviews AF's performance and its progress against the strategic objectives and action plans on a quarterly basis. Minutes of these reviews are posted on the Internet and intranet to promote transparency.

4.1c Performance Improvement

4.1c(1) Senior leaders use performance review findings and key comparative and competitive data to project future performance based on an extrapolation of historic trends—unless they can identify an anticipated action or change in circumstances that will result in a discontinuous change. Any differences in these projections and those originally projected (see Figure 2.1-2) are identified, discussed, and reconciled. Any results at an optimal minimum or maximum performance are reviewed by the data owner to ensure that the performance is maintained.

4.1c(2) Opportunities for breakthrough improvement or strategic advantage are identified and transferred through a comprehensive set of mechanisms, as described in 4.2a(1). These opportunities are then formally evaluated, validated, aligned with the strategic plan, and operationally prioritized by the senior leaders. The applicable group then assigns responsibility for newly deployed initiatives to an identified process owner (or project team). The goals are cascaded down to the appropriate level of the organization, and goal performance is monitored through AF's Performance Measurement System.

AF deploys potential opportunities for innovation and/or improvement to suppliers, collaborators, and partners when they are involved in the processes under consideration or when their core competencies can be leveraged to increase the likelihood of success.

4.2 Information and Knowledge Management

4.2a Data and Information

4.2a(1) AF verifies and ensures the quality of organizational data and information using the approaches shown in Figure 4.2-1, through a robust infrastructure maintained by DDS. With AF working in collaboration with data owners, requirements have been established and fully deployed to the appropriate functions. All data entered into the IT system go through a series of management reviews and/or rigorous checks to verify them for accuracy. Data are collected and transferred among various systems, employing industry standard interfaces to improve transfer reliability and accuracy. The EHR provides timely, secure, accurate data and information to staff through an Internet connection (6.2b). Established procedures and guidelines are reviewed to protect information and ensure its integrity.

In addition, the members of the Medical Records Process Team are trained, like all support service staff, on the most effective way to enter and file data. They then perform quality checks on the data they have entered, and each day they review a sample of other team members' work. These reviews are tracked, and any identified errors are corrected by the responsible staff member. Further, a cross-location team (known as the "Info Interns") reviews information system needs at least annually with DDS and requests upgrades, as needed, in computer hardware and software.

Figure 4.2-1: Data and Information Properties

Properties	Management Approaches
Accuracy/Validity	• Data audits/reviews • Financial reconciliation • Software/hardware/operating system updates • Standardization of codes • Integration among electronic systems • Standardized data entry and reporting templates
Integrity	• Systems audits by DDS and Quality Resources • Systems integration • Automation and error-detection/avoidance • Virus intrusion software
Reliability	• Database backup systems • System and network redundancies • Environmentally controlled facilities • Disaster recovery planning/downtime processes • Generator back-up/uninterrupted power supplies • Downtime recovery plans and processes • Workstation replacement every three years
Currency	• Scheduled software/hardware updates • Annual assessment of network infrastructure • Meetings with hardware/software vendors • Real-time data transfer • Monthly data review/reporting

4.2a(2) AF makes data and information available to all stakeholders through a wide range of electronic, written, and in-person methods, depending on the type of information, intended use, and the user's preferred method of receipt (Figure 4.2-2). For AF's workforce, much information is available electronically through the EHR, providing timely, easy access from anywhere. Other tools like the intranet site provide readily available information.

General IT needs are identified during the annual Strategic Planning Process, in which a rolling three-year IT strategy is developed that aligns with the overall strategic plan. Daily needs for data and information systems are identified by PCTs and functional departments. End-users participate in system selection, design, and pilot testing of new systems and applications to ensure effectiveness and user-friendliness. DDS conducts an annual hardware inventory and defined review/refresh cycle to ensure that hardware and software are reliable and meet all rigorous security requirements while retaining a user-friendly structure. In 2012, AF replaced several nonintegrated systems with a single enterprise-wide architecture. Feedback from staff also is reviewed monthly by DDS for continued improvement, and "super-users" are designated to assist staff with real-time education and support.

Patients can print electronic health information for education and continued-care instructions. In addition to direct communication with their health care providers, patients can obtain

Figure 4.2-2: Data and Information Availability

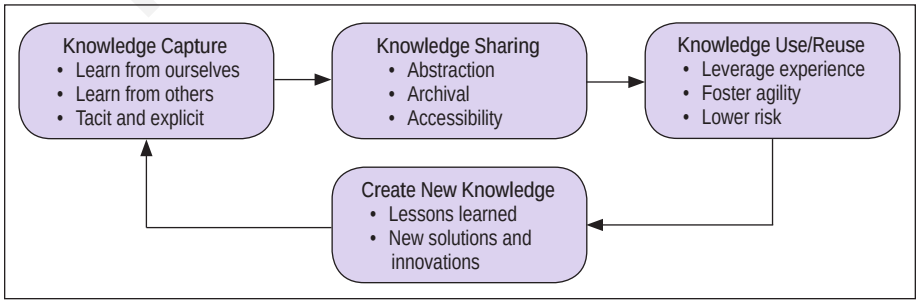
Users	Access and Information Type
Patients	• Direct mailings • Rounding • Internet • Patient Portal for personal health information, statements/ payments, medical record, appointment scheduling • Email • Phone • Radio/TV
Community	• Internet • Physicians and services • Wellness management classes • Addiction, chronic disease management • Exercise, diet, and nutritional information • Medical self-help • Community partnerships • Community classes
Staff and Volunteers	• Internet • Daily Huddles • Communications boards • Email, newsletters, signage • Satisfaction surveys • EHR • Meetings • Policies and procedures
Partners/ Vendors/ Collaborators	• Meetings • Contracts and agreements • Project teams • KMP databases • KIC

needed information through the AF website and its Patient Portal, which allows them to request appointments online, send and receive messages from their caregivers, receive preventive care reminders, request prescription renewals, and find healthy community activities. Patients and community members also have access to various forums such as classes and community events, and they can obtain additional information through AF's partners.

4.2b Organizational Knowledge

4.2b(1) Like many organizations, AF is facing a transition as many of its more experienced employees are retiring and a younger, less-experienced cohort is taking their place. In 2011, AF began a formal "knowledge transfer" process, focusing at first on tacit (i.e., uncodified) knowledge. In 2013, this was expanded to the fully deployed KMP, which allows AF to systematically collect, transfer, and use its organizational knowledge throughout the organization (Figure 4.2-3). In 2014, AF extended use of the process to include knowledge from key suppliers, partners, and collaborators and, through virtual private network (VPN) connections, allow them access to some content.

Figure 4.2-3: Knowledge Management Process



To ensure the effective availability and transfer of explicit knowledge, all employees have access to all IT systems and tools, within the bounds of patient privacy and confidentiality. All data and information are available online (explicit knowledge), as well as through interactions such as face-to-face meetings (tacit knowledge). Data sharing via electronic collaboration is supported with a range of services including email systems, shared servers, and a variety of electronic tools. All desktop computers provide Internet access in a user-friendly environment.

Since AF won the Baldrige Award in 2009, it has had many opportunities both to share its knowledge and approaches with others, as well as to learn from them. All of these best practices, along with those from across the company, are documented in a database with easy access via a web page. AF provides numerous opportunities for tacit knowledge sharing, including innovative "storytelling" sessions, where employees or guest speakers talk about topics of interest to the staff. One of AF's most effective approaches for knowledge management is Communities of Practice (CoPs), a blended approach that combines tacit and explicit methods to allow peer groups to interact and support each other in areas of common work and interests. Another blended approach is the use of the Knowledge and Innovation Center (KIC) at SSU, which is used by AF staff, as well as by suppliers, partners, and collaborators, to share knowledge while pursuing innovative projects.

The KMP provides a structure to blend and correlate data to build new knowledge for managing "big data" collection, analysis, and use in daily operations, as well as in strategic planning and identifying opportunities for innovation. In 2016, the AF Foundation funded a grant for graduate students at SSU to develop statistical models to extract data from AF's internal databases and integrate them with external data and information from the State Association of CHCs and regional health care partners. This effort is now being used to capitalize and build upon AF's core competency (CC) 2 to improve understanding of emerging community health issues.

AF transfers relevant knowledge to and from stakeholders through both explicit and tacit approaches. In 2012, AF deployed the new Enterprise Portal to enhance the user-friendliness of the intranet. Many of the tools and technologies housed there are extended to AF's customers, suppliers, and partners via the internet. Performance reviews with suppliers, who often attend, aid in transferring information. AF's various approaches for managing organizational knowledge are summarized in Figure 4.2-4.

Figure 4.2-4: Knowledge Management Approaches

Collect and transfer workforce knowledge	*Tacit Approaches:* • Rounding • Training/cross-training/required annual education • Storytelling sessions • Orientation • Department and leadership meetings • Huddles *Explicit Approaches:* • Satisfaction surveys • Policies and procedures • Best practices database • Benchmarking database • Improvement project library database • Shared data directories • SharePoint e-rooms • Communication boards • Intranet • Newsletters and bulletin boards • EHR *Blended Approaches:* • CoPs • Performance reviews • KIC
Blend and correlate data	• Strategic planning SWOT analysis • Board of Directors reports • Gainsharing Dashboard (Figure 7.3-9) • Clinic performance comparisons • National benchmarking comparisons
Transfer knowledge to/from stakeholders	*Patient/Family Knowledge:* • Internet/Patient Portal • Satisfaction surveys • Rounding • Complaint Management and Service Recovery Process *Community Knowledge:* • Publicly published data • Health fairs • Educational seminars *Supplier/Partner/Collaborator Knowledge:* • Contracts, reviews, and performance evaluations • Email/phone updates • Vendor orientation
Share and implement best practices	• Storytelling sessions • Leadership meetings • Recognition approaches • Daily Huddles • CoPs • Best practices database • Benchmarking database
Transfer knowledge for use in innovation and strategic planning	• Board of Directors reports and meetings • KMP • Best practices database • Benchmarking database • CoPs • Market research • KIC

The KMP allows AF to assemble and transfer relevant knowledge for innovation and strategic planning. AF captures, shares, and reuses lessons learned and other knowledge that are stored in multiple databases. This information is reviewed by senior leaders during the Strategic Planning Process (Figure 2.1-1) to ensure that planning incorporates this organizational knowledge.

4.2b(2) Best practices are identified through FOCUS scorecard reviews, as well as through additional CoPs (4.2b[1]). Best practices are also identified through discussions at staff department meetings, medical staff department meetings, and quarterly leadership meetings, as well as via other written internal communication tools. Additionally, there is an annual Quality Summit to specifically highlight best practices in the areas of quality, patient safety, patient satisfaction, and financial stewardship. At the conference, poster presentations as well as verbal presentations highlight best practices from staff, physicians, and leadership from across the organization. For example, at the recent conference in March, representatives from the Pharmacy Department gave a presentation on reducing adverse drug events. One specific aspect was improving insulin management by preventing hypoglycemia. By sharing best practices, AF now has multiple clinics following those practices and the remainder in the implementation phase. It is an expectation that when someone attends an external educational event, the person will document the best practices discovered through the knowledge transfer methods shown in Figure 4.2-4.

4.2b(3) Supported by the KMP, AF systematically embeds learning into all aspects of operations. The organization continuously explores how to leverage technology to enhance organizational learning by developing and deploying electronic knowledge sharing tools. Key learnings and best practices are shared among all clinics (4.1c[2]). Organizational learning is embedded in the PIF (Figure P.2-5) through data collection, analysis, process improvement, and cycles of learning and best-practice sharing. Learning is deployed through multiple communication tools (Figure 4.2-4). In patient care areas, huddles foster sharing of job-embedded knowledge. Knowledge also is deployed through the Learning and Development System (5.2b[1]).

Improvements and Innovations

Year	Improvement
2016	• Formal clinic change management plan implemented • "Fair living wage" implemented
2015	• Recruitment bonus for employee referrals • Active shooter procedure fully deployed • Workplace health, safety, and security targets revised
2014	• Team competency requirements enhanced • Skills competencies integrated with HR database • Healthy Living program introduced
2013	• Workforce capacity projections include state data • Mid-year performance interview introduced
2012	• Work to Learn scholarship program expanded to include veterans • Community educator and volunteers included in PCTs • Workforce engagement drivers revised and validated • Promotional checklist implemented

5.1 Workforce Environment

5.1a Workforce Capability and Capacity

5.1a(1) Short- and long-term workforce capability and capacity needs are addressed during the People Review each May as part of the Strategic Planning Process. HR Director Tony Joachin provides input to the Strategic Planning Process on workforce capability and gaps related to strategic objectives, challenges, and anticipated changes in the environment, enabling the organization to address needed skills as part of long-term workforce planning that includes volunteers. Beginning in 2013, plans for capacity growth considered projections based on trends in patient census and acuity for both AF as well as the state. The strategic objectives provide direction to HR as to the organization's capability and capacity needs. These needs, in turn, are translated into short-term action plans for HR and other functions as appropriate.

AF uses a comprehensive approach to identify the characteristics and skills needed by potential staff. As a step in the process for designing jobs, HR staff members work with hiring managers to identify and embed in job descriptions required characteristics and skills in four competency areas: (1) clinical or technical, (2) team, (3) cultural, and (4) customer service. For each competency area, AF has established behavioral characteristics. Clinical or technical competencies are typically defined by licensing or certification requirements or professional standards. Team competencies include characteristics of high-performing PCTs, as documented by researchers at Talkeetna Medical School (an enhancement added in 2014), and characteristics desired by colleagues, as determined by the Oates Group and others. Cultural competencies include language proficiency, empathy, and other skills, as determined by the SSU School of Public Health's Rural Health Office and the state health education center. Service competencies include characteristics associated with attaining high patient satisfaction, such as empathy and listening. Prior to posting and recruiting, HR reviews new job descriptions with members of the People Potential Team (PPT), a cross-location team with clinical and administrative staff representation that serves in an advisory capacity to Tony Joachin.

The current approach began in 2002, when AF adopted the PCT model and recognized the need to revise clinical job descriptions to incorporate new competencies. HR staff, working with the PPT, reviewed all job descriptions to bring existing jobs into alignment. Subsequent benchmarking by the PPT led to several improvements over the years, including integration of the process with the HR database in 2014 to help manage career progression plans. All new job classifications go through this approach before recruitment efforts begin. Competencies in all four areas now are part of the Performance Planning and Evaluation Process, and are embedded in promotional requirements.

5.1a(2) The task of finding and retaining qualified staff for AF includes creating a workforce as diverse as the communities it serves. AF first recruits locally and regionally to reflect the community, including Hispanic and Native American populations, and also because local or regional applicants typically are more likely to be retained. If AF is unsuccessful in this approach, it then recruits nationally. All open positions are posted internally on the intranet to provide career advancement opportunities for current staff members and to tap into their informal professional networks. AF provides a recruitment bonus of $500 to staff members who recommend a new hire. This approach has been very successful, with more than 20 new employees recruited through staff members since it was implemented three years ago. AF also is proud of the fact that there are a number of family members employed at AF, including several multigenerational families, a strong indicator of employee engagement. AF reaches out to potential employees through local papers and specific communities statewide (e.g., the Hispanic American medical community), as well as through the "Career Opportunities" link on the Internet page. HR also notifies career counselors of AF openings for staff and volunteers at service-area high schools and community colleges, as well as notifies key contacts in Talkeetna and SSU health care professional programs.

AF is working today on recruiting the workforce of tomorrow. For the past 14 years, it has run the Work to Learn scholarship program, funded by the AF Foundation and operated in collaboration with community college partners. Work to Learn provides a select group of entry-level employees with foundation scholarships at the time of hire, allowing them to pursue a two-year degree with certification in a clinical skill. Graduates agree to remain employed at AF after certification for a period based on the time spent in training. AF has expanded the program over the years to include other job roles, and in 2012, a special emphasis on recruiting and retaining veterans was included as part of the program. Teen volunteer positions, school-based clinics and related education programs, and organization-wide observance of national Take Your Child to Work Day are additional methods AF uses to introduce children and youth to health care as a potential career. Community educators and

volunteers also recruit young people from the community to be trained as health care workers in cooperation with the State Health Education Center as part of the effort to increase the supply of health care workers in this rural area. To recruit physicians, dentists, pharmacists, and midlevel providers, AF collaborates with education partners and the National Health Service Corps (NHSC), which provides loan forgiveness and scholarships. Clinicians in the AF Ambassador Corps participate in career days and classroom visits at state universities and local community colleges to inform students about careers at AF, including opportunities such as rural health preceptorships in medicine, dentistry, and nursing, and a postgraduate program for family medicine and dental school residents.

Recruitment of volunteers occurs through both formal and informal methods. The "Get Involved" link on the AF Internet site includes instructions on how to apply as a volunteer, as do the CCKs, and staff members distribute "Get Involved" pamphlets when they participate in community service events. But the primary source of volunteers is through word-of-mouth recommendations from staff or current volunteers.

As part of the hiring process, a panel of staff members and volunteers representing the community conducts scripted, behavioral-based interviews that address the characteristics and skills identified for each position. Volunteers also go through a matching process that begins with a self-assessment of the applicant's skills and interests and includes a group interview.

The first year of employment is critical for developing staff loyalty, and retention at one year is a key performance indicator (see Figure 7.3-2). AF focuses on this critical period—especially the first 90 days—in several ways. New staff members are known as "rising stars." A special symbol on their name tags, similar to the STAR award pin (5.2a[4]), helps with identification so others can welcome them and offer assistance—a practice adapted from a 2008 Baldrige Award recipient. New staff members, as well as newly recruited volunteers, also have a "job buddy," typically someone in the same job role, who welcomes them and contacts them weekly during the first 90 days. Staff recruited from outside the service area are welcomed by community guides, volunteers who assist new staff members in learning about and getting settled in the community. To further acclimate new hires, Ramon Gonzalez invites them to a luncheon held each quarter.

5.1a(3) AF fortunately has never had a workforce reduction. In the past, AF has eliminated some roles, mostly due to automation. When this has occurred, AF has absorbed all of the employees involved through retraining and subsequent reassignments, without reduction in salary or benefits. A contingency plan was put in place in 2016 in the event that AF would need to close one or more clinics either temporarily or permanently. The plan includes consideration for reassigning or outplacing the affected staff and reassigning volunteers. AF addresses growth through the capacity and capability planning approaches described in 5.1a(1).

The PCT model has been in use for so long at AF that it is fully integrated into the culture and way of working. This model also helps ensure continuity in the case of departing employees, since team members fill in as needed and can easily assimilate new colleagues into the team. Changes in work systems usually relate to integrating new partners into AF's operations. For example, as AF implements a new partnership with a dialysis provider, it has chartered a cross-organizational team to develop workflow procedures and information links to facilitate seamless operation from the patient's perspective.

5.1a(4) AF capitalizes on its three CCs by establishing interdisciplinary and cross-organizational committees and teams, the PCT model, and a fully integrated volunteer workforce—all of which facilitate the exchange of ideas for planning, designing, managing, and delivering care and making improvements. In 2002, AF pioneered the reorganization of jobs, roles, and responsibilities in health care, establishing PCTs as the service delivery model organization-wide. The PCT model organizes care around patient needs and promotes active, ongoing partnerships between patients and providers, enabling the model to be particularly effective for managing chronic disease and promoting health literacy and self-management skills (CC1 and CC2). A typical family medicine PCT includes a family medicine physician, a physician assistant, a medical assistant, an administrative support staff member, a community educator, and one or more volunteers. The introduction of a community educator and volunteers in 2012 was an innovative refinement to the PCT model. Some staff members, such as the community educator, may participate in more than one PCT. AF now has 23 PCTs, each led by a physician or dentist. To continually improve their services and the outcomes their patients achieve, PCTs develop practice profiles and monitor process performance.

PCTs rely on both "high tech" and "high touch" to accomplish their work, using the process management approach described in 6.1b. They use a variety of tools and technology to gather and use information, including touch pads (implemented in 2015 through a grant from the Melodyann Foundation) with access to patients' PHPs (3.1a[1]), the EHR, and the clinical database. They also rely on close collaboration among team members, who share responsibility for team goals aligned with the FOCUS areas of the Strategic Plan. Daily Huddles help teams anticipate patient and staff needs at the start of the day and review follow-up needs from the previous day. Biweekly, each PCT reviews progress on its scorecard as a team, initiating or monitoring actions to improve, and PCTs meet monthly with their county directors to review progress, priorities, best practices, and lessons learned in the context of the larger organization. Mechanisms to facilitate communication and cooperation among the entire workforce include the AF intranet, with real-time collaborative tools; scorecards with common performance metrics; and online CoPs focused on specific disciplines and projects related to key clinical conditions (see CC2). All of these help employees exceed performance expectations.

Unlike clinical staff members, administrative staff members—those in finance, HR, performance excellence, and development—are organized into small functional groups that provide the enabling infrastructure and services to support clinical operations and drive strategic initiatives. Each PCT has an assigned liaison for each administrative area to promote rapid support and ongoing communication across clinics and

counties, and to facilitate the transfer of best practices. These functional groups collaborate annually in assessing the satisfaction of PCTs with AF support services and use the information to improve.

Volunteers (called promotores or promotoras) are a major component of AF's workforce. Volunteers help integrate clinical expertise with cultural competence (see CC1) and provide insight into access barriers and cultural norms that undermine healthy behaviors. They conduct community education in partnership with clinicians, provide transportation to clinics and screening events, provide child care in waiting rooms, help enroll families in benefits programs, and acclimate new staff members and volunteers. As educators, volunteers are particularly effective with peers. Teen volunteers in the high school-based clinic promote approaches to avoid teen pregnancies, as well as awareness of early prenatal care; former gang members promote nonviolent conflict resolution; and volunteers with chronic disease serve as role models in self-care management sessions led by a physician (see CC2). Through their community networking (see CC3), volunteers help AF reach out to potential patients without an established source of care (e.g., migrant workers, homeless people), and they also promote AF's commitment to developing community health care resources.

5.1b Workforce Climate

5.1b(1) Workplace health, safety, and security targets are shown in Figure 5.1-1. In 2015, the targets were revised to include the entire workforce, including volunteers.

In 2014, recognizing the need to promote healthy lifestyles not just with the patient population but also with the workforce, AF instituted the Healthy Living program. This approach was benchmarked from Pomegranate Health, also a state quality award recipient. Employees who choose to participate in the program receive a membership discount to local health clubs, as well as a reduction in their medical insurance premiums. The program has a strong prevention focus and provides incentives for members to participate in programs that reduce health risks (e.g., smoking cessation, weight loss, cholesterol reduction, and exercise). Enrollment has increased significantly since the program was initiated (Figure 7.3-10).

New Staff and Volunteer Orientation and a mandatory annual refresher course provide education and training on safety basics: safe working procedures, infection control, prevention and reporting of injuries, and ergonomics. Additional safety education and training are available in specific areas. Defensive driving training is required for staff and volunteers providing transportation. Personal security training is required for most staff and volunteers. Each clinic has a security officer during hours of operation, and all facilities are equipped with alarm systems at the front desk that enable staff to notify police immediately in the event of a threat to patients or staff. In cooperation with local law enforcement agencies, an active shooter procedure was implemented in 2015, with training deployed to staff at all clinics and vans. All clinics and mobile vans are fully ADA compliant.

Figure 5.1-1: Workplace Health, Safety, and Security Targets

Measure	Current Target	Results
Lost-Time Injuries	<1 per 100	Figure 7.1-31
Total Temporary Disability Days	<14 per 100	Figure 7.1-31
Sharps Injuries	<1 per 100	Figure 7.1-31
Annual TB Test Compliance	100%	Figure 7.1-31
Security Incidents	<5 per facility	Figure 7.1-31
Van/Auto Insurance Claims	<3 per 100,000 miles	Figure 7.1-31

5.1b(2) AF strives to model the practices needed to create a healthy community. A key component is access to affordable health care, which most staff rate as an important benefit or compensation factor. AF partners with the State Association of CHCs to provide a flexible family benefit package with self-insured medical, dental, and vision programs to all staff working 30 hours or more per week. AF also provides a 403(b) retirement plan for staff members and matches 50% of every dollar they contribute, up to 5% of their salaries. AF provides multiple benefits to encourage staff development (Figure 5.1-2).

Figure 5.1-2: Workforce Benefits and Policies

Area	Benefit Program
Health and Wellness	• Low-cost medical, vision, and dental coverage • Flexible spending accounts • Long-term care and disability insurance • Annual health screenings • Healthy Living program (employees receive reduced health insurance premium rates) • Flu and hepatitis vaccinations • Preventive ergonomics program • Injury, illness, and infection prevention education • Discounted fitness center memberships
Financial	• 403(b) retirement plan with 50% matching • Gainsharing • Financial counseling • Counseling for retirement planning • Financial fund for medical emergencies • Optional accidental death and dismemberment insurance for family members • Complimentary notary services • Scholarships for children of employees • "Fair living wage" policy
Work-Life Balance	• Child care center for infants 6 weeks to 3 years • Flexible job-share work arrangements • Flex time • Discretionary days off • Optional legal planning • Employee Assistance Program • Extended leave for new parents
Professional Development	• Tuition assistance up to $1,000 annually • RN-to-BSN completion bonus of $2,000 • Paid attendance at professional conferences • Educational leave program • Access to professional journals • Internet online learning programs • Paid professional association membership • Computer loan/purchase program
Discounts	• Recreational passes • Wireless calling plans • Pharmacy and prescriptions • Meal tickets for volunteers • Family member fitness club discounts

Volunteers also qualify for education support through grants. In recent surveys, it was determined that while some staff chose not to pursue further education themselves, they were very interested in obtaining educational support for their children. As a result, several scholarships have been established for staff members' children who attend community and state colleges to pursue training in health care professions. Licensed and credentialed staff are offered support for seminars, presentations, and specialty certifications and are strongly encouraged to maintain their involvement in state and regional professional associations. Vacation, flex time, and job sharing enable staff to allocate time to family needs and personal pursuits. In addition to traditional paid holidays, staff enjoy three discretionary days, giving them time off each year for personally meaningful observances. In 2016, AF committed to providing a "fair living wage" to all staff and began adjusting current salary levels for the lowest-paid employees.

5.2 Workforce Engagement

5.2a Workforce Engagement and Performance

5.2a(1) Examples of AF's methods to build a culture of organization-wide, open communication; high performance; employee engagement; and empowerment are shown in Figure 5.2-1.

AF demonstrates its commitment to developing individual staff members and the workforce as a whole, and to adding to the health care resources of its communities through collaborations for health care training with area schools, including SSU, community colleges, and the State Health Education Center. Work to Learn scholarships are available through the AF Foundation to encourage staff and volunteers to pursue professional training programs (e.g., programs for master of nursing [MSN] and RN degrees, and programs for dental assistants, pharmacy technicians, and radiology technicians). AF also has secured other sources of educational funding, and provides flexible hours, job-sharing, and tuition assistance programs to support professional development (5.2b[3]).

Two initiatives have had a powerful impact on motivating staff to reach their full potential—implementing the PCT model and providing opportunities for professional development (5.2b). The PCT model emphasizes team performance and the contribution each team member makes to common goals. Organizing staff into PCTs breaks down hierarchical relationships and encourages collaboration, development, and mentoring. PCTs promote cross-specialty communication through Daily Huddles and biweekly scorecard reviews. Electronic tools such as the intranet, social media postings, and email promote cross-organizational communication through the posting of scorecards and improvement stories. Collaborative work tools are used by informal groups such as CoPs, in which PCTs with expertise in managing one or more chronic conditions help others improve (4.2a[1]). Regular, planned staff rotations facilitate knowledge transfer across PCTs.

Figure 5.2-1: Key Culture-Building Approaches

Method	Purpose	Frequency
Daily Huddles	C, H, E	Daily
PCTs, committees, work groups	C, H, E	Varying
Online learning modules	H, E	As required
Email and social media	C, E	Ongoing
Workshops	H, E	As scheduled
Town Hall Meetings	C, E	Quarterly
Collaborative tools	C, H, E	Ongoing
CoPs	C, H, E	Ongoing
Staff rotations	C, H	As scheduled
Liaisons	C, H, E	Ongoing

C = communication/collaboration, H = high performance, E = engagement and empowerment

5.2a(2) In 1999, seeking more effective ways to attract and retain staff, senior leaders attended a national conference focused on how to become the employer of choice in a given market, based on research by the Oates Group. They learned that an organization that attains high performance on specific, identified dimensions of employee satisfaction improves its employee recruitment and retention. The dimensions identified by the Oates Group as representative of an "employer of choice" were reviewed and approved by staff and volunteers, and these dimensions form the basis for AF's annual Oates Staff Satisfaction Survey. The dimensions are reviewed as part of the annual Strategic Planning Process. In 2012, using this process and updated research from Oates, AF reviewed and validated the new engagement drivers with the workforce, and determined that there were slight differences between those for millennials compared to others (Figure P.1-6). These dimensions have been the basis for the survey since 2013.

5.2a(3) AF conducts an annual Oates Staff Satisfaction Survey, an online 23-item survey that addresses the defined employer of choice dimensions (Figure P.1-6). The survey results are segmented by location and employees' roles, tenure, and work status (full-, part-time). A shorter version is used for volunteers (virtually identical, but without questions on compensation) and is administered either online or by phone in English and Spanish, since many volunteers do not have computer access. At their quarterly meetings, Tony Joachin and the PPT review results related to staff well-being and satisfaction from across the organization. To help prioritize needed improvements, the overall and segmented staff well-being and satisfaction results are reviewed against AF's turnover, absenteeism, grievances, safety, and productivity, and patient satisfaction is compared with published state rates. Results at the PCT, functional group, and clinic/mobile van levels are reviewed and compared to identify team and site priorities for improvement. In addition, a senior administrator at each clinic conducts monthly breakfast meetings with 10 to 12 staff and volunteers to get interim feedback on issues and proposed actions. Tony Joachin presents these analyses and recommendations to the SLT. Results and action plans are also shared with staff and volunteers on the intranet, in the newsletter, and at quarterly meetings; they serve as important input to the Strategic Planning Process.

5.2a(4) The Strategic Planning Process results in the development of strategic objectives, goals, and targets that are organized

into scorecards using the FOCUS framework (4.1a[1]), and AF's Staff Performance Planning and Feedback Process is linked to strategic planning. Staff members meet twice yearly with their supervisors (PCT members meet with the PCT leader). One meeting is to review progress on goals for the prior year and set priorities for the next, including the staff member's IDP. The personal goals and IDP align with and derive from the strategic plan and relevant action plans and include a focus on patients and service to other customers, both internal and external. A midyear session (added in 2013) enables staff members and their supervisors to review progress to date, remove barriers, make adjustments, and focus on career development. In addition, community educators meet biannually with their assigned volunteers to exchange feedback on the volunteers' current activities and to develop future plans.

Figure 5.2-2: Recognition and Reward Approaches

Approach	Administrative Staff	Nurses	Physicians	Volunteers	Frequency
STAR	☑	☑	☑	☑	Ongoing
SUPERSTAR	☑	☑	☑	☑	Monthly
Gainsharing	☑	☑	☑		Annual
Service Awards	☑	☑	☑	☑	Annual
Leadership Award	☑	☑	☑	☑	Monthly
Living Our Values Award	☑	☑	☑	☑	Monthly
Volunteer Luncheon				☑	Annual
Nurses' Week		☑			Annual
Patient Kudos Award	☑	☑	☑	☑	Ongoing
Thank You Notes	☑	☑	☑	☑	Ongoing

STAR is AF's principal recognition program. Any staff member or volunteer may recognize another—as an individual or as a team—for exceptional performance in clinical or technical quality, patient or community service or satisfaction, productivity, or cost savings. STAR nominations must include a brief description of the recipient's accomplishment and its relationship to AF's VMV. Recognition includes a letter of appreciation from AF's leadership, a food gift for the recipient's work group, and a small STAR pin. From among the STARs named at each facility each month, leaders select a SUPERSTAR whose picture is posted in the facility. STAR stories are told on bulletin boards, through emails and newsletters to the community, and at quarterly AF Town Hall Meetings held in each county. STAR complements the informal recognition methods used by AF's senior leaders (1.1b). Senior leaders use STAR to personally cite employees who contribute to innovation and take intelligent risks to improve operational performance and patient focus. AF also has a formal gainsharing plan, with payouts tied to achievement of FOCUS goals defined annually during strategic planning. Gainsharing started in 2004 as an incentive program based on achievement of financial targets, and a payout has occurred in each year since (see Figure 7.3-9). The program was redesigned in 2009 to align it with the FOCUS framework and extend benefits to the entire staff. Additional recognition approaches used throughout AF are listed in Figure 5.2-2.

5.2b Workforce and Leader Development

5.2b(1) Staff and volunteer education and training (Figure 5.2-3) are critical to carrying out the mission of AF and achieving its action plans. AF has a workforce development plan (2.2a[4]) that is reviewed and updated annually during the Strategic Planning Process to ensure that staff members have the knowledge and skills required to achieve organizational, team, and individual action plan goals. Inputs include staff performance evaluations, education and training results, and Oates Staff Satisfaction Survey data, as well as organizational needs related to strategic objectives, regulatory and technical requirements, anticipated changes in the work environment, and new opportunities through partnerships. The analyses enable the PPT to capture consistent data about staff members', supervisors', and volunteers' perceptions of education and training needs and preferred delivery approaches; aggregate the data readily; and analyze responses by location, job title, and other relevant factors. These analyses are used to make quarterly adjustments and serve as inputs to annual updates of the education and training plan.

The education and training plan is developed by Tony Joachin in collaboration with the PPT and approved by senior leaders. Each quarter, the PPT aggregates and analyzes staff input on education and training from post-training participant feedback, post-training knowledge and skills test results, the annual Staff Satisfaction Survey, and results of a semiannual survey of staff and supervisors. Community educators use the same survey with volunteers. The PPT reviews and takes action on requests for additional training, as well as unanticipated opportunities, such as workshops available through partners.

As part of their IDPs, all staff members and some specialized volunteers identify education and training that will help them fulfill job requirements, meet FOCUS targets, and pursue personal development goals. For example, all staff take courses on use of the PIF for performance improvement; PCTs pursue customer service training to improve the focus on patients; and volunteers identified by the community educator are trained in raising community awareness about childbirth and prenatal care, as well as how to arrange for government insurance programs, clinic access, and transportation. Some education and training needs remain fairly constant from year to year, such as health and safety requirements for TJC accreditation or continuing medical education credits for clinicians. Other needs change in response to new organizational needs, priorities, and emerging technology.

Monthly Grand Rounds are used to address the particular education/training needs of clinicians and to promote evidence-based and ethical health care. Sponsorship by the SSU Schools of Medicine and Dentistry enables clinicians to receive continuing education credits, and AF encourages attendance by making Grand Rounds available by videoconference at three sites and inviting clinicians from partner hospitals. AF also makes

Figure 5.2-3: Learning and Development Approaches

Focus Area	Sample Approaches	Audience
CCs, strategic challenges, and action plans	• New staff and volunteer orientation (VMV) • Action plan writing • Team training	A, V A A, V
Performance improvement and innovation	• PIF model • PIF tools (Lean, Six Sigma) • Benchmarking basics • Process management • Analytics • Various clinical topics • Continuing medical education • Nursing Leadership Program • Simulation Lab	A, V A A A A C C C L
Ethics and ethical business practices	• Monthly Grand Rounds • Business ethics • Medical ethics • Just Culture • HIPAA/information security • Equal Employment and Opportunity Commission (EEOC) • Patient safety	C A C A, V A, V A A, V
Customer focus	• Patient safety • Service skills (complaint resolution, service expectations, managing "difficult" customers) • Cultural awareness and competency • Managing patient logistics • Packer survey results	A, V A, V A, V C, V L
Leadership development	• Advanced PIF tools (Lean, Six Sigma) • Data analysis • Mentoring • Leading teams and projects • Advanced degree programs • National conference attendance • Just Culture • Simulation Lab	L, C L L L, A L L A C, L

Audience: A = All staff, C = Clinical staff, V = Volunteers, L = Leaders/ Leadership candidates

available through the intranet a variety of online programs that enable clinicians to stay up to date on clinical and research literature, often in conjunction with pre- and post-tests, to get continuing education credits. These programs include information about the use of clinical guidelines, as well as data collection methods and tools, and they serve as an important mechanism to educate new PCT members. All have a community education component suitable for volunteers.

New Staff and Volunteer Orientation begins the workforce's understanding of AF's core competencies, strategic challenges, and action plans by introducing all staff and volunteers to AF's VMV, the history and traditions of the community and cultural competencies, HIPAA and other ethics/compliance responsibilities, safety basics, and PIF. Specific training is required for some roles, such as additional safety training for clinical staff (e.g., medication management, infection control) and defensive driving for volunteers responsible for transportation. AF continues to offer New Staff and Volunteer Orientation as a live group session, reflecting strong feedback from attendees who cited the importance of hearing firsthand from senior leaders about AF's VMV and culture, key communities, and responsibilities.

Because so many volunteers provide child care in waiting areas, offer patient and family transportation, and assist in community education and outreach, all are required to participate in education and training related to child and family development—an online series with a companion study guide on AF's key communities and services. The volunteer coordinator and community educators plan when and where to offer training and track its completion through the intranet. Some interactive group learning occurs through AF's partnerships with SSU and local community colleges, CactusCom, and Winding River Casinos. In addition, some clinical education and training that is focused on knowledge transfer is offered through distance learning arrangements that permit interaction online or by videoconference.

To provide the time necessary to transfer knowledge from departing employees, AF requires two- to four-weeks' notice for voluntary termination. Also, as part of performance planning and feedback, supervisors evaluate the likelihood of an employee departing in the next six months and make plans accordingly. As soon as an imminent departure is known, supervisors meet with the departing employee to ensure that critical knowledge for the job has been documented and to develop a plan for both explicit and tacit knowledge transfer. They also identify which remaining staff members know the most about the job's responsibilities and assignments and therefore can most effectively facilitate the transition to a replacement employee. In addition, AF encourages departing employees to remain during the transition period to provide one-on-one orientation and training to the new employee.

To reinforce their new knowledge and skills, in addition to the job buddy (5.1a[2]), newly trained staff and volunteers are supported with mentoring by peers or managers. In addition, in the "train-the-trainer" approach, a qualified instructor guides the staff member or volunteer through the first one or two sessions to ensure demonstrated proficiency. For clinical or technical training, newly trained staff members often are paired with a highly proficient staff member so they can learn from the "best of the best." Online tests immediately after training and/or at 30, 60, or 90 days, as appropriate, also reinforce the use of new knowledge and skills on the job, and AF tracks completion and results. AF uses this approach to reinforce training on HIPAA requirements and TJC National Patient Safety Goals related to handwashing and "read-back" of orders over the phone.

5.2b(2) Staff education and training effectiveness is measured on an individual and aggregate basis using Kirkpatrick methods (all four levels were implemented in 2016), including pre- and post-tests and demonstrated proficiency. Results are compared with goals set during the development of the education and training plan the preceding year. The PPT segments results by location, job type, and other factors, as appropriate, and also examines organizational results specifically related to training, such as safety and compliance audits and patient satisfaction. Based on this analysis, Tony Joachin and the PPT identify priorities for improvement. Through his participation on the

Education and Training Committee of the State Association of CHCs, he compares AF's education and training plan with those of similar organizations, influences the education/training priorities at the state level, and incorporates these learnings into the May People Review during strategic planning.

5.2b(3) Career progression for staff is managed as part of the Staff Performance Planning and Feedback Process (5.2a[4]), and it receives particular emphasis at the May People Review meeting. To support that discussion, in 2012, AF developed a promotional checklist for every job description that outlines requirements for a higher-level assignment. This supports staff members in their decisions about leveraging education and training opportunities, tuition reimbursement, flexible work arrangements, AF Foundation scholarships, programs such as Work to Learn, and courses offered through the State Association of CHCs and the State Health Education Center. Actions identified for career progression are incorporated into staff members' IDPs. Volunteers also have development paths, created with their community educator, designed to increase their skills and impact on the community. A typical progression for a volunteer might be to move from providing transportation to patients or assisting with clinic operations as a PCT member to providing health education and facilitating community forums, and possibly to board membership.

The Board of Directors and CEO share overall responsibility for succession plans, which are developed or revised annually as part of the strategic planning cycle. Plans for board members are driven by the term of appointment. AF maintains a pool of potential board members, with a transition time ranging from immediate to within two years. Sources for board members include patients, volunteers, community leaders, and members of key partner organizations. Succession plans exist for all senior leaders, all PCT leaders, and key PCT members. For senior leaders, the board requires a minimum of two replacement candidates, with at least one ready to transition within 12 months. Although IDPs are tailored for each individual, most include short assignments to operational areas in which the candidate has no experience and provide an opportunity for him or her to partner with a senior leader in a mentorship, as well as participate in the annual Strategic Planning Process. Leading community involvement efforts is another way to develop potential (1.2c[2]). A similar development plan is used to develop and ensure replacements for key volunteer leaders, such as the coordinator of grant proposals.

Category 6 Operations

Improvements and Innovations

Year	Improvement
2016	• Enhanced the Patient Portal
2015	• New server room • Cybersecurity process implemented
2014	• Expanded use of Lean tools for process improvement and cycle time reduction
2013	• Formalized the Innovation Management System
2012	• Enterprise-wide system consolidation

6.1 Work Processes

6.1a Service and Process Design

6.1a(1) AF determines key health care service and work process requirements through the Strategic Planning Process, which includes a community needs assessment and scan of changing regulatory requirements. Information from the VOC (Figure 3.1-1); research on best practices; and close collaboration with partners, collaborators, and suppliers/vendors also help AF determine key requirements. In addition, AF has determined its key health care process requirements based on a common set of requirements defined by the Institute of Medicine (IOM) in *Crossing the Quality Chasm* (2001) as the six aims: safe, effective, efficient, timely, patient-centered, and equitable. These requirements, or CTQs, are highly interdependent, and all must be addressed to deliver value to the patient and other key stakeholders. For example, an overdue screening mammogram that reveals an advanced tumor is not only untimely but also less effective for the patient—and less efficient for the payor. If the patient fails to have the mammogram on time because of a language barrier, the care is fundamentally inequitable.

Evidence-based medicine promotes safe, effective, efficient, and timely care. The medical director leads the Healing Partners Team (HPT), an interdisciplinary, cross-organization team with PCT representation that keeps abreast of emerging evidence-based clinical practices and their implications for key health care process requirements. The team reviews data and information from the State Association of CHCs, professional association literature, national learning collaboratives, and benchmarking in its quarterly meetings. It makes formal recommendations to senior leaders as part of strategic planning.

To promote patient-centered care, AF uses data and information from its key customer listening posts (Figure 3.1-1) related to the key process requirements of patients and families (see also 4.1a[3] on use of customer data). Inclusion of patients and family members on design teams and review of proposed designs by PFABs (3.2a[2]) are other methods for capturing patient and family input. AF also uses its listening posts to capture community, partner, and payor input, and it collects input from suppliers through regularly scheduled meetings.

Designing equitable care is critical for AF. In determining key process requirements, AF incorporates the Culturally and Linguistically Appropriate Services Standards from the U.S. Department of Health and Human Services Office of Minority Health. These outline 14 requirements (some mandatory for federally funded PCMHs) to promote equal access and reduce

health disparities, including the provision of translation services and educational materials in the patient's language and ongoing staff education and training in the provision of culturally competent care.

6.1a(2) Key work processes and their requirements are shown in Figure 6.1-1. Access processes include scheduling appointments and managing inquiries. Enrollment processes include creating the PHP, establishing eligibility and applying for benefits,

Figure 6.1-1: Key Health Care Processes, Focus Areas, and Measures

Key Processes	Key Focus Areas	Measures	Results
Access		Future capacity	7.1-25
		Third next available appointment	7.1-26
		Office visit cycle time	7.1-27
Assessment, Planning, and Delivery of Care	**Adult Screening, Prevention, and Treatment**		
	Lifestyle Risk Factors	% with BMI >30	7.1-1, 7.1-2
		% screened for smoking	7.1-3
	Behavioral Health	% screened for depression	7.1-4
		% screened for domestic violence	7.1-5
	Cancer	% screened for breast cancer	7.1-6
		% screened for cervical cancer	7.1-7
		% screened for colon cancer	7.1-8
	Communicable Diseases	% of high-risk patients immunized for influenza	7.1-9
		% of high-risk patients immunized for pneumococcus	7.1-10
		% with completed TB treatment	7.1-11
	Chronic Disease		
	Diabetes	% with HbA1c screening	7.1-12
		% with dilated eye exam	AOS
		% with microalbumin screening	AOS
	Asthma	% with appropriate anti-inflammatory medications	7.1-13
		% with current severity assessment	7.1-13
		Average number of symptom-free days in past 2 weeks	7.1-13
	Heart Disease	% of hypertensives with blood pressure in control	7.1-14
		% of hypertensives with cholesterol screening	7.1-14
		% with LDL cholesterol <130	7.1-14
		% with beta blocker 6 months after heart attack	AOS
	Maternal, Infant, and Child Health		
	Pregnancy and Childbirth	Number of low birth-weight babies per 100 births	7.1-15
		Number with prenatal care in first trimester per 100 births	7.1-16
	Pediatric Care—Well Child	% with comprehensive H and P (ages 3–6)	7.1-17
		% with comprehensive H and P (ages 12–21)	7.1-18
		% with appropriate immunizations (ages 3–6)	7.1-19
		% with appropriate immunizations (ages 12–21)	7.1-20
	Pediatric Care—Acute	% with appropriate treatment for upper respiratory infection (URI)	7.1-21
		% tested for pharyngitis	7.1-22
	Dental Services		
		% of adults with dental exam in past year	7.1-23
		% of 8 year olds with sealant present	7.1-24
Information, Education, and Support		% with documented self-management goals	AOS

selecting a primary care provider matched to patient and family preferences, and arranging for the transfer of medical records. Assessment, planning, and delivery of care processes include evaluating the patient (e.g., comprehensive history and physical examination [H and P]) and formulating a plan of care based on evidence-based guidelines and patient preferences. Information, education, and support processes include setting personal health goals, monitoring self-management goals and results, and building knowledge and skills. All of these processes include follow-up procedures, such as reporting test results, managing referrals, coordinating community resources, and assessing and responding to failures to keep appointments.

6.1a(3) AF uses a PDCA model (Figure 6.1-2) to design its key health care processes to meet key requirements. (As a cycle of learning and improvement, AF found "adjust" was more understandable and actionable than "act" for employees.) A design team, which includes patients and, as appropriate, other customers and stakeholders, views the process and desired outcome from the patient's perspective and identifies critical inputs for designing new processes and improving existing processes. To translate that information into process requirements, the team collects and analyzes data related to patient safety; regulatory, accreditation, and payor requirements; and new technology, and it incorporates organizational knowledge and the need for agility into the design of key processes. The team also incorporates critical efficiency and effectiveness factors into the design to help achieve desired health care outcomes, reduced cycle time, high productivity, and operational cost control. The process implementation includes documenting and sharing the process in the *Staff and Volunteer Handbook* and providing training for appropriate staff. The design team also continuously monitors the processes to ensure that the expected performance is being achieved.

6.1b Process Management and Improvement

6.1b(1) AF ensures that the day-to-day operation of work processes meets key process requirements through the Performance Measurement System (Figure 4.1-1) and the ongoing monitoring of key organizational and departmental metrics via the FOCUS scorecard. The performance measures, including in-process (or more appropriate for health care, *predictive* measures) and outcome measures, are shown in Figure 6.1-1. AF views measures related to screening and prevention to be predictive of clinical outcomes. These measures directly relate to the quality of outcomes and the performance of AF's health care services provided to its patient population.

PCTs use both in-process and outcome measures (Figure 6.1-1) developed during the PDCA cycle to assess, control, and improve health care processes. In-process measures enable PCTs to recognize performance gaps earlier and make adjustments more quickly. For example, access to an appointment when wanted, a key driver of patient satisfaction, is measured by tracking patients' satisfaction with their ability to get an appointment (an outcome measure that is reported quarterly) and by appointment lead time (an in-process measure that is tracked and addressed weekly).

Frequent monitoring of both in-process and outcome measures during day-to-day operations enables AF to ensure that health care processes are meeting requirements (including patient safety, regulatory, accreditation, and payor requirements). PCTs measure key health care process performance at both patient and population levels, and they assess and manage individual patient care based on the patient's PHP (e.g., by tracking completion of interventions indicated by guidelines for preventive care). When appropriate, feedback from patients, other customers, and stakeholders is incorporated in the performance review. PCTs

Figure 6.1-2: PDCA Model for Process Design

Plan	1.	View the process and outcome from the patient's perspective. All health care processes are tied to patients and their families. The patient's "voice" is translated into a needs statement.
	2.	Translate patient needs into actionable, measurable requirements that will be used to ensure that the process meets expectations for *safety*, *effectiveness*, *efficiency*, *timeliness*, *patient-centeredness*, and *equity*. These CTQs are the basis for the process flow. Identify any other relevant requirements that must be met (e.g., related to regulations, partners, or suppliers). CTQs are flowed down throughout the process design to ensure that the translated voice of the patient (i.e., VOC) is reflected in process steps and metrics.
	3.	Research the proposed process. External benchmarks and best practices are sought (e.g., from the State Association of CHCs, national learning collaboratives, Baldrige Award recipients), and information is entered in the Knowledge Management System. An FMEA also is completed to identify areas of risk and mitigate them with changes and/or process controls prior to developing the design.
	4.	Flowchart the proposed process. The process is flowcharted to meet requirements and take advantage of best practices, technology, and other innovations. All steps are reviewed to determine whether technology can be used for efficiency. Identify any related support processes that must be created or modified.
	5.	Establish metrics for performance against CTQs (Figure 4.1-1). Metrics generally will include both in-process and outcome measures.
Do	6.	Pilot the process through several cycles.
Check	7.	Evaluate process performance throughout the pilot and formally at the end of the pilot period, getting feedback from patients and their families.
Adjust	8.	Adjust and improve the process as necessary.
	9.	Implement the process and include it in the online *Staff and Volunteer Handbook*. Determine if the measures should be added to the FOCUS scorecard.
	10.	Monitor the process. An ongoing review is conducted by PCTs, clinics, and other delivery mechanisms. Results of the overall review are reported, including ongoing feedback from patients.

aggregate and analyze their performance for their population, looking for trends that point to improvement opportunities or show the impact of changes they are testing. The PCT FOCUS scorecard is the principal framework supporting this review, although the EHR enables the PCT to aggregate and analyze virtually all of its patient-related data to evaluate its own performance and compare it with that of other PCTs.

6.1b(2) Through the PHP, AF is able to address each patient's expectations and preferences and to help patients participate in making decisions about their health care. In collaboration with the primary care provider, every enrolled patient formulates a PHP that incorporates evidence-based recommendations for care (e.g., prenatal care in the first trimester) and individual preferences (e.g., family member or lay healer participation in childbirth). Traditional healing practices and herbal remedies are typical components with cultural origins. In formulating the PHP, the patient and provider discuss health needs, establish realistic priorities and goals with measurable targets, and tailor the plan to patient and family values and expectations. For example, although the aim for optimal diabetes control is HbA1c less than 7.0, the PHP for a diabetes patient dangerously out of control may specify a less aggressive short-term target and include a weight-reduction program with meal plans and recipes geared to the family budget and access to healthy food only during work hours. The PHP is integrated into the EHR and is available to patients in print, through the CCKs, or by AF web-based access. A systematic review of the PHP at each service experience leads to real-time adjustments made by the patient and provider as required. The information system automatically generates provider prompts and patient reminders when specific interventions are due (e.g., each fall, patients 65 and older are reminded when and where to get an influenza vaccine).

Volunteers play an important part in identifying and responding to patient expectations. AF recruits "health coaches" from its volunteer network and trains them to work with patients and provide group support during patient visits. The Mothers Aiding Mothers (MAM) program links mothers and grandmothers with pregnant teenagers and teenage mothers. The MAM health coach will work with a young mother to ensure that she goes to appointments and to answer questions about newborn care. In addition to the MAM program, health coaches are available to help patients who want to quit smoking, families with an asthmatic child, and diabetics.

6.1b(3) Support processes are defined as those necessary to support the delivery of direct care to patients. Key support processes are determined through the Strategic Planning Process as part of the SWOT analysis and during the design of key health care processes. When new services are introduced, a key step in the design process (6.1a[3]) is the identification of support processes needed to ensure that the service can be delivered as designed to meet patients' and other stakeholders' requirements. AF's key support processes, related requirements, and associated measures are identified in Figure 6.1-3 (due to application space limitations, results are AOS). Many support processes are centralized to optimize resources, although some, such as transportation and custodial services, must be delivered on-site.

Process owners (usually the functional managers who have responsibility for a process) manage overall process performance and ensure that they meet key organizational support requirements.

6.1b(4) To improve health care processes, AF uses the integrated improvement methodology described in P.2c, which includes use of the Baldrige framework, PCTs, the OASIS Improvement Model (Figure 6.1-4), and the PDCA approach. The OASIS Improvement Model outlines the steps of the improvement process. In the first step, to identify opportunities for improvement, AF uses a variety of inputs, including the results of systematic health care process measurement and data analysis, as well as information from Daily Huddles and patient

Figure 6.1-3: Key Business and Support Processes

Processes	Requirements	Outcome Metrics	Figures/ Items
Pharmacy Services	• Medications dispensed accurately • Medications dispensed quickly	• Medication accuracy rates • Turnaround time	AOS AOS
Laboratory Services	• Accurate and timely results • Low cost	• Laboratory errors • Return on assets	AOS AOS
Human Resources	• Timely hiring • Effective hiring and onboarding	• Hiring cycle time • Turnover rates	7.3-5 7.3-1, 7.3-2
Medical Record Management	• Accurate and timely records	• Medical records accuracy rate • Caregiver satisfaction	7.1-28 AOS
Information Technology Management (through DDS)	• Always available • Accessible where and when needed	• Unplanned system downtime • Internal customer satisfaction	7.1-29 AOS
Financial Resources Management	• Timely budget development • Accurate and timely invoicing and collection • Accurate and timely accounts payable • Accurate and timely payroll	• Cash on hand • Return on assets • Account Accuracy • Account Accuracy	AOS 7.5-4 AOS AOS

*Space limitation (results AOS)

Figure 6.1-4: OASIS Improvement Model

	Steps	Examples of Tools and Resources
O	Opportunity identification	Gap analysis, brainstorming, benchmarking, audit and assessment reports, feedback from listening and learning methods
A	Assess or analyze	Process mapping, root cause analysis, FMEA, quality functional development, statistical analyses
S	Set targets and time lines	Gantt charts, action plans
I	Improve	Design of Experiments (DOE), process re-engineering, poka-yoke, 5S
S	Share and sustain	Knowledge management, online collaborative tools, control charts, AARs

walk-throughs. In addition, at least quarterly, the HPT selects a key patient group for focus (e.g., hypertensives, asthmatics, or Spanish-speaking seniors), and an HPT member accompanies a patient through the process of care, evaluating AF's key health care processes in real time "through the patient's eyes" by tracking wait times, observing staff-patient interactions, and exploring the care experience with the patient and family members. Results are shared with the appropriate PCT and reviewed in aggregate to uncover patterns across PCTs that represent opportunities for improvement.

Once a PCT identifies an opportunity for improvement, it performs root cause and other analyses, sets targets and time lines, and implements the improvement using the PDCA model (Figure 6.1-2). Pilot results and learning are used to refine the change prior to full deployment. To communicate and share improvements organization-wide, AF posts improvement results and learnings on the intranet. In addition, PCTs perform proactive internal benchmarking, and improvements are shared at quarterly all-staff meetings. The HPT systematically reviews posted improvements to identify opportunities for organization-wide change and helps design their deployment. Firsthand observation at the pilot site and staff rotations also help deploy changes to other PCTs. Although many improvements come from inside, AF also learns and improves by benchmarking against recipients of the Baldrige and Saguaro State Awards for Performance Excellence, by participating in state and national learning collaboratives with other CHCs, and through the HPT's continual and proactive scanning of health industry literature to identify new requirements and ways to meet them.

Through this process, AF has implemented numerous improvements that have led to better performance, reduced variability, and improved health care, as well as kept AF's services current. For example, in 2009, walk-throughs helped identify the inefficiency of providing chronic disease information and education to patients individually and led to the group appointment option for patients with hypertension, diabetes, and chronic respiratory disease. Available today at every site, this option enables staff to deliver education and follow-up interventions in a more efficient group setting, while providing patients with interaction and group support. In 2010, one PCT at a Daily Huddle mentioned having difficulty serving the large number of children who needed vision and hearing screenings before school started. Today, by renting additional equipment in August, staff at five sites can meet the increased demand for school physicals with no decrease in access or efficiency.

6.1c Supply Chain Management

AF has three types of suppliers: strategic partners, vendor partners, and suppliers. Strategic partners are integral to operations, and the services they provide are critical to AF's mission and strategy. They participate with AF in planning and are expected to assume all responsibility for the services they provide. DDS is a strategic partner with responsibility for the Information Technology Management Process. Vendor partners are organizations that have proven themselves over time. They are treated as partners and are aligned with the values of AF, but the services they provide are not mission-critical. Shiny Clean; HR Leaders, Inc.; and Gil's Garage are vendor partners with long-term contracts. Several support processes are executed entirely by strategic and vendor partners so that AF staff can focus on the delivery of care. Other goods and services are contracted for shorter terms and based on best overall value from suppliers. AF also participates in the State Association of CHCs' purchasing consortium, MedProducts, Inc. The consortium offers competitive pricing on medications, medical supplies, and laboratory services through its combined purchasing power.

6.1d Innovation Management

When AF determines that incremental change is not sufficient to meet targets or achieve benchmark performance, or AF decides to pursue a strategic opportunity that is determined to be an intelligent risk, the organization implements its Innovation Management Process (Figure 6.1-5).

Figure 6.1-5: Innovation Management Process

Inspection	1.	Identify unnecessary process variability or opportunity for strategic advantage.
Governance	2.	Align the opportunity/threat with strategy, assess the potential risk/reward of addressing it, evaluate organizational change readiness, and then operationally prioritize it.
Implementation	3.	Identify necessary resources to address the opportunity/threat.
	4.	Build the team with internal and external stakeholders.
	5.	Perform a needs assessment to more clearly define the problem.
	6.	Rapidly drive improvement (via DMAIC/PDCA) and identify potential countermeasure(s).
	7.	Evaluate potential countermeasures for effectiveness/return on investment (ROI), design pilot intervention (leveraging intelligent risk), and confirm its effectiveness (validating with data) to ensure improvement effectiveness. Potentially establish new evidence-based practice.
	8.	Develop system-wide deployment based on successful pilot (and reward/recognize successful deployment).
	9.	Hardwire the new process (and reward/recognize successful compliance with the new process) and continue to monitor performance.

These newly adopted innovations or improved processes are constantly monitored over time for performance against requirements or to detect changing customer needs. When determined to be no longer viable or capable of effectively meeting customer or organizational requirements, these innovations or processes are discontinued, and the cycle to establish a more capable process or innovation is once again initiated. As needed, the pursuit of current strategic opportunities is abandoned in favor of those providing greater ROI or those that might better address a strategic challenge.

6.2 Operational Effectiveness

6.2a Process Efficiency and Effectiveness

AF incorporates cycle time, productivity, and other efficiency and effectiveness factors as part of the work process design described in 6.1a(2). PCTs use multiple strategies to prevent errors and reduce rework, including standardization, automation, and the use of PDCA and small tests of change. Where evidence-based guidelines exist or best practices are widely accepted, the HPT develops organization-wide care guidelines, which ensure that patients receive necessary interventions—but only those required for the best outcomes. PCTs also standardize roles and responsibilities, distributing responsibilities so that all team members perform to their full potential, while preventing gaps and redundancy. Medical assistants ensure that patients get all appropriate screening tests in a timely fashion by reviewing the PHP for each scheduled patient. IT supports error prevention and waste reduction. For example, electronic transmission of prescriptions to AF's on-site pharmacies eliminates the potential errors associated with handwritten prescriptions, the most common medication management issue in ambulatory care. It also increases the number of patients who receive medication education from AF's own pharmacists, addressing a second common problem: patients' misunderstanding of how to use prescribed medication. The EHR provides electronic reminders and alerts (e.g., when an HbA1c test is due or a lab value is dangerous), promoting timely action by providers. Technology helps manage individual patient's care and also supports analysis of trends for the population served by the PCT. In addition, frequent communication through Daily Huddles helps teams avoid errors and rework and spot recurring issues that may be opportunities for improvement.

As part of its "no-blame" environment, AF has an anonymous reporting mechanism linked to a system that tracks corrective actions and aggregates and analyzes data for organizational learning. The system tracks both errors that resulted in injury and those that did not (i.e., near misses). For convenience, staff can report errors through several methods: electronically (via the intranet), on paper, or by voice message on the error reporting hotline. AF's focus is on learning from errors so that similar situations can be prevented in the future. Root cause analyses are conducted of all errors that led to patient, staff, or volunteer harm, and related FMEAs are updated. AF proactively conducts an FMEA to prevent errors in high-risk processes. For example, critical test results require timely, reliable communication to avoid serious adverse outcomes for patients. In 2010, AF adopted the following best practices: communicate the result directly to the responsible provider, who can take action; require acknowledgment of the receipt of critical test results; have a back-up system with clear delineation of when to escalate; use central call systems to coordinate call schedules; agree on which tests are categorized as "critical"; and use the same policy across settings. Other approaches to prevent errors and rework include a focus on TJC patient safety goals (e.g., emphasizing handwashing to decrease patient and staff infections) or, in some processes, Lean techniques such as the 5S or poka-yoke.

As a member of the purchasing consortium, AF works with MedProducts, Inc., to establish clear quality, delivery, and cost requirements. This keeps overall costs down and places the burden of inspection on suppliers. The cost of audits and inspections also is minimized by training staff to perform work as documented in the procedures in the online *Staff and Volunteer Handbook*. Checking for accuracy is an embedded step in the work of every staff member in a business or support process. In addition, teams perform their own quality checks. For example, the Medical Records Management Process is critical for providing correct and safe care to patients. Errors made in medical records could have significant negative effects on patients, caregivers, and AF's costs. The "no-blame" environment makes this possible, as staff members are recognized for identifying errors that could create significant downstream problems. Any systemic issues are addressed by assigning a project team to investigate, determine, and implement an effective solution. Since making routine reviews part of the daily tasks in 2003, AF has decreased errors and rework (results AOS).

AF minimizes costs associated with audits by maintaining an audit-ready state at all times. For example, when AF earned TJC accreditation, no special preparation was needed because maintaining an audit-ready state was incorporated into the organization's routine practices. This audit-ready state is maintained by consistently following the procedures documented in the online *Staff and Volunteer Handbook*. Process owners periodically audit the processes for which they are responsible, and the Internal Audit Team may conduct unannounced audits in any area.

Support processes in particular are targeted for cost reductions each year so more resources can be applied to direct patient care. Employees are more than willing to participate in these efforts, since part of the savings is passed on to them through AF's gainsharing program (5.2a[4]).

Fundraising, particularly from large grants and major gifts, is an integral part of the resource strategy. The Development Department is involved in strategic planning and charged each year with raising more funds from such sources as public and private grants, major gifts, and fundraisers. The department stays abreast of the missions of federal, state, and local sources, as well as private foundations, to seek funding for specific purposes. It leverages its resources by focusing on high-dollar, high-impact grants and gifts. For example, AF received a grant from the foundation of a leading computer chip manufacturer for more than $1 million to fund satellite installation, home installation of a number of computers for disease management, and videoconferencing. The mobile vans were funded in part by a federal grant matched by a private foundation, and AF collaborated with a regional hospital on a grant to train volunteers

and provide stipends for them to go to homes and community centers to teach families with young children about healthy living, effective parenting, and environmental issues. This grant was funded by a large private foundation with a global mission to enhance childhood health.

6.2b Management of Information Systems

6.2b(1) To ensure reliability and security, AF and DDS standardize and integrate hardware, software, and clinical devices across the organization. DDS conducts an annual hardware inventory and maintains a defined review/refresh cycle to ensure that hardware and software are reliable and meet all rigorous security requirements while retaining a user-friendly structure. The consolidation in 2012 to a single, integrated enterprise-wide system architecture has greatly improved system reliability (see Figure 7.1-29). AF's various approaches for ensuring reliability in its hardware and software systems are summarized in Figure 6.2-1.

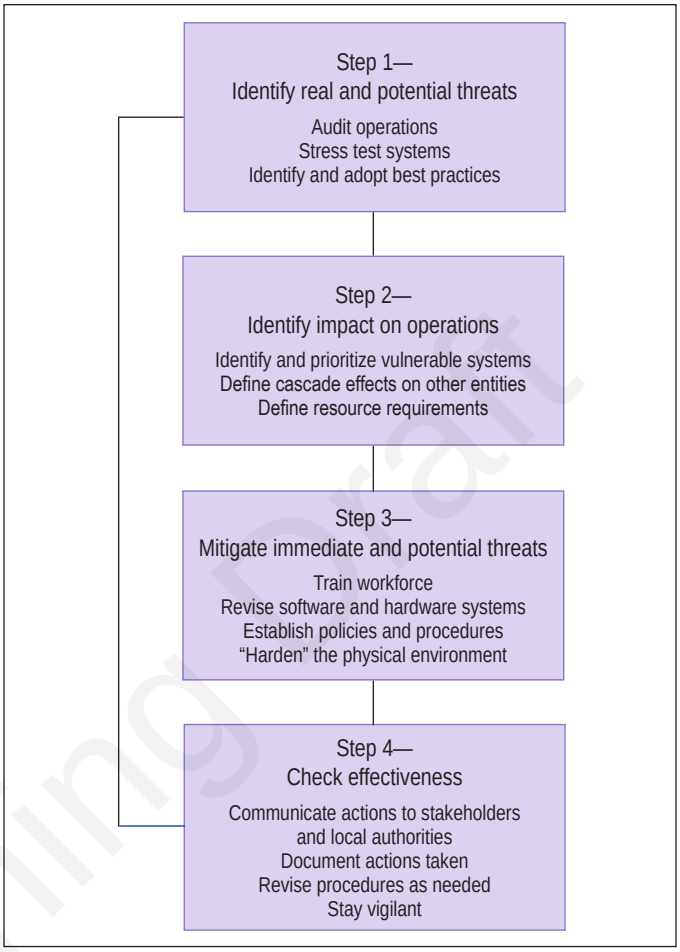
The Emergency Operations Plan (EOP; 6.2c[2]) ensures that hardware and software systems, data, and information continue to be secure and available during an emergency. A defined procedure for downtime periods has been fully deployed. New downtime software was installed on local workstations in 2015; the software provides pertinent patient information to clinicians. Continuous availability of data is ensured through on-site generators securing critical systems and processes. The new server room, installed in 2015, includes a chemical fire suppression system, redundant air conditioning units, and water shields over hardware. Backups are stored in a secure off-site location in Phoenix, and a full system restore can be achieved in under four hours.

6.2b(2) Recognizing the growing threat of security breaches, in 2015, a team from AF and DDS benchmarked several defense contractors, including a Baldrige Award recipient, to learn their approaches. The information from these meetings helped AF identify and prioritize systems in need of the highest levels of security—and how to protect them. The result is the Cybersecurity Process (Figure 6.2-2). One key learning was that security breaches come from two sources: (1) external, either mischievous (amateur hackers) or malicious (professional data theft); and (2) internal, either curious (HIPAA or personnel file "peeping") or careless (lax password management) in nature. Therefore, AF's process addresses both sources.

Figure 6.2-1: Approaches to Ensure Hardware/Software Reliability

Hardware	Software
• Redundant backup servers	• Routine auto-updates
• Mainframe database backup systems	• Automatic backups
• Environmentally controlled facilities	• Monthly scheduled downtime
• Disaster recovery planning/ downtime processes	• DDS help desk (24/7 availability)
• Generator back-up/uninterrupted power supplies	• Pilot testing before installations
• Three-year replacement cycle	• Standardized software suite

Figure 6.2-2: AF's Cybersecurity Process



To protect from cybersecurity attacks, AF has a risk-based enterprise security program and a defense-in-depth strategy that includes a layered approach of encryption and authentication. External consultants are used in assessing vulnerabilities and monitoring the environment through periodic audits, in providing guidance on reducing risk, and as a resource to improve security awareness.

All workforce members, including volunteers, who have system access must annually review security and confidentiality policies, using training modules that follow HIPAA guidelines. Forced password changes occur every 90 days, with lock-out occurring if the user has not changed the password or taken the required training. Additional methods used to protect data and information security are shown in Figure 6.2-3. IT facilities are monitored by security cameras and include badge entry for secure personnel.

Steps 2 and 3 in the Cybersecurity Process define AF's approach to detect, address, and recover from security breaches. AF produces daily security reports to track unauthorized access or attempts to access electronic records. DDS takes immediate corrective action. In the event of a privacy breach—a potential termination offense—Jay Nguyen conducts an investigation and develops a corrective action plan. A privacy hotline is available for anonymous reporting of breaches. AF also shares learning from its process and experience with local law enforcement

authorities, as well as with suppliers, the State Association of CHCs, and health care partners so they can apply these practices to protect their own systems.

While AF's current cybersecurity efforts have been deemed adequate in assessments done by an external security expert, AF recognized the need for continual improvement in this rapidly moving environment. To further enhance AF's cybersecurity, in late 2016, using the framework of Presidential Policy Directive/PPD-41, AF and DDS began to develop an even greater comprehensive strategy that addresses cyber threats and asset responses, threat awareness, and management/mitigation of incidents. In May 2017, AF will partner with the National Institute of Standards and Technology (NIST) to perform a pilot assessment on its Cybersecurity Process, using the Baldrige framework.

6.2c Safety and Emergency Preparedness

6.2c(1) Providing a safe operating environment is systematically addressed as part of the EOP (6.2c[2]). Each clinic has a Safety Committee and a safety officer, with a designated safety champion in each PCT. Responsibilities rotate annually, giving many staff members a chance to lead the safety effort. Safety and infection control rounds are conducted biweekly, and results are communicated to the PCTs and clinic managers, who are responsible for corrective action. The Safety Committee at each site (and the mobile vans) meet monthly to review the results of safety rounds, as well as investigations of accidents and near misses. Lost-time accidents and security incidents are reported to the PCT leader, Tony Joachin, and Ramon Gonzalez within 24 hours of their occurrence. The appropriate Safety Committee is responsible for identifying and addressing the root cause, and a corrective action plan is put in place. Senior leaders review all incidents and action plans monthly. There are no significant differences in the safety and security environments across all of the clinics; however, the mobile vans have the additional consideration of traffic safety. Workplace safety targets are shown in Figure 5.1-1.

Each facility has a safety plan that is supported by required education and training and carried out in cooperation with the facility safety officer. The plan includes periodic announced and unannounced drills to test staff knowledge in action (e.g., in case of fire, a violent patient or family member, an active shooter, child abduction, or power failure), as well as tests of organization-wide competency in areas required by HIPAA. Results are reviewed by the AF Safety Committee, composed of all the clinic safety officers, and action is taken to address unacceptable performance, often at a work group or site level. All

Figure 6.2-3: Approaches for Ensuring Data and Information **Security and Confidentiality**

Security	• Multistep log-in granted by position • Encryption of all electronic data • Network firewalls • Identity theft protection • Automatic log-off • Remote access data removal from lost devices • 10-digit password protection and mobile requirements • Mandatory 90-day password changes • Mobile device requirements policy • Computer location asset tags • New systems reviewed for security risks
Confidentiality	• Patient and employee record access reports • Access rights addressed during orientation • Annual HIPAA privacy compliance training • Auto-computer access/removal for noncompliance with annual privacy training requirement

direct patient care staff members are certified in basic cardiac life support and trained to operate the defibrillator present in every clinic.

6.2c(2) As defined in the EOP, the entire AF organization and all clinics and mobile vans have emergency preparedness plans that are updated annually. The approach is proactive, considering vulnerabilities and mitigation planning that is specific and unique to each location. Continuity and recovery plans are documented in the EOP manual, including emergency and fall-back procedures, resumption procedures, and test schedules. Every six months, the counties' emergency response agencies practice responding to various disaster scenarios, such as a biological weapons attack, wildfires, and chemical spills. AF participates in these drills—the only clinic-based organization to do so.

The generators are tested monthly and during emergency preparedness exercises. Redundant systems are in place and support all critical functions, including the EHR, imaging, and patient registration. To ensure additional redundancy and protection, AF has a second data center located in Phoenix that can serve as the primary data center if needed. Data and equipment are protected by a fire suppression system. The wide area network and phone lines have backup systems, and all critical locations have backup generators. An emergency communications procedure is in place should telephone or paging systems become inoperable. Suppliers' and partners' contact information is included in the emergency communications plan.

7 Results

7.1 Health Care and Process Results

7.1a Health Care and Customer-Focused Service Results

To track, improve, and demonstrate health care results, AF uses a comprehensive set of ambulatory care measures based on the Ambulatory Care Quality Alliance's (AQA's) Clinical Performance Measures for Ambulatory Care (and some recommended in the Healthy People 2020 report), Data and Information for Health Care International (DDDI) measures (some of which overlap with AQA's measures), reporting requirements for BPHC-sponsored collaborative projects to reduce health disparities, and the particular needs of AF's key communities. Committed to achieving health care results comparable to the best anywhere, AF compares its performance against the DDDI highest performer and 90th percentile performance, and it strives to meet and exceed *Healthy People 2020* goals by 2018. Participation in the Benchmarking Consortium of the State Association of CHCs enables AF to compare its performance against that of its peers on multiple health care results. (While AF segments much of its results data by county, its overall performance as a community health center is determined by averaging the results for all three counties.) AF also uses comparative state data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS).

Health care results are shown by county. Results for specific clinics are AOS. Van- and clinic-based services are designed to achieve comparable outcomes; therefore, results for van-based services are included in results for the appropriate county and described separately only where they differ significantly. The information system includes patient registries that permit segmentation of health care results by site, provider, and key patient demographic factors. Additional segmented data are AOS.

Lifestyle risk factors and behavioral health are systematically evaluated at all initial and routine periodic visits based on AF's adult screening and prevention clinical guidelines, which are embedded in the PHP. Like the prevailing trend across the United States, obesity is increasing among AF patients; however, at a much slower rate. In addition, the body mass index (BMI) levels in all three counties have been significantly lower than the state's average levels for CHCs for the past three years (Figures 7.1-1 and 7.1-2), with two counties better than the state-best CHC performance. These favorable trends

Figure 7.1-1: Lifestyle Risk Factor: % Adults with BMI >30

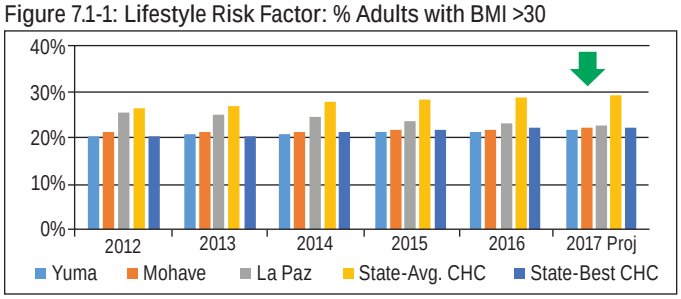
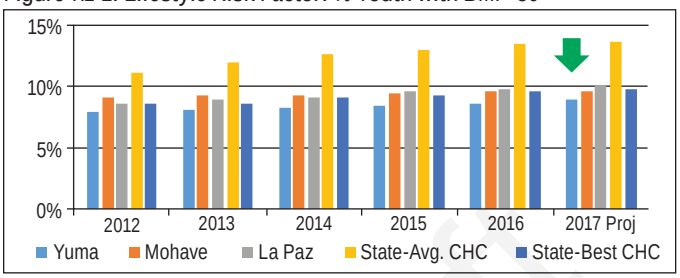


Figure 7.1-2: Lifestyle Risk Factor: % Youth with BMI >30



reflect AF's multipronged approach: community education, family enrollment in food benefit programs, customized ethnic meal plans on CCKs, nutrition education during group medical appointments and all dental visits, and school-based programs to influence children's eating habits. AF systematically screens patients for smoking. Smokers are flagged in the PHP, and medical and dental assistants collect and record information on patients' readiness to quit (e.g., some time, next six months, now), offer support matched to readiness, and document screening results for reinforcement by the primary medical and dental providers. AF's performance for all three counties on screening for smoking (Figure 7.1-3) is projected to exceed the DDDI 90th percentile and is at or near the *Healthy People 2020* goal.

According to the CDC, annually, major depression affects about 6.7% of U.S. adults, resulting in lost productivity, absenteeism, and high medical costs; up to 10% of those afflicted die from suicide. Among all ethnic groups, Hispanics experience the highest incidence. Although the screening rates for depression among U.S. primary care doctors remain very low and even lower for domestic violence, AF systematically screens all patients at enrollment and at routine periodic visits, with information documented in the patient's EHR. Dramatic improvement is associated with the deployment of AF's screening and prevention clinical guidelines across PCTs in 2012 (Figures 7.1-4 and 7.1-5). All three counties are at or near the state-best CHC rates.

Cancer screening rates are key indicators of the effectiveness of AF's prevention and screening services. A substantial improvement starting in 2010 is associated with implementation of the PCT model and enhanced responsibility of medical assistants for ensuring compliance with screening and prevention guidelines. The gain in breast cancer screening (Figure 7.1-6) corresponds to AF's Save-a-Life campaign, launched in one

Figure 7.1-3: Lifestyle Risk Factor: Screening for Smoking

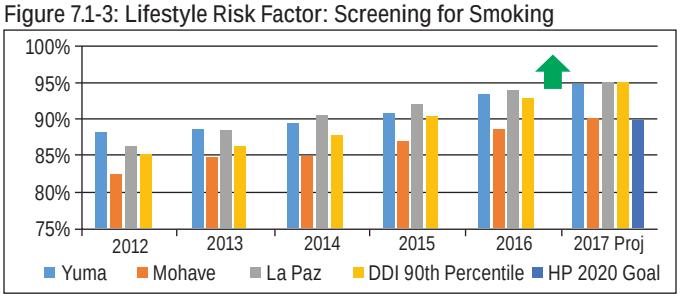


Figure 7.1-4: Behavioral Health: Screening for Depression

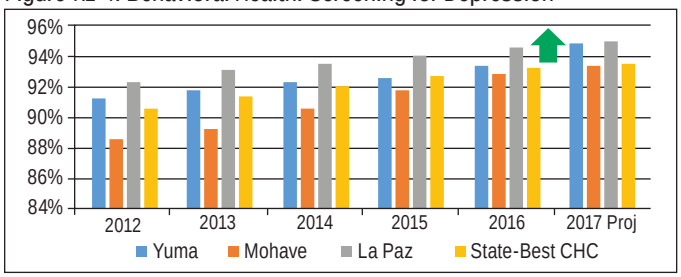


Figure 7.1-5: Behavioral Health: Screening for Domestic Violence

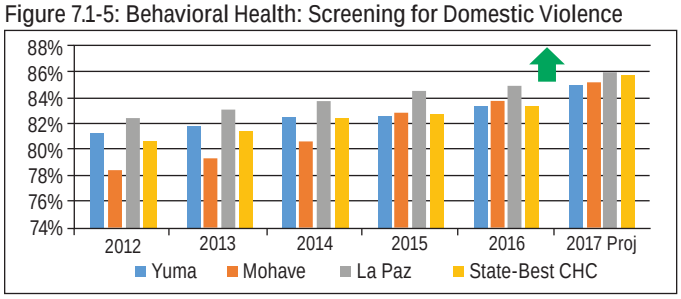
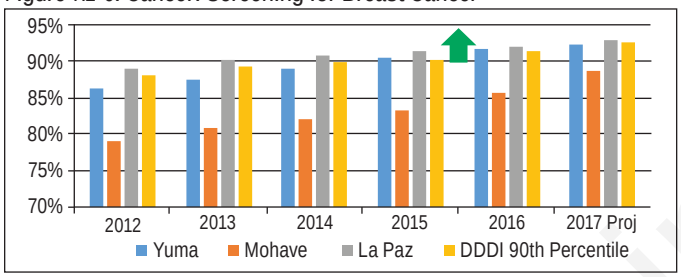


Figure 7.1-6: Cancer: Screening for Breast Cancer



PCT in 2010 and now organization-wide. Other contributors to improved performance include expanding mobile services to border residents in 2011 and opening the Women's Health Center in 2012. Screening for cervical cancer (Figure 7.1-7) shows similar favorable trends.

Across the United States, screening for colon cancer lags behind screening for breast and cervical cancer. Performance in all three counties (Figure 7.1-8) improved dramatically in 2012, when AF redesigned its processes for scheduling and transportation, increasing access to diagnostic procedures by hospital partners. This improvement also closed the gap between clinic-served patients and those served by mobile vans, for whom the screening rate was lower in all counties. Performance in 2016 is better than the DDDI 90th percentile in Mohave County, where an Elders Council campaign targeting retirees was developed; performance is also better than the DDDI 90th percentile in

Figure 7.1-7: Cancer: Screening for Cervical Cancer

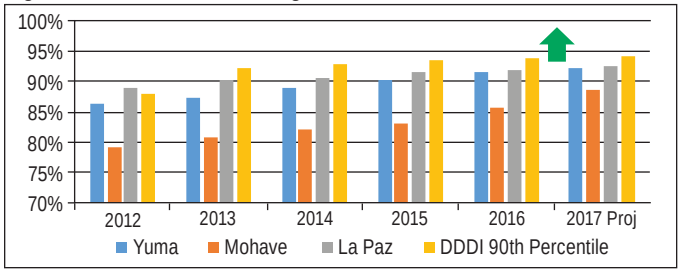
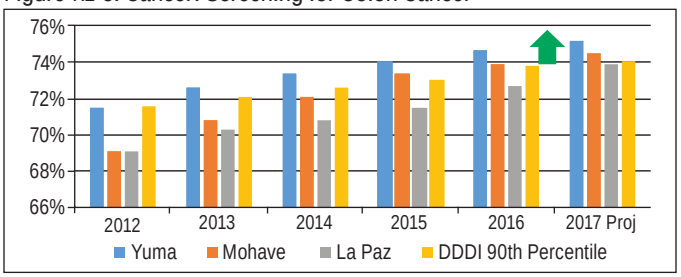


Figure 7.1-8: Cancer: Screening for Colon Cancer



Yuma County. The campaign has since been deployed to the other two counties with similar favorable trends.

The percentage of high-risk persons receiving influenza and pneumococcal vaccines (Figures 7.1-9 and 7.1-10) has increased since 2010. This strong performance indicates the effectiveness of the PHP in electronically tracking and reminding providers of needed immunizations, making any service experience an immunization opportunity. AF also began providing the shingles vaccine for patients over 50 and has recently begun an educational campaign to promote vaccination against HPV in children between the ages of 11 and 13. See Figures 7.1-10-A and 7.1-10-B.

TB treatment requires extended therapy, typically for six months or more. Inadequate treatment is associated with transmission of the disease and development of resistant strains. In all three counties, documented full treatment has improved, from rates

Figure 7.1-9: Communicable Diseases: Influenza Immunization

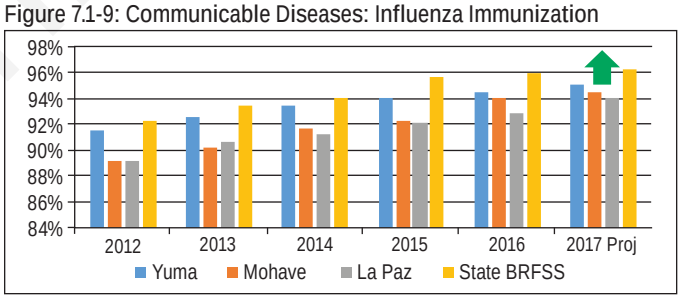


Figure 7.1-10: Communicable Diseases: Pneumococcus Immunization

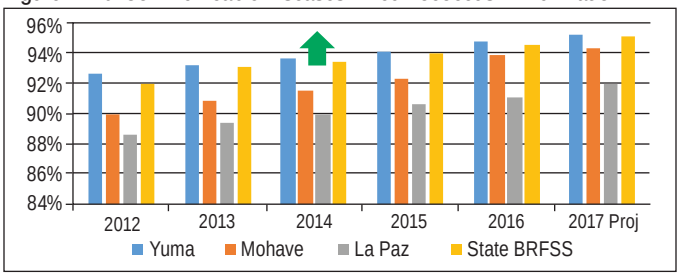


Figure 7.1-10-A: Shingles Vaccines

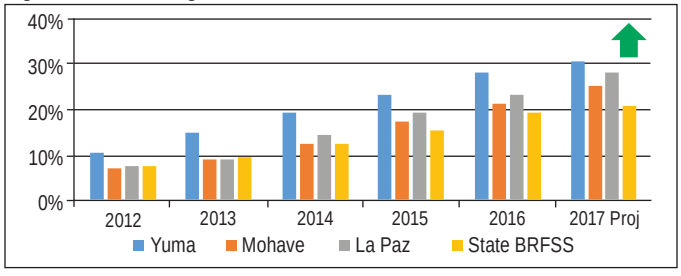
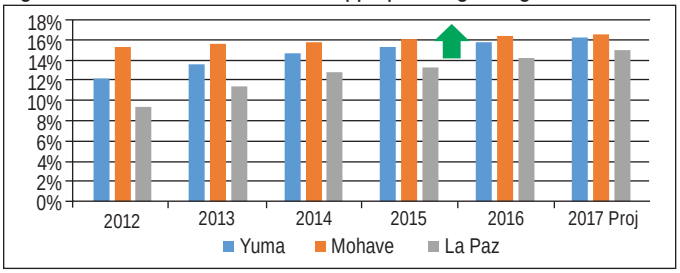


Figure 7.1-10-B: HPV Vaccines within Appropriate Age Range



well below national and state performance (Figure 7.1-11). Although performance lags behind the state-best CHC, AF's results are favorable, particularly for Yuma County, given the high incidence of TB and the challenges in maintaining treatment and accomplishing follow up among residents of border communities.

AF's clinical guideline for diabetes prescribes periodic screening and therapy to keep blood sugar and cholesterol levels in control. Performance on three key screening tests—HbA1c screening, an eye exam, and a urine protein test—has improved steadily since 2012 (Figure 7.1-12). AF uses multiple strategies to achieve a high rate of dilated eye exams, typically difficult for organizations that do not provide on-site vision care. These strategies include reinforcement of the importance by dentists and pharmacists, transportation to a network of partner optometrists, and a secure fax-back form to confirm the appointment and to document findings in the patient's PHP. Although HbA1c <7.0 typically is the goal for diabetes patients, AF focuses on reducing the percentage of patients in poor control (i.e., HbA1c >9.5).

Asthma is the most prevalent chronic disease among children and the sixth most prevalent among adults. Poorly managed asthma leads to hospitalization and Emergency Department (ED) care, lost school and work days, and needless health risks and costs. AF's clinical guideline for asthma prescribes appropriate medication based on the severity assessment.

Participation in a CHC learning collaborative, with implementation of clinical guidelines for pediatric and adult asthma in 2012, resulted in a favorable trend in administering appropriate treatment with anti-inflammatory medication; in 2016, performance surpassed DDDI 90th-percentile performance (Figure 7.1-13) Also, nearly 80% of patients have a current severity assessment. More effective management has increased the average number of symptom-free days in a two-week period from 7.9 to 9.5, close to the collaborative goal of 10. In 2013, the year after guideline implementation, hospitalization and ED visits for asthma dropped 32.4% in Yuma County.

AF's heart disease clinical guidelines include management of hypertension and high cholesterol (Figure 7.1-14). Blood pressure control has improved, with performance slightly below the DDDI 90th percentile. AF's performance in cholesterol screening exceeds the DDDI 90th percentile, and its percentage of patients with LDL cholesterol <130 approaches the DDDI 90th percentile.

Prenatal care in the first trimester is an important indicator of access to services; lower rates are typical among teens, minorities, and low-income groups. Early prenatal care is associated with higher birth weight and more favorable infant health care outcomes. The number of newborns with low birth weight (<2500 grams) per 100 births (Figure 7.1-15) has dropped in all three counties. AF's multipronged approach—building community and patient awareness; providing educational materials for teenage mothers; and providing support services, transportation, and mobile van access in rural locations—has resulted in improving performance for timely prenatal care (in the first trimester), approaching the *Healthy People 2020* target (Figure 7.1-16).

Children and adolescents (0–21 years) covered by Medicaid are required to have early and periodic screening, diagnostic, and treatment (EPSDT) services (e.g., a comprehensive H and P; age-appropriate immunizations; vision, hearing, and lead screening; and parental anticipatory guidance). Providing

Figure 7.1-11: Communicable Diseases: Completion of Treatment for TB

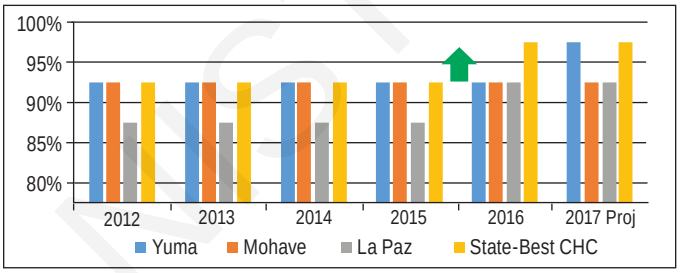


Figure 7.1-12: Diabetes Care: Screening in Past Year

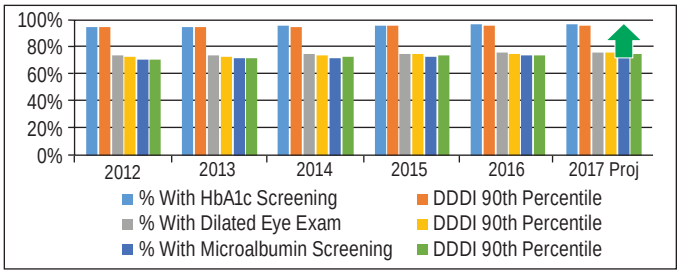


Figure 7.1-13: Asthma Care

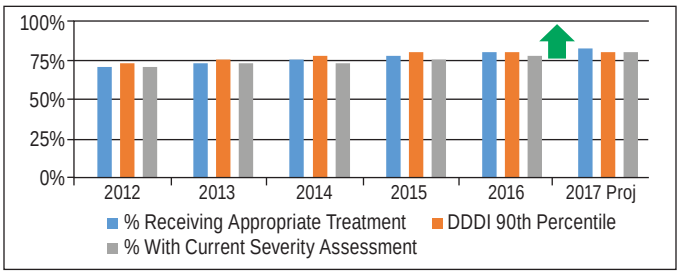


Figure 7.1-14: Heart Care

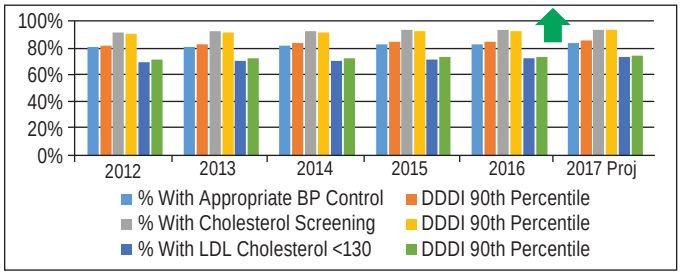


Figure 7.1-15: Pregnancy and Childbirth: Newborns with Low Birth Weight

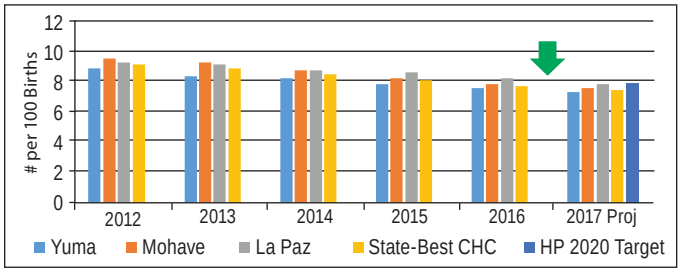
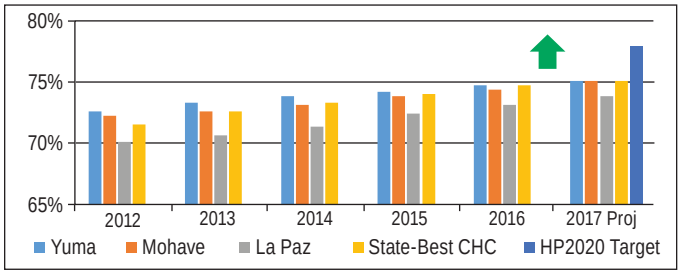


Figure 7.1-16: Pregnancy and Childbirth: Pregnant Women with Early Prenatal Care



appropriate well-care to children aged three to six is critical for anticipating health or developmental barriers to school readiness and ensuring up-to-date immunizations before a child's entry into day care programs or kindergarten. (AF tracks performance on specific EPSDT interventions; however, screening tests and anticipatory guidance are embedded in age-specific well-child guidelines, and results shown for well-visits represent performance on individual interventions.) AF's performance in two of the three counties for H and Ps for children aged three to six (Figure 7.1-17) exceeded the DDDI 90th percentile and this benchmark for immunizations (Figure 7.1-19). Providing age-appropriate care and immunizations for adolescents (Figures 7.1-18 and 7.1-20) has improved in all three counties,

Figure 7.1-17: Pediatric Care—Well Child Comprehensive H and P (Ages 3–6)

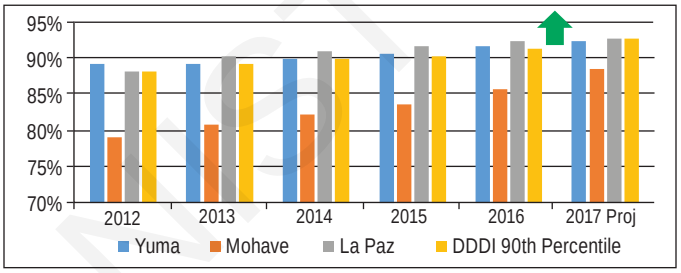


Figure 7.1-18: Pediatric Care—Well Child Comprehensive H and P (Ages 12–21)

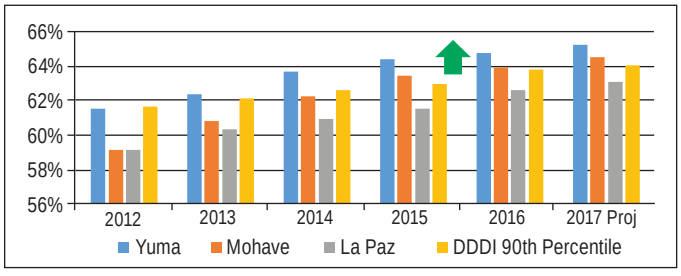


Figure 7.1-19: Pediatric Care—Well Child Appropriate Immunizations (Ages 3–6)

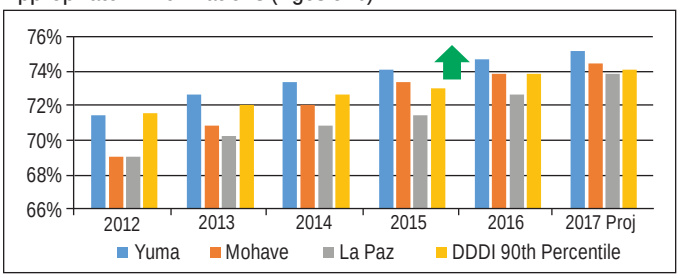
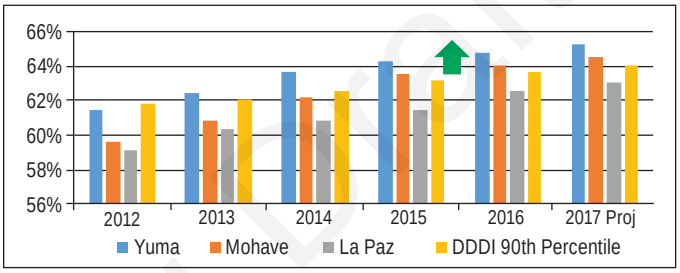


Figure 7.1-20: Pediatric Care—Well Child Appropriate Immunizations (Ages 12–21)



with performance highest in Yuma County, home to AF's two school-based clinics. Yuma's performance compares favorably to the DDDI 90th percentile. Adolescent results segmented by age (AOS) show that younger teens (ages 12 to 15) are significantly more likely to have age-appropriate periodic care (74.6%) and immunizations (71.4%) than older teens—a consistent pattern across counties that is highly correlated with the school dropout rate in these communities. Prescribing antibiotics for cold symptoms and sore throats is widespread in the United States, adding unnecessary risk and cost. AF's pediatric acute care guideline calls for symptomatic treatment of viral upper respiratory infections (URIs) and testing to determine the cause of sore throats (e.g., streptococcal pharyngitis) and the appropriate treatment. In two of the three counties, performance on both measures (Figures 7.1-21 and 7.1-22) exceeded or neared the DDDI 90th percentile.

Oral health contributes significantly to overall health, and poor oral hygiene complicates diabetes, heart disease, and other chronic problems. AF dentists check each patient's online PHP to reinforce medical treatment and self-management goals. Over the past five years, the percentage of adults receiving yearly dental care (Figure 7.1-23) and the percentage of eight-year-olds with sealant present to prevent dental caries (Figure 7.1-24) increased in all three counties.

Figure 7.1-21: Pediatric Care—Acute: Appropriate Treatment for URI

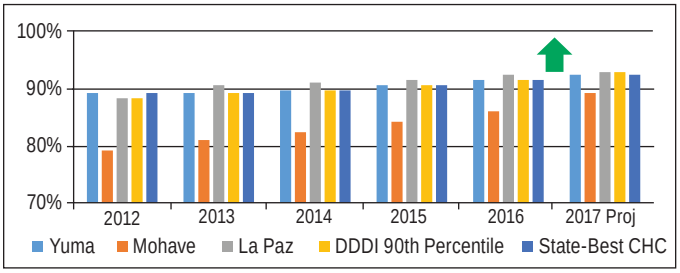


Figure 7.1-22: Pediatric Care—Acute: Testing for Pharyngitis

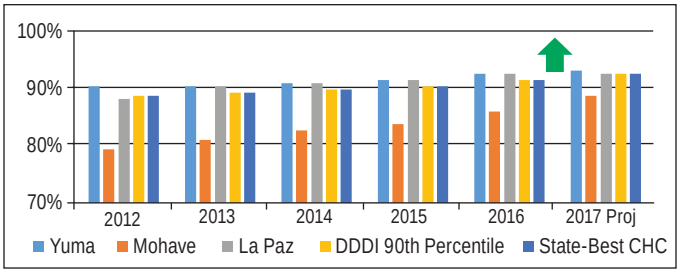


Figure 7.1-23: Dental Health (Adults): Dental Exam in Past Year

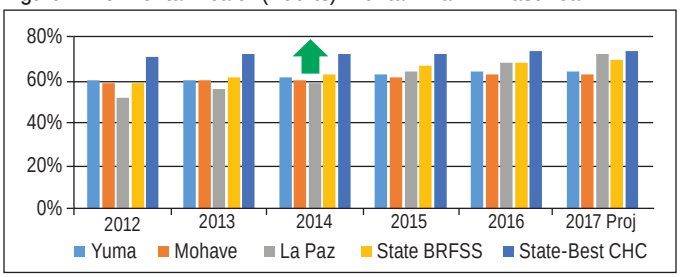
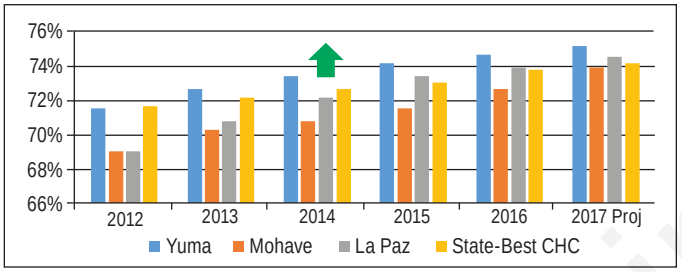


Figure 7.1-24: Dental Health (Children): 8-Year-Olds With Sealant Present



7.1b Work Process Effectiveness Results

7.1b(1) Improving access to care is an important goal for AF. By using the PIF model and sharing best practices across all clinics, AF has made significant improvements in patient access over the past four years. AF tracks several indicators for patient access. Future capacity (Figure 7.1-25) is the percentage of appointment slots that are open and available for scheduling patients over the next four weeks. The goal is to fill no more than 75% of future appointment slots. All counties have shown improvement, and La Paz is on target to meet this goal. The "third next available" appointment (Figure 7.1-26) is the average number of days between the time a patient requests an appointment with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. This access measure is more accurate than the "next available" appointment because it eliminates chance occurrences such as appointments that are available because of last-minute cancellations. The goal is to decrease the number of days to the third next available appointment to zero (same day) for primary care. All three counties have shown significant improvement.

Wait time to be seen after appointment time is another measure of process effectiveness and efficiency. It also relates to patient satisfaction. Improvements in all three counties can be seen in Figure 7.1-27.

Another measure of efficiency and effectiveness is the accuracy rate of medical records (Figure 7.1-28). While all of the counties

Figure 7.1-25: Future Capacity: Open Appointment Slots

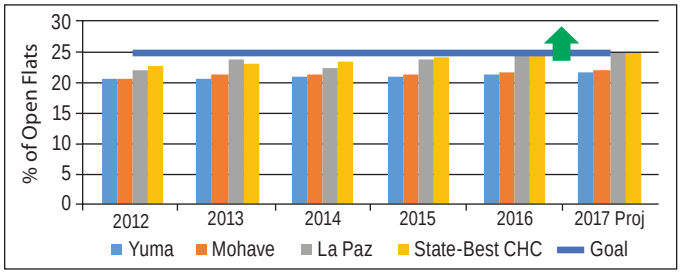


Figure 7.1-26: Third Next Available Appointment

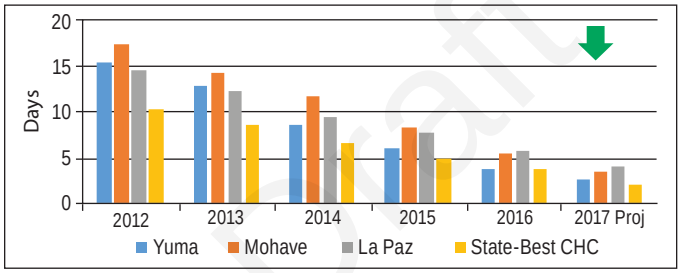


Figure 7.1-27: Wait Time to be Seen After Appointment Time

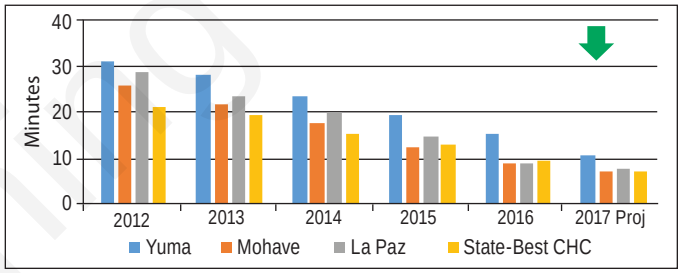
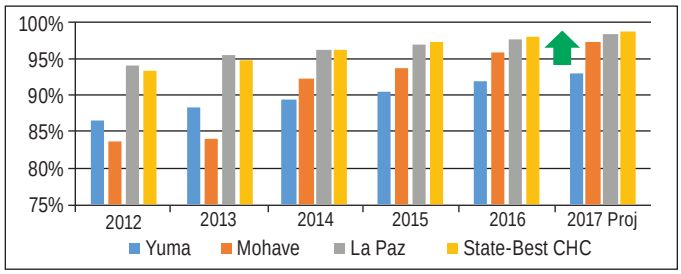


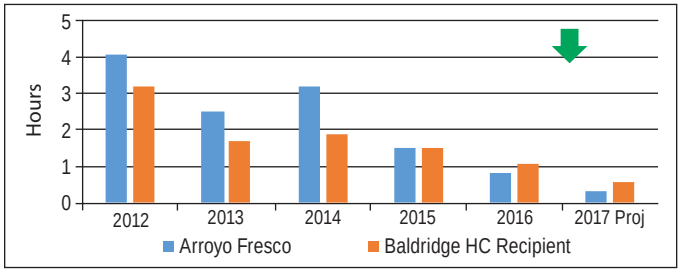
Figure 7.1-28: Medical Records Accuracy Rates



demonstrate a beneficial trend, two are at or near the state-best CHC performance.

Unplanned system downtown can create disruptions in processes requiring work-arounds to maintain operations. Since 2012, AF has improved its system reliability to world-class performance in unplanned system downtime (Figure 7.1-29).

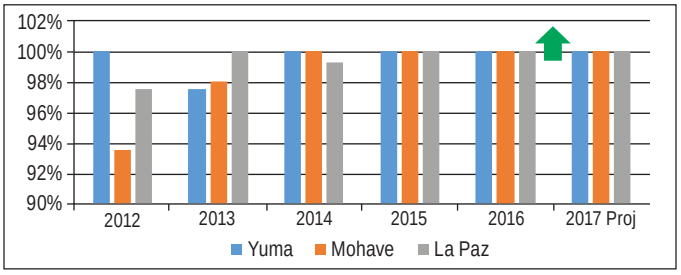
Figure 7.1-29: Unplanned System Downtime



7.1b(2) AF has a comprehensive program for emergency preparedness, described in 6.2cdescri. One of the key factors in being prepared is the timely completion of required drills. Since 2015, all three counties have been at 100% compliance (Figure 7.1-30).

Results demonstrating a safe work environment are shown in Figures 7.1-31 through 7.1-33. Results for key measures for workplace health safety and security continue to improve, and most surpass the levels of a 2015 Baldrige Award recipient (Figure 7.1-31). To ensure it continues this performance, AF maintains a rigorous, proactive training and inspection program (Figure 7.1-32). These efforts are recognized by AF staff members, as shown in their survey responses (Figure 7.1-33).

Figure 7.1-30: Emergency Preparedness—Required Drills Completed On Time



7.1c Supply-Chain Management Results

Supply order accuracy (Figure 7.1-34) is critical to efficient operations across AF's three counties. AF has been near the Buck & Major benchmark (adjusted for volume and number of line items) since 2012. In addition, AF benefits from the cost savings made possible by its membership in a purchasing consortium. These savings have continued to increase since 2012 (Figure 7.1-35) and contribute to AF's ability to compensate for unreimbursed care.

Figure 7.1-34: Supply Order Accuracy

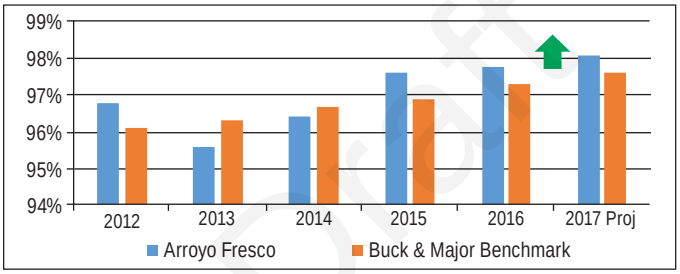


Figure 7.1-31: Workplace Health, Safety and Security

	2012	2013	2014	2015	2016	2017 (proj.)	2015 Baldrige Benchmark
Lost-Time Injuries	0.07	0.12	0	0.053	0	0	0.45
Total Temporary Disability Days	12	9	11	4	6	6	9
Sharps Injuries	0.4	0.45	0.37	0.22	0.23	0.2	0.5
Annual TB Test Compliance	100%	100%	100%	100%	100%	100%	100%
Security Incidents (all locations)	6	6	4	4	5	4	N/A
Van/Auto Insurance Claims/100,000 miles	1.7	1.4	1.25	1.1	0.83	0.88	0.75

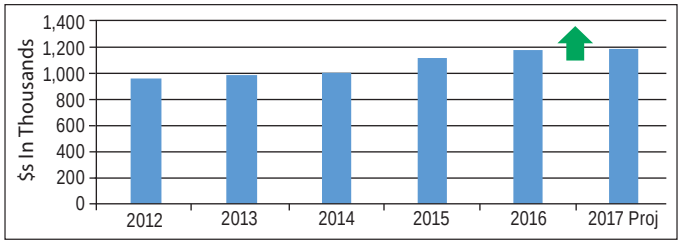
Figure 7.1-32: Proactive Health, Safety and Security Measures

	2012	2013	2014	2015	2016	2017 (proj.)
Annual TB Testing	100%	100%	100%	100%	100%	100%
Annual Fit Testing	100%	100%	100%	100%	100%	100%
Chemical Inventories Conducted	100%	100%	100%	100%	100%	100%
Hazardous Waste Inspections Conducted	100%	100%	100%	100%	100%	100%
Fire Systems Tested	100%	100%	100%	100%	100%	100%
Fire Drills Conducted	100%	100%	100%	100%	100%	100%
Active Shooter Drills Conducted	100%	100%	100%	100%	100%	100%
Emergency Power Systems Tested	100%	100%	100%	100%	100%	100%
Defensive Driving Course	100%	100%	100%	100%	100%	100%

Figure 7.1-33: Survey Results: "AF provides a safe operating environment"

	2012	2013	2014	2015	2016	2017 (proj.)
AF	91.3%	94.7%	96.2%	95.8%	97.2%	97.5%
State Best CHC	88.3%	89.5%	91.7%	92.0%	93.0%	93.5%

Figure 7.1-35: Cost Savings From Purchasing Consortium



7.2 Customer-Focused Results

7.2a Patient- and Other Customer-Focused Results

7.2a(1) For the past five years, AF has consistently scored well above the Packer top decile in patient satisfaction (Figures 7.2-1 through 7.2-7). AF attributes these results as "patient and family satisfaction" since many surveys actually are completed by family members (parents of children or children of elderly parents) and reflect their opinion, as well as those of the patient. More detailed segmented results, including by county and PCT, as well as results dating back to 1999, are AOS. When used as a comparison, "State CHC Best" refers to the best performance, other than that of AF.

Patient satisfaction exceeds the top decile across all freestanding clinics for both medical (Figure 7.2-2) and dental (Figure 7.2-3) services.

Figure 7.2-1: Aggregate Patient Satisfaction

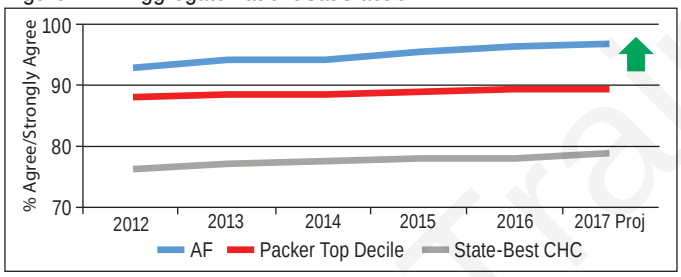


Figure 7.2-2: Patient/Family Satisfaction with Medical Services

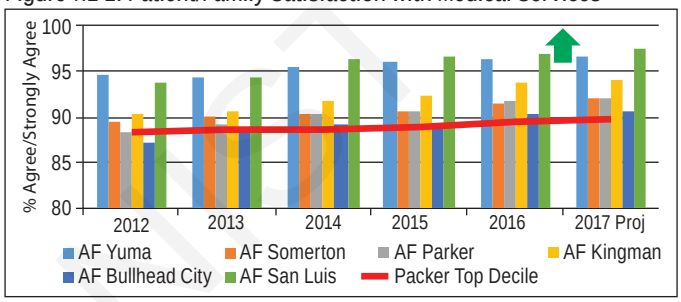
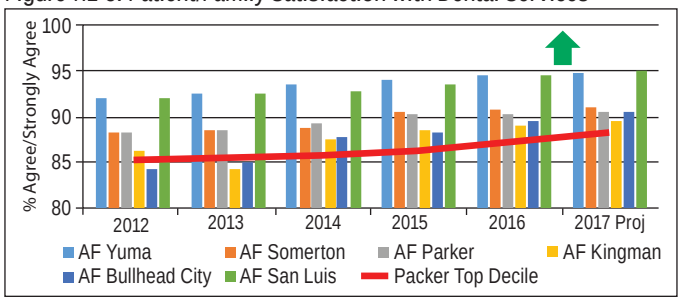


Figure 7.2-3: Patient/Family Satisfaction with Dental Services



Satisfaction with in-school services is consistently high for both elementary and high school students, and again exceeds the top-decile benchmark by a large margin (Figure 7.2-4).

While significantly better than the Packer top-decile comparison, overall satisfaction for mobile van services (Figure 7.2-5) lags similar AF results for the freestanding clinics. Analysis of the data and input from focus groups in 2016 indicates that, while the convenience of the mobile van was appreciated, it is not always available in respondents' neighborhoods at their desired time. As a result of this analysis, schedules have been adjusted for all mobile vans.

AF demonstrates sustained high performance in all key requirement factors for patients and families (Figure 7.2-6).

AF's support services also rate highly with patients and families (Figure 7.2-7). Results for other services, including vision and hearing screening programs, are AOS.

Figure 7.2-4: Patient/Family Satisfaction with School Services

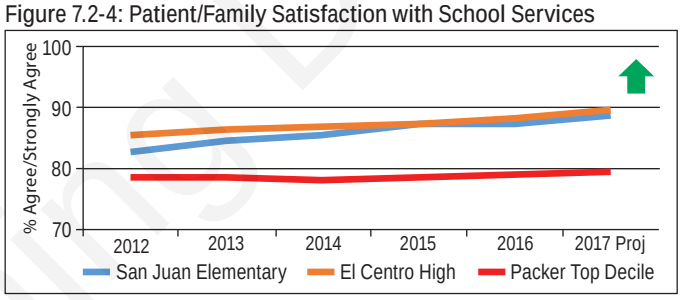


Figure 7.2-5: Patient/Family Satisfaction with Mobile Van Services

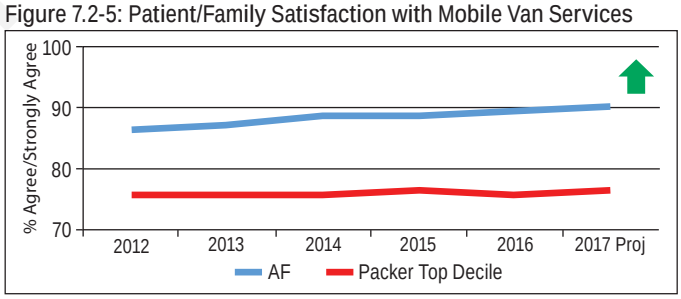


Figure 7.2-6: Patient/Family Satisfaction for Key Requirements

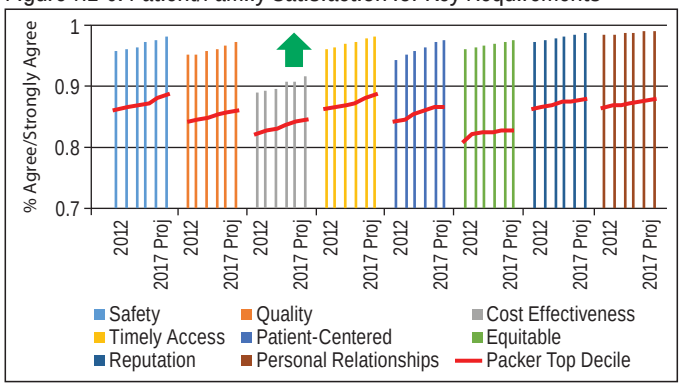
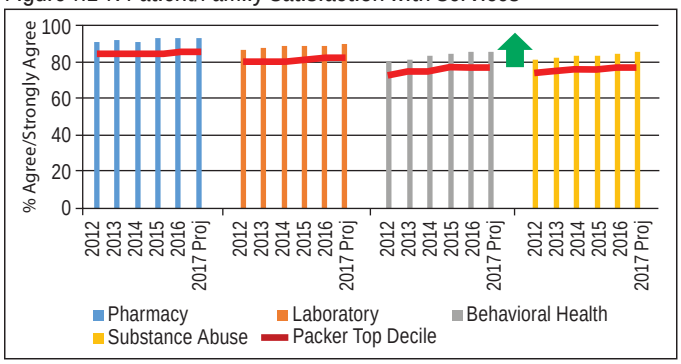


Figure 7.2-7: Patient/Family Satisfaction with Services



Community stakeholders also rate AF highly in all of their key requirements areas. This survey, conducted by Packer, includes residents of all three counties in which AF operates (Figure 7.2-8).

AF conducts an annual survey of its partners' satisfaction with their relationship with AF (Figure 7.2-9). Since it is an internally conducted survey, no comparisons are available.

Payor satisfaction with relationships with state CHCs is determined through a survey conducted by Packer for the State CHC Benchmarking Consortium. AF is ranked the best in the state (Figure 7.2-10).

AF measures dissatisfaction by the percentage of respondents in the Packer survey who "strongly disagree" about the quality of its services. AF's performance is significantly lower (better) than the Packer lowest decile (Figure 7.2-11).

In 2014, AF introduced a new approach to measuring and managing complaints (3.2b[2]), in which it ranks the impact and severity of each complaint. The three-year trend is favorable (Figure 7.2-12). AF has not yet been able to find a suitable benchmark for this metric.

Figure 7.2-8: Community Satisfaction by Key Requirements

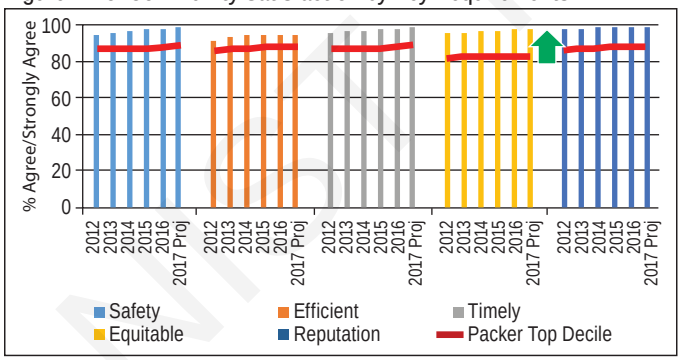


Figure 7.2-9: Partner Satisfaction by Key Requirements

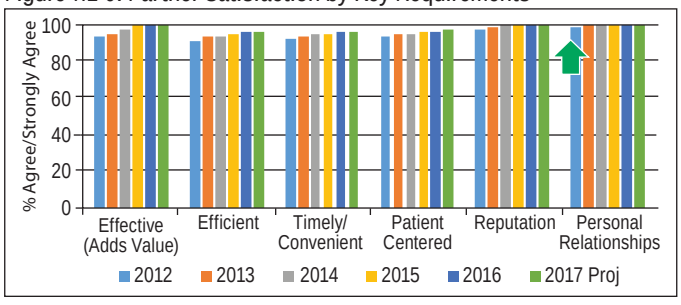


Figure 7.2-10: Payor Satisfaction

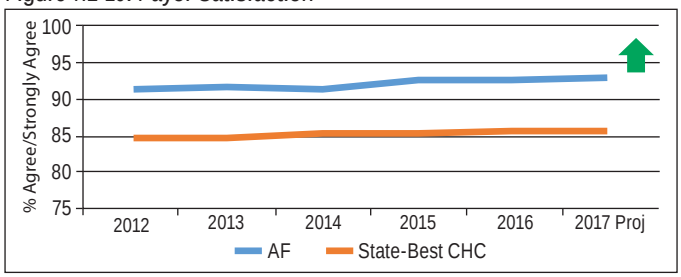


Figure 7.2-11: Patient/Family Member Dissatisfaction

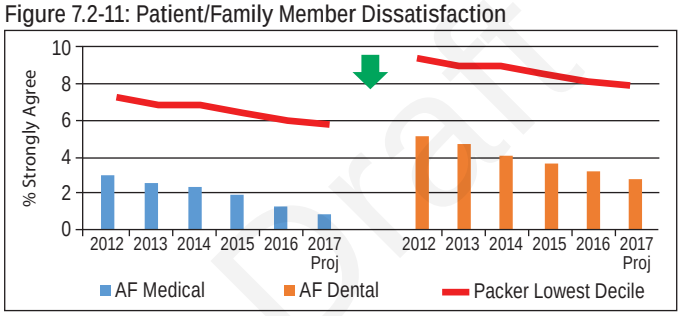
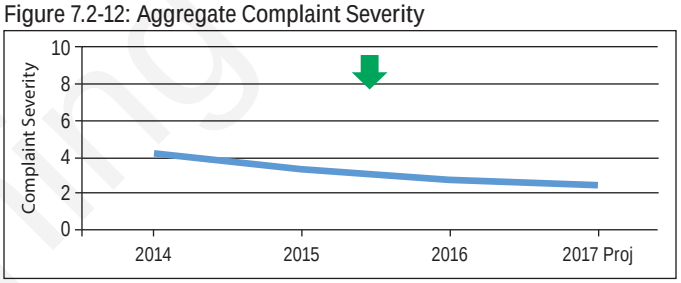


Figure 7.2-12: Aggregate Complaint Severity



Patients and their families also rate AF highly for satisfaction with the resolution of their complaints (Figure 7.2-13), and the ratio of complaints to compliments received has been trending positively (Figure 7.2-14).

Figure 7.2-13: Satisfaction with Complaint Resolution

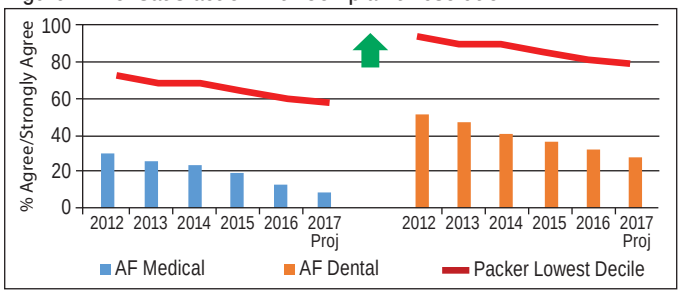
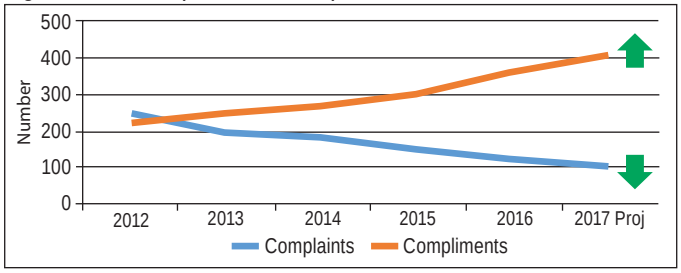


Figure 7.2-14: Complaints vs. Compliments



7.2a(2) AF scores well in indicators of patient and family engagement. Willingness to recommend AF is in the top decile for AF medical services, and at the top decile for dental services (Figure 7.2-15). AF also has a custom question in the Packer survey: "Have you ever recommended AF to another person?" More than 70% of survey respondents actually have recommended AF (Figure 7.2-16). Since this is a custom question, Packer has no relevant comparative results in its database.

Community perception of which CHCs provide the best care is determined through the Packer survey conducted for the State CHC Benchmarking Consortium. AF is ranked well above the next best CHC in the state (Figure 7.2-17).

Community engagement with AF is increasing. AF continues to receive favorable mentions in social media and local print, web, radio, and TV comments (Figure 7.2-18).

Figure 7.2-15: Would Recommend AF

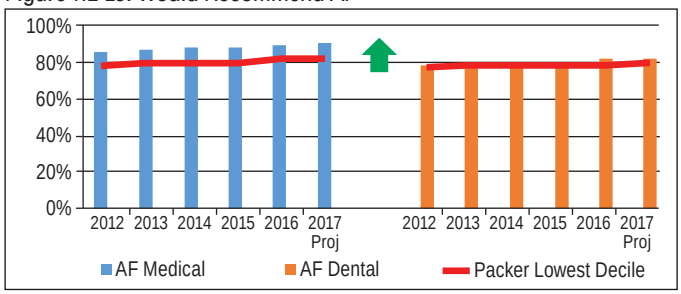


Figure 7.2-16: Did Recommend AF

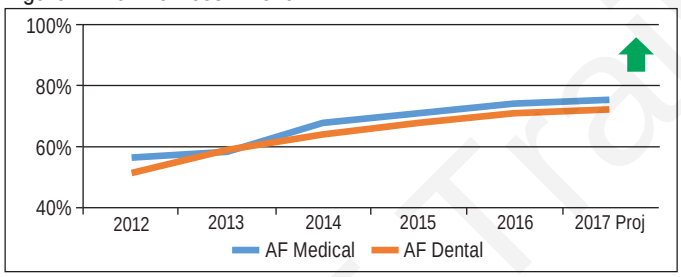


Figure 7.2-17: Community Perception—Best Care

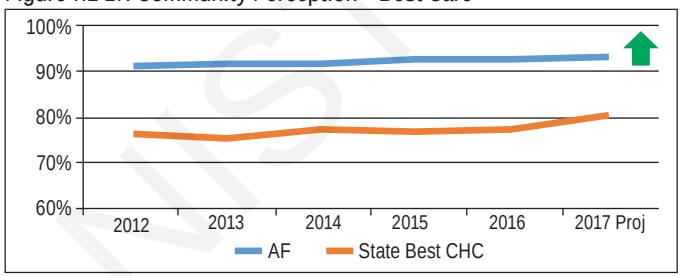
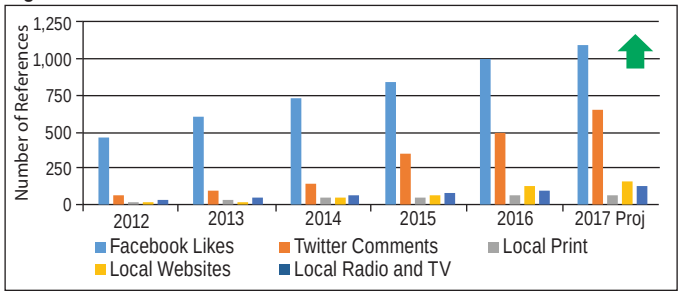


Figure 7.2-18: Favorable Media References



7.3 Workforce-Focused Results

7.3a Workforce-Focused Results

7.3a(1) To measure workforce capability and capacity, AF has focused on three areas to reduce employee turnover: (1) retaining first-year staff (5.1a[2]), (2) improving the workplace environment (5.1b[1]), and (3) enhancing workforce benefits and policies (5.1b[2]). The implementation of the "fair living wage" contributed to the decline in turnover in 2016, particularly for administrative staff (Figure 7.3-1) and new hires (Figure 7.3-2). In turn, AF's vacancy rate remains the best in the state (Figure 7.3-3). The projected increases in 2017 for administrative and management are due to anticipated retirements of long-term employees. Succession plans are in place to fill those positions internally. When used as a comparison, "State CHC Best" refers to the best performance, other than that of AF.

Clinical managers and the HR Department are diligent in ensuring licensure requirements are met (Figure 7.3-4).

Figure 7.3-1: Turnover by Employee Group

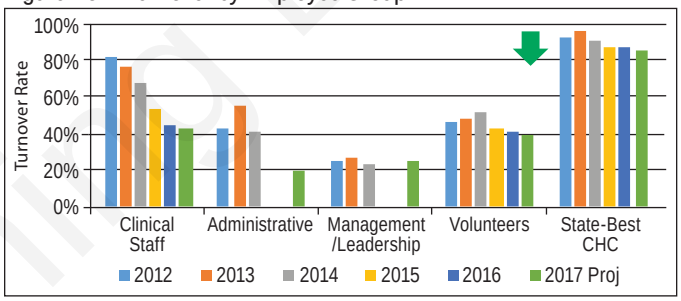


Figure 7.3-2: Turnover Rate for Employees <1-Year Tenure

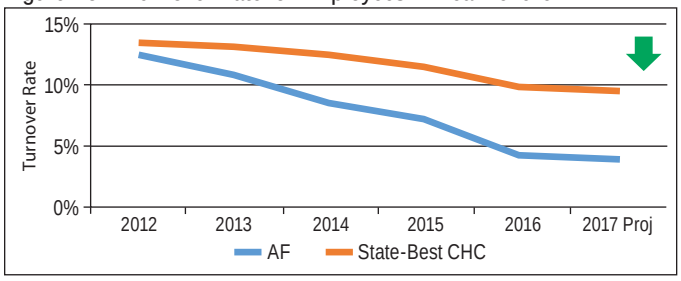


Figure 7.3-3: Vacancy Rate

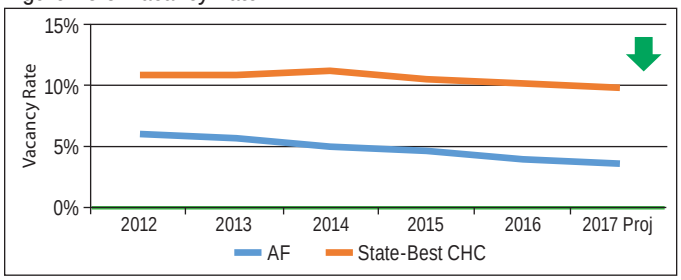


Figure 7.3-4: Licensure

	2012	2013	2014	2015	2016	2017 (proj.)
Medical staff	100%	100%	100%	100%	100%	100%
Other clinical staff	100%	100%	100%	100%	100%	100%
Facilities	100%	100%	100%	100%	100%	100%

Continued, disciplined use of process improvement tools and methodology (6.1b[3]) has led to improvements in AF's workforce processes, as seen in the decrease in the time needed to fill open positions (Figure 7.3-5), reduction in overtime (Figure 7.3-6), and improving productivity of PCTs (Figure 7.3-7). The State CHC Benchmarking Consortium does not measure overtime, and PCT productivity is a unique measure for AF; therefore, no comparisons are available for these metrics.

Efforts to improve the engagement of volunteers (Figures 7.3-14 and 7.3-15) have resulted in a corresponding increase in total volunteer hours (Figure 7.3-8) and in hours per volunteer. The State CHC Benchmarking Consortium does not measure this, but benchmarking two recent Baldrige Award recipients in health care indicates that AF performs comparably to them.

Figure 7.3-5: Time to Fill Open Positions

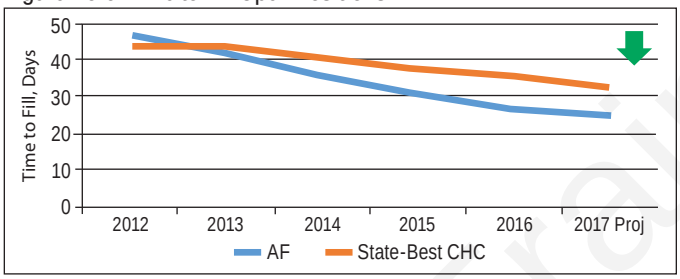


Figure 7.3-6: Overtime as of % of Salary Budget

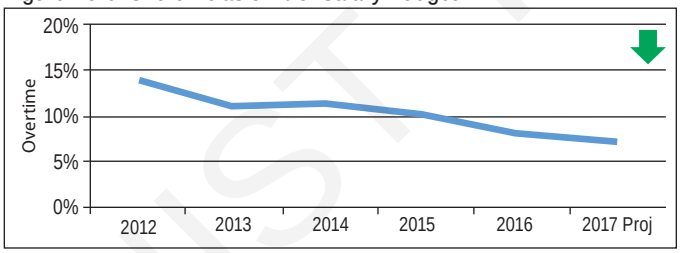


Figure 7.3-7: PCT Productivity

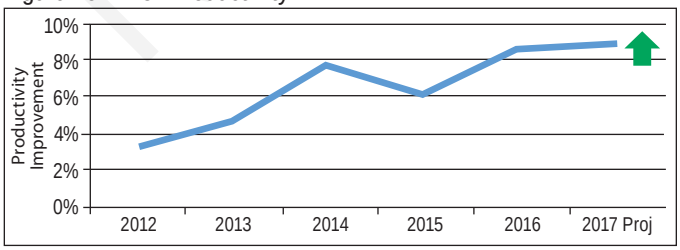
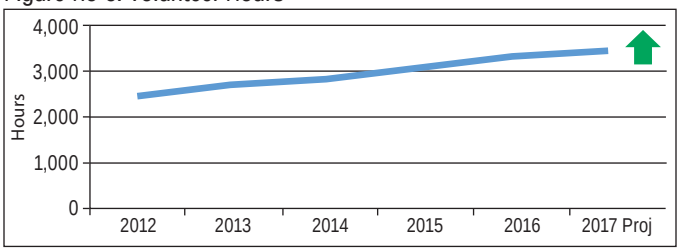


Figure 7.3-8: Volunteer Hours



7.3a(2) AF's highly-engaged workforce members have embraced the AF value of *performance* through their many contributions to the organization's efficiency and effectiveness. A portion of those savings are passed on to them each year through the Gainsharing Program (Figure 7.3-9). The payout has increased in nine of the last ten years.

Since its inception in 2014, the Healthy Living program (5.1b[1]) has seen employee participation increased to nearly 90% (Figure 7.3-10).

Recognition plays an important role in building workforce engagement at AF (5.2a[4]). Results for two of its recognition programs are shown in Figures 7.3-11 and 7.3-12. STAR allows any person to recognize another for worthwhile contributions.

Figure 7.3-9: Gainsharing Payout

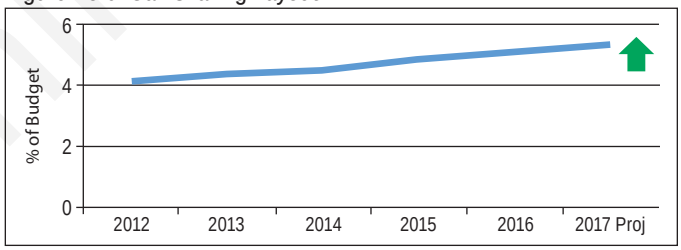


Figure 7.3-10: Healthy Living Program Participation

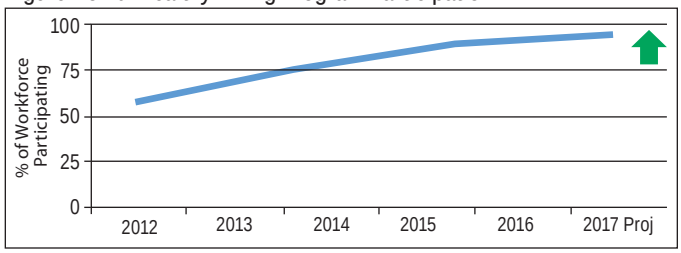


Figure 7.3-11: STAR Recognition

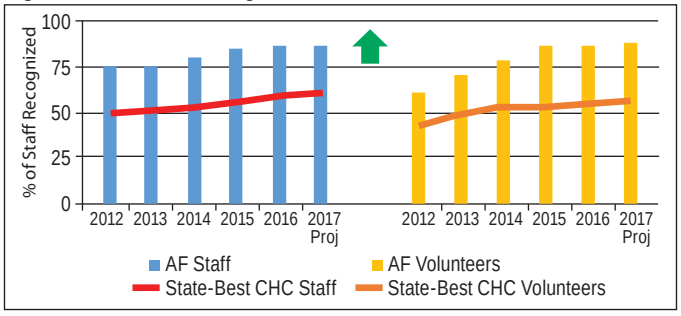
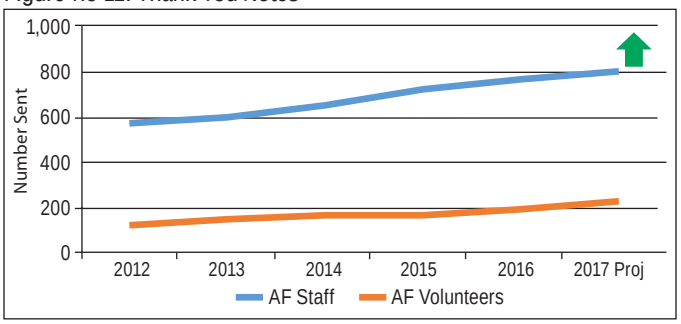


Figure 7.3-12: Thank You Notes



AF also believes that a personal touch is important in recognition. Each senior leader, including Ramon Gonzalez, handwrites personal "thank you" notes to employees for their specific actions in supporting the VMV; each leader averages more than two a week.

7.3a(3) In a recent review of workforce engagement factors (5.2a[2]), AF determined that there were slight differences for younger workers (millennials) versus older workers (Figure P.1-6). By addressing some of these factors through revised recruitment and retention policies, AF has closed the gap in engagement between these two groups (Figure 7.3-13). Staff satisfaction against all key job requirements (Figure P.1-7) remains well above the top-decile benchmark (Figure 7.3-14).

Physician (Figure 7.3-16) and volunteer satisfaction (Figure 7.3-17) also remain high.

Figure 7.3-13: Staff Engagement

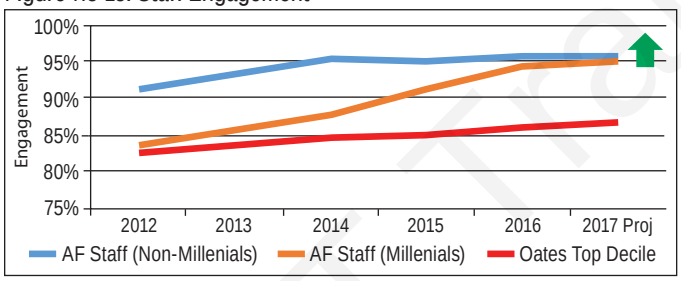


Figure 7.3-15: Key Engagement Drivers

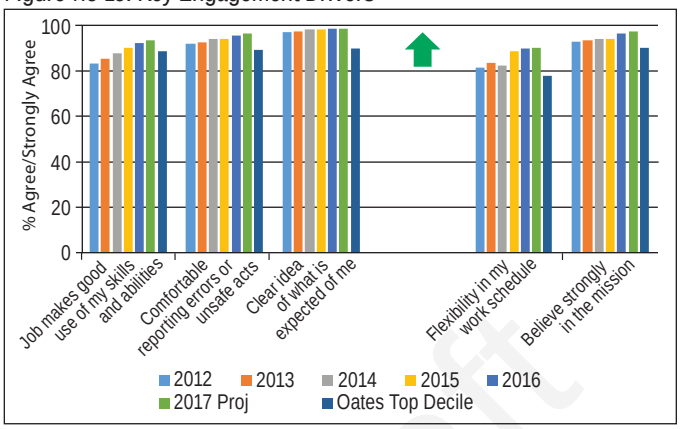


Figure 7.3-16: Physician Satisfaction

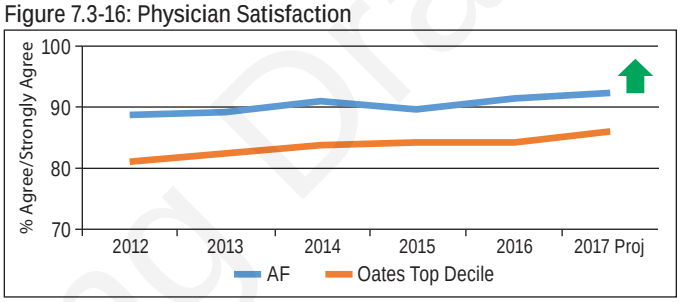
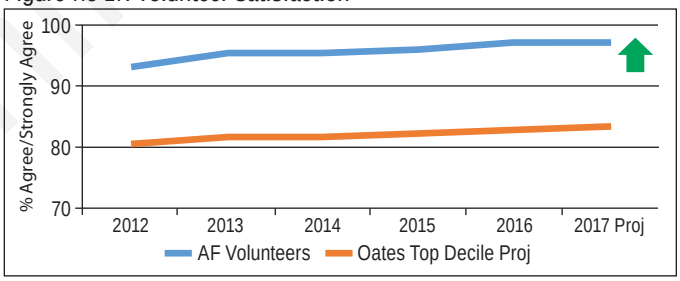


Figure 7.3-17: Volunteer Satisfaction



Two additional indicators of workforce engagement are responses to the Oates survey questions shown in Figures 7.3-18 and 7.3-19. Responses for all workforce segments exceed the top decile.

Figure 7.3-14: Staff Satisfaction for Key Requirements

	2012	2013	2014	2015	2016	2017 (proj.)	Oates Top Decile 2016
Safety	88.5%	89.3%	90.7%	89.5%	92.0%	93.7%	90.7%
Timely access	86.5%	85.5%	87.9%	89.0%	90.7%	91.5%	88.3%
Patient-centered service	97.2%	97.5%	98.2%	98.2%	98.5%	98.5%	86.5%
Equitable (including culturally sensitive) care	89.4%	89.9%	90.6%	90.0%	91.7%	92.5%	88.3%
Reputation as a high-quality health center	91.0%	91.4%	91.5%	92.3%	94.5%	94.8%	89.5%
Knowledge, skills, and tools to do the job	86.3%	86.7%	87.5%	88.3%	89.5%	90.0%	87.2%
Personal relationships and partnerships	90.2%	91.3%	93.3%	93.5%	94.1%	94.5%	86.3%
Fair pay and benefits	81.5%	83.5%	82.5%	86.7%	87.8%	88.2%	76.8%
Recognition	89.4%	89.9%	90.6%	90.0%	91.7%	92.5%	86.3%

Figure 7.3-18: Overall Engagement by Function ("I am proud to work here")

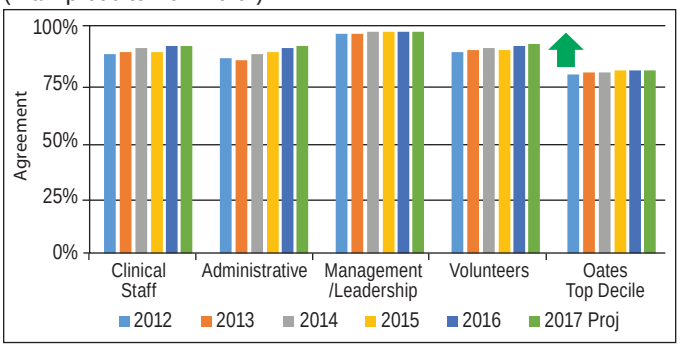
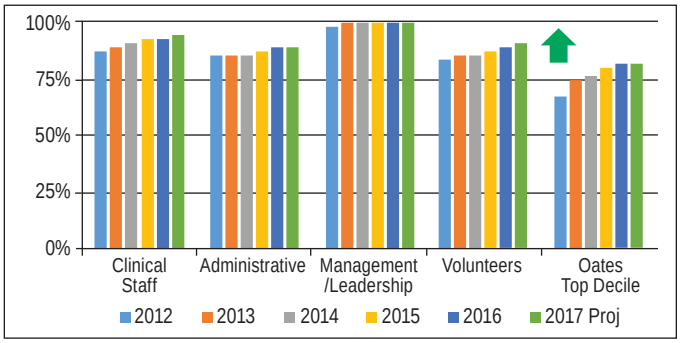


Figure 7.3-19: I Would Recommend AF as a Place to Work



7.3a(4) AF devotes significant resources to maintain and build workforce capabilities (Figure 7.3-20). The organization measures the effectiveness of its efforts through proficiency rates defined by Kirkpatrick level 2 (*learning*, as measured by pre- and post-tests) and level 3 (*behavior*, measured by spot tests and performance reviews) for core training, which includes all mandated requirements. All segments of the AF staff continue to improve their proficiency (Figure 7.3-21).

Workforce satisfaction with training and development offerings and delivery, as measured by Kirkpatrick level 1 (*reaction*, through post-training surveys and follow-up inputs), exceeds the top decile for all segments (Figure 7.3-22).

Figure 7.3-20 Workforce Development

	2012	2013	2014	2015	2016	2017 (proj.)
Degree/ Certification Program Enrollment	43	47	51	50	55	58
CEUs Awarded	903	947	951	975	993	1,000
Tuition Reimbursement ($ thousands)	40.30	41.70	44.80	52.30	59.70	62.00
Advancement (promotions from within)	5	8	11	14	19	20
Leadership Training Participation	11	14	23	37	42	48

Figure 7.3-21: Proficiency Rates for Core Training

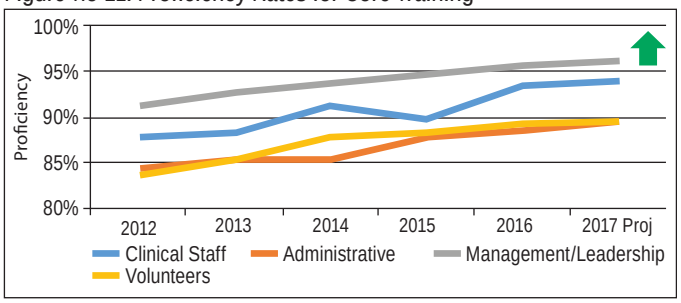
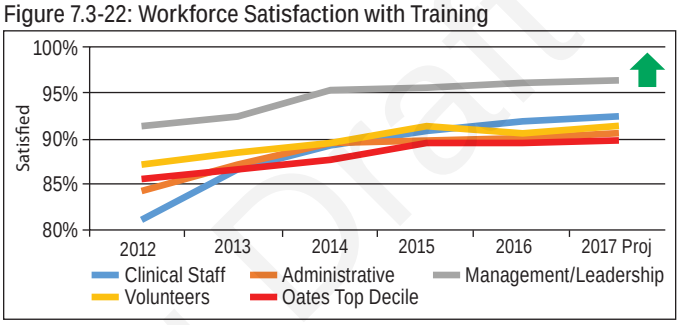


Figure 7.3-22: Workforce Satisfaction with Training



7.4 Leadership and Governance Results

7.4a Leadership, Governance, and Societal Responsibility Results

7.4a(1) Results to support the statement "senior leaders encourage frank, two-way communication" from the Oates Staff Satisfaction Survey are shown in Figure 7.4-1. AF's senior leaders have created an intentional culture that results in highly engaged employees. The effectiveness of their communication with the workforce is shown with results that exceed the Oates top decile.

7.4a(2) Results of the board assessment against the Stewart-Hagen model (Figure 7.4-2) show increasing trust in AF's governance over the last four years, and 2016 results are approaching, equal to, or in one case better than the Stewart-Hagen survey's national database benchmark (top-decile performance of peer group).

7.4a(3) Results of AF's legal, regulatory, and licensure requirements are shown in Figures 7.4-3 through 7.4-6. AF results show the best performance possible across these measures.

Figure 7.4-1: Employee Satisfaction with Senior Leader Communication

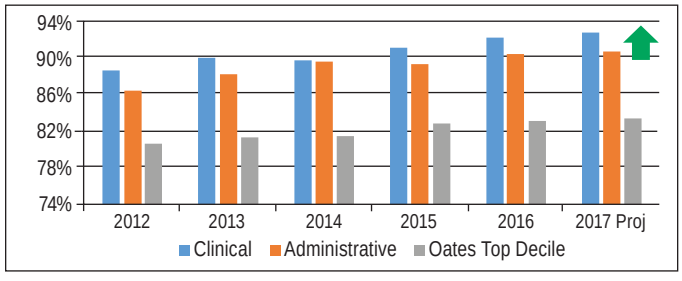


Figure 7.4-2: Trust in the Governance of the Organization

Percent of Board Members Ranking Statements as "Highly Agree"	2012	2013	2014	2015	2016	Benchmark
The board adopts a strategic plan consistent with the organization's vision, mission, and values.	75%	78%	83%	87%	92%	96%
The board understands, accepts, and acts consistently with its legal, moral, and regulatory responsibilities.	89%	91%	89%	95%	98%	98%
Board members understand that ethical behavior is often judged by perceptions and do not engage in any transactions that might appear to be self-serving.	74%	73%	77%	86%	93%	95%
The board makes issues and decisions transparent to the communities in which the organization operates.	79%	86%	89%	92%	96%	94%

Figure 7.4-3: HIPAA Compliance

	2012	2013	2014	2015	2016	2017 (proj.)
Arroyo Fresco	100	100	100	100	100	100

Figure 7.4-4: % Staff and Volunteers Trained in HIPAA

	2012	2013	2014	2015	2016	2017 (proj.)
Arroyo Fresco	100	100	100	100	100	100

Figure 7.4-5: Licensures

	2012	2013	2014	2015	2016	2017 (proj.)
Health professionals	100	100	100	100	100	100
Pharmacies	100	100	100	100	100	100
Motor Vehicle Drivers	100	100	100	100	100	100
OP Medical Facilities and Behavioral Health Facilities	100	100	100	100	100	100

Figure 7.4-6: % Staff and Volunteers Trained in Proper Disposal of Medical Waste

	2012	2013	2014	2015	2016	2017 (proj.)
Arroyo Fresco	100	100	100	100	100	100

7.4a(4) Results for ethical behavior are shown in Figure 7.4-7.

7.4a(5) Results for fulfilment of societal responsibilities are shown in Figures 7.4-8 and 7.4-9. Despite its limited resources, AF has favorable results that show its commitment to supporting key communities. AF's community support has increased significantly.

Figure 7.4-8: Support of Key Communities: Staff Members' Volunteer Hours

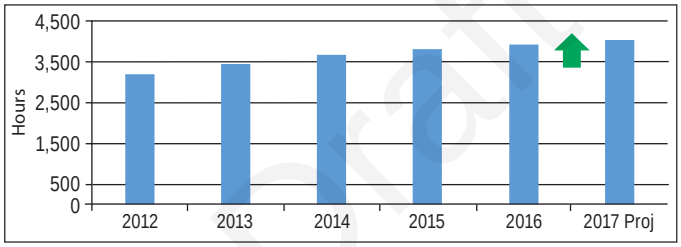


Figure 7.4-9: AF Community Support of Key Programs—Annually

Key Program	2012	2013	2014	2015	2016
Donations of low-fat, high-nutrition donations to local food banks (lbs.)	742	782	864	990	1,120
Participation in Healthy Body Program (# of 8–13 year-olds enrolled)	65	78	86	97	109
Counseling and child care provided at Casa de Cuidar (hours)	108	123	156	208	260
Donated use of facilities for community-sponsored groups (hours)	213	262	361	417	570
Expect to Succeed mentoring relationships	28	30	46	52	63

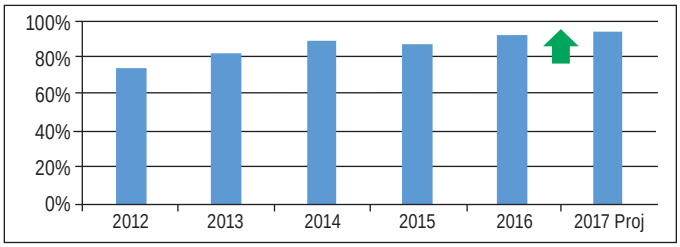
7.4b Strategy Implementation Results

Results for the successful accomplishment of action plans related to the strategic objectives are shown in Figure 7.4-10. Results for building core competencies are demonstrated in the excellent outcomes shown in 7.1a(1) and reflected in the satisfaction and engagement reported in 7.2. An example of a result of intelligent risk taking is the current strategic opportunity to partner with a dialysis provider.

Figure 7.4-7: Staff, Volunteer, and Community Responses to Ethics-Related Questions

Source	Statements Ranked as "Highly Agree"	2012	2013	2014	2015	2016	Benchmark
Oates Staff Satisfaction Survey	AF's senior leaders expect me and motivate me to do what is right for our patients and the communities we serve.	94%	96%	98%	97%	98%	67%
Volunteer Survey	I choose to volunteer at AF because of its high ethical standards.	88%	87%	89%	92%	93%	71%
Community Climate Survey	I trust AF to respond to the needs of its patients and the community.	88%	88%	89%	91%	95%	94%
Community Climate Survey	I believe that AF communicates timely and accurate information.	86%	89%	93%	93%	95%	96%

Figure 7.4-10: Achievement of Action Plans



7.5 Financial and Market Results

7.5a Financial and Market Results

7.5a(1) AF tracks a number of financial measures in different departments based on the needs of each department's day-to-day management activities and processes, and several financial and market measures roll up to the FOCUS scorecard. Figure 7.5-1 shows AF's actual expenses and revenues, as well as its net collections. AF works very hard to maintain financial solvency by keeping costs in line with the net revenues for each fiscal cycle. The days-to-payment for accounts receivable (Figure 7.5-2) have decreased for all payor types since 2012, and AF's performance related to private insurance companies was the state best in 2016. AF has maintained relatively high collection rates (Figure 7.5-3), even for self-pay patients, and AF's current overall performance nearly equals the state-best level.

Figure 7.5-1: Revenues, Expenses, and Collections

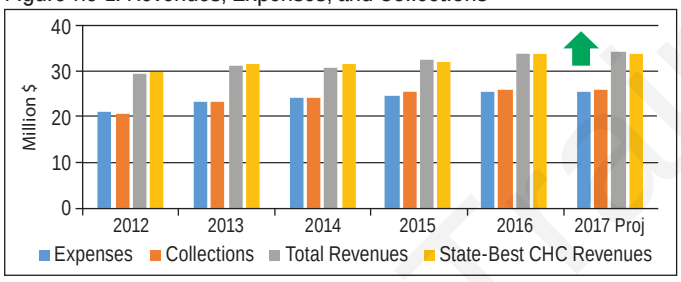


Figure 7.5-2: Accounts Receivable by Payor Type

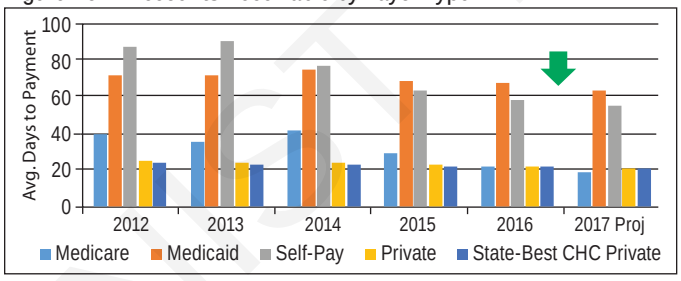
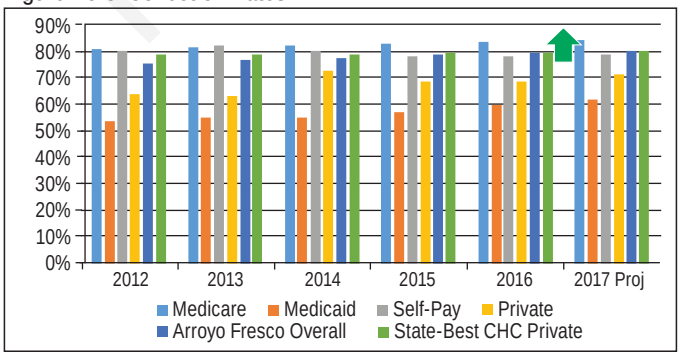


Figure 7.5-3: Collection Rates



As a nonprofit organization, AF considers the value of its medical services to be the primary measure of economic value. AF assesses this value in terms of RVUs per $1,000 of budgeted expenditures in each of the clinical units. Segmentation by clinic, physician, work unit (e.g., speech therapy, physical therapy), payment source, and the most frequent clinical conditions treated is AOS. In 2011, AF persuaded the State Association of CHCs to adopt RVUs/$1,000 budget as a measure for all CHCs in the state. Since RVUs measure clinical services provided, AF uses RVUs/$1,000 net asset value as a measure of return on assets (Figure 7.5-4). AF's performance on this measure has been the best—or near the best—among state CHCs.

7.5a(2) To help identify market trends and determine resources or strategic changes needed for the future, AF tracks its marketplace performance by county and its health care services. Consistent with its mission to serve patients regardless of their ability to pay, AF holds a higher market share in Yuma and La Paz counties (Figure 7.5-5), which have a higher percentage of the population below the poverty threshold. Figure 7.5-6 shows a sample of AF's results by major service types. Results for additional major service types, as well as data segmented by individual services (e.g., for heart disease and well-child care), are AOS. A lower percentage of market share for chronic disease reflects the fact that AF refers many complex chronic disease cases to specialists.

Figure 7.5-4: Return on Assets in Clinical Units

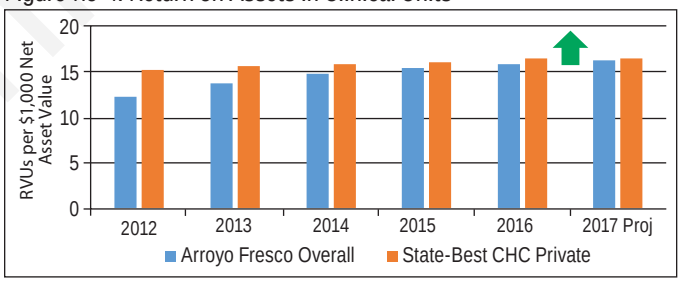


Figure 7.5-5: Market Share by County

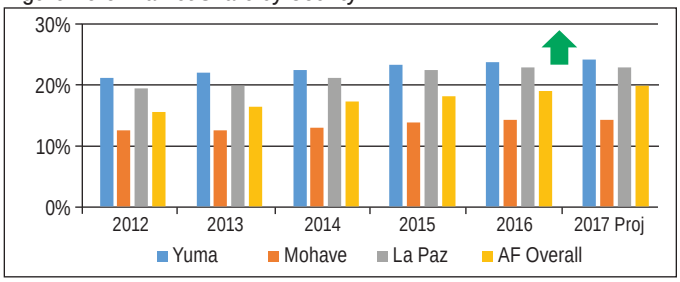


Figure 7.5-6: Market Share by Service