2006

National Institute of Standards and Technology
Technology Administration • Department of Commerce
Baldrige National Quality Program

Arroyo Fresco Community Health Center Case Study

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The Arroyo Fresco Community Health Center Case Study was prepared for use in the 2006 Malcolm Baldrige National Quality Award Examiner Preparation Course. The Arroyo Fresco Community Health Center Case Study describes a fictitious nonprofit organization in the health care sector. There is no connection between the fictitious Arroyo Fresco Community Health Center and any other organization, either named Arroyo Fresco Community Health Center or otherwise. Other organizations cited in the case study also are fictitious, except for several national and government organizations. Because the case study is developed to train Baldrige Examiners and others and to provide an example of the possible content of a Baldrige application, there are areas in the case study where Criteria requirements are not addressed.

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Malcolm Baldrige National Quality Award

OMB Clearance #0693-0006
Expiration Date: January 31, 2007

1. Applicant

Official Name Arroyo Fresco Community Health Center

Other Name n/a

Prior Name n/a

Headquarters Address 1345 Desert Bloom Ave.
Yuma, AZ 85364

Has the applicant self-certified for eligibility in a prior year(s)?

☐ Yes ☒ No ☐ Do Not Know

If "yes," indicate the year(s) in which the applicant submitted the Eligibility Certification Package and the name(s) of the applicant at that time, if different.

Year(s)

Name(s) of Applicant

2. Highest-Ranking Official

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name Ramon Gonzalez

Title CEO

Telephone No. (555) ARROYOF (277-6963), ext. 12

E-Mail r_gonzalez@af.net

Address 1345 Desert Bloom Ave.
Yuma, AZ 85364

Fax No. (555) 277-6967

3. Eligibility Contact Point

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name Roger Sinclair

Title Director of Performance Excellence

Telephone No. (555) 487-6235

Fax No. (555) 487-6277

E-Mail r_sinclair@af.net

Address 2219 Lakeview Blvd.
San Luis, AZ 85349

Overnight Mailing Address (Do not use a P.O. Box number.)
same as above

4. Alternate Eligibility Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name Judy Jackson-Gomez

Telephone No. (555) ARROYOF (277-6963), ext. 18

Fax No. (555) 277-6967

5. Applicant Status

a. Has the applicant officially or legally existed for at least one year, or prior to April 11, 2005? *(Check one.)*

☒ Yes ☐ No

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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5. Applicant Status—continued

b. Has your organization ever been a Malcolm Baldrige National Quality Award recipient? *(Check one.)*

❑ Yes ☒ No

If you checked "No," proceed to item 6.

c. If yes, was your organization an Award recipient in 2000 or earlier? *(Check one.)*

❑ Yes ❑ No

If you checked "No," your organization is not eligible to reapply this year for the Award or for feedback (please contact the Baldrige National Quality Program Office at 800-898-4506 if you have any questions). If you checked "Yes," please choose one of the following options:

❑ Applying for feedback only ❑ Applying for the Malcolm Baldrige National Quality Award

6. Award Category and For-Profit/Nonprofit Designation *(Check as appropriate.)*

❑ Manufacturing (For-Profit Only) ❑ Education (For-Profit) ❑ Health Care (For-Profit)
❑ Service (For-Profit Only) ❑ Education (Nonprofit) ☒ Health Care (Nonprofit)
❑ Small Business (For-Profit Only)

Criteria being used: *(Check one.)*

❑ *Criteria for Performance Excellence*

❑ *Education Criteria for Performance Excellence*

☒ *Health Care Criteria for Performance Excellence*

Note: For-profit education and health care organizations may choose to use the Criteria for Performance Excellence *and apply in the service or small business categories. However, they probably will find their sector-specific Criteria* (Education Criteria for Performance Excellence *or* Health Care Criteria for Performance Excellence) *more appropriate.*

7. Industrial Classification

List up to three of the most descriptive three- or four-digit NAICS codes. *(See page 24 of the PDF version of the* Baldrige Award Application Forms at *www.baldrige.nist.gov/Award_Application.htm*.)

a. 6214 b. 6211 c. _____

8. Size and Location of Applicant

a. Total number of
- employees (business) _____
- faculty/staff (education) _____
- staff (health care) 379

b. For the preceding fiscal year,
- check one financial descriptor: ❑ Sales ❑ Revenues ☒ Budgets
- check the range: ❑ 0–$1M ❑ $1M–$10M ☒ $10M–$100M ❑ $100M–$500M ❑ $500M–$1B ❑ More than $1B

If you are unable to respond to any item, please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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8. Size and Location of Applicant—continued

c. Number of sites: U.S./Territories 11 Outside U.S./Territories _____

d. Percentage of employees: U.S./Territories 100% Outside U.S./Territories _____

e. Percentage of physical assets: U.S./Territories 100% Outside U.S./Territories _____

f. Operational practices associated with all major organizational functions must be accessible for examination in the United States. If some activities are performed outside the applicant's organization (e.g., by a component of the applicant that is outside the United States or its territories, the parent organization, or its other subunits), will the applicant, if selected for a site visit, make available in the United States sufficient personnel, documentation, and facilities to allow full examination of its operational practices for all major functions of its worldwide operations?

❑ Yes ❑ No ☒ Not Applicable

g. In the event the applicant receives an Award, can the applicant make available sufficient personnel and documentation to share its practices at The Quest for Excellence Conference and at its U.S. facilities?

☒ Yes ❑ No

h. Attach a line and box organization chart for the applicant. In each box, include the name of the unit or division and its head.

9. Subunits *(If the applicant is not a subunit as defined on pages 7–8, please proceed to question 10.)*

a. Is the applicant _____ a larger parent or system? *(Check all that apply.)*

❑ a subsidiary of ❑ controlled by ❑ administered by ❑ owned by
❑ a division of ❑ a unit of ❑ a school of

b. Parent organization ("Parent" means the highest organizational level eligible to apply for the Award.)

Name _____

Address _____

_____

Number of worldwide employees of the parent _____

Highest-Ranking Official

Name _____

Title _____

c. Is the applicant the only subunit of the parent organization intending to apply? *(Check one.)*

❑ Yes ❑ No *(Briefly explain)* ❑ Do Not Know

d. Briefly describe the major functions provided to the applicant by the parent or by other subunits of the parent. Examples of such functions include but are not limited to strategic planning, business acquisition, research and development, data gathering and analysis, human resources, 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.

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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9. Subunits—continued

e. Is the applicant self-sufficient enough to respond to all seven Baldrige Criteria Categories?

❑ Yes ❑ No *(Briefly explain.)*

f. Provide the name and date of the official document (e.g., annual report, organization literature, press release) supporting the subunit designation. **Attach relevant portions** of the document showing clear definition of the applicant as a discrete entity.

Note: Applicants supplying a Web site as documentation must print the relevant pages and include these with the application.

Name of the Document _____ Date _____

g. Briefly describe the organizational structure and relationship to the parent.

Attach a line and box organization chart(s) showing the relationship of the applicant to the highest management level of the parent, including all intervening levels. Each box within the chart should include the name of the head of the unit or division.

h. Is the applicant's product or service unique within the parent organization? *(Check one.)*

❑ Yes ❑ No

If "No," do other units within the parent provide the same products or services to a different customer base? *(Check one.)*

❑ Yes ❑ No

If neither of the "Yes" boxes in "h" is checked, complete 1, 2, and 3 below.

(1) Provide a brief description of how the market and product(s) or service(s) are similar.

(2) Indicate the organizational relationships of all units that provide similar or identical products or services, including the approximate sales, revenues, or budgets for each.

(3) Describe how the applicant is different from its parent and the other subunits of the organization (e.g., differences in market, location, or name).

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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9. Subunits—continued

i. **Manufacturing and service subunits of parents with >500 employees, only.**

- Are more than 50 percent of the applicant's products or services sold or provided directly to customers outside the applicant's organization, the parent organization, and organizations controlled by the applicant or the parent? *(Check one.)*

  ❑ Yes ❑ No

- Does the applicant have more than 500 employees? *(Check one.)*

  ❑ Yes ❑ No

- Do the applicant's employees make up more than 25 percent of the worldwide employees of the parent? *(Check one.)*

  ❑ Yes ❑ No

j. **All business subunits, regardless of parent size.**

- Was the applicant independent prior to being acquired, and does it continue to operate independently under its own identity? *(Check one.)*

  ❑ Yes ❑ No ❑ Not Applicable

Note: If self-certification is based on the subunit being independent prior to being acquired and continuing to operate independently under its own identity, attach relevant portions of an official document to support this response.

- Is the applicant separately incorporated and distinct from other subunits of the parent? *(Check one.)*

  ❑ Yes ❑ No

Note: If self-certification is based on the subunit being separately incorporated and distinct from other subunits of the parent, attach relevant portions of an official document (e.g., articles of incorporation) to support this response.

Note: If all answers to "i" and "j" are "No," contact the Baldrige Office at (800) 898-4506 before submitting your form.

10. Supplemental Sections *(Check one.)*

☒ The applicant 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, types of employees, and planning.

❑ The applicant has (a) multiple performance systems that support all of its product and/or service lines and/or (b) products or services that are not essentially similar in terms of customers/users, technology, types of employees, and planning.

If you checked the second option, please describe briefly the differences among the multiple performance systems of your organization in terms of customers, types of employees, technology, planning, and quality systems.

Note: The applicant's Eligibility Contact Point will be contacted if the second option is checked. Applicants may have two or more diverse product and/or service lines (i.e., in different NAICS codes) with customers, types of employees, technology, planning, and quality systems that are so different that the application report alone does not allow sufficient detail for a fair examination. Such applicants may submit one or more supplemental sections in addition to the application report. The use of supplemental sections must be approved during the eligibility certification process and is mandatory once approved.

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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11. Application Format

If your organization applies for the 2006 Award, in which format would you submit the Application Package? *(Check one.)*

☒ 25 paper copies (due date May 25, 2006) ☐ CD (due date May 11, 2006)

12. Confidentiality Considerations

Baldrige Examiners are authorized to use cell phones, cordless phones, and VoIP to discuss your application.

☒ Yes ☐ No

13. Self-Certification Statement, Signature of the Highest-Ranking Official

I state and attest that

(1) I have reviewed the information provided by my organization in this Eligibility Certification Package.

(2) to the best of my knowledge,

- no untrue statement of a material fact is contained in this Eligibility Certification Package, and
- no omission of a material fact has been made in this package.

(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 at any time during the 2006 Award Process cycle, if the information is found not to support eligibility, my organization will no longer receive consideration for the Award and will receive only a feedback report.

Signature of Highest-Ranking Official _____ Date April 6, 2006

Printed Name Ramon Gonzalez

14. Eligibility Certification Filing Fee

Enclose a $150 nonrefundable fee to cover the cost of the eligibility certification filing process. Make the check or money order payable to

Malcolm Baldrige National Quality Award.

You also may pay by VISA, MasterCard, or American Express. Please indicate the method of payment below:

☒ Check or money order (enclosed) ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number _____ Authorized Signature _____

Expiration Date _____ Printed Name _____

Billing Address for Credit Card _____ Today's Date _____

_____

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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15. Nomination to the Board of Examiners

One senior member from each organization whose Eligibility Certification Package is **postmarked on or before March 10, 2006**, may become a member of the 2006 Board of Examiners. The opportunity to learn and the required commitment of time are substantial. The time commitment is a minimum of 110 hours between April and December (including approximately 40 hours in April/May to complete prework for the Examiner Preparation Course, 4 days in May to attend the Examiner Preparation Course, and another 35–50 hours in June to complete a Stage 1, Independent Review). If requested by the Program, Examiners also are expected to participate in the Stage 2, Consensus Review (approximately 25 hours) and Stage 3, Site Visit Review (approximately 9 days).

Nominees must be citizens or permanent residents of the United States and be located in the United States or its territories.

☒ Roger Sinclair from our organization will serve on the 2006 Board of Examiners.
Name of Senior Member Nominee*

*Please, no substitutions after April 11, 2006.

Nominee's contact information:

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Nominee's Title Director of Performance Excellence

Name of Nominee's Organization: Arroyo Fresco Community Health Center

Nominee's Work Address: Arroyo Fresco Family Health Center, 2219 Lakeview Blvd., San Luis, AZ 85349

Work Phone (555) 487-6235*

Work Fax (555) 487-6277*

Work E-Mail Address r_sinclair@af.net*

Nominee's Home Address: 87902 Willards Way, San Luis, AZ 85349

Home Phone (555) 487-2839

Home Fax (555) 487-8723

Home E-Mail Address rsinclair@me.com

If you are unable to respond to any item, please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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The following information is needed by the Malcolm Baldrige National Quality Program Office to avoid conflicts of interest when assigning Examiners to evaluate your application and by Examiners in performing their evaluations.

1. Site Listing and Descriptors

Please refer to the instructions on page 19 of the PDF version of the *Baldrige Award Application Forms* at www.baldrige.nist.gov/Award_Application.htm to complete this Site Listing and Descriptors form. It is important that the totals for the number of employees, faculty, and/or staff; percentage of sales, revenues, or budgets; and sites on this form match the totals provided in response to 8a, 8b, and 8c on pages 2 and 3 of the 2006 Eligibility Certification Form. For example, if you report 600 employees in response to question 8a, the total number of employees provided in the Site Listing and Descriptors form should be 600 (see example below). Duplicate the Site Listing and Descriptors page if all sites cannot be listed on a single page.

EXAMPLE			
Address of Site(s)	**Number** ☐ Employees ☒ Faculty ☒ Staff	**Percentage** ☐ Sales ☐ Revenues ☒ Budgets	**For each site, describe the relevant products, services, and/or technologies.**
Coyote Hall 85 Campus Way	381 Faculty 200 Staff	95%	Administrative headquarters, instructional and educational services
Cactus Hall 85 IT Parkway	17 Faculty 2 Staff	5%	Satellite campus for information technology instruction, including a technology lab

Address of Site(s)	**Number** ☐ Employees ☐ Faculty ☒ Staff *(Check one or more above, and list below the number at each site.)*	**Percentage** ☐ Sales ☐ Revenues ☒ Budgets *(Check one above, and list below the % at each site.)*	**For each site, describe the relevant products, services, and/or technologies.**
Arroyo Fresco Family Health Center—North Yuma 1345 Desert Bloom Ave Yuma, AZ 85364	59	15	Medical and dental services Administrative and information services
Arroyo Fresco Family Health Center—East Yuma 18137 Fourth Ave Yuma, AZ 85367	42	10	Medical and dental services
Arroyo Fresco Women's Health Center—North Yuma 3529 El Centro Ave Yuma, AZ 85365	39	11	Obstetrics and gynecology

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

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Address of Site(s)	Number ☐ Employees ☐ Faculty ☒ Staff *(Check one or more above, and list below the number at each site.)*	Percentage ☐ Sales ☐ Revenues ☒ Budgets *(Check one above, and list below the % at each site.)*	For each site, describe the relevant products, services, and/or technologies.
Arroyo Fresco Family Health Center—San Luis 2219 Plaza Del Oro Yuma, AZ 85349	40	10	Medical and dental services
Arroyo Fresco Family Health Center—Somerton 672 Calle Viejo Somerton, AZ 85350	25	9	Medical services (and dental services by mobile van)
Arroyo Fresco Family Health Center—Parker 4010 Colorado St. Parker, AZ 85344	21	5	Medical services (and dental services by mobile van)
Arroyo Fresco Family Health Center—Kingman 6527 Old Mine Rd. Kingman, AZ 86401	36	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 Family Health Center—Bullhead City 39675 Fisherman's Way Bullhead City, AZ 86429	41	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 Health Center—Lake Havasu City 2219 Lakeview Blvd. San Luis, AZ 85349	47	11	Medical and dental services
San Juan Elementary School 2058 Plaza del San Juan Yuma, AZ 85364	14	5	Medical services (and dental services by mobile van)
El Centro High School 2590 El Centro Ave. Yuma, AZ 85364	15	5	Medical services (and dental services by mobile van)

Provide all the information for each site, except where multiple sites produce similar products or services. For multiple site cases, refer to 8c on page 3 of the Eligibility Certification Form. Also, see the 2006 Eligibility Certification Form—Instructions on page 9 of the PDF version of the *Baldrige Award Application Forms* at www.baldrige.nist.gov/Award_Application.htm.

Use as many additional copies of this form as needed to include all sites.

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2. Key Business/Organization Factors

List, briefly describe, or identify the following key organization factors. Be as specific as possible to help us avoid real or perceived conflicts of interest when assigning Examiners to evaluate your application. "Key" means those organizations that constitute 5 percent or more of the applicant's competitors, customers/users, or suppliers.

A. List of key competitors

Other community health centers in adjacent counties and agencies offering access to health care services regardless of patients' ability to pay; community-based private medical and dental health care providers; Indian Health Services facilities; Veterans Health Administration facilities; health care providers in Mexico (for border residents)

B. List of key customers/users

Patients and their families in the three western counties of Arizona—Yuma, La Paz, and Mohave—regardless of their ability to pay
Hospitals and specialists in the above counties

C. List of key suppliers/partners

Desert Data Solutions (DDS) for information technology management and support; HR Leaders, Inc., for qualified contract staff; Gil's Garage for repair and maintenance of vans; Shiny Clean for indoor and outdoor custodial services; and MedProducts, Inc., for medical and dental supplies and pharmacy and lab services.

Partners include CactusCom (a large telecommunications company), Winding River Casinos, Saguaro State University, a regional pharmaceutical company, several local community colleges, and community hospitals.

D. Description of the applicant's major markets (local, regional, national, and international)

The three western counties of Arizona: Yuma, La Paz, and Mohave

E. The name of the organization's financial auditor

Johansen, Simon, and Clark

F. The applicant's fiscal year (e.g., October 1–September 30)

January 1–December 31

If you are unable to respond to any item,
please contact the Baldrige National Quality Program Office at (800) 898-4506 before submitting your form.

Arroyo Fresco Community Health Center
Organization Chart

Malcolm Baldrige National Quality Award

Provide all information requested. A copy of page 1 of this 2006 Application Form must be included in each of the 25 paper copies of the application report (or, alternatively, in the PDF version on a CD).

1. Applicant

Applicant Name Arroyo Fresco Community Health Center

Mailing Address 1345 Desert Bloom Ave.
Yuma, AZ 85364

2. Award Category (*Check one.*)

☐ Manufacturing ☐ Service ☐ Small Business
☐ Education ☒ Health Care

For small businesses, indicate whether the larger percentage of sales is in service or manufacturing. (*Check one.*)

☐ Manufacturing ☐ Service

Criteria being used (*Check one.*)

☐ Business ☐ Education ☒ Health Care

3. Official Contact Point

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name Roger Sinclair

Title Director of Performance Excellence

Mailing Address 2219 Lakeview Blvd.
San Luis, AZ 85349

Overnight Mailing Address
(Do not use P.O. Box number.)
same as above

Telephone No. (555) 487-6235

Fax No. (555) 487-6277

4. Alternate Official Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name Judy Jackson-Gomez

Telephone No. (555) ARROYOF (277-6963), ext. 18

Fax No. (555) 277-6967

5. Release and Ethics Statements

a. Release Statement

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

Should our organization be selected for a site visit, we agree to host the site visit and to facilitate an open and unbiased examination. We understand that our organization must pay reasonable costs associated with a site visit. The site visit fees range from $1,500 to $35,000, depending on the type of applicant. (The fees are shown on page 4 of the PDF version of the *Baldrige Award Application Forms* at www.baldrige.nist.gov/Award_Application.htm.)

If our organization is selected to receive an Award, we agree to share nonproprietary information on our successful performance excellence strategies with other U.S. organizations.

b. Ethics Statement and Signature of the Highest-Ranking Official

I state and attest that

(1) I have reviewed the information provided by my organization in this Application Package.

(2) to the best of my knowledge,

- no untrue statement of a material fact is contained in this Application Package, and
- no omission of a material fact that I am legally permitted to disclose and that affects my organization's ethical and legal practices has been made. This includes but is not limited to sanctions and ethical breaches.

Date May 21, 2006

Signature Ramon Gonzalez

☒ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Printed Name Ramon Gonzalez

Title CEO

Applicant Name Arroyo Fresco

Mailing Address 1345 Desert Bloom Ave.
Yuma, AZ 85364

Telephone No. (555) ARROYOF (277-6963), ext. 12

Fax No. (555) 277-6967

Malcolm Baldrige National Quality Award

6. Confidential Information

Please note: To help ensure the confidentiality of the information requested, submission requirements for this page (page 2) of your Application Form differ from those for page 1 of the form and for the application report. Whether you submit 25 paper copies or a CD of your application report, one completed **paper** copy of page 2 may be submitted with your Award Application Package, or the information may be telephoned to ASQ at (414) 298-8789, extension 7205. *Do **not** include this page (page 2) in the 25 copies of your application report.*

a. Social Security Number and Date of Birth of the Highest-Ranking Official

If your application is selected for Stage 3 review, this information will be used in the process for determining role model organizations. (See pages 3–4 of the PDF version of the *Baldrige Award Application Forms* at www.baldrige.nist.gov/Award_Application.htm.)

Name Ramon Gonzalez

Social Security Number XXX-XXX-XXXX

Date of Birth June 3, 1949

b. Application Fees (see page 30 for instructions)

Enclosed is $ 2,000 to cover one application report and 0 supplemental sections.

Note: An additional $1,250 is required if you are submitting the application report on a CD.

Make the check or money order payable to

Malcolm Baldrige National Quality Award.

You also may pay by VISA, MasterCard, or American Express. Please indicate your method of payment below:

☒ Check or money order (enclosed)

☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number _____

Expiration Date _____

Today's Date _____

Billing Address for Credit Card _____

_____

Authorized Signature _____

Printed Name _____

7. Submission

The complete Award Application Package must be postmarked or consigned to an overnight delivery service no later than May 25, 2006 (May 11, 2006, if submitting on a CD) for delivery to

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

OMB Clearance #0693-0006
Expiration Date: January 31, 2007

Glossary of Terms and Abbreviations

360-Degree Review Process: A process for performance feedback that includes feedback from superiors, peers, and reports

5S: A Japanese concept for good housekeeping and visual management: (1) Sort (*Seiri*), (2) Straighten (*Seiton*), (3) Shine (*Seiso*), (4) Standardize (*Seiketsu*), and (5) Sustain (*Shitsuke*)

A

AAFP: American Academy of Family Physicians, a national professional membership organization of family physicians from which AF gets clinical guidelines, performance indicators, and comparative data

AAP: American Academy of Pediatrics, a national professional membership organization of pediatricians from which AF gets clinical guidelines, performance indicators, and comparative data

AAR: After Action Review, a formal method to debrief and evaluate an initiative to identify strengths and opportunities for improvement

ACEI: Angiotensin-Converting Enzyme Inhibitors, a group of pharmaceuticals that are used primarily in treatment of hypertension and congestive heart failure

ACOG: American College of Obstetricians and Gynecologists, the national professional membership organization of obstetricians and gynecologists from which AF gets clinical guidelines, performance indicators, and comparative data

AF: Arroyo Fresco, which in Spanish means "cool, flowing stream"

AQA: Ambulatory Care Quality Alliance, a large body of U.S. health care stakeholders—clinicians, consumers, health insurers, and others—working collaboratively to develop a strategy for measuring, reporting, and improving performance at the physician level and to promote availability of uniform information for consumer decisions about quality

B

BRFSS: Behavioral Risk Factor Surveillance System, a database, managed by the Centers for Disease Control and Prevention, on U.S. health risk prevalence and trends

BPHC: Bureau of Primary Health Care, the agency within HRSA responsible for oversight of federally funded community health centers

C

Community: The community at large served by AF

Catchball: A form of two-way communication that takes place among multiple levels of the organization during action plan development

CCK: Care Connection Kiosk, the multi-use portable electronic information unit used in all facilities and in the community to disseminate health information, gather ideas and feedback, and give patients access to their own PHPs and health information

CDC: Centers for Disease Control and Prevention, one of HHS's major operating components, which is responsible for monitoring U.S. health and health behaviors, conducting research, taking part in advocacy and policy development, and promoting health improvement. AF gets clinical guidelines, performance indicators, and comparative data from the CDC.

CEO: Chief Executive Officer—Ramon Gonzalez

CFO: Chief Financial Officer—Jay Nguyen

CHCs: Community Health Centers, nonprofit, community-owned organizations like AF that provide primary and preventive services to the underserved and strive to improve access and eliminate health disparities regardless of people's ability to pay

CHF: Congestive heart failure

CM: Clinical microsystem, a small group of providers, along with their patients, processes, information, and information systems; the elements of a CM are interdependent and share a common purpose.

CME: Continuing Medical Education, the requirements physicians (and other clinicians) must fulfill on an ongoing basis in order to maintain licensure and, as appropriate, board certification

CMS: Centers for Medicare and Medicaid Services, the HHS agency responsible for the administration of Medicare and (in partnership with the states) for the administration of Medicaid, the State Children's Health Insurance Program, and health insurance portability. CMS surveys health care facilities nationwide to ensure compliance with quality standards, including HIPAA.

Committee on Rural Health Issues: A statewide group responsible for comprehensive planning to improve health care access in rural areas

COPD: Chronic obstructive pulmonary disease

CTQ: Critical to Quality, a product's or process's key measurable characteristics, including performance standards or specification limits, that must be met to satisfy the customer

Culturally Competent Care: Care designed to address patient differences in language and cultural norms so that the care meets culturally driven needs, expectations, and preferences. Providing culturally competent care is important to promote access, ensure the effectiveness of care, and reduce health disparities associated with language and race or ethnicity.

D

Daily Huddle: The practice of CM staff to gather at the beginning of the day to review planned actions for the day and anticipate patient and staff needs

Data Docs: A cross-location team representing CMs and functional groups that helps evaluate and improve AF's performance measurement system

DDS: Desert Data Solutions, AF's information technology strategic partner

DO: Director of Operations

DOE: Design of Experiments

E

ED: Emergency Department

Elders Council: A council in each county composed of patient and family members that provides input on the specific needs, expectations, and preferences of elders

EHR: Electronic health record

EPA: Environmental Protection Agency, the federal agency responsible for developing and enforcing regulations pertaining to environmental quality

EPSDT: Early Periodic Screening, Diagnosis, and Treatment, the health services required to be provided for Medicaid enrollees 0–21 years old

F

FMEA: Failure Modes and Effects Analysis, a structured method to identify, prioritize, and address potential failures in high-risk processes

FOCUS: Financial performance, Organizational learning, Clinical excellence, Utilization, and Satisfaction—refers to AF's framework for performance measurement

H

HbA1c: Glycosylated hemoglobin, which is measured in a blood test commonly used to assess blood sugar control in diabetes patients

HCDI: Health Care Data and Information, a set of indicators of health care outcomes and service delivery used by a national health care quality organization

HPT: Healing Partners Team, a cross-location team responsible for reviewing health care results; keeping track of changes in legal, regulatory, and accrediting requirements, as well as clinical science and industry best practices; and identifying cross-organizational opportunities for improvement

HHS: U.S. Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act of 1996, which includes multiple provisions to protect patient privacy and confidentiality

HP 2010: Healthy People 2010, a national public health initiative that identifies priority areas for improvement with measurable ten-year goals. States and many communities have developed programs to support goal achievement

HR: Human Resource(s)

HRSA: Health Resources and Services Administration, the HHS agency responsible for improving access to underserved populations and reducing unequal care and outcomes

I

IDP: Individual Development Plan, the approach that establishes individual employee goals and development plans, a key element in the performance management system

IHS: Indian Health Service, the HHS agency responsible for ensuring comprehensive and culturally competent personal and public health services for Alaska Natives and American Indians

Info Interns: A cross-location team responsible for reviewing and providing input at least annually on AF's information system capabilities and needs

IOM: Institute of Medicine, a group of health care experts and key stakeholders within the National Academy of Sciences that is responsible for a recent series of landmark reports on U.S. health care quality, beginning with *To Err Is Human* (1999), which put the spotlight on patient safety

IT: Information Technology

J

JCAHO: Joint Commission on Accreditation of Healthcare Organizations, a national accrediting body for many different types of health care organizations. JCAHO conducts required periodic performance reviews of CHCs on behalf of HRSA.

L

LDL: Low-density lipoprotein, a type of cholesterol

Lean: An initiative focused on eliminating all forms of waste and reducing cycle time while becoming more responsive to customer demand

M

MA: Medical Assistant

MAM: Mothers Aiding Mothers, a volunteer program in which mothers and grandmothers mentor teenage mothers

N

NACHC: National Association of Community Health Centers, a membership organization focused on advocacy, policy development, and education and training. It provides a source of leadership and board development

NHSC: National Health Service Corps, a program within HRSA's Bureau of Health Professions focused on recruiting and retaining health professionals in underserved areas

NP: Nurse Practitioner

O

OASIS: AF's principal process improvement methodology

OSHA: Occupational Safety and Health Administration, the agency in the U.S. Department of Labor responsible for developing and enforcing regulations pertaining to the safety and health of U.S. workers

P

PA: Physician Assistant

Partners Committee: A committee representing all external stakeholders that meets quarterly to provide input and guidance to AF's planning process

Payor: In health care, an organization that pays a patient's health care expenses. For example, a third-party payor is any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

PFAB: Patient-Family Advisory Board, the eight-member board at each location composed of patients and family members that meets quarterly to provide feedback on current services and input on future needs and plans

PDCA: Plan-Do-Check-Act

People Review: A step in the Strategic Planning Process to address workforce capability and needs and to develop the HR plan

PHP: Personal Health Plan, the plan that patients and providers develop based on assessed needs and personal preferences and goals

Poka-yoke: From the Japanese *yokeru* (to avoid), and *poka* (inadvertent errors)—a methodology to prevent errors or to make them easily identifiable

PPT: People Potential Team, a cross-location team responsible for reviewing workforce results, identifying cross-organizational improvement opportunities, and providing feedback on development and measurement approaches

Progress Scan: The FOCUS scorecard review performed at least monthly by County Directors and clinic managers to detect adverse trends

Promotoras (or -es): The term frequently used for AF's volunteers, who promote health in many different ways

Pugh Matrix: A method for prioritizing and selecting options using a matrix to score alternatives against a set of evaluation criteria

Q

QPG: Quality and Productivity Group

R

RN: Registered Nurse

S

Saguaro State Award for Performance Excellence: The state-level performance excellence award based on the Baldrige Criteria for Performance Excellence

SWST: Service With Spirit Team, a cross-location team responsible for reviewing customer-related results, identifying cross-organizational improvement priorities, and providing feedback on approaches to customer listening and learning and satisfaction measurement

Six Sigma: A methodology and an associated set of tools to reduce variability and eliminate defects

SSU: Saguaro State University, a key education partner

***Staff and Volunteer Handbook*:** The online system for knowledge management, which includes, for example, organizational policies and clinical guidelines

STAR: Superior Teamwork Achieves Results, AF's principal employee recognition program

State Association of CHCs: State Association of Community Health Centers, the nonprofit member organization that provides advocacy, education and training, and group purchasing opportunities, as well as statewide collaborative learning and benchmarking

SWOT: Strengths, Weaknesses, Opportunities, and Threats—an analysis performed as an input to the Strategic Planning Process

T

Takt Time: The pace of production or service delivery needed to meet customer demand

TB: Tuberculosis

Town Hall Meeting: An open meeting held annually in each county that provides an opportunity for two-way communication between AF leaders and key stakeholders

U

Uniform Data System: The database managed by BPHC that includes aggregate clinical and operational data for CHCs nationwide

URI: Upper respiratory infection

V

VA: U.S. Department of Veterans Affairs

Veterans Health Administration: An organization under the VA that provides a broad spectrum of medical, surgical, and rehabilitative care

VMV: Vision, mission, and values

W

WIC: Women, Infants, and Children, a national health and nutrition program for low-income mothers and young children that is administered by the Food and Nutrition Service of the U.S. Department of Agriculture

P Preface: 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 40 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, case management, health education, and home visitation, which increase access to care. More than 1,000 such centers serve some 15 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 400,000 people—about one-third of the state's overall population. Yuma County borders Mexico.

P.1-1 2005 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	379 (62% direct patient care)
Volunteers	250

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

Demographics	Yuma	La Paz	Mohave	AZ
Persons per square mile	29	4.4	11.6	45
Persons below poverty threshold	19.2%	19.6%	13.9%	13.9%
Under 5 years old	7.9%	4.9%	6.0%	7.5%
Under 18 years old	28.9%	21.1%	23.1%	26.6%
65 years old and over	16.5%	25.8%	20.5%	13.0%
White	68.3%	74.2%	90.1%	75.5%
African American	2.2%	0.8%	0.5%	3.1%
Native American	1.6%	12.5%	2.4%	5.0%
Asian/Pacific Islander	1.0%	0.5%	0.9%	1.9%
Other (different race or two or more races)	26.8%	12.0%	6.1%	14.5%
Hispanic heritage*	50.5%	22.4%	11.1%	25.3%
Home language other than English	45.5%	21.6%	10.7%	25.9%

*Persons of Hispanic heritage can be of any race.

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 vacationers 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., twice the national rates of tuberculosis and hepatitis A) and a higher mortality rate for accidents. Women's health is a priority in Yuma County; 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.

P.1a(1) Main health care services and delivery mechanisms: 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 the Bureau of Primary Health Care (BPHC).

AF delivers care through the clinical microsystem (CM)—a small interdisciplinary team 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 CM include the patients, clinicians, and support staff; information and information technology; and the care processes. AF has 25 CMs organized according to its key services. For example, each clinic has at least one family medicine CM.

P.1a(2) Organizational culture: AF was founded in 1968 by Joe Regam 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 where one can 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 BPHC. In 1990, AF merged

Figure P.1-3 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.

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 a formal statement of vision, mission, and values (VMV). (See Figure P.1-3.)

P.1a(3) Staff profile: AF has 379 employees (12% of whom are part-time), and the workforce mirrors the race/ethnicity and culture of the population served (Figure P.1-4). Clinical providers, who make up 62% 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% of the workforce, and 5% of staff are senior leaders or managers.

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

P.1a(4) Major technologies, equipment, and facilities: 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

Figure P.1-4 Staff Profile

Gender	Male	42.2%
	Female	57.8%
Race/ Ethnicity	White	77.7%
	African American	1.2%
	Native American	5.5%
	Asian/Pacific Islander	0.8%
	Other (different race or two or more races)	15.2%
	Hispanic heritage*	26.1%
Education	Postgraduate	24.7%
	Two–four years of college	38.1%
	High school	37.2%

*Persons of Hispanic heritage can be of any race.

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 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 through individual, classroom, and peer counseling sessions. Laboratory tests and X-rays for students 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 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 information technology 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, a telecommunications partner.

P.1a(5) Legal and regulatory environment: 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 under section 330 of the Public Health Service Act. To maintain their federal funding, CHCs are required by HRSA to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). 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 2004. 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) Organizational structure and governance system: AF is governed by a voluntary 15-member Board of Directors chaired by the founder and former CEO, Joe Regam (see 1.2a[1]). By-laws and federal program regulations require that at least 51% of voting members be recipients of AF services. Gonzalez and his senior leadership team are nonvoting members of 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). Each has cross-organizational representation from CMs and functional groups. They share and integrate data and information across AF and link the top team and the front line.

P.1b(2) Key patient and customer groups, stakeholder groups, and health care market segments: AF's key customer and stakeholder groups are patients and their families, the community, physicians, staff, volunteers, partners, and payors, and their key requirements are shown in Figure P.1-5. As appropriate, AF segments its key stakeholder groups 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. Many are patients and patients' family members themselves. 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), enabling AF to manage resource gaps or reallocate resources to other priorities. AF's health care market segments are the patients in the three counties of its service area.

P.1b(3) Role of suppliers and partners: 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 of supplies or services, and continuity of operations for providing clinical care.

- **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, as well as with local community colleges. Collaborative efforts include training and preceptorships supervised by AF providers.

- **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, such as health education and mobile van services at schools, churches, and shelters.

- **Industry Partners:** AF partners with a regional pharmaceutical company on a prescription assistance program. AF has partnered with CactusCom, a large telecommunications company, since 1999 for leadership and technology development and training resources. In 2004, AF began a partnership with Winding River

Figure P.1-5 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
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

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 information technology (IT) expertise and support to small, nonprofit organizations. Vendor partners are HR Leaders, Inc., a provider of temporary clinical and office staff; Shiny Clean custodial service, which provides indoor and outdoor maintenance and housekeeping services; and Gil's Garage, a vehicle maintenance company that services AF's mobile vans.

P.1b(4) Key supplier and partnering relationships and communication mechanisms: All partners and suppliers participate in annual training related to ethics, legal obligations, and AF's VMV. The Partners Committee, with representatives from all of AF's key stakeholders, participates actively in the Strategic Planning Process, and committee members serve in a liaison role between AF and the stakeholder groups they represent. AF regularly meets with all suppliers to establish performance expectations up front and to review performance.

P2 Organizational Challenges

P.2a Competitive Environment

P.2a(1) Competitive position: As described in P.1a(2), AF has expanded significantly from its humble beginnings. In 2005, 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 (21%) and La Paz (19%) than Mohave (12%). Although AF operates in a high-need service area and guarantees service regardless of patients' ability to pay, it nevertheless competes for patients and seeks to attract patients from all income strata. Figure P.2-1 outlines areas for competition/collaboration in AF's service area. AF also competes for staff members across its entire service area (see Figure P.2-3).

P.2a(2) Principal factors that determine success: Over the last decade, CHCs nationwide have 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 continues to grow. To remain financially stable and support continued growth and improvement, AF must ensure operational efficiency and productivity, decrease expenses, capitalize on the use of IT to reduce waste and promote productivity, and expand and strengthen its access to capital.

Figure P.2-2 Key Comparative Data Sources

Comparison Group	Data Sources
National	• Agency for Healthcare Research and Quality • BPHC/HRSA • Centers for Disease Control and Prevention (CDC) • Centers for Medicare/Medicaid Services (CMS) • Healthy People 2010 • JCAHO • Health Care Data and Information (HCDI) • Professional Associations (AAFP, AAP, ACOG) • Packer Patient Satisfaction Survey • Oates Staff Satisfaction Survey • Quality and Productivity Group (QPG) • Baldrige Award for Performance Excellence
State and Local	• Healthy Arizona 2010 • State Association of CHCs • State CHC Benchmarking Consortium • Saguaro State Award for Performance Excellence

P.2a(3) Key available sources of comparative and competitive data (Figure P.2-2): 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 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, including 7 serving similar populations.

P.2b Strategic Challenges

AF identifies its strategic challenges during its annual Strategic Planning Process and aligns them with five key performance areas (Figure P.2-3). The FOCUS framework (1.1a[3]) establishes performance measures and reports in a series of linked and aligned scorecards for the whole organization, its care delivery sites, CMs, and functions.

Figure P.2-1 Key Areas for Competition/Collaboration

Area	Competitor/Collaborator
All patients	Other community health centers 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 may provide outpatient care under contractual arrangements with the Veterans Health Administration, while 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.2-3 Key Strategic Challenges

Area	Key Strategic Challenge
Financial performance	• 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, and — cutbacks in Medicaid eligibility at the state level.
Organizational learning	• Address workforce gaps, in particular, clinical providers and staff with specific technical skills (e.g., physicians, nurses, pharmacists, pharmacy and radiology technicians).
Clinical excellence	• Address the low incidence of prevention and screening and the higher incidence of chronic and communicable disease in the service area.
Utilization	• Establish and manage mechanisms to provide specialty care and unmet service needs, in particular, to uninsured patients.
Satisfaction	• Meet staff recruitment and retention challenges related to remote locations; a needy, vulnerable patient population; and a total compensation package. • Maintain/enhance relationships with patients, the community, and external partners, including divergent service expectations.

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 a decade later represent just 22 percent of total revenue. The balance of funding comes from state and local service contracts and awards; Medicaid, Medicare, and other insurance programs; patient payments; an annuity from the AF Foundation; and donations from individuals, groups, and corporations (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 2000 and 2003.

Figure P.2-4 Revenue Sources (2005)

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

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 1997, the leaders adopted the Baldrige Criteria as their business framework. Using organizational feedback and benchmarking role model health care organizations, they have refined AF's performance improvement approach, based on Plan-Do-Check-Act, into the current system, which integrates the Baldrige framework, the use of CMs, and the OASIS Improvement Model (Figure 6.2-2), as shown in Figure P.2-5.

In 2002, AF sought to organize care centered around the patient and family while enhancing its operational efficiency. CMs were established in AF's redesign of its key health care delivery processes. CMs develop an understanding of their patient populations using a practice profile, a map, and standardized care processes built on evidence-based or widely accepted best practices, and they continually examine their results to identify improvement opportunities, test changes, and share their learning with other CMs.

Regular evaluation of the effectiveness of AF's processes and approaches occurs through both informal and formal performance reviews (Figure 4.1-1). Organizational learning—represented by knowledge and best practices—is shared electronically, in print, and face-to-face. Participation in the State Association of CHCs' improvement activities and the national learning collaborative on Action to Eliminate Health Disparities are two additional approaches AF uses to compare its performance against similar organizations with similar aims and identify opportunities for improvement. AF was proud to receive the Saguaro State Award for Performance Excellence in 2005.

Figure P.2-5 AF's Integrated Improvement Model

1: Leadership

1.1 Senior Leadership

1.1a Vision and Values

1.1a(1) Set and deploy vision and values: Ramon Gonzalez and his leadership team review and reaffirm AF's VMV as part of the annual Strategic Planning Process. 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 through 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 site, 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) Foster and require legal and ethical behavior: Senior leaders have created an environment that fosters legal and ethical behavior that reflects all AF 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. Based on the nature of the work performed and results of a precourse survey, staff, board members, and volunteers are then 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 if an issue is not resolved satisfactorily. Within the CMs, any concern about ethical issues is dealt with quickly as part of the Daily Huddle.

1.1a(3) Create a sustainable organization: The senior leaders have chosen to stay at AF because of their own personal commitment to the organization's VMV. They know these can only be actualized if the organization's sustainability is ensured. A sustainability assessment is conducted as part of the Strategic Planning Process (Figure 2.1-1). In addition, senior leaders further sustainability and create an environment for performance improvement, accomplishment of AF's mission and strategic objectives, innovation, organizational agility, and learning through their use of the FOCUS framework, as described below and in the Items referenced. Through this framework, senior leaders

- focus on fiscal responsibility and innovation in the ways that additional resources are leveraged (**F**inancial performance: Item 6.2)
- facilitate organizational learning through benchmarking and by identifying best practices, and they provide both personal and organizational development and knowledge sharing (**O**rganizational learning: Items 4.2b and 5.1a[1])

Figure 1.1-1 Arroyo Fresco Leadership System

- increase AF's ability to adapt to rapid changes in the clinical environment (**C**linical excellence: Items 2.1a[2] and 2.2a[2])
- expand partnerships to increase the services offered to patients, their families, and staff (**U**tilization)
- address the needs and desires of today for staff and volunteers while building longer-term loyalty through developmental plans and succession plans (**S**atisfaction: Items 5.1c[3], 5.2, and 5.3)

Also, once a quarter, senior leaders perform another staff member's job for which they are qualified. This "rotation" back into a line function helps them identify—and remove—any organizational barriers to agility.

1.1b Communication and Organizational Performance

1.1b(1) Senior leaders communicate, empower, and motivate: Staff and volunteers are empowered and motivated in various ways. AF's culture is one of teamwork with a clear sense of purpose. People are given the opportunity to bring their intelligence, ingenuity, and passion to bear on the aspect of health care delivery or patient support in which they are engaged. 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, three years ago, Tony Joachin introduced 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.

In addition to the more formal programs described in Item 5.1b, senior leaders use informal ways to reward and recognize staff and volunteers. For example, senior leaders spontaneously thank staff members and volunteers for demonstrating the values of the organization. Staff members and volunteers are featured 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, someone who has made a contribution to improved health care services or outcomes might receive a thank-you note and a pedometer. A volunteer who reads to children who are waiting during their parents' appointments could receive a certificate, along with a gift card to a local bookstore.

1.1b(2) Senior leaders create a focus on action: Senior leaders create and reinforce a focus on action to accomplish the organi-

Figure 1.1-2 Communication Methods

Method	Frequency	Participants	Primary Focus
Intranet	Daily	S, V	Access online *Staff and Volunteer Handbook*, lessons learned, urgent issues.
Internet	Daily	All	Access hours by location, services provided, scheduling of appointments, health care topics, links to other relevant sites, and the Annual Report.
Huddles	Daily	S, V	Share time-sensitive information and best practices, address ethical concerns, amd identify improvement opportunities.
Staff Meetings (at each site)	Weekly	S, V	Communicate operations for all sites and vans.
All-Staff Meetings	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.
Clinic Visits	Quarterly	S, V, PF	Senior leaders rotate across the clinics to conduct face-to-face discussions.
Champion Messaging	Monthly	All	Share progress on strategic initiatives.
Senior Leader Walk-Around	Daily	S, V, PF, P, C	Listen and learn.
Site Champion	Weekly	S	Work with site managers to do a Progress Scan.
Board Meetings	Monthly	B, C	Provide oversight of the organization; discuss any issue raised by a member of the community.
Staff Orientation	As Needed	S, V	Present VMV; discuss ethics and diversity (culturally competent care).
Strategic Planning Session	Annually	S, V, B, P, C	Gather inputs from all stakeholders, conduct a risk assessment, and prioritize needs.
Newsletters	Monthly	All	Recognize staff and volunteers; share results of leadership system and board assessments.
Bulletin Boards	Weekly	S, V, PF, C	Recognize staff and volunteers; note opportunities.
Town Hall Meetings (by county)	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, C=Community
*Held during the National Health Center Week

zation's objectives through the reviews listed in Figure 4.1-1. Daily Huddles provide real-time reinforcement of the actions needed for the organization to achieve its vision. The pervasive use of the OASIS Improvement Model reflects the commitment to continuous improvement. Each of these vehicles includes patients and families, partners, staff, and volunteers, providing a balance across all of the organization's stakeholders.

1.2 Governance and Social Responsibilities

1.2a Organizational Governance

1.2a(1) Key factors in governance system: The Board of Director's Quality, Ethics, Community, Partner Relations, Development, and Audit Committees reinforce strong governance and accountability for management's actions. Also, senior leaders are accountable to the board, as well as to the larger community they serve, and the board annually evaluates the CEO's performance. In addition, representation from AF's diverse stakeholder groups on the board helps ensure protection of stakeholder interests. Fiscal accountability is accomplished through quarterly budget reviews and monthly financial reports, and the board regularly reviews capital expenditures. To accomplish independence in 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.

To address transparency in operations and disclosure policies, board members annually disclose conflicts of interests 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. All board meetings are announced in advance, and the public is invited to attend. Anyone in the community may request that an item be added to the agenda for discussion. In 2003, the senior leaders and the board adopted formal principles of governance. The entire board and senior leadership team 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 topics related to effective boards for nonprofit organizations. These representatives share their learnings at the next board meeting.

1.2a(2) Senior leader performance evaluation: Performance of all senior leaders is evaluated at an individual level, as well as at the leadership system level. Each senior leader 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 Individual Development Plan (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 senior leadership team. Using the OASIS Improvement 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 a monthly community newsletter.

1.2b Legal and Ethical Behavior

1.2b(1) Address adverse impacts on society: As members of the communities in which they serve, senior leaders also feel any adverse impacts that might result from the organization's health care services and operations. Their approach is to prevent 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. 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 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, the senior leaders reinforce a "no blame" climate so that staff and volunteers are encouraged to identify problems or potential problems in the organization and its operations.

1.2b(2) Promote and ensure ethical behavior: 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. The organization promotes ethical behavior as described in Item 1.1a. Key processes and measures or indicators for enabling and monitoring ethical behavior are shown in Figure 1.2-4. Senior leaders explicitly contrast the "no blame" environment for identifying problems with a "zero tolerance" policy for breaches of ethical behavior. The board's Ethics Committee is charged with investigating any potential breaches of conduct.

1.2c Support of Key Communities and Community Health

AF is a nonprofit organization with very challenging resource constraints. Therefore, the 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.

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

Requirement	Key Processes	Measure	Goal
Corporate Compliance and Ethics	Training in good board governance	% Board members trained	100%
Fiduciary Responsibility	Internal and external audits External audits	Audit results	No irregularities
Accreditation	JCAHO survey HRSA survey	Survey results	No recommendations for improvement
HIPAA	Training	% Compliance % Staff and volunteers trained	100% compliance 100% trained
Licensure	Licensing for health professionals	Staff licensure	100%
	Licenses for pharmacies	Pharmacies licensure	100%
	Licenses for motor vehicle drivers	Van drivers licensure	100%
	Licenses for outpatient medical facilities and behavioral health facilities	Facilities licensure	100%
Environmental Protection Agency (EPA)	Proper disposal of medical waste	% Staff and volunteers trained % Recycled waste	100% 45%
Safety	Safety inspections	# OSHA recordables	0
	Job-specific training for staff and volunteers	% Staff and volunteers trained	100%
Americans with Disabilities Act	Access to facilities and services	Compliance audit results	100% compliance

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

Risk	Key Processes	Measures	Goals
Patient safety	Medication management	Medication accuracy	100%
	Hand-washing	Observations	100%
Environmental impact of waste	Waste management and recycling	% Recycled waste	45%

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, they 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 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 the 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 provides 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 to be the most successful food drive in the food bank's history.

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

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

Figure 1.2-5 Key Community Support Areas

Focus Area	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, 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 2010, 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.

2: Strategic Planning

2.1 Strategy Development

2.1a Strategy Development Process

2.1a(1) Planning process: 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 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 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 health center locations, and a representative from the volunteer group 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, CCKs, and 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
- 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

Figure 2.1-1 Major Elements in the Strategic Planning Process

Month	Activity	Input(s)	Output(s)	Who's Involved
Jan.	• Partners Committee meeting	• External trends in technology • Partner feedback	• Technology assessment • Input for SWOT analysis	• Partners Committee members • The Info Interns (4.2a[4])
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	• 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	• Staff-related results, recruitment issues, training and credentialing requirements • Community and volunteer needs and requirements • People needs from cross-location team	• HR strategic challenges, leadership system improvement opportunities; short- and long-term HR plans (e.g., training and succession plans) • Community involvement areas	• Senior leaders, health center managers, volunteers • Caring Community subteam • People Potential Team (5.1c[1]) • Service With Spirit Team (3.1a[2]) • Healing Partners Team (5.2a[2])
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 CMs	• 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	• Draft Strategic Plan around FOCUS objectives	• Board members, senior leadership, and local health center 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.	• Develop budgets	• Strategic Plan and resource requirements • Finalized SWOT analysis	• Annual operating budgets and resource allocation; 5-year capital and funding plans; local action plans	• Senior leaders and local health center managers
Nov.	• Communicate plan internally and externally	• Strategic Plan details and objectives	• Communications plan and content	• Senior leaders • All staff and volunteers • All external stakeholders
Dec.	• Develop aligned personal objectives • Evaluate the planning process	• Strategic objectives and local action plans • OASIS Improvement Model/AAR	• Personal goals for coming year • Improvement plan for next cycle	• All staff members • All process participants

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 five-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 population in the state over the next five years. AF's long-range horizon matches that time frame, ensuring alignment with the state's objectives and directions for health care delivery.

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. Following a Baldrige-based assessment 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 Patient-Family Advisory Boards, the State Association of CHCs, and local church and civic groups.

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 (2.1a[2]). Second, partners identify and bring innovative concepts and technologies from outside health care, such as the implementation of CCKs (3.1a[2]). 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, and it resulted in the establishment of the AF Foundation, which supports improved heath 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.

The Strategic Planning Process incorporates a review and improvement cycle using the OASIS Improvement Model. 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 After Action Review (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. In addition to implementing scenario planning events (1999) and expanding Partners Committee membership (2000), improvements include publishing the major plan elements on the Internet for public information (2001), linking the performance management process to staff members' IDPs that support achievement of the Strategic Plan (2002), and implementing the formal AAR (2003).

2.1a(2) Addressing key factors: A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis is an important component of the planning process, using numerous internal and external inputs gathered throughout the year from the Partners Committee meetings, board retreats, and regular meetings with staff, volunteers, and other partners and stakeholders. These inputs include

- health care needs and service delivery requirements
- state and local health care representatives' views on competitive and collaborative issues in health care delivery
- Medicaid and managed care contracts and provider, health insurance, and regulatory issues
- analysis of current and projected finances, including grant status and government and other funding
- people needs, including training and succession planning (5.1c[3] and 5.2) and performance related to staff members' and volunteers' safety, satisfaction, and dissatisfaction (5.3)
- learning derived from the scenario planning exercises
- information from partners and external stakeholders regarding technology issues and partners' satisfaction
- review of data and measurement needs (4.1a[1])
- review of IT needs (4.2a[1])
- demographic and market trends (e.g., trends in the patient base, including retention and referrals)
- AF's competitive position in health care outcomes
- results of benchmarking initiatives, including collaborative participation
- review of performance versus key benchmarks, performance related to key operational and clinical measures, support process performance, and CM team performance and requirements
- business continuity and emergency preparedness using FMEA to identify and address potential risks (6.2b)
- community involvement opportunities
- Critical to Quality (CTQ) flowdown analysis of patient satisfaction and complaint results to determine how well AF is meeting patient and market needs compared to its competitors

Each member of the leadership team, with the support of staff members, is personally responsible for ensuring that his or her specific assigned areas of information are gathered, analyzed, and communicated prior to the planning session. Each leader subsequently acts as a champion for one or more initiatives that are outputs of the plan. Based on review of these inputs, senior leaders develop strategic objectives in five areas—**F**inancial performance, **O**rganizational learning, **C**linical excellence, **U**tilization, and **S**atisfaction—abbreviated as "FOCUS" to help staff understand the importance of concentrating efforts on a few, vital initiatives that maximize the use of the limited resources.

AF assesses its ability to execute the short-term plan and its long-term sustainability with a resource-based 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?"). If the answer is "no" for the plan as a whole, a Pugh matrix is used to prioritize initiatives, and those of lower importance are held for consideration in future strategic planning sessions. For specific initiatives that lack resources, the leadership champion for that initiative is charged with developing a "go/no go" plan that fills the resource gaps without suboptimizing the overall plan. After this exercise is completed in October, senior leaders develop a zero-based budget that is deployed to all units. To ensure long-term viability, the board also conducts an assessment of organizational sustainability and possible revisions to the VMV at its March retreat. Before the Strategic Plan is finalized and published, the board and the senior leadership team do a final review against AF's VMV to ensure high-level alignment.

2.1b Strategic Objectives

2.1b(1) Key objectives and timetable: AF's short- and long-term strategic objectives are outlined in Figure 2.1-2. The initiatives for each goal are identified as either short-term (within the next year) or long-term (within the next five years). Some initiatives may contain both short- and long-term components. In such cases, separate checkpoints are developed for the different components of the initiative.

2.1b(2) Addressing challenges: As shown in Figure 2.1-2, the Strategic Planning Process ensures that AF addresses each of the short- and long-term strategic challenges that face the organization. The plan addresses and balances the needs of all stakeholder groups, using the Pugh matrix and FOCUS framework.

2.2 Strategy Deployment

2.2a Action Plan Development and Deployment

2.2a(1) Developing and deploying action plans: 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 (i.e., the CMs), and (4) individual staff members. CM teams also provide early input on their local needs into the Strategic Planning Process (Figure 2.1-1). Thus, the plan deployment process incorporates a "catchball" approach. Plan deployment begins with the involvement of all senior managers in the Strategic Planning Process. After the overall Strategic Plan is validated and annual budgets are developed, the senior leadership team and local clinic managers develop specific action plans for deployment to their work units.

Occasionally, board subcommittees also may task some members to manage specific initiatives. Volunteers also participate in action plan development at the first three levels. Resource allocation for the overall plan occurs as described in 2.1a(2). 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.

Figure 2.1-2 Arroyo Fresco's "FOCUS" Strategic Objectives

Strategic Challenges	Strategic Objective(s)	Term	Stakeholders
Financial Performance			
Balance mission to serve—regardless of patients' ability to pay—against tight fiscal environments at federal, state, and local levels.	Increase net income by decreasing overall cost-to-serve through reductions in administrative and indirect patient costs.	Short/ Long	PF/C/S/P
Organizational Learning			
Address workforce gaps, in particular, clinical providers and staff with specific technical skills.	Take advantage of available internal and external resources to fill workforce gaps.	Short/ Long	S/C/PF/P
Clinical Excellence			
Address low incidence of prevention and screening and the higher incidence of chronic and communicable disease in the service area.	Increase the overall ratio of patient visits to staff.	Long	PF/S
	Develop internal and external resources to address unmet health care needs in the service area to increase the number of new patients served.	Long	PF/C/PH/P
Utilization			
Establish and manage mechanisms to provide specialty care and unmet service needs, in particular, to uninsured patients.	Expand partnerships and collaborative arrangements with state and local organizations and health care providers to increase the number of new patients served.	Short/ Long	PF/S/P
Satisfaction			
Meet recruitment/retention challenges related to remote locations, a vulnerable patient population, and a total compensation package.	Improve satisfaction levels on staff survey "employer of choice" dimensions.	Short/ Long	S
	Improve satisfaction levels on volunteer survey.	Short/ Long	V
Maintain/enhance relationships with patients, the community, and external partners.	Improve external stakeholders' satisfaction.	Short/ Long	PF/C/P

Term definitions: short=by end of 2006; long=by end of 2010
Stakeholders: Patients/Families=PF; Community=C; Staff=S; V=Volunteers, Physicians=PH; Partners=P

Once resource availability is validated using the Pugh matrix (2.1a[2]), the annual plans at the organizational, county, and CM levels are subdivided into 90-day action plans. The mechanisms described in 4.1b and Figure 4.1-1 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 stakeholders. 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 (5.1b). Achievement of these action plans and personal objectives links to the performance review process for all staff members.

2.2a(2) Modifying action plans: The need to modify action plans may be identified as a result of regular review meetings (4.1b[1]) at either the service entity or the organizational level. For example, the semiannual reviews by process owners (6.2a[6]) 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, e-mail exchanges, or at the next scheduled management review meeting and are implemented following approval by the local managers or the senior leadership team. 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.

2.2a(3) Key short- and long-term action plans: Figure 2.2-1 shows examples of AF's action plans representing a cross-section of organizational, county, and CM objectives. As noted, these plans derive from the strategic objectives listed in Figure 2.1-2. For senior leaders, these objectives also may translate directly into their personal improvement objectives. For example, Roger Sinclair has personal responsibility for the clinical initiative to "re-engineer patient flow process to reduce cycle time."

2.2a(4) Key human resource plans: Human resource plans are developed as an integral part of the Strategic Planning Process. 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 human resource challenges (e.g., recruitment, training, and succession planning needs) and drafts of short- and long-range human resource 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 human resource plan related to AF's strategic objective to increase staff satisfaction is included in Figure 2.2-1.

2.2a(5) Performance measures: Key performance measures used in the Strategic Plan and related action plans are listed in Figures 2.2-1 and 2.2-2, with results presented throughout Category 7. These measures align with AF's overall performance measurement system (Item 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 CMs 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.

2.2b Performance Projection

Projections for AF's short-term (2006) and long-term (2010) performance are provided in Figure 2.2-2. These projections take into account, as available, 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 2010 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 2010 targets and then to exceed the state's long-term targets.

Figure 2.2-1 Representative Examples of Arroyo Fresco's FOCUS Action Plans

Strategic Objectives (Figure 2.1-2)	Related Action Plan(s)	Sample Measure(s)	Respon-sibility*	Figure(s)
Financial Performance				
Increase net income by decreasing overall cost-to-serve through reductions in administrative and indirect patient costs.	Improve return on assets in clinical units.	RVUs per net asset value	O, C	7.3-4
	Improve collection rates.	Collection rates	O	7.3-2–7.3-3
Organizational Learning				
Take advantage of available internal and external resources to fill workforce gaps.	Provide current staff the time and resources to expand their skills. Provide online learning opportunities/paid time off for study.	Staff proficiency rates	O, C, M	7.4-3a, 7.4-4a,b, & 7.4-5
	Actively recruit and train volunteers with targeted skills, especially retired health care professionals in the region.	Volunteer proficiency rates	O, C, M	7.4-3b
	Promote enrollment in development programs in health care professions.	Staff and volunteer enrollment rates	O, C, M	7.4-5
	Increase the grant funding for training and scholarships.	Grant success rate	O	7.5-8
Clinical Excellence				
Increase the overall ratio of patient visits to staff.	Re-engineer patient flow process to reduce cycle time.	Office visit cycle time	O, C, M	7.5-3
Develop internal and external resources to address unmet health care needs in the service area to increase the number of new patients served.	Pediatrics: Increase immunization rates for children and adolescents.	Immunization rates	O, C, M	7.1-9c,d
	Females: • Increase screening rates for domestic abuse, depression, cervical cancer, and colon cancer. • Increase mammography services.	Screening rates Mammograms	O, C, M	7.1-2a,b & 7.1-3a,b,c
	Males: • Increase screening rates for depression. • Increase screening rates for colon cancer.	Screening rates	O, C, M	7.1-2a, 7.1-3c
	Other: • Increase screening/support in clinical preventive areas (e.g., smoking cessation, obesity). • Increase immunization rates (e.g., for influenza). • Increase diabetic screening.	Screening rates Immunization rates Screening rates	O, C, M	7.1-1a,b, 7.1-4a,b & 7.1-5
Utilization				
Expand partnerships and collaborative arrangements with state and local organizations and health care providers to increase the number of new patients served.	Increase the number of new patients served by developing cultural understanding for staff members through local community groups; partnering with public health departments to identify underserved and unserved populations; partnering with local community and faith-based orgs. to promote health screening services; and exploring nonconventional hours for clinics and mobile vans to increase service reach.	Number of new patients served per month	O, C, M	7.5-4
	Reduce the wait time for appointments	Future capacity Third next available appointment	C, M	7.5-1 7.5-2
Satisfaction				
Improve satisfaction on staff survey "employer of choice" dimensions.	Address lower-scoring issues identified in the most recent Staff Satisfaction Survey.	Staff satisfaction scores	O, M	7.4-2a,b, 7.4-6a,b
Improve external stakeholders' satisfaction.	Address lower-scoring issues identified in the most recent patient, community, and partner satisfaction surveys.	Satisfaction scores	O, C, M	7.2—all, 7.4-7

*O=Organization level, C=County level, M=CM level

Figure 2.2-2 Performance Projections for Key FOCUS Measures

Key Measure	Figure	AF Short-Term Projection (2006)	Best Comparison Short-Term Projection	AF Long-Term Projection (2010)	Best Comparison Long-Term Projection	Source for Comparison
Financial Performance						
Return on assets in clinical units, %	7.3-4	18	18	20	19	State CHC Assoc.
Organizational Learning						
Staff and volunteer proficiency in core training, %	7.4-3a, b	95	87	100	95	State CHC Assoc.
Grant funding for training and scholarships, success rate (%)	7.5-8	83	78	90	N/A	State Assoc. of Nonprofits
Clinical Excellence						
Office visit cycle time, minutes	7.5-3	30	43	30	37	State CHC Assoc.
Mammography screenings, %	7.1-3a	83.2	81.2	90.0	90.0	HCDI
Colon cancer screenings, %	7.1-3c	58.8	61.8	75.0	75.0	HCDI
HbA1c screening in diabetics, %	7.1-5	95.0	92.4	98.0	95.0	HCDI
Pediatric immunization rate, %	7.1-9c,d	82.2	81.7	90.0	90.0	HCDI
Utilization						
Number of new patients/month	7.5-4	140	100	200	140	State CHC Assoc.
Satisfaction						
Overall patient satisfaction, % (would recommend to others)	7.2-7	75.0	76.2	90.0	86.0	Packer Survey
Overall staff satisfaction, %	7.4-6a,b	84.2	81.0	90.5	84.5	Oates Group
Overall volunteer satisfaction, %	7.4-7	85.1	81.3	89.5	83.5	Oates Group

N/A=No comparison available

3: Focus on Patients, Other Customers, and Markets

3.1 Patient, Other Customer, and Health Care Market Knowledge

3.1a Patient, Other Customer, and Health Care Market Knowledge

3.1a(1) Identify patients and markets: 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 Service With Spirit Team (SWST), a cross-location team led by Teresa Aguilar with representation from CMs and functional groups, prepares an analysis using 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 2010 data, state and local health department data, and a review of local health care safety net services and utilization. The team compares the demographics, health status, and service utilization of AF's current enrollees against similar information for the counties it 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. Starting with the launch of AF's first mobile medical services van in 1988, senior leaders have used such 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, and expanding medical and dental services by van along the Yuma County border in 2003. Similarly, based on 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.

3.1a(2) Listen and learn: AF uses a variety of methods to listen and learn to determine key patient, family, and other stakeholder requirements (Figure 3.1-1). For patients and families, these include satisfaction surveys, complaint data (including requests to change the primary care provider), and information gathered through staff and volunteer interactions. Each facility has an eight-member Patient-Family Advisory Board that meets quarterly with AF staff to give feedback on AF services and future needs and plans. Each meeting includes discussion of one question provided by AF senior leaders or the board, and feedback is organized using a consistent reporting template. The decision in 2004 to expand mobile services in La Paz County by reallocating resources from La Paz's only medical clinic was made after input from all AF Patient-Family Advisory Boards. Members often are asked to join design and improvement teams to ensure that patient and family perspectives are incorporated at the front end.

To listen and learn from patients and their families and from the community at large, AF uses the innovative, portable CCKs. The 30 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. Kiosk users enter an anonymous demographic and health profile. One program enables AF to capture users' perceptions of their health status, their preferences, and an assessment of their own and the community's future needs. Users evaluate clinical and enabling services received, make side-by-side comparisons, and rank proposed service prototypes and their elements. 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 Web sites' quality and their relevance for AF's patient population. CCKs also contain information on 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. Trained high-school volunteers provide demonstrations in waiting rooms for both children and adults. Based on underuse by elderly clinic enrollees when the CCKs were initiated, AF now sponsors a monthly evening social hour, Second Time Around, in which an Elder Council member (3.2a[1]) partners with a content expert to co-teach basic computer use and other topics requested by seniors.

Patients enrolling for care at AF complete individual profiles, or Personal Health Plans (PHPs) (6.1a[4]), that include their self-designated race/ethnicity and primary spoken and written language. AF provides assistance in completing these profiles, as needed. The PHPs are systematically updated annually, or sooner upon request. PHPs ensure that clinicians have reliable cultural data about their patients, which are key to providing culturally competent care. AF also records personal preferences, such as the patient's preferred medical providers and the name the patient wishes to be called. Essential individual patient requirements and preferences are reviewed in Daily Huddles, and each patient's profile is readily accessible online during the patient's visit. Patient demographic and preference data also are aggregated at site, county, and organization levels.

To determine and respond to partners' requirements, needs, and expectations, AF's senior leaders meet four times a year with the Partners Committee. At each session, the group discusses current and future needs, as well as opportunities for improving the alliances. In addition, an annual telephone survey of partners serves as a valuable listening and learning tool (3.2b[1]), 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, CM representatives and other

Figure 3.1-1 Key Customer Listening and Learning Methods

Methods and Key Examples	Target Audiences			
	PF*	C*	PA*	PR*
Satisfaction Surveys				
• Packer Patient Satisfaction Survey	X			
• Service Experience Survey	X			
• Community Climate Survey		X		
• Partners Survey			X	
Complaints				
• Letters, phone calls, face-to-face feedback	X	X	X	X
• Requests to change provider	X			
Perceptions, Needs, Preferences				
• Care Connection Kiosks	X	X		
• Personal Health Plan	X			
• Chronic disease self-management knowledge and skills questionnaire	X			
• Fax-back suggestion form			X	
Committees, Meetings				
• Board of Directors	X	X	X	
• Patient-Family Advisory Boards	X			
• Partners Committee		X	X	X
• Senior leader champion				X
• Statewide conference of CHCs and payors				X
Informal Feedback				
• Multiple and varied interactions with leaders, staff, and volunteers	X	X	X	X
Experts, Literature				
• Web sites	X	X	X	X
• Journals	X	X	X	X
• Professional associations	X	X	X	X

*PF=Patients and Families, C=Community, PA=Partners, PR=Payors

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.

The SWST is responsible for systematically analyzing customer listening post data. It aggregates, segments, and analyzes these data using time series analysis and conjoint analysis to determine key drivers and trends in satisfaction, loyalty, and positive referral for specific patient, family, and customer groups. The team uses CTQ flowdown to embed customer requirements into service design and delivery, translating each requirement into discrete elements of services needed. In addition, the team uses these customer requirements to help CMs evaluate and develop new service design concepts, using a Pugh matrix. Using patient survey data and these approaches, the team determined that "treated with dignity and respect" and "clear, two-way communication" are important predictors of patient loyalty and of satisfaction with quality of care for patients and families in all demographic groups.

3.1a(3) Keep listening and learning methods current: The SWST meets quarterly to aggregate and analyze data and information from AF's customer listening posts, and it also conducts a systematic evaluation of the methods and tools used for customer listening and learning to keep them current and relevant to AF's needs. In 2005, as a result of its 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 CMs 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.

3.2 Patient and Other Customer Relationships and Satisfaction

3.2a Patient and Other Customer Relationship Building

3.2a(1) Build relationships: At AF, relationship is a core value, translated into action through the CM model and AF's enabling services. 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 CM team for ongoing care. In addition, PHPs enable the CM 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 over time 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, child care during appointments, after-hours telephone access to an on-call provider, and on-site pharmacy services.

Opportunities for active involvement in the AF care experience—through participation in Patient-Family Advisory Boards, design and improvement teams, and as volunteers—also build and sustain relationships. At two facilities, Patient-Family Advisory Board input resulted in the addition of Native American healing gardens and the display of Native American artwork and crafts in clinics. In another facility, Patient-Family Advisory Board members served as "mystery shoppers," exploring ways to reduce noise, improve confidentiality, and upgrade signage. Recognizing the important role played by elders in AF's key communities, Patient-Family Advisory Boards 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 Web site.

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 obesity; an annual health fair highlighting self-assessment, prevention, and screening; public recognition of volunteers; a health center peer-to-peer adolescent ambassador program; and CCKs on vans and at community events, grocery stores, and drop-in educational sessions. 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 OASIS Improvement Model and related improvement tools. 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 hospital discharge planners to set up a follow-up visit at AF before the patient (current or new) leaves the ED or hospital, a practice now used in each county. In anticipation of JCAHO's proposed revisions to emergency management procedures for hospitals for 2007, a multidisciplinary AF outreach team is partnering with local hospitals to design and conduct communitywide drills and analyze the potential impact of an emergency by demographic, economic, and regional group. Two groups of medical and lay volunteers have completed documented procedures and disaster training. The new drill procedures build on lessons learned from the 2005 communitywide drill. 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 AF refers for consultation or special procedures, AF uses a fax-back rating 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 its partners to standardize and simplify referral forms and the template to document services and findings.

3.2a(2) Key access mechanisms: AF offers multiple 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 the CCK), and printed materials. For patients enrolled at AF, password-protected online access enables them to make appointments, obtain lab test results, or send an e-mail message to their primary care provider. A 2003 survey showed that online access was possible for 53% of AF patients through computers in their homes, the home of a friend, at work or school, or in a public library. AF telephones have after-hours voice-mail 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. 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., American Academy of Family Physicians [AAFP], the American College of Obstetricians and Gynecologists [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.

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. 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.

AF uses data and information from its 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. In 2003, for example, members of the Board of Directors and Patient-Family Advisory Boards piloted the prototype CCKs. 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) Manage complaints: AF uses a systematic Complaint Management and Service Recovery Process (Figure 3.2-2). 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, who contacts the patient or stakeholder within 24 hours to resolve the complaint. A second team of SSU business school students developed additional complaint coding and analytical tools. All complaints now 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. 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 site and service type and stakeholder and cultural group, reviewed monthly by the executive team, and communicated electronically to staff quarterly, along with requests for prevention tips. The top tips are published in the AF newsletter.

Figure 3.2-1 Key Access Mechanisms

Mechanism	Patients/ Families	Community	Partners	Payors
Letter	1, 2, 3, 4	1, 2, 3, 4	1, 2, 4	1, 2, 4
Telephone	1, 2, 3 ,4	1, 2, 3, 4	1, 2, 4	1, 2, 4
Voice mail	1, 2, 3, 4	1, 2, 3, 4	1, 2, 4	1, 2, 4
On-call provider	2, 3			
AF Web site or CCK	1, 2, 3 ,4	1 ,2, 3 ,4	1, 2, 4	1, 2, 4
Face-to-face	1, 2, 3, 4	1, 2, 3, 4	1, 2, 4	1, 2, 4
Print materials	1, 2	1, 2	1, 2	1 ,2
Interpreter	1, 2, 3, 4	1, 2, 3, 4	1, 2, 4	1, 2
Insurance eligibility/ enrollment	3	3	N/A	N/A
Transportation	3	3	N/A	N/A
Child care	3	3	N/A	N/A
Leaders' open door policy	4	4	2, 4	2, 4

1=general information, 2=specific inquiry, 3=service access, 4=complaint, comment

3.2a(4) Keep relationship-building approaches current: The SWST reviews AF's approaches to building relationships with key customers. The team examines practices across CMs, 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 (2000), Mothers Aiding Mothers (2001), Promotores/ Promotoras Program (2003), and CCKs (2004).

Figure 3.2-2 Complaint Management and Service Recovery Process

1.	Apologize for any inconvenience.
2.	Listen, empathize, and ask clarifying questions.
3.	Solve problem quickly in partnership with the person(s) making the complaint.
4.	Offer atonement.
5.	Keep the promise.
6.	Follow up.
7.	Conduct root cause analysis; prevent recurrence.

3.2b Patient and Other Customer Satisfaction Determination

3.2b(1) Determine satisfaction: AF began systematic measurement of patient satisfaction and dissatisfaction in 1999 with an internally developed survey but soon recognized the need for benchmarks and peer comparisons. Ramon Gonzalez led the State Association of CHCs, through the Benchmarking Consortium, 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 survey enables AF to compare its performance against organizations in the vendor's national database and against its state peers on six dimensions: access to care, coordination, information and education, continuity and transition, emotional support, and respect for patient preferences. 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, state CHCs added two customized questions that enable them to track and compare performance on cultural competence. The vendor mails satisfaction surveys to a random sample of AF patients within two weeks of their service experience.

AF also measures patient satisfaction at the point and time of service through a Service Experience Survey. Typically, patients (except those too ill or injured) complete a brief 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. At the end of the visit, patients evaluate the degree to which their goals were met and rate the experience for access, convenience, timeliness, communication, and respect. Questions correlate with those on the longer mailed survey. Medical or dental assistants manage the data collection, using scripted messages. This survey method can be tailored with customized questions for a sample of patients or a defined period to track progress on specific improvement initiatives within one or more CMs.

AF measures community satisfaction with the Community Climate Survey, 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 keep a constant finger on the community's pulse in its own service area. These responses are captured in an online database and shared on the intranet. 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. 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, input on partner support for new initiatives and greater participation.

3.2b(2) Obtain actionable feedback: 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 3.2-2). The completed real-time surveys are scanned daily, creating an online database of responses available on the intranet. This process helps CMs track their progress and get immediate feedback on how they compare with others. In 2004, CMs in La Paz noted that satisfaction ratings from their Spanish-speaking patients were decreasing for communication and respect. A medical assistant and nurse practitioner from Yuma County rotated in and helped the La Paz CMs identify more effective ways to work with Spanish-speaking patients and their families. With additional support from the SWST, a new learning module on cultural sensitivity was developed, tested, and deployed, resulting in increased satisfaction of Spanish-speaking patients at six of seven sites selected as appropriate for deployment.

Packer makes quantitative satisfaction survey results and transcribed open-ended comments available online within 48 hours of receiving completed surveys from patients. AF receives a quarterly analysis that shows the frequency of particular problems reported and their "priority" as drivers of loyalty, and it tracks performance over eight quarters. These problem and priority reports enable AF to target the highest-leverage improvement opportunities, as well as to see the impact of improvement efforts.

3.2b(3) Satisfaction relative to others: The Packer Patient Satisfaction Survey enables AF to compare its performance against that of health care provider organizations nationally and CHC peers. The Community Climate Survey also permits comparison against CHC peers. 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 CM to promote internal benchmarking. By identifying top performers, AF facilitates knowledge transfer, often by staff rotations across sites. Volunteers serve as an informal source of information for leaders and staff about patients' satisfaction with AF versus their satisfaction with other health care providers.

3.2b(4) Keep satisfaction determination approaches current: One way AF keeps its approaches to determining satisfaction current is by using a nationally recognized, research-based survey from a vendor that 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, using information from federal and state agencies, such as the BPHC and the State Association of CHCs, as well as a proactive, systematic literature scan as an input to strategic planning.

4: Measurement, Analysis, and Knowledge Management

4.1 Measurement, Analysis, and Review of Organizational Performance

4.1a Performance Measurement

4.1a(1) Select, collect, align, and integrate data: A key element of AF's measurement, analysis, and review 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 representing all the CMs and functional groups (affectionately referred to as the "Data Docs") 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, such as hand-washing and other safety measures required by JCAHO. 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 CMs, and the team's broad representation also results in innovative approaches to measurement. For example, in 2004, 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 senior leadership team reviews and approves all key organizational performance indicators that will be part of AF's FOCUS scorecard. Each CM team may add a few customized measures to track performance against specific services it provides or to reflect the special needs of its patient groups. However, all CM 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. 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 CM team.

4.1a(2) Comparative data: 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. On a quarterly basis, the senior leaders and the leadership teams at each clinic use the comparative data to identify gaps in performance and define targets for improvement. If specific actions for improving the performance are not known, a team will be chartered to identify them, using the OASIS Improvement Model. For example, CMs 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 improve performance organization-wide.

4.1a(3) Keep performance measurement system current: 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. 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 its performance for treating congestive heart failure (CHF), a La Paz family medicine CM asked the Data Docs to add new measures to the FOCUS scorecard in 2005: Left Ventricular Function measurement and ACE inhibitor (ACEI) use under "Clinical," CHF visits under "Utilization," and ACEI cost under "Financial." Results are available for only nine months (and therefore not reported), but there is evidence of improvement, with only a slight increase in the number of CHF visits and an actual reduction in ACEI cost related to the introduction of a generic drug into the formulary (the result of an OASIS project conducted by administrative and clinical staff).

4.1b Performance Analysis and Review

4.1b(1) Performance analysis and review: Senior leaders review organizational performance on a regular basis, using the FOCUS scorecard posted on the intranet for progress against plan and performance against relevant comparisons. They use a variety of analytical methods to ensure that conclusions are valid. Some of these are listed in Figure 4.1-1, along with some of the reviews they support. Since the scorecard is coded using stoplight colors (red, yellow, green), measures in red are rapidly detected as primary areas of concern, and those in yellow as early intervention opportunities. If organizational performance is

changing in a statistically significant manner, teams use the OASIS Improvement 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 (for example, diabetes indicators) are plotted on control charts to provide an early indication of adverse trends and to ensure that appropriate intervention is taken. Since CMs are trained in the interpretation of these charts, they do not overreact to an abrupt but statistically insignificant change. Measures from each CM are rolled up at the clinic level and aggregated by county and for AF as a whole to assess organizational performance. The FOCUS scorecard provides the capability to drill down into an aggregated measure simply by clicking on a data point.

4.1b(2) Translate findings into priorities: Because of the continuing challenge of resources, AF developed a prioritization system based on the "three highs": high cost, high risk, and high volume. Using data on the frequency of a diagnosis or procedure, senior leaders review the top 80% of diagnoses or procedures, then assign priorities based on the three highs. Faced with several potential issues for intervention, alternatives are evaluated against these three criteria and prioritized based on their relative importance. In the example cited in 4.1a(3), La Paz clinicians recognized that the number of patients being hospitalized with CHF was increasing, and the increase was associated with a decrease in ACEI prescriptions. A similar pattern was identified in Yuma and Mohave counties. The three teams with the highest volume of patients with CHF used the OASIS Improvement Model to increase ACEI prescriptions by creating a process, in partnership with pharmacists, to identify when CHF patients fail to fill or renew prescriptions. Depending on the level of the performance review, action may be initiated within a CM or functional group or may be chartered by the senior leaders. The improvement effort may involve partners, suppliers, or volunteers. Recently, a team working to improve care for patients with chronic obstructive pulmonary disease (COPD) developed a streamlined method, supported by volunteers, to deliver medications to homebound COPD patients. La Paz clinicians, who care for their own patients in the hospital, tested the new approach for six months in 2005 and experienced a 12% drop in COPD admissions. The pilot program now is being implemented across other sites.

4.2 Information and Knowledge Management

4.2a Data and Information Availability

4.2a(1) Make data and information available: Information and knowledge management is under the leadership of Jay Nguyen. With the support and expertise of DDS, AF has deployed an intranet site with helpful information for staff, volunteers, providers, partners, and suppliers. The intranet site includes a telemedicine component that allows staff to perform medical consultations remotely and to connect with the SSU Medical Center for more complex subspecialty consultations. In addition, the intranet has useful staff information, such as the online *Staff and Volunteer Handbook*, for quick reference. Other needed data and information are made available through the communication methods shown in Figure 1.1-2. A wealth of data and information is provided to patients, their families, and the community via AF's Internet site and other methods described in Category 3. All information for the patient population and the community is available in English and Spanish.

4.2a(2) Ensure reliability, security, and user-friendliness: With the low level of health care reimbursement for the patients it serves, AF must be frugal with the funds used for purchasing equipment and software. DDS ensures that industry-standard hardware and software are deployed throughout the system to promote reliability. The network server environment and all workstations are maintained with the current version of a common operating system. AF also has secured agreements with several local suppliers to purchase computers and software applications at deep discounts. For the past six years, AF has solicited in-kind donations of hardware from three large companies in Arizona as they retired last-generation equipment. This equipment has even included some Personal Digital Assistants and tablet computers used in the mobile vans. DDS checks all donated equipment prior to deployment for compatibility with current

Figure 4.1-1 Performance Reviews—Based on the FOCUS Scorecard

Reviewer(s)	Frequency	Analyses	Expected Outcome
Senior Leaders	Monthly	• Tabular, with descriptive statistics • Trend chart with a moving average • Control charts • Drill down into multiple segments	• Rapid, but measured, response to changes in trends or progress toward goals • Detection of unfavorable trends in any area • Identification and implementation of corrective actions
Clinic leadership teams	Weekly	• Tabular, with descriptive statistics • Trend chart with a moving average • Control charts • Drill down to team and provider	• Tracking and improvement of clinic and provider performance • Identification of mentoring opportunities for CMs
CMs and functional groups (including clinic office staff)	Weekly	• Tabular, with descriptive statistics • Trend chart with a moving average • Control charts • Drill down to clinic, CM, group, payor, and provider	• Individual performance monitoring and improvement • Mentoring of peers and ancillary staff members • Improved team atmosphere • Assurance that educational requirements and needs are being met
All	Daily Huddles	• Trend charts • Control charts	• Needed interventions to correct out-of-control conditions or address adverse trends

systems, hardware and software suitability and functionality, and freedom from viruses, worms, or other problems. The success of these innovative approaches is shown with a system uptime averaging 99.9% for the past 12 months. Security is ensured through a unique user's login and password, which restrict system access to those data relevant for the user.

DDS provides Help Desk support during all hours of operation to support users of the system. DDS also conducts an annual survey of intranet, Internet, and CCK users specifically related to reliability and user-friendliness. Each of these mechanisms has an online feedback option directed to the respective Web masters so that any critical issues may be addressed in the interim. Results of the surveys are used as inputs for the Strategic Plan.

4.2a(3) Continued availability in emergency: The DDS Disaster Plan, which is part of the overall Emergency Management Plan, provides for backup and off-site storage of data and information, as well as almost immediate recovery and online capability in the event of an emergency. All server data files are automatically backed up daily and stored off site by DDS. Monthly, complete system backups are stored off site, as well, so that DDS can perform a complete system restoration within a few hours, if necessary. Since remote clinics have periodic power brown-outs and complete outages, uninterruptible power supplies are connected to all servers, both centrally and remotely. All central servers are redundant and maintained in active mode to ensure a concurrent backup for all patient-related data. If a server fails, the mirror system immediately assumes control to maintain critical patient-care functions, and an e-mail is sent to the DDS technician and the affected location manager to alert them to the breakdown. Although AF has never experienced a complete outage, a contingency plan provides for printing necessary chart materials so that patient care can continue if one occurs. DDS conducts mock restoration drills quarterly to test backups and ensure system recovery within two hours.

4.2a(4) Keep data and information availability current: A review of data and information availability mechanisms is conducted during the annual Strategic Planning Process at the same time that changes or emerging trends in the health care industry are identified. Necessary changes are identified and deployed in action plans and reviewed regularly, along with all other action plans. In addition, a cross-location team (known as the "Info Interns") reviews information system needs at least annually with DDS and requests upgrades in computer hardware and software. Prior to meeting with DDS, the Info Interns conduct focus groups with CMs, functional groups, volunteers, patients, providers, partners, and suppliers to solicit their feedback. Requests for improvements are reviewed by the Info Interns and DDS if they occur outside the planning cycle and presented to the senior leaders to determine which require urgent attention and which can wait for the next planning cycle. For example, in 2003, an AF physician saw a demonstration of a patient satisfaction survey collected on a data-entry kiosk at a meeting of the AAFP. During the next improvement cycle, DDS worked with staff members to implement a computerized patient survey and information kiosks (see information on CCKs in Category 3), using computers that were due to be retired from service.

4.2b Organizational Knowledge Management

AF's staff, volunteers, and partners represent a substantive knowledge resource. AF uses a wide variety of two-way and other communication mechanisms to transfer knowledge to and from its staff members and volunteers (Figures 1.1-2 and 5.1-1), including interactive meetings, the intranet, staff rotations, and mentoring programs. In addition, to transfer clinical staff knowledge, each CM has an electronic log that is updated by team members with information that relates to the daily work of each clinic. Using a sophisticated search engine, AF searches these logs monthly for trends that indicate the need for a local improvement, and data are aggregated across the system to identify an organizational issue. To transfer knowledge from and to patients and other customers, AF uses a variety of communication, listening and learning, and access mechanisms (Figures 1.1-2, 3.1-1, and 3.2-1), such as its Web site and intranet system, CCKs, and participation in the PFAB and the Partners Committee, which includes partners/suppliers, payors, and community representatives.

AF also uses multiple methods to identify, share, and implement best practices. It captures, catalogs, and retrieves information for organizational improvement based on a classification framework introduced by the QPG (6.2a[1]). It also assimilates and correlates patient information from EHRs to support clinical decisions, and each CM builds on this information to redesign systems and implement innovations using the OASIS Improvement Model. Innovations are then shared through the intranet via real-time, collaborative tools that enable document exchange, help update calendars and project schedules, and create reminders for specific performance goals. Using these tools, staff and volunteers have created online communities of practice across the organization to work on specific projects. Since these tools were introduced, the number of cross-organizational teams collaborating in this way has quadrupled from 3 to 12 in 2005.

4.2c Data, Information, and Knowledge Quality

AF has established a variety of approaches and methods to ensure the quality of its electronic and paper sources of data, information, and knowledge, including their accuracy, integrity, reliability, timeliness, security, and confidentiality (see examples in Figure 4.2-1). Training is key to the implementation of these approaches. For example, all staff members are trained in the use

Figure 4.2-1 Methods to Ensure Data, Information, and Knowledge Quality

Property	Examples of Methods
Accuracy, Integrity, and Reliability	Training, automated data checks and data input control features, Help Desk, data back-up and off-site storage, Disaster Plan, antivirus and antispyware software
Timeliness	Real-time data entry, electronic reports, 24/7 intranet data access at all locations and off-site
Security and Confidentiality	Training (e.g., on HIPAA regulations and Code of Ethical Conduct), system security sweeps, firewalls, passwords, shredding of confidential paper documents

of the information system at the time they are hired, and refresher courses conducted by DDS are available quarterly. The training includes HIPAA regulations and sections of the Code of Ethical Conduct related to computer security, as well as the confidentiality of paper documents.

To help ensure the accuracy, reliability, and integrity of electronic data, automated data checks are conducted daily, using rule-based filters, such as age and gender (e.g., a male who is pregnant). An exception report flags the errors to the team accountable for entering the erroneous data. The team then determines the appropriate action, such as changes in data-entry screens or additional training for users. AF's intranet is a major factor in ensuring the timeliness of the organization's data and information, enabling real-time data entry, as well as 24/7 organization-wide access to needed information. In addition, in partnership with DDS, AF has implemented numerous mechanisms to ensure the security and confidentiality of electronic documents. Confidential papers are locked in a secure area when not in use and shredded when no longer needed.

5: Human Resource Focus

5.1 Work Systems

5.1a Organization and Management of Work

5.1a(1) Organize and manage work and jobs: To promote cooperation, initiative, empowerment, and its culture, AF uses CMs and functional work groups. In 2002, AF reorganized jobs, roles, and responsibilities, establishing CMs as the service delivery model organization-wide. For example, a typical family medicine CM includes a family medicine physician, a physician assistant, a medical assistant, an administrative support staff member, a community educator, and volunteers. The introduction of a community educator and volunteers was an innovative refinement to the CM model. CMs now include 5 to 15 volunteers (see 5.1a[2]), and some staff members, such as community educators, may participate in more than one CM. AF has 25 CMs, each led by a physician or dentist. The CM organizes care around patient needs and promotes active, ongoing partnerships between patients and providers, which enable it to be particularly effective for managing chronic disease and promoting health literacy and self-management skills. To continually improve their services and the outcomes their patients achieve, CMs develop practice profiles and monitor process performance.

CMs rely on a variety of tools and technology to gather and use information and on close collaboration among team members, who share responsibility for team goals aligned with the FOCUS areas of the Strategic Plan. Daily Huddles help the team anticipate patient and staff needs at the start of the day and review follow-up needs from the previous day. Biweekly, CMs review progress on their scorecards as a team, initiating or monitoring actions to improve, and they meet monthly with their County Director to review progress, priorities, and lessons learned in the context of the larger organization. Mechanisms to facilitate communication and cooperation among CMs include the AF intranet, with real-time collaborative tools; scorecards with common performance metrics; and online communities focused on specific projects related to key clinical conditions (4.2b).

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. A designated person for each administrative area serves as a liaison to CMs to promote rapid and ongoing communication across clinics and counties and facilitate transfer of best practices. In addition, these functional groups collaborate annually in assessing the satisfaction of CMs with AF support services and use the information to improve.

5.1a(2) Capitalize on diverse cultures, ideas, and thinking: AF's workforce mirrors the diversity of the three-county service area. AF capitalizes on this diversity by establishing interdisciplinary and cross-organizational committees and teams, the CM 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. Volunteers (called *promotores* or *promotoras*) help integrate clinical expertise with cultural competence and provide insight into access barriers and cultural norms that undermine healthy behaviors. Volunteers 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. 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. Through their community networking, 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. Volunteers are a major source of new AF board members.

5.1a(3) Effective communication and skill sharing: A sample of AF's methods to achieve organization-wide communication and skill sharing is shown in Figure 5.1-1. CMs promote cross-professional communication through Daily Huddles and biweekly scorecard reviews. The intranet promotes cross-organizational communication by means of e-mail, posted scorecards and improvement stories, collaborative work tools, and communities of practice, in which CMs with expertise in managing one or more chronic conditions help others improve (4.2b). Regular, planned staff rotations facilitate knowledge transfer across CMs.

5.1b Staff Performance Management System

The Strategic Planning Process results in the development of

Figure 5.1-1 Key Staff Communication, Skill-Sharing, and Knowledge-Transfer Methods

Method	Purpose	Frequency
Huddles	C, S, K, two-way	Daily
CMs, committees, work groups	C, S, K, two-way	Varying
Online learning modules	S, K	As required
E-mail	C, two-way	Ongoing
Workshops	S, K, two-way	As scheduled
Town Hall Meetings	C, two-way	Annual
Collaborative tools	C, S, K, two-way	Ongoing
Communities of practice	C, S, K, two-way	Ongoing
Staff rotations	C, S, K, two-way	As scheduled
Liaisons	C, K	Ongoing

C=communication, S=skill sharing, K=knowledge transfer

strategic objectives, goals, and targets that are organized into scorecards using the FOCUS framework, and AF's staff performance planning and feedback process is linked to strategic planning. Staff meet twice yearly with their supervisors (for CM members, the CM 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. A midyear session 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 plans for future ones.

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, e-mails, and newsletters to the community and at the annual AF Town Hall Meeting held in each county. STAR complements the informal recognition methods used by AF's senior leaders (1.1b). AF also has a formal gainsharing plan, with payouts tied to achievement of FOCUS goals defined annually during strategic planning. Gainsharing started in 1998 as an incentive program based on achievement of financial targets. The program was redesigned in 2001 to align it with the FOCUS framework and extend benefits to the entire workforce.

5.1c Recruitment and Career Progression

5.1c(1) Identify characteristics and skills needed: AF uses two approaches to identify characteristics and skills needed by potential staff. As a step in the process for designing jobs, HR staff 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) 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 CMs, as documented by researchers at Talkeetna Medical School, and characteristics desired by colleagues, as determined by the Oates Group and others. Cultural competencies include language proficiency 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 patient satisfaction. 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 HR Director Tony Joachin.

The current approach began in 2002, when AF adopted the CM model and recognized the need to revise clinical job descriptions to incorporate new competencies. Over the past three years, HR staff, working with the PPT, have reviewed all job descriptions to bring existing jobs into alignment. Competencies in all four areas now are part of the performance planning and evaluation process and are embedded in promotional requirements (5.1b, 5.1c[3]).

Identifying characteristics and skills needed by potential staff also occurs annually as part of the strategic planning cycle. 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 characteristics and skills as part of long-term workforce planning.

5.1c(2) Recruit, hire, and retain: Finding qualified staff is a strategic challenge for most health care organizations. For AF, the challenge includes creating a workforce as diverse as the communities it serves. AF first recruits locally and regionally, then nationally as required, because local or regional applicants typically are more likely to be retained. All open positions are posted internally on the intranet to provide career advancement opportunities for current staff members and tap into their informal professional networks. AF reaches out to potential employees through newspaper advertising in all local papers and statewide in print media aimed at specific communities (e.g., the Hispanic American medical community). It also systematically notifies career counselors at service-area high schools and community colleges, as well as key contacts in SSU health care professional programs, of AF job openings. Twice a month, volunteers post and distribute throughout the community flyers listing job opportunities.

AF's approaches for recruiting clinical professionals include strategies for advancing current staff members and for attracting new ones. In 2002, faced with strong competition for entry-level employees, AF launched the Work to Learn scholarship program (5.2b), funded by the Arroyo Fresco Foundation and operated in collaboration with its 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. After a successful pilot in 2003,

with five employees trained as medical assistants, AF expanded the program to other job roles. To recruit physicians, dentists, 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 work at AF, including opportunities such as rural health preceptorships in medicine, dentistry, and nursing and a post-graduate program for family medicine and dental school residents.

As part of the hiring process, a panel of staff members and volunteers representing the community to be served conduct behavioral-based interviews that address the characteristics and skills identified for the position (5.1c[1]). Volunteers also go through a matching process that begins with a self-assessment of their 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 for all supervisors. 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, helps identify them so others can welcome them and offer assistance—a practice adapted from a 2004 Baldrige Award recipient. New staff members 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.

AF also is working today on recruiting the workforce of tomorrow. Teen volunteer positions, school-based clinics and related education programs, and organization-wide observance of national Take Your Child to Work Day are three 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.

5.1c(3) Succession planning and career progression: The board and CEO share responsibility for succession planning. Succession plans 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 possible 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 and, where appropriate, for CM leaders. For senior leaders, the board requires a minimum of two replacement candidates, with at least one ready to transition within 18 months. Although development plans 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 the annual Strategic Planning Process. Leading community involvement efforts is another way to develop potential (1.2c). A similar development plan is used to develop and ensure replacements for key volunteer leaders, such as the coordinator of grant proposals.

Career progression for staff is managed as part of the performance planning and review process, and it receives particular emphasis at the midyear meeting. To support that discussion, AF has developed a promotional checklist for every job description that outlines requirements for a higher-level assignment. This tool 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 to providing health education and facilitating community forums.

5.2 Staff Learning and Motivation

5.2a Staff Education, Training, and Development

5.2a(1) Contribute to achievement of action plans: Staff and volunteer education and training (Figure 5.2-1) are critical to carrying out the mission of AF and achieving its action plans. AF has a workforce development plan 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 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 education and training plan is developed by Tony Joachin in collaboration with the PPT and approved by the senior leaders. Quarterly, the PPT reviews and takes action on requests for additional training, as well as unanticipated opportunities, such as workshops available through partners.

5.2a(2) Address key organizational needs: Some education and training needs remain fairly constant from year to year, such as health and safety requirements for JCAHO accreditation or continuing medical education (CME) credits for clinicians. Others change in response to new organizational needs, priorities, and emerging technology. For example, in 2003, an organization-wide initiative to address HIPAA requirements was a centerpiece in the education and training plan. In 2004, a special workshop was provided to educate staff and volunteers about the CCKs that now are used as a primary information-gathering tool across AF, and the technology continues to be addressed in both New Staff and Volunteer Orientation and HIPAA training. Over the past five years, key clinical and access initiatives have been supported by organization-wide education and training programs (see Figures 7.4-4a and 7.4-4b) that now are available online and systematically updated by the Healing Partners Team (HPT), another cross-location team that serves in an advisory capacity to

Medical Director George Hughes. 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 CM members. All have a community education component suitable for volunteers.

As part of their IDPs, all staff and volunteers identify education and training that will help them fulfill job requirements, meet FOCUS targets, and pursue personal development goals. For example, a CM team may pursue customer service training to improve patient satisfaction results. To increase the number of pregnant women who seek early prenatal care, volunteers identified by the community educator may be trained in raising community awareness about childbirth and prenatal care, as well as how to arrange for government insurance programs, clinic access, and transportation.

Figure 5.2-1 Education and Training

Training	Topic	Method	Availability
New Staff and Volunteer Orientation*	Vision, mission, values Community cultures Diversity HIPAA Ethics Safety OASIS Team and service skills	Group, live, and videoconference	Monthly
Annual refresher*	Each of the above topics	Individual, online	24/7
Safety	Medication safety Infection control Ergonomics Secure workplace Defensive driving	Individual, online	24/7
HIPAA*	Confidentiality	Individual, online	24/7
Leadership and management development	Leading teams and initiatives FOCUS leadership	Seminars led by senior leaders	Quarterly
Key clinical initiatives	Asthma Cancer Depression Diabetes Heart disease Oral health Prevention/screening	Online for staff (intranet) and patients/families (CCK) Group, live for community	24/7 As scheduled
Key access initiatives	Community outreach Eligibility and enrollment Transportation strategies Scheduling	Group, live Online	As scheduled 24/7
Grand Rounds (medicine and dentistry)	Various clinical topics	Group, live, and videoconference	Monthly
Clinical care	Various clinical topics	Individual, online	24/7
Information technology	E-mail Intranet Word processing Statistical analysis Graphics Special applications (e.g., telemedicine, CCK, online collaboration tools)	Group, live	As scheduled at DDS
Service excellence	Complaint resolution Cultural diversity and service expectations Managing “difficult” customers	Group, live	As scheduled at Winding River

*Required for all staff and volunteers

New Staff and Volunteer Orientation introduces 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 the OASIS Improvement Model. 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. 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.

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

5.2a(3) Get input from staff, supervisors, and managers: Community educators help CMs identify their education, training, and development needs based on team input and training effectiveness results. Team leaders and community educators share training and education needs and approaches in quarterly meetings. For example, certain team members may be developed to serve as experts, and nurse midwives and obstetricians trained a team

of *promotoras* to build community awareness of the importance of early prenatal care. Similar knowledge experts are developed for each prevention and chronic disease management area. Staff and volunteers who are not in CMs work with their supervisors to identify their training needs.

Quarterly, the PPT aggregates and analyzes staff input on education and training. Key sources of data and information include post-training participant feedback, post-training knowledge and skills test results, and results of a semiannual survey of staff (by broadcast e-mail) and supervisors (by a specially designed online survey available during planning and feedback sessions with their employees). Community educators use the same survey with volunteers. The online survey enables 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. It also considers data and information from the annual Staff Satisfaction Survey. These analyses are used to make quarterly adjustments and serve as inputs to annual updates of the education and training plan.

5.2a(4) Deliver education and training: Because of the distance between facilities, limited coverage for direct patient care staff, and few resources for large-group meetings, AF delivers much of its education and training online. Most programs are designed to include pre- and post-training tests, and all have participant post-training feedback surveys. The online system also tracks staff participation by location, job type, and other relevant factors. Some commercial programs are supplemented with electronic study guides (e.g., modules on safety and on child and family development) prepared by AF staff that assist participants in connecting the training to AF's unique environment.

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, its key communities, and its responsibilities. Orientation is held in a different county each month but is videoconferenced to sites in the other two counties to accommodate those for whom travel is inconvenient. Annual Town Hall Meetings also are live group sessions with an option for videoconference participation. 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.

Other training strategies include "train-the-trainer," a common approach used to transfer knowledge from one CM to others and for training *promotores*, and mentoring, which is available to all new staff members and volunteers during their first three months on the job.

5.2a(5) Reinforce use of new knowledge and skills: 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 often are paired with a staff member who has a high degree of proficiency so they can learn from the "best of the best." Online tests immediately after training 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 JCAHO National Patient Safety Goals related to hand-washing and "read-back" of orders over the phone.

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. 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.

5.2a(6) Evaluate education and training effectiveness: Staff education and training effectiveness is measured on an individual and aggregate basis by pre- and post-tests and demonstrated proficiency, and results are compared with goals set during the development of the education and training plan the preceding year. AF 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 similar organizations' and influences the education/training priorities at the state level.

5.2b Provide Motivation and Career Development

Two initiatives have had a powerful impact on motivating staff to reach their full potential—implementing the CM model and providing opportunities for professional development. The CM model emphasizes team performance and the contribution each team member makes to common goals. Reorganizing into CMs helped break down hierarchical relationships and encouraged collaboration, development, and mentoring. 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 MA and RN degrees; programs for dental assistants, pharmacy technicians, and radiology technicians). AF also has identified other sources of educational funding, and it provides

flexible hours, job-sharing, and tuition assistance programs to support professional development.

5.3 Staff Well-Being and Satisfaction

5.3a Work Environment

5.3a(1) Improve the work environment: New Staff and Volunteer Orientation and the 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, and personal security training is required for most staff and volunteers.

Each clinic facility has a safety officer, with a safety champion in each CM. 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 CMs and clinic managers. The Safety Committees 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 CM team leader, HR Director, and CEO within 24 hours of their occurrence, and a corrective action plan is put in place. Each clinic has security officers 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. Workplace safety targets are shown in Figure 5.3-1.

Figure 5.3-1 Workplace Safety Targets

Indicator	Target
Lost-Time Injuries	Less than 1 per 100 employees
Total Temporary Disability Days	Less than 14 per 100 employees
Sharps Injuries	Less than 1 per 100 employees
Annual TB Test Compliance	100%
Security Incidents	Less than 5 per facility
Van/Auto Insurance Claims	Less than 3 per 100,000 miles

5.3a(2) Ensure workplace preparedness: 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, 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 direct patient care staff are certified in Basic Cardiac Life Support and trained to operate the defibrillator present in every clinic.

The entire organization and all clinics have emergency preparedness plans that are updated annually. 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.

5.3b Staff Support and Satisfaction

5.3b(1) Key factors affecting staff well-being, satisfaction, and motivation: 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 7 to 12 specific dimensions improves its employee recruitment and retention. Seven dimensions identified by the Oates Group as representative of an "employer of choice" were reviewed and approved by staff and volunteers (Figure 5.3-2), and they form the basis for AF's annual Staff Satisfaction Survey. The survey is administered annually, and results are segmented by location and employees' roles, tenure, and work status (full-time, part-time). The seven dimensions are reviewed as part of the annual Strategic Planning Process.

Figure 5.3-2 Employer of Choice Dimensions

Meaningful Work
Credible Leadership
Positive Team Relationships
A Worthy Organization
Opportunities for Growth and Development
Effective Recognition and Rewards
Resources and Flexibility

5.3b(2) Services, benefits, and policies: AF strives to model the practices needed to create a healthy community. A key component is access to affordable health care, which staff rate as the most important benefit or compensation factor. AF partners with the State Association of CHCs to provide a family benefit package with self-insured medical, dental, and vision programs to all staff working 30 hours or more per week. These programs have a strong prevention focus and provide incentives for members to participate in programs that reduce health risks (e.g., smoking cessation, weight loss, cholesterol reduction, exercise). AF also provides a 403b retirement plan for staff members and matches 50% of every dollar they contribute, up to 2.5% of their salaries. To increase the availability of its health care and other workers, AF provides multiple benefits to encourage staff development: reimbursement of tuition and fees for college programs leading to license or certification, educational leave, flex time, and job-sharing arrangements. 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 pursuits

other than education. In addition to traditional paid holidays, staff enjoy three discretionary days, giving them time off each year for personally meaningful observances.

5.3b(3) Staff well-being, satisfaction, and motivation: AF conducts an annual Oates Staff Satisfaction Survey, an online 23-item survey that addresses the seven employer of choice dimensions. A shorter version is used for volunteers (virtually identical, but without questions on compensation) and is administered by phone in English and Spanish, since many volunteers do not have computer access. Results are reviewed with staff for each team and volunteer group. 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 affecting satisfaction. Turnover, absenteeism, grievances, safety, and productivity are tracked quarterly by clinic, department, and role and compared with state rates to monitor trends. Results are compared internally to determine if any location or unit is experiencing difficulty. Analyses of these data, as well as the Staff Satisfaction Survey results, are reviewed by senior leaders to identify and address employee concerns or dissatisfaction and used as input for the Strategic Planning Process.

5.3b(4) Relate assessment findings to business results: At their quarterly meetings, Tony Joachin and the PPT review results related to staff well-being and satisfaction from across the organization. Results at the CM, functional group, and facility levels are reviewed and compared to identify team and site priorities for improvement. In addition, unfavorable results for specific staff satisfaction dimensions (e.g., team relations, credible leadership, growth and development) are noted. To help prioritize needed improvements, the overall and segmented staff well-being and satisfaction results are compared with AF's productivity, patient satisfaction, and clinical outcomes. Tony Joachin presents these analyses and recommendations to the senior leadership team. Results and action plans are shared with staff and volunteers on the intranet, in the newsletter, and at quarterly meetings. They also serve as important input to the Strategic Planning Process.

6: Process Management

6.1 Health Care Processes

6.1a(1) Key health care services and service delivery processes: AF determines its key health care services and service delivery processes (Figure 6.1-1) during the Strategic Planning Process. Key inputs to the determination include a community needs assessment, federal mandates applicable to federally funded community health centers, and input from partners and other key stakeholders. AF's key health care processes contribute to improved health care service outcomes by providing systematic methods through which CMs establish continuous and coordinated healing relationships with a care team and a practice system.

Access processes include scheduling appointments and managing inquiries. Enrollment processes include creating the PHP, establishing eligibility and applying for benefits, 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 (i.e., 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(2) Key health care process requirements: AF has determined its key health care process requirements (Figure 6.1-2, step 2) 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 failed 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 HPT, an interdisciplinary cross-organization team with CM representation that keeps abreast of emerging evidence-based clinical practices and their implications for key health care process requirements. The team uses data and information from the State Association of CHCs, professional association literature, national learning collaboratives, and benchmarking for review 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. Inclusion of patients and family members on design teams and review of proposed designs by Patient-Family Advisory Boards 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 its 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 CHCs) 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. In addition, AF uses recommendations related to culturally competent systems from a national organization for quality in children's health care.

The State Association of CHCs helps AF stay abreast of key process requirements related to patient safety; regulatory, accrediting, and legal compliance; and funding and payors through an annual forum on these topics and periodic "alerts" to leaders as requirements change. This input supplements information from professional association meetings, Internet and journal surveillance, and other industry listening posts.

6.1a(3) Design of key health care processes: AF's HPT convenes an interdisciplinary design team that uses an expanded

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

Key Process	Key Focus Area	Measures	Figure
Access		Future capacity	7.5-1
		Third next available appointment	7.5-2
		Office visit cycle time	7.5-3
		Get appointment when wanted (problem score)	7.2-1a
Enrollment		Number of new patient visits per month	7.5-4
Assessment, Planning, and Delivery of Care	**Adult Screening, Prevention, and Treatment**		
	Lifestyle Risk Factors	% with BMI >30	7.1-1a
		% screened for smoking	7.1-1b
	Behavioral Health	% screened for depression	7.1-2a
		% screened for domestic violence	7.1-2b
	Cancer	% screened for breast cancer	7.1-3a
		% screened for cervical cancer	7.1-3b
		% screened for colon cancer	7.1-3c
	Communicable Diseases	% of high-risk patients immunized for influenza	7.1-4a
		% of high-risk patients immunized for pneumococcus	7.1-4b
		% with completed TB treatment	7.1-4c
	Chronic Disease		
	Diabetes	% with HbA1c screening	7.1-5
		% with dilated eye exam	7.1-5
		% with microalbumin screening	7.1-5
		% with HbA1c in poor control (>9.5)	7.1 (text)
		% with LDL cholesterol <130	7.1 (text)
	Asthma	% with appropriate anti-inflammatory medications	7.1-6
		% with current severity assessment	7.1-6
		Average number of symptom-free days in past 2 weeks	7.1-6
	Heart Disease	% of hypertensives with blood pressure in control	7.1-7
		% of hypertensives with cholesterol screening	7.1-7
		% with LDL cholesterol <130	7.1-7
		% with beta blocker 6 months after heart attack	7.1-12
	Maternal, Infant, and Child Health		
	Pregnancy and Childbirth	Number of low birth-weight babies per 100 births	7.1-8a
		Number with prenatal care in first trimester per 100 births	7.1-8b
	Pediatric Care—Well Child	% with comprehensive H and P (ages 3–6)	7.1-9a
		% with comprehensive H and P (ages 12–21)	7.1-9b
		% with appropriate immunizations (ages 3–6)	7.1-9c
		% with appropriate immunizations (ages 12–21)	7.1-9d
	Pediatric Care—Acute	% with appropriate treatment for upper respiratory infection (URI)	7.1-9e
		% tested for pharyngitis	7.1-9f
	Dental Services		
		% of adults with dental exam in past year	7.1-10a
		% of 8-year-olds with sealant present	7.1-10b
Information, Education, and Support		% with documented self-management goals	7.1-11
		Addressed family/living situation (problem score)	7.2-3a
		Questions not addressed (problem score)	7.2-3b

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 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. 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.
Act	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 CMs, clinics, and other delivery mechanisms. Results of the overall review are reported, including ongoing feedback from patients.

Plan-Do-Check-Act (PDCA) model (Figure 6.1-2) to design its key health care processes to meet key requirements. The 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 operative 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.

6.1a(4) Address patients' expectations: Through the PHP, AF is able to address patients' 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 only healthy food 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 influenza vaccine).

AF strives to build in all patients the motivation, knowledge base, and skills and confidence needed to make decisions about and manage their own health. Self-management capability is correlated with better health outcomes, higher satisfaction, and more efficient use of services, especially among patients with chronic disease. CMs evaluate the self-management capability of these patients annually with a brief questionnaire that assesses their knowledge of their condition and their ability to follow the care plan; participate in decision making; monitor and manage symptoms; manage the physical, emotional, and social impact of the condition; and make lifestyle changes that promote health. The medical assistant reviews patient responses and follows up with open-ended questions that identify barriers to self-management. Results become part of the PHP and may result in changes to the care plan; aggregate results may lead to a CM improvement effort for other chronic disease patients.

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.

6.1a(5) Key performance assessments: CMs use both in-process and outcome measures (Figure 6.1-1) developed during the PDCA cycle to assess, control, and improve its health care processes. These measures have been identified using input from patients, other customers, and stakeholders, as appropriate, during the process design. In-process measures enable CMs 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 its health care processes are meeting requirements (including patient safety, regulatory, accreditation, and payor requirements). CMs 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. Biweekly, CMs 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 CM FOCUS scorecard is the principal framework supporting this review, although the EHR enables the CM to aggregate and analyze virtually all its patient-related data to evaluate its own performance and compare it with that of other CMs.

6.1a(6) Minimize overall costs and prevent errors: CMs 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. CMs 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. Information technology 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 patients' care and also supports analysis of trends for the population served by the CM. 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 2004, 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 JCAHO patient safety goals (e.g., emphasizing hand-washing to decrease patient and staff infections) or, in some processes, Lean techniques such as the 5S or Poka-Yoke.

6.1a(7) Improve health care processes: To improve its health care processes, AF uses the integrated improvement methodology described in P.2c, which includes use of the Baldrige framework, CMs, the OASIS Improvement Model (Figure 6.2-2), 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 its systematic health care process measurement and data analysis, as well as information from Daily Huddles and Patient 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 CM and reviewed in aggregate to uncover patterns across CMs that represent opportunities for improvement.

Once a CM 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, CMs 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 help design their deployment. Firsthand observation at the pilot site and staff rotations also help deploy changes to other CMs. Although many improvements come from inside, AF also learns and improves by benchmarking against recipients of the Baldrige and Saguaro Awards for Performance Excellence, participating in state and national learning collaboratives with other CHCs, and through the HPTs' 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, improved health care, and kept AF's services current. For example, in 2003, 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 2004, one CM 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.

6.2 Support Processes and Operational Planning

6.2a Business and Other Support Processes

6.2a(1) Key business and other support processes: AF defines its business processes as those required to maintain financial health and growth to achieve its mission. Support processes are defined as those necessary to support the delivery of direct care to patients. Key business and support processes are identified 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 (6.1.a[3]) is the identification of business/support processes needed to ensure that the service can be delivered as designed to meet patients' and other stakeholders' requirements. AF's key business and support processes, related requirements, and associated measures are identified in Figure 6.2-1 (space limitations do not permit most business and support process results to be reported in Category 7, but results are available on site). Leaders and teams responsible for processes are expected to both "manage the present" by tracking current processes (6.2.a[4]) and "shape the future" by identifying possible opportunities for improvements (6.2.a[6]). Many business and support processes are centralized to optimize resources, although some, such as transportation and custodial services, must be delivered on site.

Since business and support processes have much in common with processes in industries other than health care, AF uses the process framework from the QPG to identify and categorize business and support processes. CactusCom sponsors AF's nonprofit membership in the QPG. As a member of the QPG, AF also has access to its benchmarking database and to comparison data and best practices from other organizations that perform similar processes.

Process owners (usually the functional managers who have responsibility for a process) manage overall process performance and lead improvement activities. When a process requires more resources, a team composed of staff members and volunteers is formed, and volunteers may lead a team if they have specific, applicable expertise. For example, the retired executive director of a nonprofit agency leads the Grant Writing Team and "reports" to the Director of Development.

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.

6.2a(2) Key support process requirements: Roger Sinclair gathers information on process requirements (Figure 6.2-1) from customer listening and learning methods (3.1), key health care and support process performance results, and information provided from the Patient-Family Advisory Boards and the Partners Committee. Direct feedback on support process performance is sought from customers (internal and external) through short semiannual surveys. Customer, partner, and supplier input, including satisfaction and complaint information, is gathered through the ongoing collection of requirements data. Process owners and their teams review the information, identify themes and emerging or shifting requirements, and take appropriate actions.

6.2a(3) Design of key support processes: Business and support processes are designed using a ten-step PDCA approach similar to the one used for designing health care processes (Figure 6.1-2). This approach has been modified to make it suitable for business and support process design (e.g., it incorporates some elements of Lean). AF does not design processes that are outsourced and performed by strategic partners. For these processes, AF ensures that requirements are clear, and it reviews the processes and expected outcomes both internally and with the

Figure 6.2-1 Key Business and Support Processes

Process	Requirements	Outcome Metrics	Figure/Item
Pharmacy Services	• Medications dispensed accurately • Medications dispensed quickly • Low cost	• Medication accuracy rates • Number dispensed/day • Return on assets	* * 7.3-4
Laboratory Services	• Accurate and timely results • Low cost	• Laboratory errors • Return on assets	7.5-6 7.3-4
Child Care	• Children safe and secure	• Patient and family satisfaction	7.2-7
Patient Education and Translation	• Patients and families understand diagnosis and treatment options	• Language problems • Adequate information	7.2-4a 7.2-3b, 7.2-4b
Patient Transportation	• On time • Accident-free • Safe driving	• Patient satisfaction • 0 injuries	7.2-7 *
Medical Record Management	• Accurate and timely records	• Medical records accuracy rate • Caregiver satisfaction	7.5-5 *
Information Technology Management (through DDS)	• Always available • Accessible where and when needed • Cost-effective	• System up time • Internal customer satisfaction	7.5-7 *
Materials and Services Procurement (through MedProducts, Inc.)	• Timely letting of contracts • Select qualified vendors aligned with values • Maintain effective partnerships	• Internal and external satisfaction with services • Cost savings	* 7.3-5
External Relations Management	• Maintain effective relations	• Partners' perception of value	7.2-9
Property Management Includes • Custodial Services (Shiny Clean) • Transportation Maintenance (Gil's Garage)	• Safety issues addressed immediately • Vehicles maintained to keep in service • Cost is competitive • Work orders completed according to standards • Facilities cleaned on time and according to standards • Prevent security violations • Identify and intervene in threatening situations	• Patient/customer satisfaction • 0 injuries • Return on assets	7.2-7 * 7.3-4
Compliance Management	• No noncompliances • Maintain audit-ready state • Minimize costs associated with audits and accreditation	• Number of noncompliances • Return on assets	7.6 (text) 7.3-4
Financial Resources Acquisition (Grant Writing and Reporting; Donations)	• Meet targets for funding from grant sources • Accurate and timely grant reporting	• Grant success rate • Donations • Funders' satisfaction with reporting; continued funding	7.5-8, 7.5-9 7.3-6 *
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	* 7.3-4

*Space Limitation (results available on site)

partners to ensure that they meet the needs of internal and external customers.

6.2a(4) Key support process performance measures: Outcome measures are shown in Figure 6.2-1. (In-process measures are used extensively but are not shown due to space limitations.) Process owners and team members monitor processes daily to ensure that key performance requirements are being met. Staff know the expected process performance, track in-process performance to requirements, and take corrective action as necessary. All areas and process teams use the Daily Huddle to exchange information about process performance and communicate issues and ideas. In addition, input from customers, suppliers, and partners is included in the process performance review, as appropriate. Performance tracking often is managed with simple checklists and check sheets recorded in spreadsheets and posted on the intranet. Statistical process control is in place for key process metrics. Staff are trained to intervene when a process signals an out-of-control condition. Twice a month, the results are rolled up to the process owner for reporting overall process performance for those measures on the FOCUS scorecard. Complaints are reported back to the process owner as soon as they are received and are addressed with the Complaint Management and Service Recovery Process (Figure 3.2-2) or with more

in-depth root cause analysis and process improvement tools if the problem is severe, long-standing, or critical in nature.

6.2a(5) Minimize overall costs: 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 costs. The members of the medical records process team are trained, like all support process 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. 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 with training and counseling. Since making routine reviews part of the daily tasks in 2003, AF has decreased errors and rework.

AF minimizes costs associated with audits by maintaining an audit-ready state at all times. For example, when AF earned JCAHO 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.

6.2a(6) Improve key business and support processes: To improve its key business and support processes, AF uses the same integrated improvement methodology (P.2c) it employs for its health care processes. The Baldrige-based feedback received annually is a key input for identifying areas for improvement. Another key input is the feedback solicited from external and internal customers through regularly administered surveys and other listening and learning methods. At least annually, the senior leaders review all the identified opportunities, prioritize them using the Pugh matrix, and make assignments to the appropriate process owner, who addresses the opportunity using the OASIS Improvement Model (Figure 6.2-2). To proactively improve processes, at least semiannually process owners and teams review data and determine what level of improvement is necessary. If improvements are warranted based on process performance, stakeholder feedback, or a strategic priority, an improvement team is formed from the staff and volunteers in impacted areas.

As the OASIS Improvement Model has expanded to include other improvement tools, AF has applied Six Sigma and Lean principles to several of its business and support processes. The Six Sigma approach is used for intractable or high-priority issues meeting the "three highs" criteria (high cost, high risk, and high volume) discussed in 4.1b(2). CactusCom has a mature implementation of Six Sigma and Lean and has conducted Champion training for senior leaders and more detailed training for some staff and volunteers with relevant projects. CactusCom still provides a certified Six Sigma resource person one day a month to conduct project reviews with leaders, help prioritize future projects, coach teams in using more sophisticated data analysis techniques, and provide additional training.

Improvements and lessons learned are shared through the online *Staff and Volunteer Handbook*. Process owners, who are responsible for business and support processes across the system, also are responsible for ensuring that improvements are implemented systemwide. In addition, improvements are shared on bulletin boards, in newsletters, and in online communities.

6.2b Operational Planning

6.2b(1) Ensure adequate financial resources: Adequate resources are ensured through the zero-based budgeting process linked to the five-year capital and funding plans developed during the Strategic Planning Process (2.1a[2]). Once the Strategic Plan and goals for the upcoming fiscal year are developed, each group prepares a budget to provide planned services. Productivity standards, external benchmarks, and desired technology implementations are factored into the budget process to ensure that staff and other resources are budgeted at the appropriate level. Once budgets are developed and rolled up, Jay Nyugen performs an analysis to identify any resource issues and feasibility concerns. He reduces risk by conservatively projecting revenues, managing the timing of revenue realization and expenses, paying careful attention to cash management, and requiring a continuous and detailed budget-monitoring process. As part of the contingency plans that are developed each budget cycle, mechanisms are in place to temporarily reduce expenditures of nonmission-critical expenses if needed. Aggressive cost-cutting targets that require continual improvement, more effective use of technology, and innovation are developed each year for the entire system.

Figure 6.2-2 OASIS Improvement Model

	Step	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, AAR

Support processes in particular are targeted for cost reductions each year so more resources can be applied to direct patient care.

Fund-raising, 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 fund-raisers. 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 state 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(2) Ensure continuity of operations: Continuity of operations is ensured through AF's Emergency Management Plan. The focus is on emergency preparedness for power outages, desert sand storms that can immobilize mechanical equipment, or an influx of illnesses or injuries caused by contagious disease or disasters. Emergency response plans have been developed with local first responders. The DDS Disaster Plan (4.2a[3]) is a subset of the overall Emergency Management Plan and provides for backup, off-site storage, and almost immediate recovery and online capability. Other communitywide drills are conducted with local hospitals (3.2a[1]).

AF also is prepared to respond in the event that a clinic or service delivery mechanism is disabled. Other clinics can temporarily assume responsibility for that clinic's services, and arrangements have been made with Gil's Garage and other transportation companies to transport patients to the backup clinic. Mock evacuation drills are conducted, and emergency preparations are reviewed monthly. Full mock disaster response drills are conducted unannounced at least annually in conjunction with local partners. While AF is located far from the Gulf Coast, volunteers gathered surplus supplies and traveled to that area to provide support immediately after the 2005 hurricanes. Upon their return, a thorough review and evaluation of the Emergency Management Plan was initiated based on lessons learned. Few changes were necessary to the plan, but provisions for full evacuations were made more robust so that AF could ensure the safety of patients and their families, staff, volunteers, and other community members on its own without waiting for other responders to assist in completing evacuations.

7: Results

7.1 Health Care and Service Delivery Outcomes

7.1a Health Care Results

To track, improve, and demonstrate health care outcomes and service delivery 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 recommended in the IOM's 2005 report *Performance Measurement: Accelerating Improvement*), HCDI measures (some of which overlap with AQA's measures), the 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 HCDI highest performer and 90th percentile performance, and it strives to meet and exceed Healthy People 2010 goals by 2007. 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. 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, CM, provider, and key patient demographic factors. Appropriate segmented data (available on site) are essential for CMs to evaluate performance, identify improvement opportunities, track the impact of changes, and learn.

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. In contrast to the prevailing trend across the United States, obesity is decreasing among AF patients, with body mass index (BMI) levels in all three counties significantly lower than the state's average level for CHCs for the past three years (Figure 7.1-1a). Mohave County currently equals the state-best CHC performance. These favorable trends reflect AF's multipronged approach: community education, family enrollment in food benefit programs,

Figure 7.1-1a Lifestyle Risk Factor: % With a BMI>30

Figure 7.1-1b Lifestyle Risk Factor: Screening for Smoking

Figure 7.1-2a Behavioral Health: Screening for Depression

Figure 7.1-2b Behavioral Health: Screening for Domestic Violence

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 2005 performance for all three counties on screening for smoking (Figure 7.1-1b) exceeds the HCDI 90th percentile (77.3%), and La Paz and Mohave outperform the best HCDI performance (82.2%). In addition, all three counties are at or near the Healthy People 2010 goal.

Annually, major depression affects about 10% 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 U.S. primary care doctors screen only about 10% of patients for depression and many fewer 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 CMs in 2002 (Figures 7.1-2a and 7.1-2b). Yuma County has equaled the state-best CHC performance for the past two years.

Cancer screening rates are key indicators of the effectiveness of AF's prevention and screening services. A substantial improvement starting in 2002 is associated with implementation of the CM model and enhanced responsibility of medical assistants for ensuring compliance with screening and prevention guidelines. The gain in breast cancer screening (Figure 7.1-3a) corresponds to AF's Save-a-Life campaign, launched in one CM in 2001 and now organization-wide. Other contributors to improved performance include expanding mobile services to border residents in 2003 and opening the Women's Health Center in 2004. In Yuma County, AF's breast and cervical cancer screening rates (Figures 7.1-3a and 7.1-3b) have surpassed the HCDI 90th percentile performance since 2003. In 2005, Mohave's performance also exceeded the HCDI benchmark for these measures, and all three counties exceeded the 2004 state BRFSS performance level for breast cancer screening.

Across the United States, screening for colon cancer lags behind screening for breast and cervical cancer. Performance in

Figure 7.1-3a Cancer: Screening for Breast Cancer

Figure 7.1-3b Cancer: Screening for Cervical Cancer

Figure 7.1-3c Cancer: Screening for Colon Cancer

all three counties (Figure 7.1-3c) improved dramatically in 2003, 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 2005 nearly equals the HCDI 90th percentile in Mohave County, where a campaign targeting retirees that was

Figure 7.1-4a Communicable Diseases: Influenza Immunization

Figure 7.1-4b Communicable Diseases: Pneumococcus Immunization

deployed by the Mohave Elder Council is being adapted for Yuma and La Paz in 2006.

The percentage of high-risk persons receiving influenza and pneumococcal vaccines (Figures 7.1-4a and 7.1-4b) has increased since 1999, with substantial improvement since 2002 associated with the implementation of the CM model and AF's screening and prevention clinical guidelines. 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's 2005 performance in all three counties achieved the Healthy People 2010 goal for both measures, and it exceeded the state BRFSS immunization level in 2003 and 2004.

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 well below national and state performance in 1999 to near the Healthy People 2010 goal of 90% (Figure 7.1-4c). Although performance lags behind the state-best CHC, AF's results are favorable, particularly for

Figure 7.1-4c Communicable Diseases: Completion of Treatment for TB

Figure 7.1-5 Diabetes Care: Screening in Past Year

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 1999, with a significant increase following implementation of the guideline and CMs in 2002 (Figure 7.1-5). In 2005, screening rates for HbA1c and microalbumin exceeded those of the HCDI benchmark. 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 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). Similarly, although LDL cholesterol <100 is the goal for most patients with diabetes, AF strives to increase the percentage with LDL cholesterol <130. From 1999 to 2005, AF reduced the percentage of patients with HbA1c >9.5 from 42% to 22.9% and increased the percentage of patients with LDL cholesterol <130 from 54.9% to 70.1%. On both measures, AF's 2005 performance approaches that of the HCDI 90th percentile.

Figure 7.1-6 Asthma Care

Asthma is the most prevalent chronic disease among children and the sixth most prevalent among adults. Poorly managed asthma leads to hospitalization and 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 2003, resulted in a three-year increase in administering appropriate treatment with anti-inflammatory medication, with performance surpassing the HCDI 90th percentile performance in 2005 (Figure 7.1-6) and close to the HCDI best performer (86.3%) and state-best CHC (85.1%), although still short of the collaborative goal (95%). Also, 85% 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 7.6 to 9.4, close to the collaborative goal of 10. In 2004, 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 7.1-7). Blood pressure control has improved since 1999, with 2005 performance slightly below the HCDI 90th percentile. Also in 2005, AF's performance in cholesterol screening exceeded the HCDI 90th percentile, and its percentage of patients with LDL cholesterol <130 approached the HCDI 90th percentile.

Prenatal care in the first trimester is an important indicator of access to services; lower rates are typical among teens,

Figure 7.1-7 Heart Care

Figure 7.1-8a Pregnancy and Childbirth: Newborns With Low Birth Weight

Figure 7.1-8b Pregnancy and Childbirth: Pregnant Women With Early Prenatal Care

Figure 7.1-9a Pediatric Care–Well Child (ages 3–6): Comprehensive H and P

minorities, and low-income groups. Early prenatal care is associated with higher birth weight and more favorable infant health care outcomes. Since 2002, the number of newborns with low birth weight (<2500 grams) per 100 births (Figure 7.1-8a) has dropped in all three counties, and, overall, AF was the state-best CHC on this measure for the past two years. 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 the 2005 state-best CHC performance for timely prenatal care (in the first trimester), approaching the HCDI 90th percentile (Figure 7.1-8b).

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 history and physical examination [H and P]; age-appropriate immunizations; vision, hearing, and lead screening; and parental anticipatory guidance). Providing 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 children'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.) In 2005, AF's performance in all three counties for H and Ps for children aged three to six (Figure 7.1-9a) exceeded the HCDI 90th percentile, and Yuma exceeded this benchmark for immunizations (Figure 7.1-9c). Providing age-appropriate care and immunizations for adolescents (Figures 7.1-9b and 7.1-9d) has improved in all three counties, with performance highest in Yuma County, home to AF's two school-based clinics. Yuma's 2004 and 2005 performance compares favorably to the HCDI 90th percentile. Adolescent results segmented by age (available on site) 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.

Figure 7.1-9b Pediatric Care–Well Child (ages 12–21): Comprehensive H and P

Figure 7.1-9c Pediatric Care–Well Child (ages 3–6): Appropriate Immunizations

Figure 7.1-9d Pediatric Care–Well Child (ages 12–21): Appropriate Immunizations

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 infection (URI) and testing to determine the cause of sore throats (e.g., streptococcal pharyngitis) and the appropriate treatment. In 2005, AF was the state-best CHC on both measures (Figures 7.1-9e and 7.1-9f), and its overall performance exceeded or neared the HCDI 90th percentile.

Figure 7.1-9e Pediatric Care–Acute: Appropriate Treatment for URI

Figure 7.1-9f Pediatric Care–Acute: Testing for Pharyngitis

Figure 7.1-10a Dental Health (Adults): Dental Exam in Past Year

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 four years, the percentage of adults receiving yearly dental care (Figure 7.1-10a) and the percentage of eight-year-olds with sealant present to prevent dental caries (Figure 7.1-10b) increased in all three counties. Yuma's 2005 performance on both these measures equals that of the state-best CHC.

Figure 7.1-10b Dental Health (Children): 8-Year-Olds With Sealant Present

Figure 7.1-11 Information and Education: Patients With Self-Management Goals

Figure 7.1-12 Heart Care–Follow-Up: Post-AMI Beta Blocker Therapy

Building knowledge and self-management skills (key elements for better chronic disease outcomes) is embedded in AF's chronic disease clinical guidelines. The percentage of patients with documented self-management goals (Figure 7.1-11) has increased steadily as guidelines for each disease have reached full deployment (for diabetes in 2001, heart disease in 2002, and asthma in 2003). Results for asthma lag slightly behind the AF goal of 85%, but for all three chronic diseases, AF currently approaches or has the state-best CHC performance.

In 2003, AF clinicians and hospital discharge planners collaborated to design and deploy a communication and scheduling process for heart attack patients to provide a seamless transition from inpatient to ongoing outpatient care. The redesigned process includes in-hospital initiation of beta blocker therapy, a follow-up outpatient appointment within a week, and a faxed summary discharge plan enabling administrative support staff to confirm appointments and contact "no-shows." The redesigned process is now in place for AF's primary referral hospital in all three counties. AF tracks persistence of beta blocker therapy six months after the acute myocardial infarction (AMI). Performance has improved steadily over the past three years (Figure 7.1-12), and in 2005, AF's performance was second among state CHCs.

7.2 Patient- and Other Customer-Focused Outcomes

7.2a Patient- and Other Customer-Focused Results

7.2a(1), (2) Patient and other customer satisfaction and perceived value: To track the satisfaction and dissatisfaction of its patients and other customers, as well as their perceived value of its services, AF uses a variety of surveys and other mechanisms. Figures 7.2-1 through 7.2-6 show the results from the Packer Patient Satisfaction Survey on six dimensions that are key drivers of patient satisfaction and dissatisfaction: access to care, coordination, information and education, continuity and transition, emotional support, and respect for patient preferences. AF compares its performance against that of the national norm from the survey database, as well as the best CHC in the state. It also segments results by CM (available on site) to help target improvement opportunities.

Important measures of access include patients' ability to schedule appointments when wanted and to get care promptly after arrival (Figures 7.2-1a and 7.2-1b). Problems with getting an appointment have decreased significantly in all three counties from 2002 to 2005, with results better

7.2-1a Access: Could Not Get Appointment When Wanted

than the national norm for the past two years. Less favorable results for La Paz County reflect the fact that the county's one facility has services only four days a week, and many rural patients get care at scheduled van stops with limited appointment options. Results for the second access measure (waited too long after arrival) also show improved performance, with 2004 and 2005 levels in all three counties comparing favorably to the national norm.

A key measure of continuity and coordination of care is related to having medications explained in a way that lets patients know what to expect and how to manage their medications (Figure 7.2-2). In all three counties, AF's performance in this area compared favorably to the national norm for 2004 and 2005, and, with a significant decrease in 2005, AF was the state-best CHC. These results reflect the increased accessibility of medication information through CCKs, implemented in 2004, and the 2005 implementation of e-prescriptions sent from clinics to AF's on-site pharmacy —a time-saving improvement that increases the availability of pharmacists to discuss medications with patients.

Key measures of emotional support include discussing with patients the impact of home and family on health and ensuring that patients' questions are addressed (Figures 7.2-3a and 7.2-3b). AF's CM model, the patients' relationship with a chosen provider and team, and approaches such as a brief survey focused on objectives for the visit provide emotional support. Performance on addressing questions lags in La Paz County, which has a larger population of seniors. The Service With Spirit Team segmented all county results by age and found that seniors in each county were more likely than younger patients to have trouble getting their questions addressed. At the end of 2005, a special task force with representation from Patient-Family Advisory Boards, the Elders Council, volunteers, and CM representatives was formed to identify and implement approaches for improving performance for this key patient segment.

Language-related communication barriers and adequacy of information are two key measures of information and education (Figures 7.2-4a and 7.2-4b). With interpreters available at every service site and all information available in English or Spanish, patients experience few language-related communication problems. The highest percentage of problems has been in Yuma County, which has the largest number of patients with a primary language other than English. In 2003, results segmented by primary language (available on site) revealed lower performance on this measure among Spanish-speaking patients. Changes in the

7.2-1b Access: Waited Too Long After Arrival

7.2-3a Emotional Support: Family/Living Situation Not Addressed

7.2-2 Continuity/Coordination of Care: Meds Not Explained Understandably

7.2-3b Emotional Support: Questions Not Addressed

7.2-4a Information and Education: Language Problems

7.2-4b Information and Education: Did Not Receive Enough Information

enrollment process and additional tools and training for staff in cultural competencies and the use of interpreters contributed to more favorable results in 2004. In 2005, performance in two counties was equal to or better than that of the state-best CHC. Problems with receiving enough information have decreased in all three counties, corresponding to full deployment of the CCKs in 2004, and AF was the state-best CHC on this measure in 2005.

Results for respect for patient preferences and sensitivity to and respect for culture (a custom state CHC measure) show AF's effectiveness in living its values. In all three counties, problems with participating actively in care decisions (Figure 7.2-5) were below the national norm in 2005. AF's 2005 overall performance for problems with sensitivity to and respect for culture and traditions (Figure 7.2-6) is the best in the state. This strong performance is the result of the many approaches developed and deployed by AF to incorporate its VMV into its patients' care experiences.

Patients' perception of overall care (Figure 7.2-7) is a key measure of patient-perceived value—and in particular, of patient loyalty. In 2004 and 2005, the percentage of AF's patients in all three counties who would recommend AF to a

7.2-5 Respect for Patient Preferences: Not Involved in Care Decisions

7.2-6 Respect for Patient Preferences: Lack of Respect for Culture

7.2-7 Patient Perception of Overall Care: Would Recommend to a Family Member or Friend

family member or friend was higher than the national norm, and 2005 performance levels for Yuma and Mohave counties approached that of the state-best CHC.

The Community Climate Survey compares users and nonusers of AF services on a variety of health care-related issues, including their confidence in the quality of care

7.2-8a Community Climate Survey: Have Confidence in the Quality of Care

7.2-8b Community Climate Survey: Have Confidence in the Quality of Care

delivered. Results for community confidence (Figures 7.2-8a–7.2-8c) show a steady increase in the last three years among users and nonusers for each county and type of service, indicating AF's improving reputation. In addition, in 2005, AF's overall performance on community confidence (Figure 7.2-8a), as well as its performance for pediatrics (Figure 7.2-8b) and senior care (Figure 7.2-8c), was the state best for users and nonusers. In 2003, however, the confidence of nonusers was about half that of users related to quality care for chronic disease patients and seniors. Senior leaders and the board explored this result with Patient-Family Advisory Boards, learning that nonusers judged the quality as poorer because AF physicians refer patients for complex specialty care. To correct this misperception, AF revised its explanation of services offered to new patients and its orientation for volunteers, and it addressed the issue directly in the CCKs launched in 2004. Results for 2004 show a favorable gain, sustained in 2005.

7.2-8c Community Climate Survey: Have Confidence in the Quality of Care

7.2-9 Partners' Survey: Partnership Adds Value

In each of four key partner groups, more than 90% of representatives participating in the 2005 telephone survey conducted by the Partners Committee strongly agree or agree that their organization gets value from its relationship with AF (Figure 7.2-9). In response to open-ended questions, representatives from all four groups supported expanding their relationship from 2006 to 2008, given past accomplishments and anticipated needs. Results for additional measures of partners' satisfaction are available on site.

7.3 Financial and Market Outcomes

7.3a Financial and Market Results

7.3a(1) Financial performance: 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 7.3-1 shows AF's actual expenses and revenues for the past seven years, 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. In 2005, AF had the state-best CHC performance for total revenues. The days to payment for accounts receivable (Figure 7.3-2) have decreased for all payor types since 2001, and AF's performance related to private insurance companies was the state best in 2005. AF has maintained relatively high collection rates (Figure 7.3-3), even for self-pay patients, and its current overall performance nearly equals the state-best level. In addition, since 2000, AF has received 100% of the funding allocated to it through grants.

Figure 7.3-1 Revenues, Expenses, and Collections

Figure 7.3-2 Accounts Receivable by Payor Type

Figure 7.3-3 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 Relative Value Units (RVUs) per $1,000 of budgeted expenditures in each of the clinical units. AF chose this measure in 1996 when physicians and nurse practitioners recommended a change from the previous measure of expenditures per patient care experience, since these experiences are so different that the comparison is not meaningful. After changing to the new measure, the medical staff was better able to work with managers to make predictions of resource utilization. AF segments the data in a number of ways, including by clinic, by physician, by work unit (e.g., speech therapy, physical therapy), by payment source, and by the most frequent clinical conditions treated. In 1999, 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 7.3-4). Since 2001, AF's performance on this measure has been the best—or near the best—among state CHCs. Efforts at demonstrating fiscal responsibility are reflected in the cost savings from the purchasing consortium (Figure 7.3-5) and the growth in AF Foundation funding through both capital appreciation and donations (Figure 7.3-6).

7.3a(2) Marketplace performance: To help identify market trends and determine resources or strategic changes needed for the future, AF tracks its marketplace performance by county and by 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 7.3-7), which have a higher percentage of the

Figure 7.3-4 Return on Assets in Clinical Units

Figure 7.3-5 Cost Savings From Purchasing Consortium

population below the poverty threshold. Figure 7.3-8 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 available on site. A lower percentage of market share for chronic disease reflects the fact that AF refers complex chronic disease cases to specialists. The increase in market share for maternal, infant, and child health in 2004 correlates with the opening of the Women's Health Center in Yuma.

Figure 7.3-6 Growth in and Total Value of Foundation Funding

Figure 7.3-7 Market Share by County

Figure 7.3-8 Market Share by Service

7.4 Human Resource Outcomes

7.4a Human Resource Results

7.4a(1) Work system performance: One of the key indicators of AF's work system performance is the cost savings related to the implementation in 2002 of CMs as AF's service-delivery model (Figure 7.4-1). Since that time, as the number of CMs has grown, AF has increased the savings related to health care processes and staffing (see 6.1a[6]). In addition, the seven "employer of choice" dimensions (in particular, "positive team relationships") that form the basis of AF's Staff Satisfaction Survey (Figure 5.3-2) are closely correlated with high-performing work systems. Perceptions of CM staff members have improved for each of the seven dimensions (Figure 7.4-2a). These results are aggregated from those of each CM, clinic, and county. Results for the lowest-performing CM are presented to indicate the variation across the CMs and show that, in 2005, all CMs were at or above the Oates Group 75th percentile benchmark for all North American companies. Similarly, results have trended positively for staff in functional groups outside of CMs (Figure 7.4-2b). These positive trends correspond to the introduction of CMs in 2002 and their continued evolution,

Figure 7.4-1 Cost Savings Related to CMs

Figure 7.4-2a CM Staff Satisfaction With Key Performance Dimensions

	2002	2003	2004	2005	2005 Lowest CM	2005 Oates 75th Percentile
Credible Leadership	70%	75%	81%	84%	80%	78%
Resources and Flexibility	58%	64%	67%	71%	68%	65%
Positive Team Relationships	74%	78%	81%	83%	82%	76%
Opportunities for Growth and Development	64%	69%	72%	73%	72%	64%
Effective Recognition and Rewards	60%	70%	73%	74%	72%	67%
Meaningful Work	80%	81%	81%	84%	80%	80%
A Worthy Organization	73%	76%	82%	83%	81%	76%

Figure 7.4-2b Functional Group (Non-CM) Satisfaction With Key Performance Dimensions

	2002	2003	2004	2005	2005 Lowest Group	2005 Oates 75th Percentile
Credible Leadership	70%	75%	80%	81%	76%	78%
Resources and Flexibility	58%	64%	67%	71%	68%	65%
Positive Team Relationships	74%	78%	84%	84%	80%	76%
Opportunities for Growth and Development	64%	69%	72%	73%	68%	64%
Recognition and Rewards	60%	70%	75%	75%	67%	67%
Meaningful Work	80%	83%	87%	88%	80%	80%
A Worthy Organization	73%	76%	82%	84%	77%	76%

Figure 7.4-3a Proficiency Rates for Core Training—Staff

Figure 7.4-3b Proficiency Rates for Core Training—Volunteers

the widespread deployment of the STAR recognition program since 2002, and a dramatic increase, beginning in 2003, in the number and skill levels of volunteers, resulting in increased resources and a stronger focus on supporting staff to upgrade their skills.

7.4a(2) Staff learning: Staff and volunteer training is critical to the success of the CMs and AF. A key indicator of the effectiveness of training is the percentage of staff and volunteers who demonstrate proficiency (i.e., that they have acquired the targeted skills and knowledge) upon completion of the training. Figures 7.4-3a and 7.4-3b show proficiency rates for the core training provided in new staff and volunteer orientation and during annual refresher training. Figures 7.4-4a and 7.4-4b show the proficiency rates for the training programs that prepare teams to carry out AF's key clinical and access initiatives (Figure 5.2-1). The expansion of training for clinical initiatives corresponds to the introduction of AF's clinical guidelines. In 2003, AF placed a priority on upgrading the skills of current staff members and volunteers, resulting in increased enrollment in degree and certification programs (Figure 7.4-5). In addition, AF increased the number of Work to Learn scholarships for staff and volunteers from 5 during its 2003 pilot program to 17 in 2005.

7.4a(3) Staff well-being and satisfaction: Results from the Staff Satisfaction Survey demonstrate that AF's staff

Figure 7.4-4a Staff Proficiency Rates: Clinical Initiative Training

satisfaction has increased steadily since 2001 (Figures 7.4-6a and 7.4-6b), improving across the organization as a whole and by county and job group, with 2005 overall performance exceeding the Oates Group 75th percentile for all North American companies. Figure 7.4-7 shows volunteer satisfaction rates, also with a favorable trend and comparative performance. Rates for key measures of workplace safety and security (Figure 7.4-8) have improved significantly. AF compares its performance on these four measures against that of

Figure 7.4-4b Staff Proficiency Rates: Access Initiative Training

Figure 7.4-5 Staff and Volunteers Enrolled in Degree/ Certification Programs

Figure 7.4-6a Staff Satisfaction by County

Figure 7.4-6b Staff Satisfaction by Job Group

Figure 7.4-7 Arroyo Fresco Overall Volunteer Satisfaction

previous Baldrige Award recipients. These improvements reflect AF's implementation of standardized safety training with online pre- and post-tests, as well as expanded security awareness and defensive-driver training for staff and volunteers across all locations.

Staff turnover rates (Figures 7.4-9a and 7.4-9b) have decreased significantly, and in 2005, AF's overall turnover rate was the state best for CHCs. These results indicate the success of CM implementation, improved staff development support, and a more effective recognition approach. The results for implementation of the STAR recognition program (Figures 7.4-10) demonstrate strong performance in recognizing both staff members and volunteers, and AF's performance is the state best for volunteers in 2004 and 2005 and the state best for staff in 2005. In addition, results for gainsharing (Figure 7.4-11) show continuous improvement.

Figure 7.4-8 Safety and Security

	2000	2001	2002	2003	2004	2005	Baldrige Benchmark
Lost-Time Injuries/100 Employees	8.7	7.9	6.1	4.2	2.5	0.75	1.45
Sharps Injuries/100 Employees	4	3.5	3	3.2	2	1.5	2
Total Temporary Disability Days	130	124	89	72	37	12	26
Security Incidents	113	121	87	68	45	28	n/a
Van/Auto Insurance Claims per 100,000 Miles	5	4.6	3	1.4	0.8	0	0.82
Annual TB Test Compliance	100%	100%	100%	100%	100%	100%	100%

Figure 7.4-9a Staff Turnover by Job Group

Figure 7.4-9b Staff Turnover By County

Figure 7.4-10 STAR Recognition Program

Figure 7.4-11 Staff Gainsharing

7.5 Organizational Effectiveness Outcomes

7.5a Organizational Effectiveness Results

7.5a(1) Operational performance of key health care processes: Improving access to care is an important goal for AF. By using the OASIS Improvement 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 7.5-1) 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; in 2005, both Yuma and La Paz counties met this goal and equaled the state-best CHC's performance. The "third next available" appointment (Figure 7.5-2) 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. In 2005, AF overall had the state-best CHC performance on this measure.

Figure 7.5-1 Future Capacity: Open Appointment Slots

Figure 7.5-2 Third Next Available Appointment

Figure 7.5-3 Office Visit Cycle Time

Figure 7.5-4 Number of New Patient Visits

Figure 7.5-5 Medical Records Accuracy Rates

The office visit cycle time (Figure 7.5-3) is the number of minutes that a patient spends during an office visit. The cycle begins at the time of arrival and ends when the patient leaves the office and does not include time spent in laboratories or radiology during primary care visits. The goal is not necessarily to reduce total cycle time but to maximize the time the patient spends with the physician and other members of the care team. Office visit cycle time serves as a balancing measure for the time to the third next available appointment to ensure that improvements in one area do not have negative consequences in another. The goal is to decrease the office visit cycle time to 30 minutes or 1.5 times

Figure 7.5-6 Laboratory Errors

Figure 7.5-7 DDS System Availability

the actual time spent with clinicians. As a result of improvements in the above measures, AF has been able to increase the number of new patient visits per month (Figure 7.5-4) without a significant corresponding increase in staff.

7.5.a(2) Operational performance of other key processes: AF drives cost efficiencies and productivity savings in business and support processes by closely monitoring various financial indicators (Item 7.3). In addition, accuracy is a key indicator of the operational performance of many AF processes. For example, all counties have made steady improvements since 2003 in the accuracy rates for medical records (Figure 7.5-5). AF overall had the state-best CHC performance in 2005, and Yuma has been near the Baldrige Award recipient benchmark since 2003. Trends for laboratory errors (Figure 7.5-6) have been improving for all counties. In 2004 and 2005, AF overall had the state-best CHC performance, and Mohave equaled the rate of previous Baldrige Award recipients (0.1%). Figure 7.5-7 indicates the high level of performance and system availability provided by DDS, exceeding the available Baldrige Award recipient comparisons and equaling the QPG best performer's results in 2004 and 2005.

AF's Grant Writing Process has an impressive success rate, with a high percentage of the grant proposals submitted receiving funding (Figure 7.5-8). For the past two years, AF

Figure 7.5-8 Grant Success Rate

Figure 7.5-9 Development Funds

Figure 7.5-10 Use of Volunteers

has achieved the highest performance level of the State Association of Nonprofits on this measure. Figure 7.5-9 shows development funds (from both grants and major gifts) as a percentage of revenue. Results indicate AF's success in increasing development funds, which help provide more and better services to patients at lower costs.

Volunteers are a key element in AF's operational performance of numerous processes. In addition to providing an essential link to AF's communities, volunteers contribute time, skills, and knowledge that are critical in the context of AF's limited financial resources. Figure 7.5-10 shows the favorable results of AF's focus on volunteers, with a steady increase in the

Figure 7.6-1 Progress Toward Achieving Organizational Strategy

number of volunteers and the state-best CHC performance for the number of volunteer hours in 2005.

7.6 Leadership and Social Responsibility Outcomes

7.6a Leadership and Social Responsibility Results

7.6a(1) Accomplishment of organizational strategy and action plans: As part of the systematic process of reviewing performance at both the strategic and operational levels (Figure 4.1-1), senior leaders monitor progress toward achieving AF's strategy by tracking the cumulative percentage of action plans implemented during the year (Figure 7.6-1). In addition, AF has received a variety of external recognitions that affirm its accomplishments to date. A sample of these is shown in Figure 7.6-2.

7.6a(2) Ethical behavior and stakeholder trust: Results for AF's key measures of ethical behavior (Figure 1.2-4) demonstrate the organization's commitment in this area. AF has achieved its goal of 100% of staff completing Code of Ethical Conduct training, including job-related ethics training. Although nonprofit organizations are exempt from regulations in the Sarbanes-Oxley Act, 100% of AF board members and senior leaders have received training on its accountability standards, which are incorporated into AF's governance system. In addition, all of AF's suppliers and partners have signed the Commitment to Ethical Conduct, and the Board of Director's Ethics Committee has reviewed all potential breaches of ethical conduct. AF demonstrates high levels of stakeholder trust in its results for related statements on the Staff and Volunteer Satisfaction Surveys and the Community Climate Survey (Figure 7.6-3). The percentage of survey respondents who "agreed" or "strongly agreed" with these statements increased from 2002 to 2005, and it exceeded or approached the 2005 comparisons (the Oates 75th percentile for the Staff and Volunteer Satisfaction Surveys and the state-best CHC for the Community Climate Survey). In addition, results of the assessment of

Figure 7.6-2 Progress Toward Long-Term Goals

Year	Recognition/Award	Focus
2002–05	Senior Citizens of America—Top 25 Places to Work for Employees Over 50	Staff Satisfaction
2003–05	Latino League's Employer of Choice designation	Staff Satisfaction
2004	Southwestern region recipient of the "Make a Difference" Award for reducing health care disparities	Clinical Performance
2005	Keynote speaker at National Health Center Week	Clinical and Financial Performance
2005	Saguaro State Award for Performance Excellence	Overall Organizational Performance

Figure 7.6-3 Staff, Volunteer, and Community Responses to Ethics-Related Questions

Source	Question	2002	2003	2004	2005	2005 Comparison
Staff Survey	AF's senior leaders expect me and motivate me to do what is right for our patients and the community we serve.	96%	98%	97%	98%	67%
Volunteer Survey	I choose to volunteer at AF because of its high ethical standards.	87%	89%	92%	93%	71%
Community Survey	I trust AF to respond to the needs of its patients and the community.	88%	89%	91%	94%	97%
Community Survey	I believe that AF communicates timely and accurate information.	89%	93%	93%	95%	96%

Figure 7.6-4 Trust in the Governance of the Organization

Question	2002	2003	2004	2005	2005 Comparison
The board adopts a strategic plan consistent with the organization's vision, mission, and values.	78%	83%	87%	92%	96%
The board understands, accepts, and acts consistently with its legal, moral, and regulatory responsibilities.	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.	73%	77%	86%	92%	95%
The board makes issues and decisions transparent to the communities in which the organization operates.	79%	84%	92%	96%	94%

the board against the Stewart-Hagen model (Figure 7.6-4) show increasing trust in the AF's governance over the last four years, and 2005 results compare favorably with the survey's national database benchmark.

7.6a(3) Fiscal accountability: To ensure fiscal responsibility, AF uses an independent accounting firm to conduct annual external audits. For the past ten years, AF has had no major findings in its external audits conducted by independent auditors or by third-party payors. During the same time period, no major findings have been reported by the internal audit team to the Board Audit Committee.

7.6a(4) Accreditation, assessment, and compliance: Accreditation and regulatory results are incorporated into the overall JCAHO survey. AF received full accreditation with no recommendations for improvement on the last survey. One hundred percent of the licensed staff members have up-to-date licenses. There have been no OSHA or EPA violations for more than ten years. In addition, AF has achieved 100% compliance with HIPAA regulations for the past three years. Figure 7.6-5 shows the results of active waste management, with significant increases in recycling evident while regulated medical waste and solid waste volumes declined.

Figure 7.6-5 Waste Volume Management

Type of Waste	2002	2003	2004	2005
Regulated Medical Waste	10.3%	8%	4.9%	4.2%
State-Best CHC Regulated Medical Waste	5.8%	5.3%	4.9%	4.2%
Solid Waste	54.3%	50.3%	47.6%	42.5%
State-Best CHC Solid Waste	45%	44%	41%	42.5%
Recycled Material	34.8%	42.5%	48.3%	53.1%
State-Best CHC Recycled Material	54%	53%	55%	58%

7.6a(5) Organizational citizenship: Despite its limited resources, AF has favorable results related to organizational citizenship that demonstrate its commitment to supporting its

Figure 7.6-6 Support of Key Communities: Staff Members' Volunteer Hours

key communities. AF staff members, including senior leaders, have consistently increased the number of hours they volunteer for various community projects (Figure 7.6-6), with 2005 performance exceeding that of the benchmark—Baldrige Award recipients with comparable staff numbers. Likewise,

Figure 7.6-7 Examples of Community Support Results

Key Program	2002	2003	2004	2005
Donations of low-fat, high-nutrition donations to local food banks (lbs.)	782	864	990	1,120
Participation in "Healthy Body" Program (# of 8–13 year-olds enrolled)	56	67	83	98
Counseling and childcare provided at Casa de Cuidar (hours)	104	156	208	260
Donated use of facilities for community-sponsored groups (hours)	262	361	417	570
"Expect to Succeed" mentoring relationships	30	46	52	63

AF's participation in and donations to the organization's key areas of community support (Figure 7.6-7) have increased significantly.

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