2022

STRATEGIC POSITIONING PLAN

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Purpose

In pursuit of the Mission, the Strategic Position Plan defines the direction of PHC over the next 1-2 years through the identification of structural domains, key performance indicators, allocation of resources, alignment of efforts, and provision of data and sound reasoning to support the achievement of goals. The organization continues to function under the constraints of Covid and erratic political realities. In spite of this oppressive reality, PHC remains aligned around the five key domains of operational excellence, impeccable quality, innovations in population health, barrier-free access, and joy at work in order to **improve health equity**. Our unique values of integrity, dignity, compassion, and respect are reflected in our integrated, human-centric service model. With demand for such integrated services unmet and creativity at the forefront, PHC added an Expansion Task Force in the past year. In designing next steps, we continue to choose "courage over comfort" at each juncture as we pursue our vision of **healthy people and strong communities**. This translates into ongoing attention to and investment in optimal health services AND the underpinnings of poor health, specifically the impact of racism and poverty on achieving optimal levels of individual, organizational, and community health.

Mission: To promote optimal health and wellbeing for all, through comprehensive, patient-focused, accessible, and equitable care.

Once again PHC intends to be positioned as the BEST health care in the area. With this in mind, the Plan builds on significant learning over the past few years. Data has been reviewed for local access challenges, poverty statistics, monthly and annual quality and access numbers, staff feedback, and finances. After generative sessions with PHC's Board of Directors, feedback from the Leadership team, and input from PHC's staff, the plan represents enhancements under the Five Domains. Specifically, the performance indicators and activities are slightly narrower and deeper. Years of experimentation, many successes, much unfinished work, and increasingly comprehensive data help us hone our focus and refine our workflows.

A welcoming, increasingly diverse workforce, in partnership with FMRWM, will form high-functioning teams as they care for 16,500 individuals through integrated, patient-centered services. Virtual health services and worksites will remain a contained part of the strategy. Staff members will be well-trained and well-supported with clearly defined job duties to provide easily accessible, high-quality care. Patients will have outstanding experiences regardless of which door they enter. There will be a sustained focus in multi-faceted aspects of discrimination and its impact on health. We continue to learn how to lead with race, explicitly but not exclusively, in all areas. In addition to taking advantage of our stable financial position and successful grant writing, PHC will continue to expand solid partnerships (expanded zero-to-five-year-old programming, housing initiatives, community health workers, and legal services) to advance equal and just outcomes.

Moving from aspirational statements to organized action, in order to execute these strategies, all departments will have an action plan designed to meet these indicators by Dec. 31, 2022.

Strategic Planning Session, Leadership, and Staff Feedback - 2021

	Joy at Work	Operational Excellence	Impeccable Quality	Innovations in Population Health	Barrier-Free Access
Accomplishments	Hired Staff Engagmnt Coordinator NeoGov improvements around higher Min Wage and market changes Leadership training Childcare $ All Staff Commun. Celebrations Food!	Comprehensive Dashboard IT inventory Ongoing staff training Increased fee revenue – 9.8%, total revenue – 23% Upstream $ allocation Resources to devote to capital improvmts Expanded backbone depts. Expansion TF/Mgr Have strategic assessment tool	MA ladder and staffing 4 panel managers Quality support staff CA screening successes Data imprvmts – clean, timely, and disaggregated VBC reporting PFAC – Nat. Amer and quality data SDoH screening redesign Luma pt score – 89%	Reg staff updates Upstream graphics with MLP Data dashboard – vaccines and quality MST funding CHW grant FUSE/Housing work Hired DEI Coord. PFACs – Native Amer. And Transg groups Successful Medicare Wellness pilot	17K+ vaccinated Dropped calls <5% Pt feedback 6 month open sched MST up and running Satellites open BH –telehealth Dental –efficient Med productivity Over 6% increase pt volume Locked notes-med good, BH improving Outward communications New comm partnerships
What Remains **(not yet done or suggested changes to 2021 plan)**	Resiliency – research and strat. Plan Ongoing leadership training Training budgets Get Staff Eng. Measure above 4 DEI continued Affinity groups Small group connections Fun theme days Re-define Joy at Work Stay interviews Menstrual prods	Use Strat. Assessment tool Departmts – use data Space needed Increase pharm revenue Data in clinic workflows Documt workflows Move to accrual acctng Coding education Chart audits Pursue 0-5	Continue – refine core practices – autopilot Maintain low error rate Retain urgent/same day care Promote P4 – peds External data sharing HTN Bluetooth 0-5-wellchld care Medicare AWV Value based care team Languages on pharm labels	New program framework/screen MST in scope Respond to PFAC recommendations Outward comm – share innovations Outdoor care, home care 0-5 complete Healthcare trust building Connect pts with navigator/kiosk Food, cooking, local ag support	Online booking Pt feedback – dental Team continuity Pharm policy Med productivity Direct BH access Homeless care LGBTQ outreach Home visits LUMA use-guidelines Pt. barriers cont No wrong door BH in schools

Five Domains: Strategic Areas of Focus

JOY AT WORK

GOAL: PHC will achieve high levels of engagement through targeted recruiting with a focus on diversity and equity, staff development and growth opportunities, market wages and benefits (or better), flexible, supportive positions, and strong teamwork.

- **KEY PERFORMANCE INDICATORS:**
  - Maintain Staff Engagement at 4 or higher (out of 5)
    - Explore, measure, and intervene in resilience (or whatever word works!)
  - Retain minimum wage of $16.50 or better
  - Pay all positions at CHAMPS market or better while aligning with County approaches
  - Support access to childcare for staff
  - Pursue at least 2 DEI Committee plans and action in 2022
- **DRIVERS/Actions:**
  - Hiring and retaining practices – well and with diversity at forefront
    - Opportunities to learn, grow, contribute, and be compensated for this
  - Training - Focus on expanded DEI understanding, resilience, and leadership
    - Clear department level training budget
  - A successful PHC bottom line to support salaries

OPERATIONAL EXCELLENCE

GOAL: PHC supports timely patient care, staff efficiency, innovations in access, care, and communication, and quick responsiveness to opportunities and threats.

- **KEY PERFORMANCE INDICATORS:**
  - Track to sustainable budget that supports this Strategic Plan now and for next 3 years
    - Maintain 120 days cash on hand
    - Invest in capital expansion (10% net) and poverty-cycle breaking programs (1% operating)
  - Network and computers work 100% of time
  - Provide visually expressive data -productivity, quality, staffing, and budget available 100% of time – all departments
- **DRIVERS/Actions:**
  - Complete a three year, board approved budget by May 1, 2022
  - Invest in hardware, software, and staff to accomplish the indicators
  - Pursue improved complexity coding – training and staffing
  - Add resources through Value Based Payment contracts
  - Using Strategic Screen, avoid new programs that diminish ability to achieve KPIs

BARRIER-FREE ACCESS

GOAL: PHC ensures timely, culturally competent access to all programs for individuals it serves and continues to respond to areas of unmet need.

- **KEY PERFORMANCE INDICATORS:**
  - Care for 16,500 patients in 2022
  - Expand BH - 1000 direct BH visits + BH in three schools
  - Less than a 5% abandoned call percentage at all times
  - Online booking - for medical appointments – July 2022
- **DRIVERS/Actions:**
  - Make it easy to be 'seen' – phones, templates, technology, facility, parking, staff
  - Ensure sufficient staffing/technology - answer phones, see patients well, bill for services, and maintain backbone departments then head home on time for dinner
  - Create efficient, effective services that allow for 15 pts/day in medical, 1.7/hour in dental, 6 pts/day in BH, and 500+ prescriptions in pharmacy

INNOVATIONS IN POPULATION HEALTH

GOAL: PHC addresses systemic barriers to good health and wellbeing by partnering with people most impacted by health inequities, connecting with community organizations, and incubating new programs grounded in evidence-based and emerging best practices.

- **KEY PERFORMANCE INDICATORS:**
  - Maintain current funder relationships
  - Start and refine:
    - Community Care Team – into outdoor living spaces by April 1
    - Medical Legal Partnership – serve 15% more than 2021 -220 clients in 2022
    - Mobile Support Team – finalize Inter-local Agreement, refine program
    - Begin Early Learning Center and have 10 child participant
    - Advance DEI work – monthly meetings, two key changes accomplished
    - Make two clinical changes from Native America PFAC and Transgender PFAC
- **DRIVERS/Actions:**
  - Communicate/maintain relationships with Partners:
    - Funders – reports, acknowledgments
    - PHC Leadership, Board and Staff
    - Community Updates – website, stories
    - Relationships with City and County
  - Co-design with structurally marginalized populations
  - Expand understanding and actions regarding power sharing and building

IMPECCABLE QUALITY

GOAL: PHC provides effective, appropriate, integrated, and human-centered health care services to improve health outcomes.

- **KEY PERFORMANCE INDICATORS:**
  - 90% of patients will have a great experience
  - 90% of patients will be interviewed for SDoH barriers and strengths
  - Healthcare goal - achieve and maintain:
    i. Dental treatment plan completed in 18 months – 50%
    ii. Childhood immunizations – 44% fully immunized (if appropriately staffed)
    iii. Depression screening and follow up – 85%
    iv. Diabetes – controlled (A1c – under 9) – 72% (the measure is a golf score)
    v. Hypertension – controlled – 60%
    vi. Colorectal CA screening – 55%
    vii. Tobacco cessation – 93%
  - Healthcare equity - no difference based on race/ethnicity
  - Medication administration accuracy - < 1 error/10,000 vaccine administrations
  - Closed loop referrals/orders – 95% scheduled or closed by 9 months 6/30/22 (6 months end of year)
  - Evaluate disparities in hypertension & diabetes outcomes within Native American population
- **DRIVERS/Actions:**
  - Fully staffed team with clear roles and workflows – PSRs, Care teams with CHWs, Patient Liaison, Care Managers
  - Actionable, timely data at team level along with subpopulation data
  - Patient representative on QI Committee
  - Healthcare equity – no difference based on race/ethnicity