



Indian Health Service California Area Office 2017 Tribal Consultation

Health Board Training
Monday, April 3, 2017
1:00-5:00 PM

Michael D. Pugh

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719 671-2668

Michael Pugh, MPH



- Michael D. Pugh, MPH, President, MdP Associates, has more than 30 years of CEO experience in hospitals, health care systems, managed care, and health information technology companies. He is a consultant to senior leaders of health care delivery organizations, payer organizations, and government agencies on issues of quality, performance, strategy, and governance.
- Mr. Pugh serves as Senior Faculty at the Institute for Healthcare Improvement and co-authored two IHI white papers, “High-Impact Leadership” and “Seven Leadership Leverage Points for Organization-Level Improvement in Health Care.”
- He is an adjunct faculty member at the University of Colorado at Denver School of Business and an instructor in the Master of Science in Health Care Delivery Leadership Program at the Icahn School of Medicine at Mt. Sinai in New York. Mr. Pugh has served on the boards of the American Hospital Association, the AHA Health Forum, the Colorado Hospital Association, and The Joint Commission.

Agenda

- 1:00 – 1:30 Warm-up and Introductions
- 1:30-2:15 So you are on the Board?
- 2:15-3:00 Quality & the Board
- 3:00-3:15 Break
- 3:15-4:00 Strategy & the Board
- 4:00-4:30 Board Self-Evaluation Process
- 4:30-5:00 Open Questions and Dialog

Introductions

- Tell us about your organization
- Tell us about your board
- Tell us about your challenges
- What do you hope to learn today?
 - Flip Chart Recording



So you are on the Board?

All Health Care Boards Share Six Common Traits

- The Board is the ultimate authority
- Board only have authority when they meet are in session.
- Boards may delegate authority to an executive committee, but those actions are limited by the bylaws.
- No one individual has the authority to act for the board. They may represent or be given authority to complete a task, but only the board as a whole has the authority to act.
- Boards are not like Congress...they need to speak with one voice. Board members are obligated to unite behind the majority decision.
- Time is precious so boards must be efficient in their function.

Errol L. Biggs, Health Governance A
Guide for Effective Boards, 2011

Basic Board Responsibilities

- Set and periodically review the Mission, Values and Goals
- The only employee who reports to the Board is the CEO. The Board must hire, fire and evaluate his/her performance.
- The Board ensures the Quality of Patient Care.
- The Board ensures the organization's financial performance.
- The Board has shared responsibility for the health of their community.
- The Board must assume responsibility for itself

Errol L. Biggs, Health Governance A
Guide for Effective Boards, 2011

Legal Responsibilities of Non-profit Health Care Boards

- The Duty of Care
 - “Care that an ordinarily prudent person would exercise in a like position and under similar circumstances”
- The Duty of Loyalty
 - Undivided allegiance when making decision affecting the organization—no conflicts of interest
- The Duty of Obedience
 - Faithful to the Mission and the Bylaws

Basic Board Processes

- Set Direction and Goals
 - Financial
 - Patient Experience
 - Access/scope of services
 - Clinical Care
- Approve strategies to reach the goals
- Review progress against strategies and targets
- Ensure compliance
- Hire and fire the CEO

Individual Board Member Responsibly

- Attendance at Board and Committee meetings and special functions
- Build understanding and knowledge of the organization's mission, services, policies and programs
- Review meeting agendas and read all supporting materials in advance of the board and committee meetings
- Assist in identifying potential board members
- Avoid conflicts of interest
- Bring knowledge and experiences to board discussions to help inform decision
- Ask questions—your most important role

Good Governance: Ask the Right Questions the Right Way...

Inquiry Questions

- How will this improve patient care?
- How does this fit into our strategic plan?
- What resources are being committing to solving this problem?
- How will this impact financial our performance?
- When do you think we be able to show measurable results?

What support from the board do you need?

Attack Questions

- Why haven't you fixed that problem?
- Why didn't you bring this to the board for approval?
- Why aren't you doing something about those doctors?
- Where is your financial justification for this?
- Where are the details for this project?
- What is the FTE count this week?
- Who is responsible for this disaster?



Hope Regional Healthcare

Case Discussion 1

Hope Regional Healthcare

BACKGROUND

Hope Healthcare is a small health system serving the local health needs of about 5,000 people in the community. Located in River County, Hopetown is about a two-hour drive from Big City, a major regional metropolis. While remaining independent, Hope Healthcare is a member of the Good Care Network and contracts with Good Care's flagship hospital for management services and physician staffing. The CEO is responsible to the Hope Healthcare Board, but is an employee of the Good Care Network.

Hope Healthcare is one of the largest employers in the community and the Board is a self-perpetuating board of nine members from the local community with the CEO and President of the Medical Staff as ex-officio members without vote. There are no term limits and four of the board members, including the chair, have been on the Board for over twenty-five years. The rest of the board members have been on the board for 3-5 years, with the newest member appointed just last year. A retired local dentist has served as the Chair for the past 18 years. Like many rural health care systems, Hope Healthcare struggles from year-to-year to maintain positive cashflow and a positive bottom line. Financially they are OK, but not great.

Case Discussion #1

- What are your impressions of the Hope Healthcare Board?
- How might the Board improve its governance structure and processes?
- What might Sharon and other individual board members do differently?

Key Issues in Discussion #1

- Need for Term Limits?
- Orientation for new Board members?
- What is on the agenda? Who determines the agenda?
- Board Members not asking questions?
- Use of Committees?
- Bad Chair Behavior?
- No clear process for Board member to bring up or report community issues?

Engaging Board Members

- Orientation for new Board Members—more than a lunch
- Agenda reviewed with CEO 2 weeks in advance by Board Officers/Chair/Executive Committee
- Opportunity for Board Members to add items to future/next agenda at end of each meeting
- Process for Board members to resolve care issues
- Limit management reporting
 - Focus on strategic issues—not operational
- Committees
- Encourage questions and discussion

New Rule

If you as a board member personally have a care or patient experience problem or if you hear from other patients or sources about problems...

What do you do?

Good Board Manners

- Do your homework
- Talk to the CEO or Chair in advance of bringing up potentially controversial issues
- Listen
- Participate and ask questions to gain knowledge
- Stay focused
- Be on time

Good Management Manners

- Be respectful of board member time—remember that they are all volunteers
- Listen and answer the question asked. If you do not know, say so and follow-up...
- Meetings scheduled at convenience of board, not staff
- Specific actions required identified on agendas
- Concise, well developed advance materials
- Materials mailed in time for board members to read & review
- Support of an effective committee process

Board Member Bad Behaviors

Do Not:

- Involve yourself in management and/or operational issues outside of Board meetings and committees
- Share or divulge confidential information
 - Violate an individual patient's right to privacy
 - Non-public financial or performance information
 - Personnel or employee issues
- Become "an ear" for disgruntled employees or patients
- Represent yourself to employees or patients that you can "fix" a problem for them
- Use your board position to suggest unsolicited advice or direction to employees
- Expect special services, access or accommodations which would not be made for other patients with similar circumstances

Bad Board and CEO Manners

- Domination of discussion-speeches
- Not being prepared
- Coming late and leaving early
- Not being honest about CEO performance or organizational performance
- Secret/off the record meetings
- Playing politics
- Conflicts of interest
- Breach of confidentiality
- Being an “ear” for employees or medical staff
- “Representative” vs. board member
- Bringing operational issues to the board that are not related to strategy or performance indicators

Why Boards and CEOs get into trouble...

- Failure to ask questions
- Failure to set and understand performance expectations
- Failure to choose the right CEO or take action
- Failure to achieve a shared vision between the board, medical staff and management
- Failure to balance community responsibility w/ fiduciary responsibility
- Failure to implement appropriate board processes and structures
- Forgetting your Mission
- Managing vs. Governing
- Individual interests/COI
- The Chair as Czar

Role of Board Committees

- Where the month-to-month detailed work of the board is accomplished
- Where concerns can be shared and questions answered
- Where procedural and routine board decisions can be efficiently processed
- Where board members and management team members can form a collaborative relationship
- 90 minute meeting—plan on it.
- Committee chairs report out to the full board on committee actions and recommendations

Finance Committee

Key Duties

- Review progress against financial goals and budgets
- Keep a close eye on financial strength of the organization (balance sheet)
- Review and recommend budgets and capital expenditures to full board

Key metrics:

- cost/encounter
- Revenue/encounter
- days cash on hand
- days in A/R
- FTEs compared to budget
- Encounters/month (trend and budget)
- Capital expenditures

Patient Experience or Quality Committee

Key Duties

- Review progress against patient experience and quality goals
- Participate with management in setting patient experience improvement priorities and goals
- Provide credibility to management's efforts by receiving reports from improvement teams and on key projects
- Receive Risk Management Reports

Typical Key metrics:

- Access--Days to 3rd next appointment
- Safety—Number of Harm events, Sentinel events
- Service—Patient satisfaction scores
- Quality—Clinical measures, mortality, outcome measures
- Risk—Incident report summaries

Strategic Planning Committee

Key Duties

- Review progress against strategic goals
- Participate with management in setting strategic priorities and goals
- Provide credibility to management's efforts by receiving reports on key initiatives

Typical Key Metrics on a Strategic Scorecard:

- % of patients who got the "right care"
- Metrics associated with key initiatives
- Population Health metric
- Patient Experience Metric
- Access metric
- Financial metric
- Encounter metric



The Board's Responsibility for Quality and Service

Four Challenges faced by Health Care Governing Boards

- Getting comfortable with their responsibility for the care and safety of patients
- Setting the right expectations
- Monitoring Performance
 - Getting useful information out of mounds of data and reports
- Creating accountability

Getting Comfortable

- Barriers to good governance
 - ✓ Myth of the Three-legged Stool
 - ✓ Good doctors = Good quality
 - ✓ Deferring to experts
 - ✓ Complexity and language

Two Key Truths About Health Care Boards

- As a general rule, Boards think quality is a lot better than the administrators, doctors, and nurses do.
 - **“But you never told us in a way we could understand it.”**
- Boards make a big difference in quality
 - 25% time, interaction with medical staff, CEO compensation...
 - Vaughn T, Koepke M, Kroch et. al. 2006

The Board's Responsibility for Quality is Clear

- The Darling v. Charleston Community Memorial Hospital Case – 1965
- The California Medical Insurance Feasibility Study - 1977
- The Harvard Medical Practice Study - 1991
- The Institute of Medicine Report - 1999

LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT,
AND MEDICAL STAFF:

Pre-1965-The Franklin Model

GOVERNING BOARD

(Responsible for Finance,
Nonmedical Services,
Equipment, and Supplies)



Delegated to



MANAGEMENT

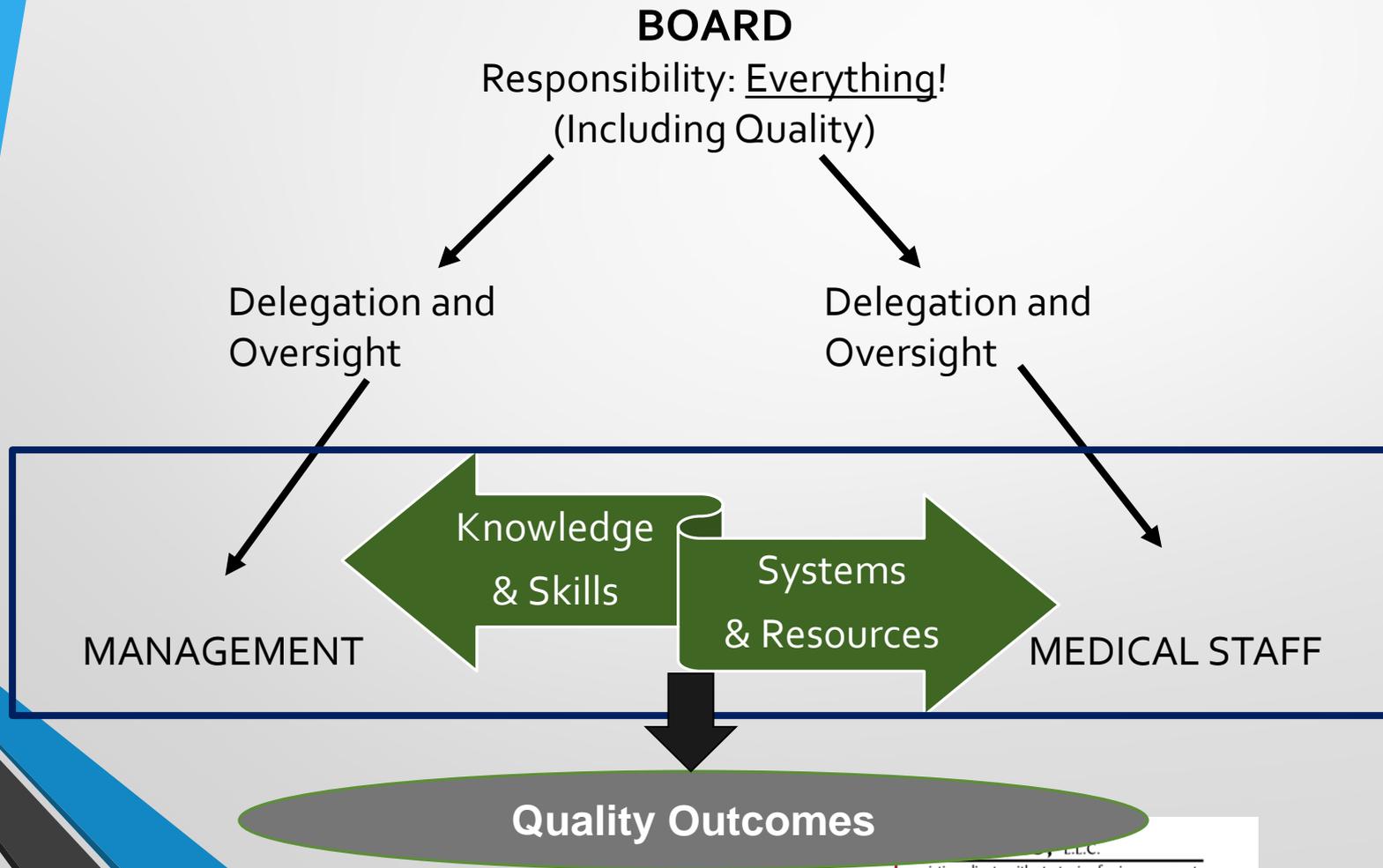


MEDICAL STAFF

(Responsible for Direct
Medical Care, and
presumably Quality)

LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT,
AND MEDICAL STAFF:

Current Post-Darling Model



How Does Your Board Answer these Questions...

How good is our health care organization?

How do we know?

Another Way to Think About How Good...

- If you are the patient, what is the right number of medication errors, infections or falls?
- If you are the patient, is it perfectly normal and acceptable to spend 12 hours in the ED?
- If you are the patient, what % of the time should you get the right care?
- If you are the patient, is it OK to transition home from the hospital without a real plan to keep you from needing to come back?

What People Really Want...

Don't hurt me
Help me
Be Nice to Me



Don Berwick, MD

Quality and Safety: Two Sides of the Same Coin



Quality: Deliver everything that will help, *and only what will help*. The goal is 100%



Safety: Do no harm. The goal is 0 Events



Hope Regional Healthcare—8 Months Later

Case Discussion 2

Case Discussion #2

- How might the Board organize to oversee progress on patient safety and quality issues?
- What questions should the Board ask?
- What data should the Board ask to routinely review?
- How might the Board participate in setting new safety and quality aims?
- What is the role of the medical staff?
- What is the role of the CEO?

Asking The Right Governance Questions About Quality and Service

- What are the important quality results we should be monitoring?
- How good do we want to be?
- Where is our performance now?
- Where should our performance be? (benchmarking/best in class)
- How does our strategy move this measure?
- What resources are we committing to this effort?

Transparency: Sometimes we cannot see what is in front of us...

- When we measure harm, eliminate the denominator...
 - You don't need denominators to compare yourself to yourself, over time
 - Denominators are often part of the problem (ADEs per 1000 doses, SSEs per 1000 patient days)
- Denominators make the problem abstract, rather than personal

What makes more sense... if the right answer is Zero?

Traditional Display (Rates)

- .005 ADEs /1000 doses
- 2.67 infections/1000 patient days
- .003 falls with harm per/1000 patient days

Actual Count

- 35 ADEs last month
- 220 hospital acquired infections last quarter
- 65 patient falls—16 with harm last month

...and whenever possible

Put a face on the data...

Jim Reinertsen, MD

Used with Permission IHI 2013

MdP Associates, L.L.C.
assisting clients with strategies for improvement

Our SSE Patients Jan- Dec, 2008

Helene C.
9/5/2008
Fall

John B.
9/06/2008
Delay in Dx

Florita H.
7/03/2008
Delay in Tx

Wade W.
7/16/2008
Delay in Tx

Baby Boy S.
8/1/2008
Wrong Pt. Procedure

Joseph R.
9/08/2008
Delay in Dx.

Tamika M
4/21/2008
Med Error

Andrea M.
6/24/2008
Wrong Procedure

Nancy H.
6/18/2008
Med Error

Jimmy P.
7/07/2008
Fall

Joann E.
9/23/2008
Wrong Site Surgery

Cynthia M.
10/27/2008
Med Error

Regina D.
12/9/2008
Wrong Site Surgery

Baby Girl V.
5/12/2008
Mother's Delay in Tx

Kyle W.
9/13/2008
Delay in Tx

Teodur C.
1/29/08, 2/12/2008
Delay in Tx

Alvin G.
8/17/2008
Fall

Nicole S.
1/4/2008
Delay in Dx

Margaret H.
2/6/2008
Med Error

Ursula H.
2/12/2008
Fall

Ms. L.
2/14/2008
Delay in Tx

Sandra M.
12/10/2008
Post Procedure Death

Karen G.
8/5/2008
Proced Cx/Delay in Tx

Cynthia K.
11/10/2008
Delay in Tx

Lance D.
10/30/2008
Delay in Tx

Nicole H.
8/12/2008
Post-proced Cx

Robert S.
10/13/2008
Fall

Mary D.
3/9/2008
Med Error

Baby Boy G.
3/25/2008
Med Error

Lorena W.
11/10/2008
Post Procedure Death

Priscilla W.
8/30/2008
Delay in Tx

Dale W.
10/12/2008
Med Error

Eugene B.
10/27/2008, 10/28/2008
Med Error, Fall

Kathy W.
12/16/2008
Post Proced Loss of
Function

Virginia L.
8/12/2008
Delay in Tx

Lester J.
9/5/2008
Fall

Chantal E.
6/26/2008
Inapprop Touching

Gary B.
6/13/2008
Fall



Robert B.
12/2/2008
Post Procedure Death

Calvin P.
4/4/2008
Med Error

Gwendolyn P.
10/28/2008
Wrong Implant

Mary C.
12/19/2008
Fall

Douglas T.
10/18/2008
Med Error



Our SSE Patients Jan-August, 2009

Annualized 77% Reduction in Serious Safety Events (SSE)

Michael F.
8/20/09
Retained Foreign Object

Juanita A.
5/15/09
Med Error

Yolanda C.
7/7/09
Care Management

Beverly S.
2/4/09
Med Error

Robert D.
5/12/09
Post Procedure Death

Sharenda W.
2/15/09
Med Error

Edward R.
4/23/09
Wrong Side Procedure



Lilliam C.
4/3/09
Retained foreign object

Dorothy R.
1/28/09
Delay In Treatment

Donna S.
6/4/09
Retained foreign object





Break



The Board and Strategy

What is Strategy?

1. Strategy is the creation of a unique and valuable position, involving a different set of activities
2. Strategy requires you to make trade-offs in competing—to choose what *not* to do.
3. Strategy involves creating “fit” among company activities

“The root of the problem is the failure to distinguish between operational effectiveness and strategy”—Michael Porter

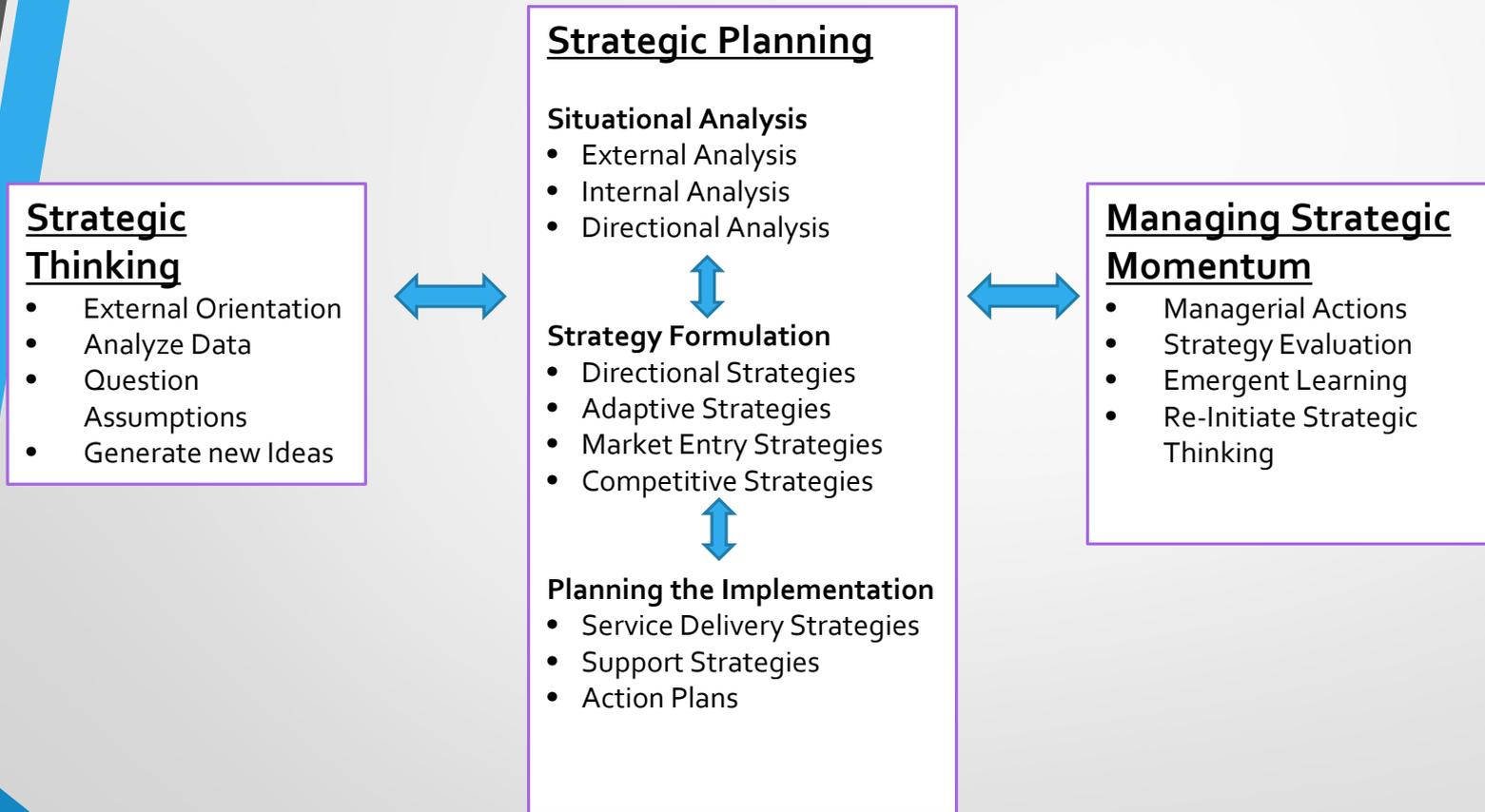
Michael Porter, “What is Strategy” HBR’s 10 Must Reads On Strategy
Originally published 1996. Reprint 96608

History of Strategic Planning in Health Care

- Long Range Planning (1950's-60's)
 - Period of high growth required managers to project demand and plan for facilities growth
 - Assumed reasonably static conditions
- Strategic Planning (60's through 80's)
 - Evolved to recognize the dynamic nature of marketplaces
 - Driven by rapid changes in technology, consumer values, competition and increased funding (Medicare)
 - Remained very building/facility/program focused
- Strategic Management (90's-current)
 - Driven by payer demands, policy and competition
 - Focus on improving quality and performance (operational effectiveness)
 - Focus on consolidation and market dominance

Strategic Management of Health Care Organizations, Seventh Edition by Peter M. Ginter, W. Jack Duncan, Linda E. Swayne; Chapter 1 Jossey-Bass 2013

Strategic Planning Map



Strategic Management of Health Care Organizations, Seventh Edition by Peter M. Ginter, W. Jack Duncan, Linda E. Swayne; Chapter 1 Page 12 Jossey-Bass 2013



Hope Regional Healthcare—18 Months Later

Case Discussion 3

Case Discussion #3

- What might be on the strategic planning committee's first agenda?
- How do you think the Board should approach the strategic planning process?
- What data do you think might be useful for the Board to consider?
- Whose job is it to run the strategic planning process?
- What level of engagement is required by the Board in the strategic planning process?

YKHC Strategic Plan Board Presentation

November 15, 2016



YKHC Mission

(why we exist)

**Working
Together to
Achieve Excellent
Health**

- YKHC Board adopted this mission statement in 2004. It remains an enduring statement of YKHC's core purpose.



YKHC Faces Many Challenges

Healthy People

Tobacco use and lifestyle choices are contributing to poor health

Teen & young adult suicides are devastating

Mortality rates are worse than the rest of Alaska and the US

Healthy Community

Approximately 50% of homes still lack running water

Sustainability of infrastructure

Care Delivery

Access and care coordination

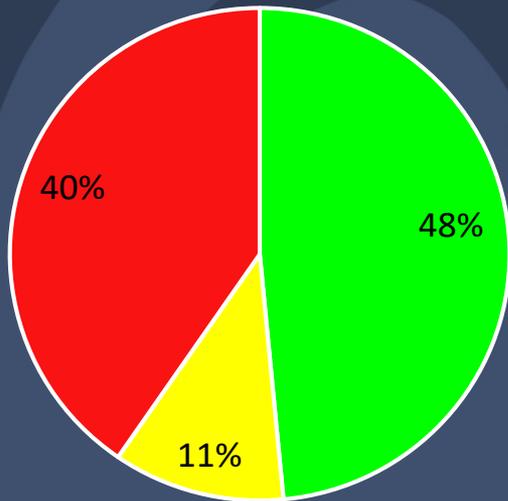
Attracting and retaining staff who share our values

Demand for Care Delivery services exceeds capacity



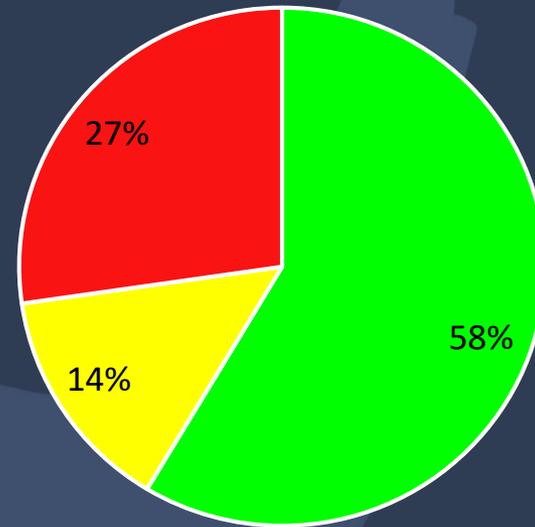
Percentage of Homes Served by System Type in YK Delta 2016

Current YK Delta Water and Sewer Service (not including Bethel)



■ Piped ■ Haul ■ Honeybucket

Funded YK Delta Water and Sewer Service (not including Bethel)



■ Piped ■ Haul ■ Honeybucket

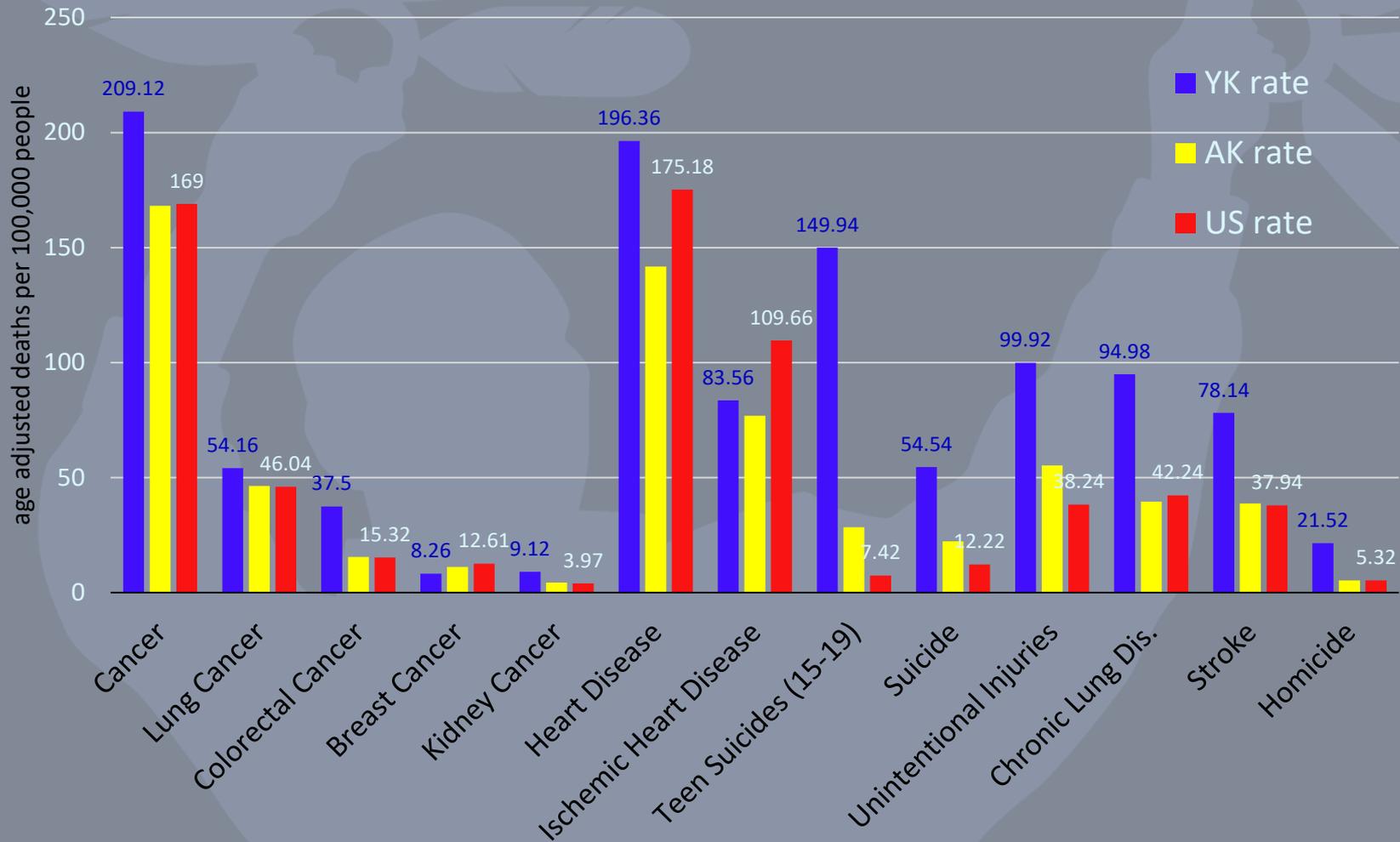


5 yr averaged, age adjusted, mortality rates (as of 2014)

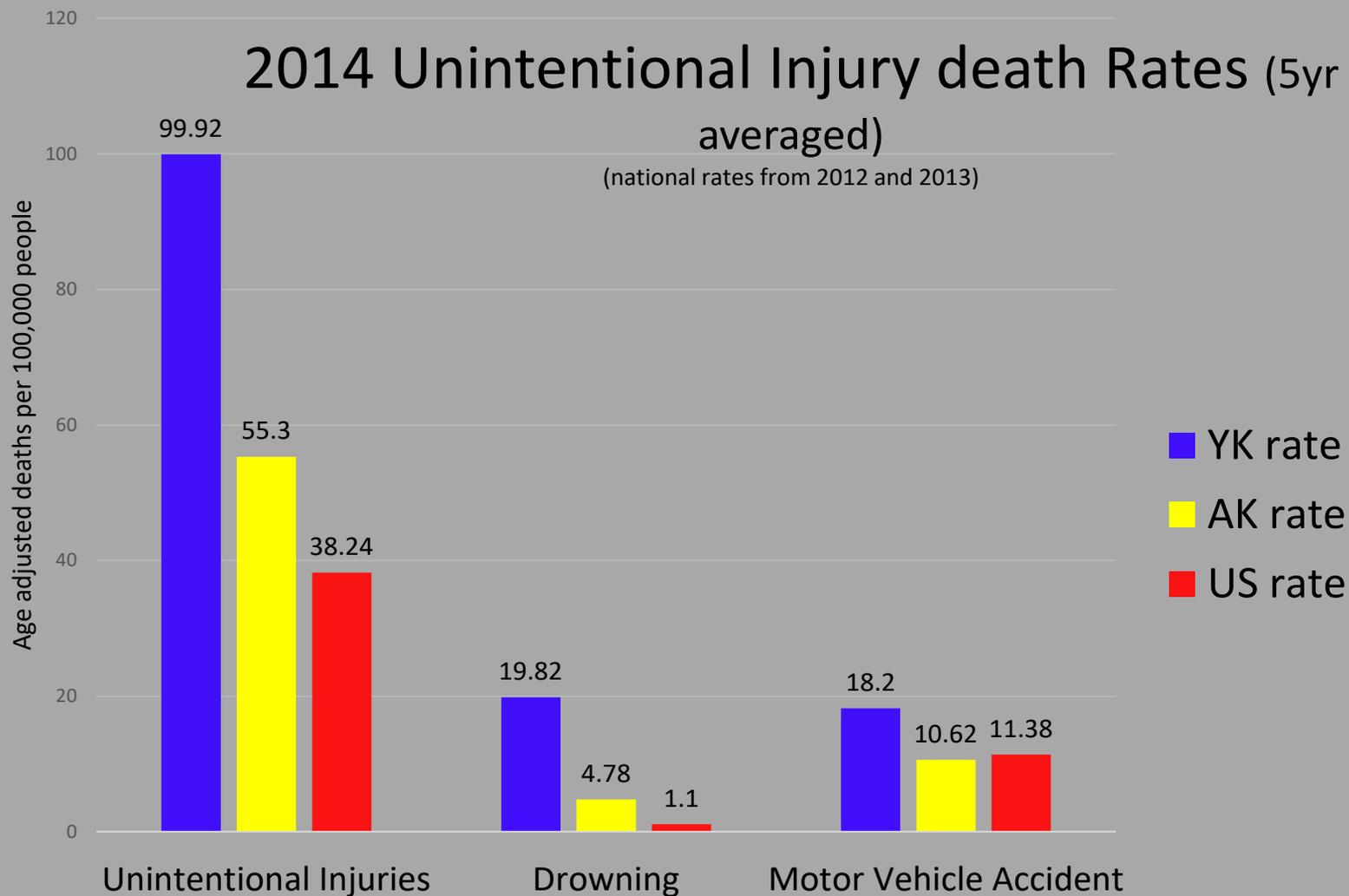
Top 4 cancers 50% of YK deaths

Ischemic heart disease is almost 3/4 of lower 48 heart disease, but less than half of YK

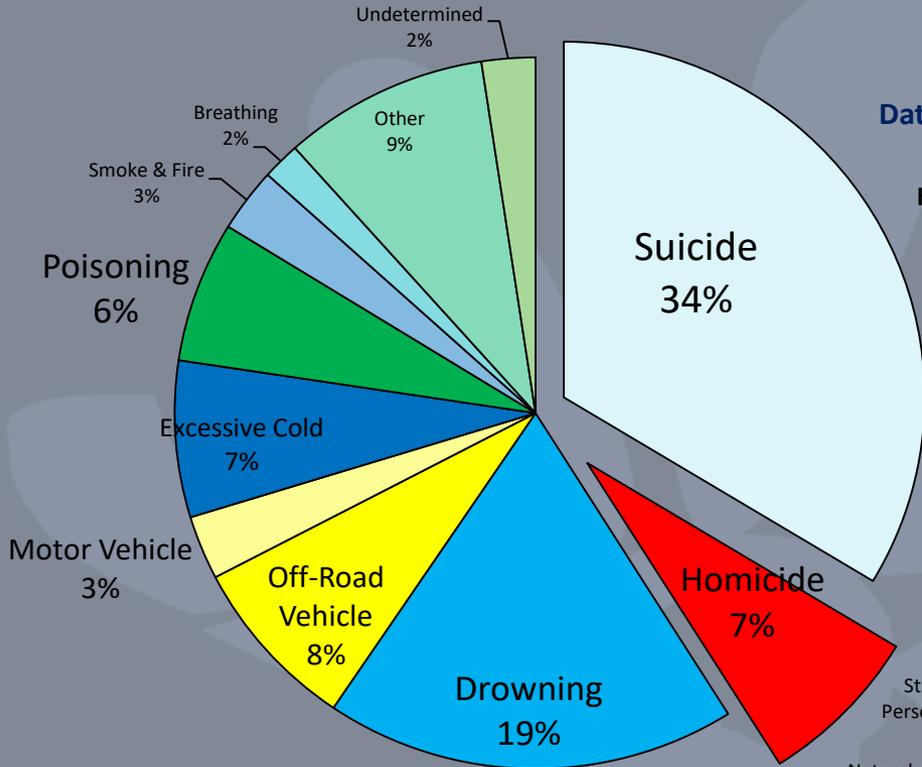
YK has twice the injury deaths as compared to state, and almost 3x the national ra



Deaths from Injury and Accident



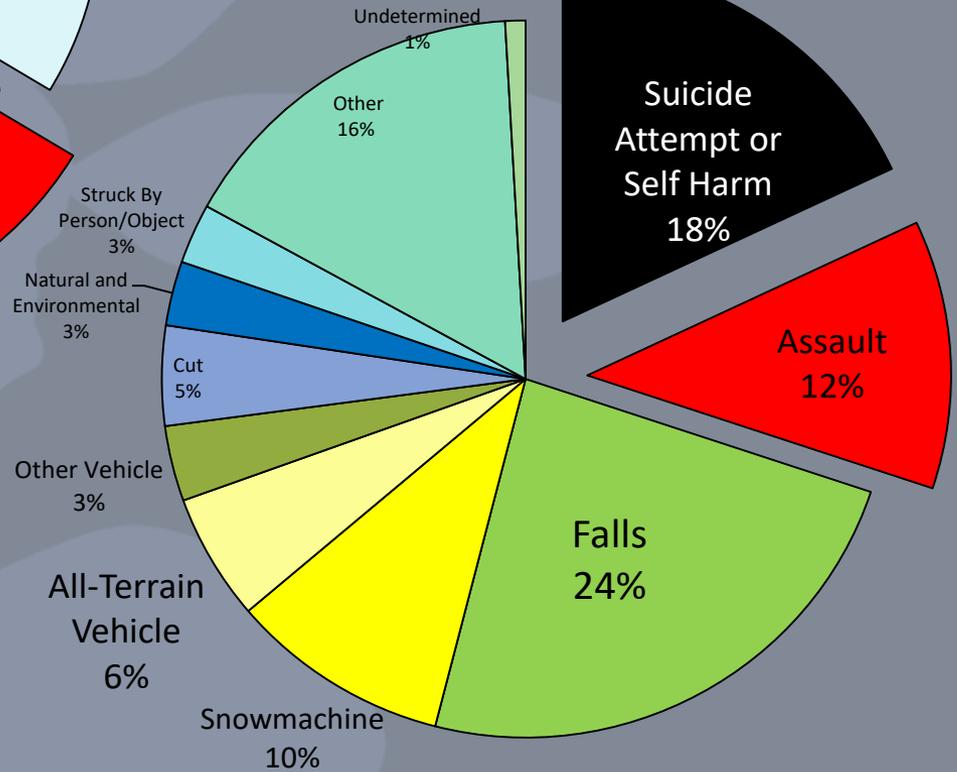
YK Injury Deaths 1992-2011



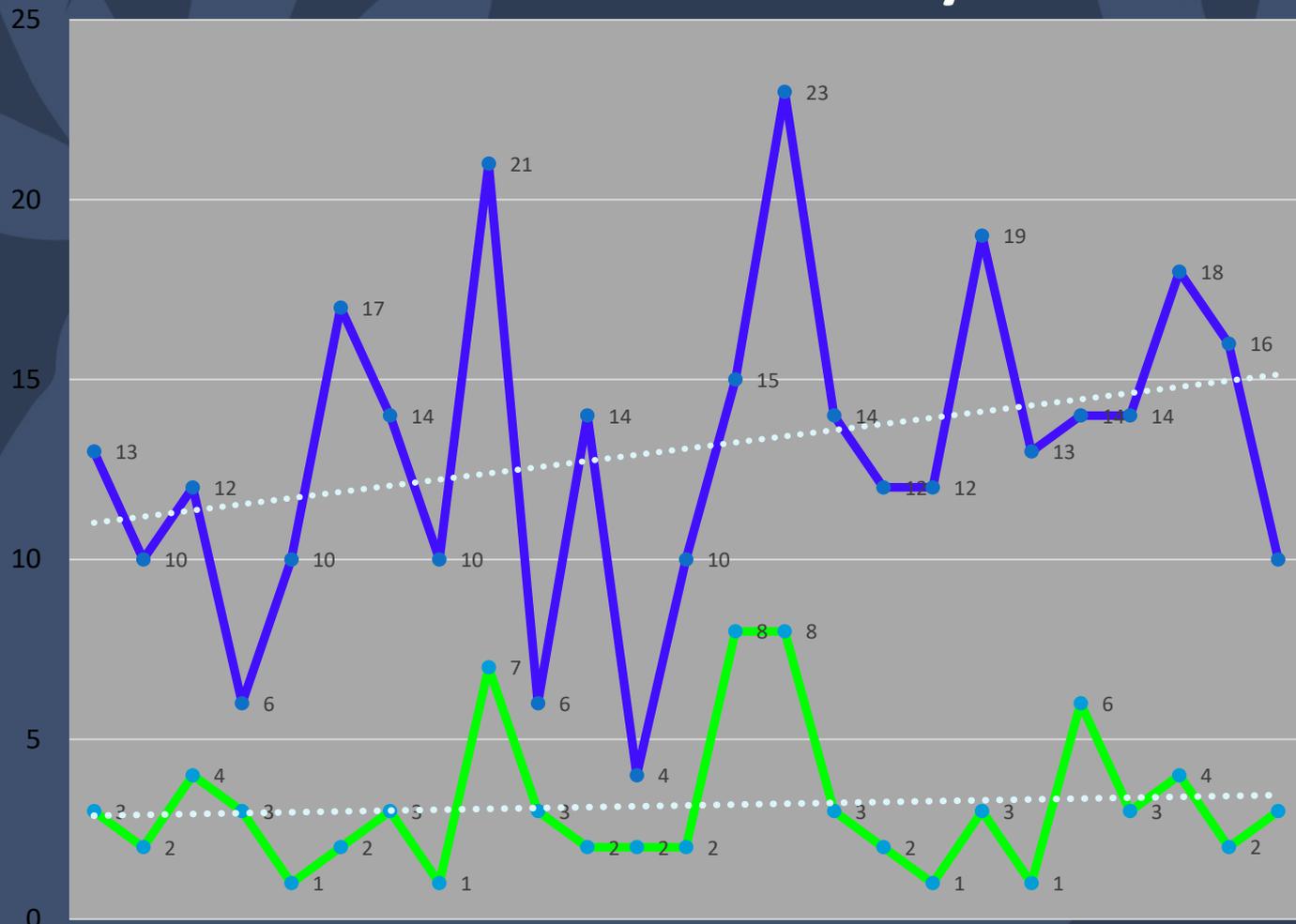
Date from Alaska Native Injury Atlas: An Update, 2014

<http://www.anthc.org/chs/wp/injprev/injurydata.cfm>

YK Injury Hospitalizations 1992-2011



YKHC Suicides by Year



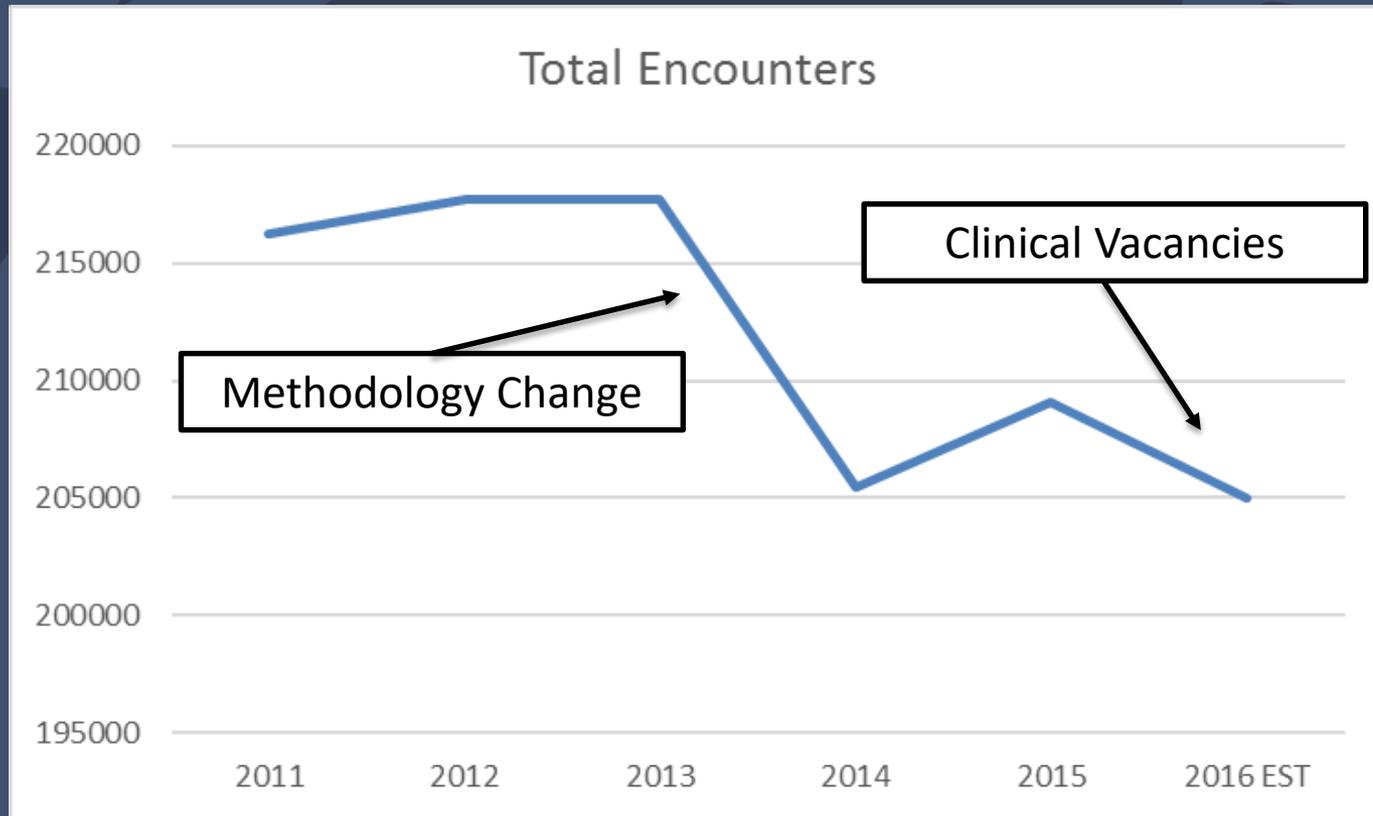
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

● # Suicides ● # Teen Suicides



Care Delivery

Increase Access and Improve Quality



Values

(what we believe in)

Our Values continue to guide our behaviors and actions

- Excellence
 - *Our goal is best practice in everything we do*
- Compassion
 - *We treat patients like they are family*
- Importance of Family
 - *We value the family of our patients, employees and corporate family*
- Personal Growth
 - *We ensure we have a well trained workforce*
- Optimism
 - *We are improving and expect the best outcomes*
- Trust
 - *We expect honesty and transparency of intention among employees, leadership and governance*
- Elder Knowledge
 - *We recognize and appreciate the wisdom of our elders and their guidance for the health of future generations*



Vision

(What we want to achieve)

Through Native Self-Determination and Culturally Relevant Health Systems, We Strive to be the Healthiest People.



YKHC's success as a corporation is ultimately defined by the health of our people



Describing the Desired Future: The Voice of Patients & Families

YKHC is my partner to live a healthier life. My opinion matters. Everyone listens to me and takes time to answer my questions. I am treated with dignity and respect. The facilities are clean and welcoming places. It is easy to get an appointment that fits my schedule. When I need care, YKHC is where I choose to receive the care that is right for me and my family. When I need specialty care, YKHC helps me make it happen. They understand my culture and way of life. I would rather get the care I need at YKHC than any other place.



Describing the Desired Future: The Voice of Tribal Leaders

We are YKHC. We partner to work on improvements. The health of our people is better than it was five years ago. YKHC provides excellent health care services for me and my family that includes our traditional healing practices and respects our culture. It is easy to get the care we need. YKHC manages our finances and facilities well and provides jobs for our people. We are proud of YKHC.



Describing the Desired Future: The Voice of Employees

I make a difference in the lives of the people of the YK Delta. I am valued and my hard work is appreciated. My voice is heard and respected. Leadership invests in me and I have the tools, support and team I need to do my job well. I am given opportunities to grow and develop. I love working here and hope to stay at YKHC for a very long time.



April Board Strategy Small Group Discussions

- How can YKHC work with village and local leaders, families and others to change behaviors to reduce:
 - Accidents, Suicides and Drownings
 - Tobacco Use
 - Cavities and children's oral health issues
- What can the board and individual board members do to support these efforts?
- How can we partner with the villages to reduce Health Aid turnover?
 - Why do you think turnover is high?
 - How could local village support for the work of Health Aids be improved?
 - How could board members help with this challenge?
 - What are your ideas for improving the overall health aid program?

Four Key Strategies

1. Healthy People

YKHC will partner with communities, to empower individuals and families, to make decisions that will improve personal health.

2. Healthy Communities

By partnering with our Tribes and other stakeholders, we recognize the interaction between the environment and the impacts it has on human health. We will work toward a safe and clean environment for our people

3. Care Delivery

We will continually strive to increase access and improve the quality of health care services at YKHC.

4. Corporate Capability and Culture

We will maintain financial and human resources to ensure the organization has the capability to continue to offer customer-oriented services throughout the region.



YUKON-KUSKOKWIM HEALTH CORPORATION

NAPARTET STRATEGY

As described by our late honorary board member Dr. Paul John, “napartet” is the mast of a boat that led he and his father out to traditional fishing waters. Similarly, at the Yukon-Kuskokwim Health Corporation (YKHC), we have adopted a Napartet Strategy that will set us on the course over the next five to ten years to advance our mission of “Working Together To Achieve Excellent Health.” Our vision is to provide culturally relevant care, resulting in the best health of our people and our communities.

MISSION

Working Together to
Achieve Excellent Health

VISION

Through Native Self-Determination and Culturally Relevant Health Systems, We Strive to be the Healthiest People

#1

HEALTHY COMMUNITY

#2

HEALTHY PEOPLE

#3

CARE DELIVERY

#4

**CORPORATE CAPABILITY
AND CULTURE**

YUKON-KUSKOKWIM HEALTH CORPORATION

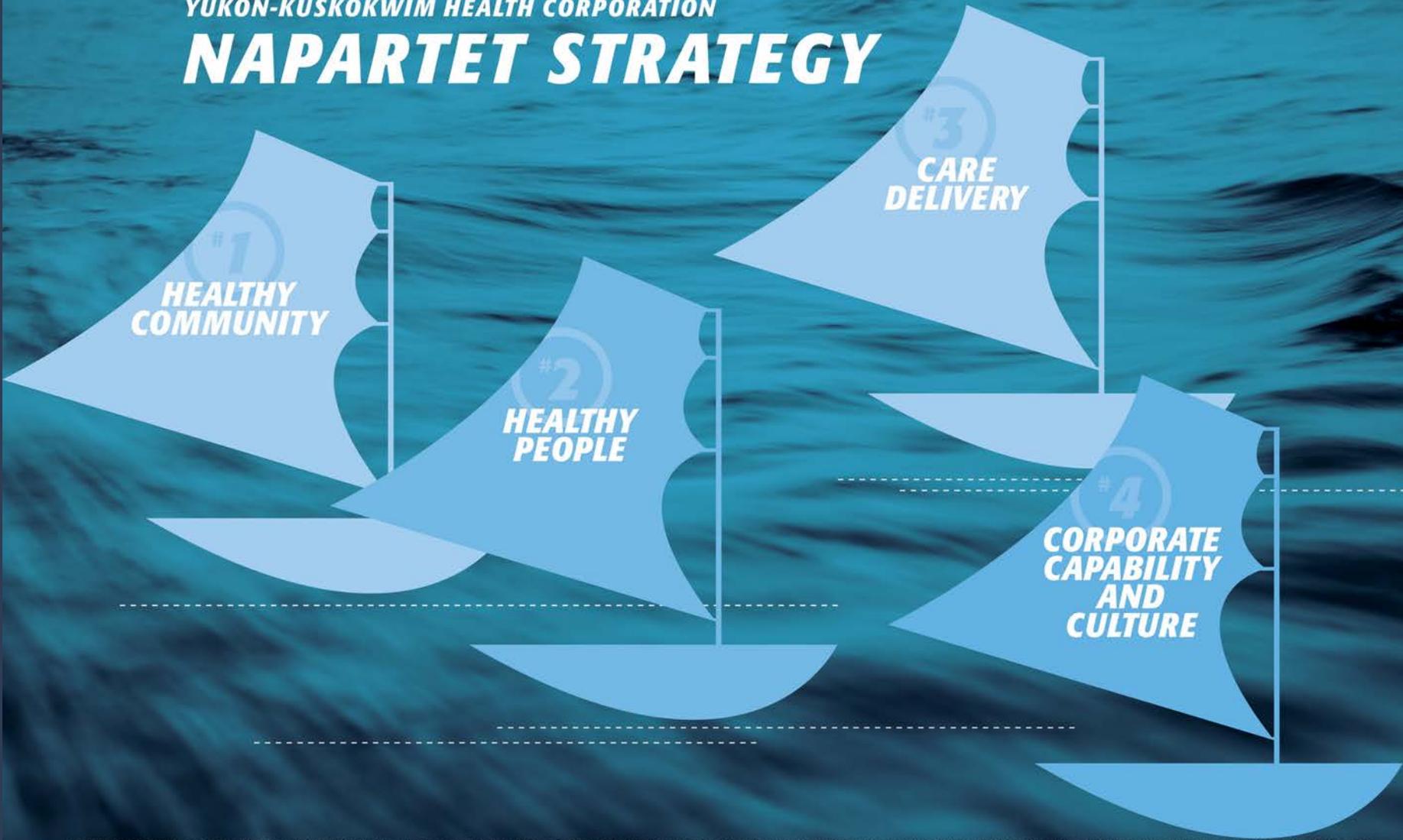
NAPARTET STRATEGY

#1
HEALTHY
COMMUNITY

#2
HEALTHY
PEOPLE

#3
CARE
DELIVERY

#4
CORPORATE
CAPABILITY
AND
CULTURE





#2

#3

#4

HEALTHY COMMUNITY

By partnering with our Tribes and other stakeholders, we recognize the interaction between the environment and the impacts it has on human health. We will work toward a safe and clean environment for our people.



EXTEND AND SUSTAIN WATER
AND SEWER PROJECTS



ADVOCATE FOR PUBLIC
FUNDING AND NEW PROJECTS



#1



#3

HEALTHY PEOPLE

YKHC will partner with communities, to empower individuals and families, to make decisions that will improve personal health.



IMPROVE OUR CHILDREN'S
ORAL HEALTH

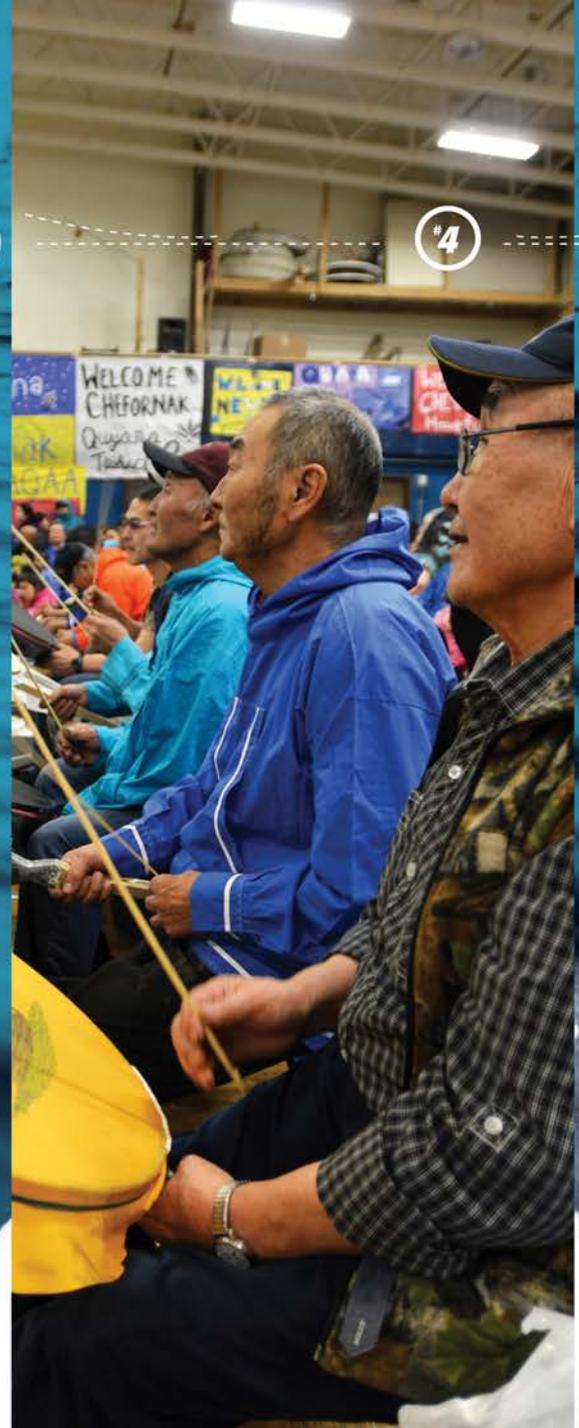


REDUCE DROWNINGS,
ACCIDENTS AND SUICIDES



REDUCE TOBACCO USE

#4



#1

#2

#3

NAPARTET
STRATEGY

#4

CARE DELIVERY

We will continually strive to increase access and improve the quality of healthcare services at YKHC.



IMPLEMENT NEW MODEL OF CARE



BEGIN & SUCCESSFULLY
COMPLETE THE PAUL JOHN
CALRICARAQ PROJECT



STRENGTHEN VILLAGE
HEALTH PROGRAMS



"1

"2

"3

CORPORATE CAPABILITY AND CULTURE

We will maintain financial and human resources to ensure the organization has the capability to continue to offer customer-oriented services throughout the region.



RECRUIT AND RETAIN
CLINICAL STAFF



USE HIGH RELIABILITY
TOOLS AND METHODS



DEVELOP & RETAIN ALASKA
NATIVE WORKFORCE

#4

NAPARTET
STRATEGY



YKHC Napartet Strategic Scorecard

(how we are going to measure our strategic success over the next 5-10 years)

Strategy: Healthy People

- Tobacco Use Rate
- Number of suicides per year
- Mortality rate from drownings & accidents

Strategy: Healthy Community

- % of homes with water and sewer

Strategy: Care Delivery

- Patient Satisfaction scores
- Total patient encounters

Strategy: Capability & Culture

- Cost per encounter
- % Workforce Alaska Native





The Board Self-Assessment Process

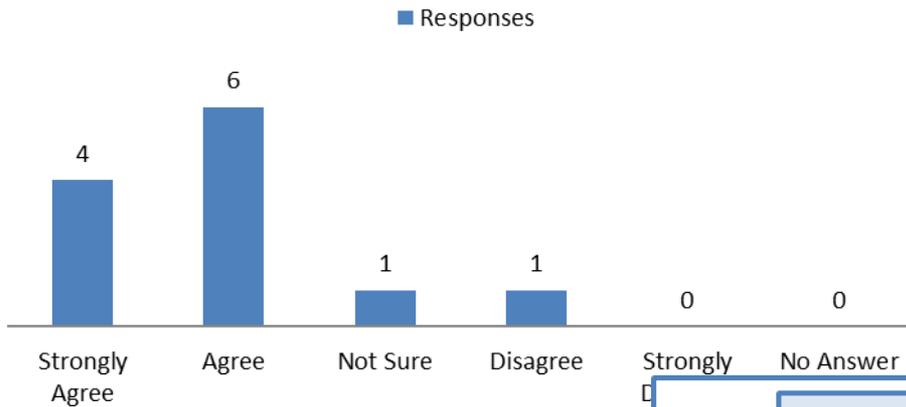
Board Self-Evaluation

- Why do it?
- How do you do it now?
- What have you learned?

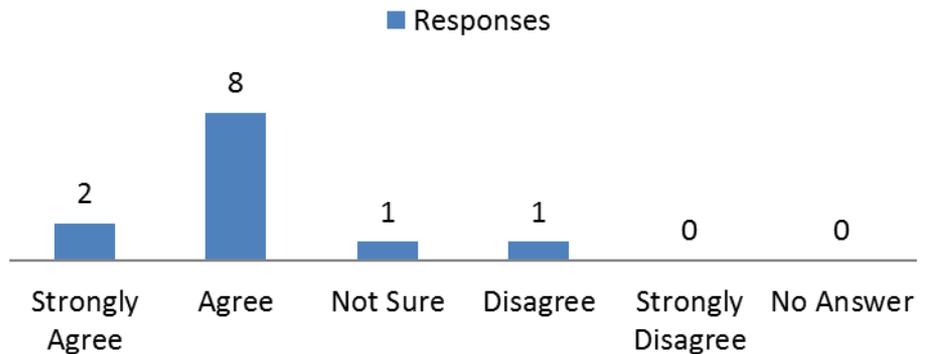
Mock Self-Evaluation Process

Typical Display

3. Board members have a good understanding of the role and responsibility of the Board.



6. The Board has a good process in place for review and evaluation of YKHC financial performance.





Questions and Dialog