# 2017 Arroyo Fresco Case Study

# Consensus Review Scorebook

# Pretraining Draft

### 04/14/2017

Notes on this version of the scorebook:

* Items 4.2, 6.2, 7.1, and 7.4 have undergone the Baldrige Program’s technical editing and grammar editing processes.
* The key themes and the remaining items are the team’s unedited work at the end of Consensus Review.
* For training purposes, items 4.2, 6.2, 7.1, and 7.4 include additional information on why examiners made the choices that they did. A typical scorebook does not contain this information.
* To “blind” the scorebook, the examiners’ initials have been replaced by “Ex1” (Examiner 1), “Ex2,” and so on throughout the scorebook.

A fully edited scorebook will be posted at <http://www.nist.gov/baldrige/examiners/resource_center/consensus_review.cfm> (under Reference shelf) in June 2017.

## Key Factors Worksheet

#### P.1a Organizational Environment

**Organization Description** Nonprofit CHC providing primary care, preventive services, enabling services in 3 highly diverse AZ counties (Yuma, La Paz, Mohave). 11 clinics, 4 mobile service vans.

**Health and Enabling Services** Clinics/mobile service serve patients at churches, schools, community centers w/23 PCTs as essential HC delivery unit. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.

**Mission** Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.

**Vision** “The people of western Arizona will become the healthiest in the state.”

**Values** Respect, trust, relationship, performance, accountability.

**Core Competencies** 1. Culturally competent, patient-centered care; 2. Expertise in treatment of diseases prevalent within applicant’s patient population; 3. Collaborative relationships that increase access to specialty care/other services.

**Patient/Population Health Status and Problems** Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.

**IT Capabilities** Support for EHR integrated with billing/scheduling. All staff have access to computers, wide array of data/information on intranet, portable CCK.

**Staff** 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.

**Volunteers** 314 volunteers (key stakeholder group): patients/family members, who help build relationships with patients/families, increase efficiency/effectiveness of care delivery.

**Drivers of Workforce Engagement** Nonmillennials: senior management communication, use of skills/abilities, comfortable reporting errors or unsafe acts, protection from health/safety hazards, clear sense of what is expected. Millennials: growth opportunities, flexible work schedule, fair pay/good benefits, personal relationships/partnerships, support of mission.

**Health and Safety Requirements** Protection from exposure to communicable diseases, radiation, chemicals, needle sticks, ergonomic injuries, accidents.

#### P.1b Organizational Relationships

**Regulatory and Accreditation Requirements** Multiple federal, state, local—including designation as FQHC, qualification for Section 330 grant funds and TJC, recognition as PCMH.

**Governance** Voluntary 15-member Board of Directors, 6 standing committees: Quality, Ethics, Community, Partner Relations, Development, Audit. More than 51% of voting members are recipients of applicant’s services; senior leaders are nonvoting board members.

**Key Customers and Requirements** Patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as high-quality health center; personal relationships/partnerships.

**Stakeholders and their Requirements** Communities, physicians, staff, volunteers, payers, partners, suppliers, collaborators: information/training on current medical technology/procedures; knowledge, skills tools to do job; fair pay/benefits, recognition/opportunity to serve and develop job skills for staff/volunteers; opportunities for collaboration/innovation for partners, suppliers, collaborators.

**Suppliers, Partners and Collaborators** Inpatient care partners in each county, advocacy providers, strategic/vendor partners, industry partners, education partners, community partner groups/community service organizations, industry/vendor partners. Role in innovation: contribute ideas, new products, tools, technology, best practices; represented on Innovation Council, receive annual training in ethical/legal obligations, MVV.

**Supply-Chain Requirements** Low cost/high value, on-time delivery, continuity of operations for providing clinical care to enhance competitiveness.

#### P.2a Competitive Environment

**Competitive Changes** ACA resulted in more stable finances. Increasing demands for care place stress on applicant.

**Market Share** In 2016: 17% in 3-county service area: Yuma (24%), La Paz (23%), Mohave (14%).

**Comparative and Competitor Information** National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program.

#### P.2b Strategic Context

**Strategic Advantages** SA1—enhanced funding under ACA; SA2—Knowledge Management System; SA3—expertise in treating clinically complex conditions; SA4—highly engaged workforce, suppliers, partners, collaborators, volunteers; SA5—flexible approaches to benefits/scheduling that meet needs of diverse workforce.

**Strategic Challenges** In five key performance areas (F—financial performance, O—organizational learning, C—clinical excellence, U—utilization, S—satisfaction) SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured; SC2—reducing workforce gaps, including clinical providers/staff w/specific technical skills; SC3—addressing low prevention/screening and higher incidence of chronic/communicable disease in service area; SC4—establishing/managing mechanisms to provide specialty care/meet service needs; SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package.

#### P.2c Performance Improvement System

**Performance Improvement Framework** PIF: leaders set directions, focus on action through clearly defined strategies/objectives, regular performance reviews, sharing/spreading best practices, use of performance tools.

## Key Themes Worksheet

### a. What are the most important strengths or outstanding practices (of potential value to other organizations) identified in the applicant’s response to Process Items?

1. The applicant shows visionary leadership in its core health care business through senior leader focus on the VMV. The VMV creates the organizational culture and permeates strategic planning and daily operations. Identification and validation of the key communities served embeds societal responsibilities into the organization’s strategies, strategy implementation and action plans, and daily operations. Use of primary care teams, personalized health plans, and community outreach and engagement that includes volunteer members of the workforce defines the applicant’s organizational culture, and forms the framework for activating patients in their own care. The organization’s contribution to societal well-being focuses on improving community health, reducing disparities, and expanding access to care, with a focus on Support for the Body, Support for the Spirit, and Support for the Mind, and addressing its communities’ health care needs, supported by activities that improve nutrition, housing, transportation, and education. These activities are in alignment with the applicant’s core competencies of patient-centered care, and expertise in treating diseases prevalent in its population, and contribute to organizational, financial and societal performance, and to meeting the applicant’s vision of a healthier population. Sources of Data/Examples: 1.1b STR#1 1.1a(1) STR#2 1.2a(2) STR#1 3.2a(2) STR#1 4.1a(1) STR#1 5.1a(4) STR#2 6.1b(2) [[1]](#footnote-1)
2. The organization promotes a focus on success, customer-focused excellence, and patient-centered care through its use of the FOCUS (Financial Performance, Organizational Learning, Clinical Excellence, Utilization, and Satisfaction) framework (Figure P.2-3). This allows the organization to address strategic challenges and align efforts in critical areas to maximize the use of limited resources. Key health care processes, determined with input from community needs assessments, federal mandates, partners, and key stakeholders, are linked to the organization’s strategic objectives through the FOCUS framework. The applicant’s Performance Measurement System (Figure 4.1-1) aggregates data from multiple listening and learning tools to capture the Voice of the Customer; and data measurement of patient satisfaction and engagement through various methods, and feeds information into the FOCUS scorecard. The FOCUS framework promotes organizational alignment between strategic and operational considerations, and integrates needs identified in the Strategic Planning Process with the applicant’s operational and performance measurement systems, contributing to an environment of organizational agility. Sources of Data/Examples: 2.2a(2) STR#1 2.2a(3,4) STR#3 3.1a STR#1 3.1b(1) STR#2 3.1b(2) STR#3 4.1a(1) STR#1 4.1a(4) STR#2
3. The organization’s systematic and comprehensive approach to employee hiring, development, engagement and support aligns with the applicant’s values of respect and performance, and support of its communities. The organization systematically identifies and defines workforce capacity and capability needs during the People Review of the Strategic Planning Process; deploys a variety of approaches to reward and recognize high performance; and employs multiple systematic approaches to build a culture of engagement, communication, and high performance, and a system of promoting ongoing education of its workforce. The organization’s workforce practices supports its communities, by recruiting from their members, through variety of safety and wellness approaches targeted to workforce, and by offering education benefits to employees, and children of workforce members, including volunteers. These approaches contribute to engaged employees, accountability for performance, employee opportunities for learning, and career development and progress, which help the applicant address key human resource strategic challenges. Sources of Data/Examples: 2.2a(3,4) STR#3 5.1a(2) STR#1 5.1a(1) STR#2 5.1b STR#3 5.2a(2,3) STR#1 5.2a(4) STR#2 5.2a(1) STR#4

### b. What are the most significant opportunities, concerns, or vulnerabilities identified in the applicant’s response to process Items?

1. There is a lack of evidence of a systematic approach to ensure access to treatment services, particularly for mental health, alcohol and substance abuse, and obesity, diabetes and heart disease, which are critical health problems for the applicant’s communities. There also is lack of evidence of a systematic approach to outreach and addressing the health care needs, and unique access and outreach challenges of the Native American and Veteran communities in the applicant’s service region. Systematic approaches to address the needs of these communities may assist the applicant in meeting its vision of a healthier population. Sources of Data/Examples: 1.1c(1) OFI#3 1.2a(1) OFI#1 3.1a OFI#1 4.1a(1),c(1), OFI#1 6.1a,b(2, 3) OFI#3
2. There are opportunities to enhance the applicant’s relationships with key partners, including inpatient hospitals and other health care provides, and there is a lack of evidence of a systematic approach to enhance satisfaction, engagement, development and retention for the physician segment of the workforce. Other than the relationship with La Sangre Vida, and an initiative with Winding River Casino, focused on substance abuse and obesity, there is little evidence that the organization has a systematic approach to managing its relationship with clinical partners. The applicant’s physician workforce and the partnerships with inpatient hospitals and other health care organization are critical to the organization’s ability to provide the full range of health care services to its patients and communities in keeping with its mission to provide residents easy and timely access to high-quality and safe health care services, and the vision of a healthier population. Sources of Data/Examples: 1.1b OFI#1 1.1a(1) OFI#2 2.1a(4) OFI#2 2.2a(2) OFI#2 4.1a(2) OFI#2 4.2a(2) OFI#1 6.1a(1),b(1, 4),c OFI#1 6.1a(2) OFI#3 6.2c2 OFI#2
3. It is not clear how the organization ensures learning, refinement and innovation in a wide range of areas. Critical areas include strategic, management and operational learning related to a changing market and health care financing environment, and potential new strategic opportunities and challenges resulting from added insurance coverage and access for patient populations under the Affordable Care Act. For example, information is lacking on how the applicant has adapted to a more comprehensive approach to care under the patient-centered medical home model, how it will meet the health care needs of a population with enhanced access to care, or how it will use insurance payments vs. grants, donations and major gifts as sources of financing to reflect the added sources of payments under the ACA. It also is not clear how strategy implementation and action plans address performance against local competitors and comparable organizations the applicant competes with for existing and potential patients. Adapting strategies and their implementation, and day-to-day operations a new patient populations and new sources of financing will contribute to an agile, responsive approach ensure success and sustainability in a rapidly changing market, and help the applicant meet the health care needs of its patients, and improve the health of its communities. Sources of Data/Examples: 2.1b(2) OFI#1 2.1a(2) OFI#3 2.2a(6) OFI#3 2.2b OFI#4 3.1a(10,b(2) OFI#2 4.1a(1),c(3) OFI#1 4.1c(2) OFI#2 4.1b OFI#3 6.1d OFI#2 6.2c1 OFI#1

### c. Considering the applicant’s key business/organization factors, what are the most significant strengths found in its response to results Items?

1. The organization reports favorable levels, trends, and comparison for screening outcomes, and some and measures for access to care, including screening outcomes (Figures 7.1-1 through 7.1-5, and Figures 7.1-12 and 7.1-14) compare favorably to the state average for CHCs. Measures of access to care (Figures 7.1-25 through 7.1-27) show positive trends and favorable comparisons. Good to excellent results are also shown for patient satisfaction, patient and other customers’ perceptions of the organization, workforce engagement, and some financial results. For example, aggregate patient satisfaction (Figure 7.2-1), medical and dental services (Figures 7.2-2 and 7.2-3) meet or exceed the top-decile comparisons since 2013, and measures for Patient/Family/Community Satisfaction by Key Requirement and Satisfaction with Services (Figures 7.2-6 and 7.2-8) show favorable trends. Financial performance results (Figures 7.5-1 and 7.5-2) meet or exceed the state-best CHC benchmark. Collectively, these results underscore the applicant’s core competencies of patient-centered care and expertise in treating diseases prevalent in its population, show a favorable response to strategic challenge of establishing and managing mechanisms to provide specialty care and meet service needs, and help contribute to meeting the mission of providing residents easy and timely access to high-quality and safe health care services, and to meeting the applicant’s vision of a healthier population. Sources of Data/Examples: 7.1a STR#1 7.1b(1) STR#2 7.2a(1) STR#1 7.2a(1) STR#2 7.2a(1) STR#3 7.2a(1) STR#4 7.5a(1) STR#1
2. Good to excellent results on employee satisfaction, engagement and retention, and the applicant’s support of its workforce (including volunteers), and excellent results for senior management communication with the workforce indicate the success of the applicant’s focus on valuing people. These results for workforce engagement (Figures 7.3-13 through 7.3-17) and recognition (Figures 7.3-9, 7.3-11 and 7.3-12), and physician (Figure 7.3-16) and volunteer satisfaction (Figure 7.3-17) outperform the Oates top decile. Further, results for Turnover by Employee Group (Figure 7.3-1), for Turnover Rate for Employees <1-year Tenure (Figure 7.3-2), and for Vacancy Rates (Figure 7.3-3) demonstrate favorable trends from 2012 to 2016, with all groups meeting or exceeding the state-best CHC levels. Also, results in STAR Recognition (Figure 7.3-11) reflect a favorable trend for both staff and volunteers, significantly outperforming the state-best CHC benchmark. These results provide evidence of the applicant’s strategic advantage of a highly engaged workforce, which is critical to the delivery of health care to the patients and communities in its service area, and may help overcoming staff recruitment and retention challenges related to the organization’s remote location. Sources of Data/Examples: 7.3a(3) STR#1 7.3a(1) STR#2 7.3a(2) STR#3

### d. Considering the applicant’s key business/organization factors, what are the most significant opportunities, vulnerabilities, and/or gaps (related to data, comparisons, linkages) found in its response to results Items?

1. Results are missing for a range of outcomes critical for the applicant, including data on the effectiveness of health care error prevention, and key health care outcomes across the continuum of care, particularly data on inpatient care and transitions between inpatient and ambulatory care. For example, outcomes are lacking for services provided by the applicant’s acute inpatient care partners, including length of stay (LOS), re-admissions, and transitions of care to the ambulatory settings. Results are also missing in the dimensions that relate to the applicant’s support of its communities and impact on the health of its key communities. Results in these important areas may enable leaders to understand the organization’s progress on its journey of performance excellence. Key components of this include the provision of the full range of safe, effective, timely health care services to meet its strategic challenges of addressing the higher incidence of chronic and communicable disease, and establishing and managing mechanisms to provide specialty care and meet service needs, in keeping with the vision of a healthier population. Sources of Data/Examples: 7.1b OFI#1 7.1a OFI#2 7.1c OFI#3 7.1a,b(1) OFI#4 7.2a(2) OFI#2 7.4a(3,4,5) OFI#1 7.5a OFI#3
2. The applicant does not provide important results in the business and financial performance sections, particularly related to the outcomes for action plans, and the impact of the ACA, and the use of the various sources of funding, including grant and gift funding. In it is not clear how the applicant’s performance compares to that of local competitors for key health care outcomes, workforce recruitment and retention and market and financial performance. For example, Aggregate Patient Satisfaction, Satisfaction with medical services, dental services, school services, mobile van services, support services and key requirements (Figures 7.2-1 through 7.2-7) lack local comparisons. Availability and analysis of results, including comparing performance in these areas to local organizations with which the applicant competes for current and future patients may contribute to ensuring financial and organizational sustainability in a rapidly changing healthcare system. Sources of Data/Examples: 7.2a(1) OFI#1 7.2a(2) OFI#2 7.3a OFI#1 7.3a OFI#3 7.4b OFI#2 7.5a(2) OFI#1
3. The applicant has opportunities to gain additional insight into its performance and market position through review of segmented data for many results. For example, in the workforce section, no segmented results are provided for physicians other than physician engagement. Leadership and societal responsibility results are not segmented by county, facility, community, or type of service, and no segmentation by market, patient, and customer segment is provided for dental, medical, and behavioral health services. Without segmentation, it may be difficult for the applicant to evaluate its relative performance in each segment to gauge the effectiveness of its planning and strategy implementation, and to assess effective approaches related to particular work team, and geographic and other patient and service segments, in keeping with its core value of identifying best practices. Analysis of segmented results may assist the organization in focusing strategic responses on key areas and identify high-performing areas and best practices to help meet strategic challenges and ensure long-term organizational success and sustainability. Sources of Data/Examples: 7.2a(1) OFI#3 7.3a OFI#2 7.5a(1) OFI#4 7.4a(1,4,5),b OFI#3

## Item Worksheet—Item 1.1

## Senior Leadership

### Relevant Key Factors

1. Nonprofit CHC providing primary care, preventive services, enabling services in 3 highly diverse AZ counties (Yuma, La Paz, Mohave). 11 clinics, 4 mobile service vans.
2. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
3. Core values: respect, trust, relationship, performance, accountability.
4. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
5. Inpatient care partners in each county, advocacy providers, strategic/vendor partners, industry partners, education partners, community partner groups/community service organizations, industry/vendor partners. Role in innovation: contribute ideas, new products, tools, technology, best practices; represented on Innovation Council, receive annual training in ethical/legal obligations, MVV.
6. SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Senior leaders use a variety of mechanisms to communicate to the workforce and the community. The mechanisms (Figure 1.1-2) support two-way communication to share and reinforce the organization’s vision, mission, and core values. Several cycles of learning have helped enhance communication through the expanded use of social media, the addition of a county director to support communication flow from senior leaders and throughout the county, and revisions to the website to enhance transparency. The breadth of these approaches may help to deliver on the key driver of workforce engagement—senior leader communication. | Ex5’s and Ex6’s feedback-ready comment provided the nugget; other examiners provided examples; Ex8 provided the statement about cycles of learning [L]; Ex5 provided the relevance. Two examiners (Ex5, Ex6) assigned a double (++) to this strength, with which Item Lead initially concurred considering the ADLI comprehensiveness of the strength. Revision for R3: Changed role of communication mechanisms from “enable” to “provide” to “support.” Eliminated “robust” as descriptor of communication system. Revision at Consensus (R4): Modified nugget sentence by removing reference to “all key stakeholders” and changing to “the workforce and the community.” Further support for double ++ is provided by Figure 7.4-1 Employee Satisfaction with Senior Leader Communication. | b |
|  | The organization’s senior leaders set, review, and validate organizational Vision, Mission, and Values (VMV), which are embedded in the Leadership System (Figure 1.1-1). The VMV are reviewed and validated annually during the Strategic Planning Process (Figure 2.1-1).. The cycle of learning in 2010 resulted in the addition of respect as a value, reflecting the provision of culturally competent care. Cognizant of cultural diversity of the workforce and community, the VMV is displayed in English and Spanish. Bilingual displays continuously remind everyone about expectations, and each senior leader champions a value to ensure broad understanding. | Comment combines 10 strengths leading to this comment about setting vision and values. The nugget of this strength is based on the feedback-ready comments of Ex2 and Ex7; the examples are based on Ex2’s and Ex8’s feedback-ready comments with the example of improvement [L] contributed by Ex8; the relevance statement was contributed by Ex6. The feedback-ready comments of Ex2 and Ex7 provided the nugget. One examiner (Ex7) assigned a double (++) to this strength. Item Lead proposes a single (+) to this strength so as not to be in conflict with the second OFI in Item 1.1, which is about the lack of deployment in 1.1a(1). Revision for R3: Clarified the nugget sentence (Ex8). Revision at Consensus (R4): Moved the strength from the third to the second position.  | a(1) |
|  | Senior leaders promote an environment that fosters and requires legal and ethical behavior among staff, volunteers, board members, and suppliers and partners. Senior leaders implement processes that include: (a) annual overview of organizational legal and ethical obligations, (b) role modeling of values, (c) training on ethics, HIPAA, and medical ethics (Figure 5.2-3) for staff, board, and volunteers, (d) creation of a “no blame” environment and just culture [1.2b(1,2)]; and (e) the “two-challenge” rule for any member disagreeing with a decision. These policies demonstrate the importance of ethical behavior to the workforce and the community. | Comment combines 8 strengths leading to this comment about promoting legal and ethical behavior. Ex3 and Ex7 provided the nugget and relevance portions for this comment, while the rest provided examples. One examiner (Ex7) assigned a double (++) to this strength. Item Lead initially concurred with the ++ given that the “no blame” and “two challenge” policies appear to be potential best practices. Revision for R3: Added relevance statement (Ex8). Per Ex1’s input, eliminated double (++) given that this appears to be standard practice in health care organizations.  | a(2) |

#### Notes

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | It is unclear how the organization communicates with key partners beyond inclusion in strategic planning. For example, leaders’ communication methods (Figure 1.1-2) do not include approaches that address key physician requirements (Figure P.1-7), and there is no systematic approach for communicating with other clinical partners, such as inpatient hospitals. There also is a lack of systematic approaches to encourage two-way communication (Figure 1.1-2) and engage patients in culturally competent care. Without these communication mechanisms, the organization may not be harnessing these partners’ ideas to support improvement and innovation. | Comment combines OFIs by Ex1, Ex2, Ex3, Ex7, Ex8, leading to this comment about how senior leaders communicate with and engage with the workforce, customers, and stakeholders. The nugget sentence came from the feedback-ready comments primarily of Ex8 and secondarily of Ex7. Ex1, Ex2, and Ex3 provided examples, while Ex8’s feedback-ready comment provided the relevance statement. Revisions for R2: Added “suppliers” and made this comment the first OFI. Revision for R3: Clarified the nugget sentence (Ex5). Per Ex1 feedback, Item Lead assigned a double (--) given the potential key theme of supplier and partner information, communication, and results. Revision at Consensus (R4): Deleted mention of “suppliers” so that the comment would focus on partners, given that the organization’s supply chain seems fine.  | b |
|  | It is not clear how and to what extent the applicant has used the communication approaches (Figure 1.1-2) and the performance improvement system (Figure P.2-5) to deploy its VMV to all patient and customer groups. Systematic deployment of the VMV to all stakeholders may likely foster their engagement in clinical excellence. | Comment combines OFIs by Ex2, Ex3, Ex4, Ex6, Ex7), leading to this comment about the deployment of vision and values. In contrast to the third Item 1.1 strength on 1.1a(1), this OFI is about the deployment of 1.1a(1). One examiner (Ex7) assigned a double (--) to this OFI. Ex7’s feedback-ready comment provided the basic structure of this comment, with examples drawn from Ex2, Ex4, and Ex6. Revision for T2: Changed the position of this OFI from first to second. Revision for R3: Clarified OFI to focus on patients and other customers. Revised relevance statement (Ex4). Revision at Consensus (R4): Replaced “patients and customers” with “all patient and customer groups” in recognition that the organization clearly communicates with some patient and customer groups.  | a(1) |
|  | It is unclear how senior leaders create an environment for success now and in the future. It is not evident if the leadership system (Figure 1.1-1) has been fully deployed, how the system is evaluated and improved, whether senior leaders participate in succession planning or new leader development, and whether the Innovation Management Process (Figure 6.1-5) guides intelligent risk taking. Fully deploying the leadership system may enable the organization to address its strategic challenge of “balancing the mission to serve all patients regardless of ability to pay against a tight fiscal environment.” | Comment combines OFIs byEx1, Ex4, Ex5, Ex6, Ex7, Ex8, leading to this comment about creating an environment for success. Ex5’s feedback-ready comment provided the basic structure of this comment, with examples drawn from Ex1, Ex4, Ex6, Ex7, and Ex8. | c(1) |

#### Notes

OFI NOT USED: 1.1a(2): It is unclear that senior leaders’ actions demonstrate their commitment to legal and ethical behavior. The apparent lack of an approach to monitor ethical behavior and cycles of learning and refinement indicate the absence of a process for promoting an organizational environment that requires such behavior. The lack of such opportunities for evaluation, improvement, and sharing of lessons learned may limit organizational gains in maturity. [AL]

 Three examiners (Ex4, Ex3, and Ex6) identified OFIs leading to this prospective comment about promoting legal and ethical behavior, with Ex6 proposing a double (--). Inclusion of this OFI would be in conflict with the strength about ethics in Items 1.1a(2) [S2, ++] and 7.4a(4).

### Scoring

**Score Value: 60**

**Score Range: 50-65%**

**Why shouldn’t the score be in the range above or below the selected one?** **There appears to be be an effective, systematic approach [A] responsive to the overall and probably multiple Item requirements, as opposed to the basic or even overall requirements. There is evidence of systematic evaluation, improvement, and learning cycles, for which an example from 2010 was provided. Leadership and strategy appear to be integrated through the Leadership System (Figure 1.1-1) and Strategic Planning System (Figure 2.1-1). Although these may indicate a scoring range of 70%-85%, the three OFIs, taken together, indicate a significant gap in deployment. The best-fit scoring range, therefore, appears to be 50%-65%, with a scoring toward the upper end of the range.**

**Revision for R3: Raised score from 60% to 65%. Revision at Consensus (R4): Returned score to 60%.**

## Item Worksheet—Item 1.2

## Governance and Societal Responsibilities

### Relevant Key Factors

1. Nonprofit CHC providing primary care, preventive services, enabling services in 3 highly diverse AZ counties (Yuma, La Paz, Mohave). 11 clinics, 4 mobile service vans.
2. Core values: respect, trust, relationship, performance, accountability.
3. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
4. Multiple federal, state, local requirements—including designation as FQHC, qualification for Section 330 grant funds and TJC, recognition as PCMH.
5. Voluntary 15-member Board of Directors, 6 standing committees: Quality, Ethics, Community, Partner Relations, Development, Audit. More than 51% of voting members are recipients of applicant’s services; senior leaders are nonvoting board members.
6. Key stakeholders: Communities, physicians, staff, volunteers, payers, partners, suppliers, collaborators: information/training on current medical technology/procedures; knowledge, skills tools to do job; fair pay/benefits, recognition/opportunity to serve and develop job skills for staff/volunteers; opportunities for collaboration/innovation for partners, suppliers, collaborators.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Senior leader performance is evaluated individually by the CEO and at the team level using multiple methods. These include a 360-degree review process incorporating data from a staff satisfaction survey, a community climate survey, and Baldrige-based assessments. Board performance is evaluated using the Stewart-Hagen model. Leadership System results are inputs for the Strategic Planning Process; action plans are developed through the PIF model to improve effectiveness, shared at staff meetings, and published in the monthly newsletter. This promotes board and leadership performance and transparency, which is one of the applicant’s values. | Ex7’s feedback-ready comment was used as the basic structure of the draft consensus comment, with enriching contributions from the other examiners. Three examiners (Ex3, Ex7, and Ex8) assigned a double (++) to this strength. Item Lead concurs given the comprehensiveness of the factors (ADLI) underlying the strength and the absence of an OFI on 1.1a(2). Revision for R3: Separated use of Stewart-Hagen model of board performance evaluation as an example. | a(2) |
|  | The organization has embedded societal responsibilities into its strategies and daily operations, beginning with the identification and validation of the key communities it serves. Its contribution to societal well-being focuses on improving community health, reducing disparities, and expanding access to care. Its key communities are the three counties where it provides services—a variety of programs that focus on Support for the Body, Support for the Spirit, and Support for the Mind. The needs addressed include nutrition, housing, transportation, and education. Community support leverages the core competency of patient-centered care. | In constructing the draft consensus comment, Ex2’s strength was used as the basis of the nugget. Ex5’s and Ex8’s feedback-ready comments were used as the sources of examples, with enrichments provided by Ex3, Ex4, and Ex7. Two examiners (Ex5, Ex7) assigned a double (++) to this strength. Item Lead prefers a single (+) given that there is no apparent cycle of evaluation and improvement in societal responsibilities, despite that there is no OFI on either 1.2c(1) or 1.2c(2) on Learning. Revision for R3: Eliminated reference to “culturally competent” in relevance statement (Ex1). Moved comment from fourth position to second position (Ex7). Revision at Consensus (R4): Deleted reference to the SPP in the nugget so as not to look like 2.1 comment. Added “transportation” to community needs addressed. | c |
|  | The Board of Directors uses six committees to address key governance factors. Annual CEO performance reviews, regularly scheduled reports of financial and quality performance, and other audits ensure board-level accountability for management actions. Regular board reviews of budgets, financial reports, capital expenditures, and external audit findings ensure fiscal accountability. Board members and senior leaders participate in scenario-based ethics training (including BoardWisdom), annually disclose conflicts of interest, and sign the Code of Ethical Conduct to promote transparency in operations and protect stakeholder interests. | Revision for R3: Rewrote nugget sentence (Ex4). Moved comment from second position to last position (Ex1, Ex5). Revision at Consensus (R4): Replaced “formal training” with “scenario-based ethics training,” which is the distinctive aspect of the organization’s approach. Moved comment from fourth position to third position.  | a(1) |
|  | The organization uses systematic approaches for ensuring legal, regulatory, and accreditation compliance (Figure 1.2-2) and addressing risks associated with health care delivery and other organizational operations (Figure 1.2-3). It utilizes Failure Modes and Effects Analysis (FMEA), facilitated by a sub-team involved in the Strategic Planning Process, to identify and address any adverse impacts on society of health care services and operations. FMEA has enabled the organization to address the risk of needle-sticks for family members of diabetic patients and ensure personal safety of patients through added lighting and an escort service. | Six examiners (Ex1, Ex2, Ex3, Ex4, Ex5, Ex7) identified strengths leading to this comment about legal, regulatory, and accreditation compliance. Ex7’s feedback-ready comment provided the nugget for the draft comment; Ex2, Ex3, and Ex5 provided examples, which focused on the use of FMEA (due to space constraints); Ex1 provided the relevance portion (legal, regulatory, and accreditation compliance). This might be in potential conflict with the third OFI on 1.1b(1), although that OFI highlights gaps in measurement and consideration of supply chain management [Approach], while this strength highlights the Deployment and Learning aspects of legal, regulatory, and accreditation compliance. Revision at Consensus (R4): Moved comment from third position to fourth position. | b(1) |

#### Notes

STRENGTH NOT USED: 1.1b(2): In support of its value of trust, the organization implements multiple processes to set clear expectations for ethical behavior, ensure ethical behavior in all transactions, and track measures for promoting and monitoring ethical behavior (Figure 1.2-4). Based on roles and the results of a pre-course survey, staff, board, and volunteers are required to complete online, interactive courses with each person signing a Code of Ethical Conduct upon completion of training; each person; further, suppliers and partners must sign a Commitment to Ethical Conduct. All suppliers and partners participate in annual training related to ethics, legal obligations, and the organization’s VMV.

-- Four examiners (Ex3, Ex4, Ex5, Ex7) provided strengths leading to this prospective comment about ethical behavior. Item Lead proposes to not include this strength comment because it would be in conflict with the OFI on missing measures (in particular, ethical breaches) in 1.2b(2). This process OFI is validated by the OFI on missing results on ethical breaches in 7.4a(4).

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is not clear that the applicant has a systematic, transparent approach for identifying and selecting board members. Other than the 51% of the voting members who must be recipients of AF services, it is not clear how and on what criteria board members are selected, what stakeholder groups are represented, what disclosure practices for potential conflicts of interest are in place, and how these relate to the applicant’s efforts to improve the governance system. The lack of such systematic, transparent approach may make it difficult for the applicant to build confidence in its integrity. | Three examiners (Ex2, Ex4, Ex7) contributed 4 OFIs leading to this comment about the governance system. Ex2’s feedback-ready comment provided the basic structure of the OFI comment with Ex7’s and DG’s contributions enriching the comment with their examples. One examiner (Ex7) assigned a double (--) to this OFI. Item Lead preferred a single (-) considering that this OFI covers Approach and Integration only, while there is a 1.1a(1) strength that has a clear Approach, Deployment, and Learning component. Revision at R1: Removed portion of OFI dealing with lack of succession planning for board members, which in not a Criteria requirement. | a(1) |
|  | It is unclear if the organization has a systematic process to promote and ensure ethical behavior in all interactions. For example, there is no evidence of a systematic process to investigate and respond to potential breaches of ethical behavior. Further, it is not clear how access to the board’s Ethics Committee is communicated to the workforce across all locations, as well as to partners and stakeholders. By fully deploying a defined, systematic, and disciplined approach, the organization may be able to better demonstrate its adherence to the core values, especially of respect, trust, and accountability. | Four examiners (Ex3, Ex4, Ex5, Ex8) contributed OFIs leading to this comment about ethical behavior. Ex3’s and Ex5’s feedback-ready comments provided the basic structure of the OFI comment with Ex3, Ex4, and Ex8’s contributions enriching the comment with their examples. Although there is a prospective strength about ethical behavior [1.2b(2)], the OFI on missing results which includes 7.4a(4) makes it more consistent to report this process OFI. Revision at R1: Provided more examples and amended the relevance statement to link the nugget and examples to adherence to core values. Revision at R1: Provided more examples and amended the relevance statement to link the nugget and examples to adherence to core values. Revision at Consensus (R4): Eliminated expectation for the governing board to investigate and respond to potential ethical breaches.  | b(2) |
|  | The key processes, measures, and goals for addressing risks associated with services and operations (Figure 1.2-3) do not include processes for the identified health care risks of exposure to communicable diseases, exposure to radiation and chemicals, ergonomic injuries, and accidents. The measures provided do not relate to outcomes; for example, HIPAA measures include compliance with training but not HIPAA violations or penalties. Further, information on how and if the applicant addresses supply chain management and its impact on health care services is not addressed. | Four examiners (Ex1, Ex4, Ex5, Ex8) identified OFIs leading to this comment about legal, regulatory, and accreditation compliance. Ex1’s feedback-ready comment provided the basis structure for the comment, with Ex4, Ex5, and Ex8 providing examples. This might be in potential conflict with the third strength on 1.1b(1), although this OFI highlights gaps in measurement and consideration of supply chain management [Approach], while the 1.1b(1) strength highlights the Deployment and Learning aspects. Revision for R3: Eliminated “While there are listed key processes, measures, and goals for addressing risks associated with services and operations (Figure 1.2-3)” from the nugget sentence. | b(1) |

#### Notes

OFI NOT USED: 1.2c(1,2): It is unclear how the organization addresses any adverse societal impacts and public concerns associated with the provision of health care and enabling services, and how this extends to its relationship with suppliers, partners and collaborators. It is also unclear how it identifies its key communities and determines areas for organizational involvement, including areas that leverage core competencies, such as culturally competent, patient-centered care, expertise in treatment of prevalent diseases, and collaborative relationships that increase access to specialty care and other services. The lack of systematic processes to identify key communities and areas for involvement may limit leaders’ ability to make fact-based decisions related to providing specialty care and addressing unmet service needs. -- Three examiners (Ex1, Ex3, Ex7) identified OFIs leading to this prospective OFI statement about societal responsibilities. Inclusion of this OFI would be in conflict with the strength about societal responsibilities. In the Item Lead’s opinion, the evidence underlying the proposed strength for 1.2c(1,2) outweighs the rationale offered for this prospective OFI.

### Scoring

**Score Value: 65**

**Score Range: 50-65%**

**Why shouldn’t the score be in the range above or below the selected one? There appears to be an effective, systematic approach, responsive to the overall requirements of the item, with at least one potential role-model practice dealing with performance evaluation. The approach appears to be well deployed with no significant gaps in deployment. Three of the four strengths recognize a fact-based, systematic evaluation and improvement process in place, although it is not evident that organizational learning has risen to the level of a key management tool. The approach to governance and societal responsibilities appears to be aligned with key organizational needs, in particular the VMV. Accordingly, the 50%-65% scoring range is appropriate, with a score in the upper end of this range.**

## Item Worksheet—Item 2.1

## Strategy Development

### Relevant Key Factors

1. Services: Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Core competencies: 1. Culturally competent, patient-centered care; 2. Expertise in treatment of diseases prevalent within applicant’s patient population; 3. Collaborative relationships that increase access to specialty care/other services.
3. Multiple federal, state, local requirements—including designation as FQHC, qualification for Section 330 grant funds and TJC, recognition as PCMH.
4. ACA resulted in more stable finances. Increasing demands for care place stress on applicant.
5. SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured; SC2—reducing workforce gaps, including clinical providers/staff w/specific technical skills; SC3—addressing low prevention/screening and higher incidence of chronic/communicable disease in service area; SC4—establishing/managing mechanisms to provide specialty care/meet service needs; SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Since 1996, the organization has used a systematic, 11-step strategic planning process (Figure 2.1-1); key SPP elements are organized by calendar year. SLs participate in all SPP activities; a cross-location team ensures that staff in all services/functions/locations provide input. Community members provide input via Internet, social media, CCKs, and Town Hall meetings; key stakeholder groups provide input/review. SPP has two time horizons: a 1-year practical focus on projects, and a 3-year focus on longer-term changes. In a 1998 improvement, external stakeholders, payors, volunteers, and PFABs were added as members to the Partners Committee. | 4 examiners indicate that this Strength should be double (Ex3, Ex5, Ex8, Ex7), so I doubled the comment for team consideration in CR. I used Ex3 comment as stem and refined the comment to reflect team inputs. Two examiners combined their a(1) Strength comments with other areas to address: one examiner (Ex7) combined with b and with a(3); another examiner (Ex1) combined with a(2). For initial CR, I propose a “pure” a(1), double Strength for a(1). BELOW THE LINE: All examiners’ comments are represented. TEAM FEEDBACK: 2.1a(1) Changed year to 1998 (per Ex7). | a(1) |
|  | The applicant uses multiple methods to collect and analyze relevant data for its SPP. Data sources include board retreats, and regular meetings with staff, volunteers, and other partners and stakeholders. SAs and SCs are evaluated in relation to the organization’s competitive position and performance vs. benchmarks. SLs and Partners Committee identify potential changes to regulatory requirements; participation in State Association of CHCs ensures currency of results of benchmarking initiatives, business continuity, compliance with regulatory requirements, and community involvement opportunities. | All 7 examiners noted a Strength for a(3); one examiner (Ex1) combined the a(3) with a(2). I used two comments (Ex8, Ex3) as the stem and refined the comment to reflect other examiners’ language and phrasing. To simplify consideration in CR, I did not combine the a(3) Strength with elements of other areas. BELOW THE LINE: All examiners’ comments are represented. TEAM REVIEW: S 2.1a(3) removed “partners committee” in response to feedback from two examiners (Ex1, Ex7). CONSENSUS: Restored “Partners Committee to a(3) Strength. | a(3) |
|  | The organization’s strategy-development process includes a systematic approach to stimulate and incorporate innovation. Specifically, the strategic planning process incorporates innovation by engaging a broad range of participants in scenario-based planning activities that promote innovative thinking and a focus on solutions and capitalizing on strategic opportunities. | Consensus: Added to 2.1 Strength comments based on discussion in consensus conversation and agreement among examiners that the applicant’s use of scenario-planning merited comment in the scorebook. | a(2) |

#### Notes

Four examiners (Ex7, Ex4, Ex5, Ex8) noted a Strength for a(2) based on the organization’s use of SWOT analyses, broad representation in SPP, and scenario planning to facilitate brainstorming and innovative solutions. One of these examiners (Ex7) noted a(2) as a double. Another examiner (Ex1) combined a(2) with the a(1) Strength. I opted for the a(2) OFI because evidence from IR inputs indicated that addressing the OFI comment would provide the organization greater opportunity to achieve a gain in maturity than would leveraging a weaker a(2) Strength.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | It is unclear that the organization’s strategic objectives and action plans (Figure 2.1-2) address all strategic challenges. For example, financial objectives (e.g., to decrease administrative/indirect patient costs) do not align with action plans to improve collection rates and relative value units, and no action plans align with strategic challenges related to recruiting paid staff members. The lack of alignment between strategic objectives, action plans, and strategic objectives may limit the organization’s ability to maintain its competitive position and fulfill its mission. | I synthesized multiple comments to incorporate language and examples. CONSENSUS: Doubled the b(2) OFI based on examiners’ consensus and added “all” as a modifier for “strategic challenges” in first sentence.  | b(2) |
|  | It is not evident that the organization uses a systematic process to determine which processes will be accomplished by its workforce and which by external partners. For example, no evidence shows that the decision-making processes includes data and information from the SPP People Review (Figure 2.1-1, May) and evidence to support decisions related to how work systems and core competencies can be improved/augmented to meet future needs. The lack of such a process may limit leaders’ ability to leverage the core competency in collaborative relationships to address patients’ and community needs for effective, high quality care. | I used the comments of two examiners (Ex1, Ex3) as the stem and refined the language. The focus of this a(4) OFI is lack of evidence-based decision-making process to decide which key processes will be accomplished internally and which will be performed by external partners. I chose to craft an a(4) OFI rather than an a(4) Strength because collaborative relationships that increase access to specialty care and other services is a CC, and the engagement of strategic partners is critical to the organization’s success now and in the future. | a(4) |
|  | It is unclear that the organization uses a systematic process to identify strategic opportunities. It is not apparent how strategic opportunities are identified in the SWOT analysis (Figure 2.1-1, July), nor is it apparent that the key strategic opportunity to partner with a dialysis service to provide a more comprehensive approach to the medical home model is reflected in key areas for innovation (Figure P.2-1). The lack of a process to identify and capitalize on strategic opportunities and decide which are intelligent risks worthy of pursuit may limit leaders’ ability to fulfill the organization’s vision. | While the organization’s scenario-planning approach is appealing and engaging, I chose to draft an a(2) OFI because opportunities to improve alignment of approaches to innovation with SCs and strategic opportunities might help to ensure the organization’s progress to the next level of maturity. TEAM FEEDBACK: I decided not to add a “let’s-give-credit” opening to the a(2) OFI (per Ex7) because I prefer to provide direct feedback to applicants without “while” and “although” prefaces that might mix the message. | a(2) |

#### Notes

TEAM FEEDBACK: One examiner (Ex7) struggles with score of 55 for 2 Strengths and 3 OFIs and suggests that we add the 2.1b OFI suggested by one examiner (Ex5 rather than Ex3): It is not evident that the current strategic objectives are adequate to address the challenges of chronic and communicable disease in the service areas and in providing specialty care. I am comfortable with the mix of S/OFI and current scoring range/score, so I did not add the b OFI, pending consensus conversation.

### Scoring

**Score Value: 55**

**Score Range: 50-65%**

**Why shouldn’t the score be in the range above or below the selected one? The score should not be in the 70%–85% range because approaches respond to the overall requirements and don’t reflect the higher levels of learning, including innovation. The score should not be lower than 50%-65% range because effective, systematic approaches that respond to overall requirements are evident, approaches are well deployed, and some organizational learning is evident.**

## Item Worksheet—Item 2.2

## Strategy Implementation

### Relevant Key Factors

1. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Core competencies: 1. Culturally competent, patient-centered care; 2. Expertise in treatment of diseases prevalent within applicant’s patient population; 3. Collaborative relationships that increase access to specialty care/other services.
3. Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.
4. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
5. ACA resulted in more stable finances. Increasing demands for care place stress on applicant.
6. SA1—enhanced funding under ACA; SA2—Knowledge Management System; SA3—expertise in treating clinically complex conditions; SA4—highly engaged workforce, suppliers, partners, collaborators, volunteers; SA5—flexible approaches to benefits/scheduling that meet needs of diverse workforce.
7. SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured; SC2—reducing workforce gaps, including clinical providers/staff w/specific technical skills; SC3—addressing low prevention/screening and higher incidence of chronic/communicable disease in service area; SC4—establishing/managing mechanisms to provide specialty care/meet service needs; SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | In support of its Performance value, the organization uses its FOCUS balanced scorecard to identify and organize short- and longer-term action plans (APs), strategic objectives, SAs, and SCs (Figure 2.1-2). Leaders develop APs at four levels: organization-wide, county, point of care, individual staff. The SLT and local clinic managers deploy APs to work units after SP is validated and budgets developed. SLs own strategic objectives and determine milestones/timetables for goals/objectives. The Pugh matrix is used to validate resource availability, and subdivides annual plans at organizational, county, and point-of-care levels into 90-day APs. | I did not double the comment because we have an a(2) OFI and the coincidence of a doubled a(1,2) Strength and a(2) OFI might be confusing to the applicant. NOTE: Proposed a(1) double OFI for lack of longer-term APs and APs that align with leadership/governance processes/results. TEAM FEEDBACK: In response to feedback from one examiner (Ex7), I added the opening relevance clause to connect the Strength to a core value. | a(1,2) |
|  | In support of its vision, the organization identifies key performance measures/indicators for the achievement of many strategic objectives and projections of future performance. Projections for short- and longer-term planning horizons include consideration of state and national comparisons. For example, targets for clinical results incorporate the Healthy People 2020 objectives, which reflects the organization’s efforts to reduce gaps between projected performance and Healthy People 2020 goals and to exceed the state’s long-term targets. | I synthesized comments to produce this a(5,6) Strength. I did not double the Strength because the a(5) portion does not rise to the level of a double. TEAM FEEDBACK: In sentence 2, I deleted “include consideration of the performance of local competitors” in response to feedback from one examiner (Ex4) who noted that this reference conflicted with OFIs elsewhere in the scorebook. | a(5,6) |
|  | The organization ensures the availability of financial and other resources to support action plans from four perspectives: people, money, time, and data. The budgeting process is integrated with the SPP (October), and scheduled reviews facilitate senior leaders’ monitoring of progress on achieving FOCUS goals (Figure 4.1-2). Senior leaders participate in the SPP People Review (Figure 2,1-1, May), which includes the assessment of workforce capability/capacity, and the CC-based review of key processes to determine whether a process should be accomplished internally or with the expertise of an external partner or supplier (Figure 2.1-1, July). | WEAK STRENGTH TEAM FEEDBACK: One examiner (Ex7) recommends adding a relevance statement, but others noted that the first sentence contains a “built-in” relevance (supporting action plans). | a(3,4) |

#### Notes

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | A systematic process to develop action plans (APs) that align with strategic objectives and longer-term planning horizons is not evident. For example, the organization’s strategic objectives (Figure 2.1-2) do not address leadership and governance, including key short- and longer-term APs associated with achieving results. Only one of three longer-term APs addresses expansion of services, which usually involves partnering. The lack of strategic objectives, APs, longer-term goals, measurements, projections, and timetables for achieving results related to key processes may limit leaders’ ability to demonstrate accountability and meet service needs. | CHECK w/Item 7.4 lead (Ex2): Are missing leadership and governance results noted in a 7.4 OFI? If so, is this double OFI double-dinging for lack of measures/indicators related to leadership/governance? I suggest that we remember the connection between expansion of services and partnering for a potential key theme around engaging partners and suppliers. | a(1) |
|  | It is unclear that the organization uses a systematic process to deploy action plans (APs) to its partners. For example, it is not evident that key performance metrics for the achievement of strategic objectives and goals (Figure 2-1-2) include measurements related to the performance of partners and suppliers. Because the organization uses partners to provide inpatient care, advocacy, and education, a systematic approach to the integration of APs might help to ensure the achievement of improved patient outcomes and the organization’s ability to achieve its vision. | I synthesized IR inputs for this a(2) OFI comment. | a(2) |
|  | It is unclear that a systematic process is used to address gaps in performance against competitors/comparable organizations in action plans (APs). For example, it is not apparent that APs for Clinical Excellence (Figure 2.1-2) reflect priorities for closing gaps in performance, or that APs reflect ACA-related changes in patients and revenues. Without a process for aligning APs with priorities for performance improvement, leaders may be unable to address the strategic challenge of the low incidence of prevention/screening and higher incidence of chronic/communicable diseases, and the impact ACA on the organization’s market. | I did not double the comment pending backup’s input and CR discussion. One examiner (Ex8) would support a double. BELOW THE LINE a(4) OFI (Ex8) may be addressed as a 5.1a(1) OFI a(3) OFI (Ex8, Ex4, Ex3) did not rise to level of other OFIs presented in terms of actionable feedback to applicant TEAM FEEDBACK: One examiner (Ex5) notes that the 2.2a(6) OFI seems prescriptive because addressing ACA is not a criteria requirement. The applicant notes ACA as a strategic advantage (SA1) and a competitiveness change (P.2a[2]). Because the applicant notes ACA as a SA and a change in its competitive environment, I think that including ACA in the OFI is supported by a KF. In consideration of this feedback and a comment from other examiners (Ex4, Ex7), shifted the focus of the comment to gaps in performance. | a(6) |
|  | It is unclear that the organization uses a systematic approach to implement modified action plans (APs) in response to circumstances that require rapid execution of new plans. Specifically, it is not evident that the organization’s SPP (Figure 2.1-1) incorporates the consideration of changes in the regulatory environment, federal law, and customer base, especially in regard to leaders’ semiannual review and approval processes. The lack of a process for implementing modified APs may limit leaders’ ability to respond to key competitive changes in ACA and increasing demands for care in the tricounty service area. | Three examiners noted an OFI for b (Ex7, Ex1, Ex2). One examiner (Ex4) noted an OFI for a, b related to lack of evidence of learning. I synthesized IR inputs for the b OFI.  | b |

#### Notes

BELOW THE LINE: a, b OFI for learning (Ex4)—waiting for CR conversations and draft of emerging KTs to determine if this OFI is useful in supporting a KT Process OFI for lack of evidence of learning.

### Scoring

**Score Value: 50**

**Score Range: 50–65%**

**Why shouldn’t the score be in the range above or below the selected one? NOT IN 70%–85% RANGE: Insufficient evidence of organizational learning based on data analyses and sharing of information. NOT IN 30%-45% RANGE: SP execution addresses overall and a few multiple requirements.**

## Item Worksheet—Item 3.1

## Voice of the Customer

### Relevant Key Factors

1. Nonprofit CHC providing primary care, preventive services, enabling services in 3 highly diverse AZ counties (Yuma, La Paz, Mohave). 11 clinics, 4 mobile service van.
2. Clinics/mobile service serve patients at churches, schools, community centers w/23 PCTs as essential HC delivery unit. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
3. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
4. Key customers: Patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as high-quality health center; personal relationships/partnerships.
5. Key stakeholders Communities, physicians, staff, volunteers, payers, partners, suppliers, collaborators: information/training on current medical technology/procedures; knowledge, skills tools to do job; fair pay/benefits, recognition/opportunity to serve and develop job skills for staff/volunteers; opportunities for collaboration/innovation for partners, suppliers, collaborators.
6. SC3—addressing low prevention/screening and higher incidence of chronic/communicable disease in service area.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Multiple listening and learning tools are used to capture VOC from current, former, potential and competitors patients to identify key requirements (Fig. 3.1-1). Approaches include the Care Connection Kiosks, an innovation that aids community outreach, Patient Family Advisory Boards, and Personal Health Profiles. To ensure actionable information The Service With Spirit Team, formed in as a cycle of learning, aggregates and analyzes customer and market data using sophisticated analytical tools to identify opportunities for improvement of services, ensure that patient requirements are being met, and review and improve listening methods. | All examiners had some comment related to the a double strength. five examiners had it as a double. Started with the comment from Ex5 and combined several of the comments about cycles of improvement and the CCKs. Incorporated comment by Ex7 on use of analytical tools. Additional wording refinement and punctuation changes provided by Ex1 and Ex5 is round 2 feedback.  | a |
|  | Patient satisfaction and engagement are measured through various methods. A survey conducted by the Packer Organization coverall all aspects of the intervention is mailed after the visit. The survey provides actionable data through monthly reports used to identify improvements . A patient experience survey with questions that correlate to the Packer survey captures real time feedback at the point of service. A short version of the survey is used to measure community satisfaction in the service area. These surveys combined with the Compliant and Service Recovery process (figure 3.2-3 enable staff top address disinfection. | All examiners had a comment related to the b1 strength. I started with the comment by Ex8 and incorporated several comments by Ex3, Ex5. and Ex1. Additional refinement in round 2 feedback suggested by Ex5 and Ex3 have me made. | b(1) |
|  | The Packer Patient Satisfaction Survey includes six questions that correlate with identified patient requirements ensuring that requirements are addressed and performance against them continually improved. These questions identify benchmark levels of performance in comparison to health care provider organizations nationally. The survey has been enhanced with two questions that measure cultural competence corresponding to the requirement of culturally competent care. Comparisons to CHC peers are available through the Community Climate survey. These benchmarks and comparisons are integrated as an input to the SPP.  | b2 comment based on Ex5 and Ex2. Based on round 2 feedback by Ex5 and JC I have made minor grammar changes.  | b(2) |

#### Notes

Comments not used: a2 comment from Ex2 on information from Key partners to understand requirements of key partners and improve relationships. (Comment did not rise to the top and unclear on how this addresses criteria)

In round 2 feedback Ex1 made the suggestion to drop culturally competent care from the third strength as it conflicts with the first OFI and a comment in 7.1. We will need to discuss this and determine if this should be dropped.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Beyond addressing Spanish language barriers and providing alternative venues for older patients to provide feedback, it is not clear how listening and learning approaches are tailored to the different patient groups, or how feedback is obtained from patients’ families as a customer group. There also is no evidence of specific outreach to Native American patient segment which represents a major market segment in one of the counties. Obtaining information from these segments and communities could assist the organization to better meet their needs, and may enhance market share by making the applicant more attractive to potential patients.  | Based on comments of 4 examiners (Ex4, Ex1, Ex3, Ex7, Ex2). This is a compilation of a and a2 comments. Started with comment by Ex7 and added input from the other examiners. One examiner had it as a double OFI. May be discussed during consensus. I did make it a double based on round 2 feedback.  | a |
|  | It is unclear how the applicant obtains information relative to partners and competitors which are not participants in the Packer Survey or/or are not represented in the Community Climate Survey. This may include partners providing ambulatory and specialty care, and health care providers in Mexico, among others. Capturing, analyzing, and taking action on this information may enhance the ability to improve outcomes and service broadening the applicant’s appeal to its communities.  | Comment is a combination of comments on competitor information by Ex4,Ex7, Ex1 and Ex8 and information missing on payors from Ex5 and Ex8. Moved comment up to second place based on a feedback comment that this may be a key theme. Comment from Ex1. Moving the comment up makes sense even if it is not a key theme.  | a(1),b(2) |
|  | There is limited evidence of learning from and refinement of the tools used to capture data and information related to satisfaction, dissatisfaction and engagement. Evaluation and refinement of satisfaction, dissatisfaction and engagement measurement mechanisms may help the applicant better leverage their core competency of culturally competent, patient-centered care.  | Comment based on feedback-ready comment by Ex5 Made wording change suggested by Ex3 in round 2 feedback. Made wording changes suggested by Ex3, Ex4 and Ex7 in round two feedback. | b(1) |

#### Notes

Not used comment by Ex4 on social media. Comment is valid but did not rise to the top.

### Scoring

**Score Value: 50**

**Score Range: 50–65%**

**Why shouldn’t the score be in the range above or below the selected one? The approaches and improvements are strong. The innovation of the SSK and SWST might justify the next range. Kept the 50–65 range and score of 55 based on the OFI for limited approaches to improvements in satisfaction, dissatisfaction and engagement approaches. Could support moving to the higher score based on the double strength in VOC 3.1a1.**

## Item Worksheet—Item 3.2

## Customer Engagement

### Relevant Key Factors

1. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
2. Core competencies: 1. Culturally competent, patient-centered care; 2. Expertise in treatment of diseases prevalent within applicant’s patient population; 3. Collaborative relationships that increase access to specialty care/other services..
3. Key customers: Patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as high-quality health center; personal relationships/partnerships..
4. SC3—addressing low prevention/screening and higher incidence of chronic/communicable disease in service area.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | Aligned with the core competency of patient-centered care, the applicant provides 19 access mechanisms (Figure 3.2-1) for patients and other customers to access information and receive support. The mechanisms are determined by the SWST using data and information from the customer listening posts. Approaches include patient profiles, establishing goals with each visit, after-hours voicemail for patients without online access; an option of English or Spanish messaging on all phone systems, CCK, and print materials. Additional support offered includes transportation, child care and a variety of education opportunities.  | The mention of the increased use of the website and social media in conflict with comments in 3.1a1 and 3.2a1 by Ex4. Two examiners gave this a double plus. Based on the strength of the combined comments I might consider gave this a double plus. The consideration of a double strength should be discussed at consensus and might move the score to the next range. The question of including a social media OFI in either 3.1 or 32 may be discussed at consensus. Changes made as result of round 2 feedback include deleting culturally competent care (Ex1) and replacing enable to seek information with access information (Ex7). Split first sentence into tow based on comment by Ex3.  | a(2) |
|  | The organization identifies current customer groups and market segments and anticipate future changes during the SPP using a cross site analysis that considers projections of health care needs based on population growth and current trends. The evaluation focuses the organization on gaps in services and healthcare disparities, in order to determine which new market segments and opportunities to pursue. Determinations are based on the accomplishment of the organization’s VMV and supports the vision of making the people of western Arizona the healthiest in the state.  | Changes made after round two feedback include rewording of the first sentence based on comments by Ex3 and Ex4 and the strengthening of the rational suggested by Ex7. | a(3) |
|  | The applicant builds engagement through the four phases of the Relationship Building Model (Figure 3.2-2), which begins with new patients establishing a Personal Health Profile that supports the delivery of culturally sensitive care customized to patient requirements. Patient interactions with primary care teams, volunteers, and partners use the PHP information to support patient satisfaction and engagement. Engagement is evidenced by patient involvement on teams and councils, and may help to enhance the brand and acquire new patients.  | Comment 3.2b1 Comment supported by aspects of comments by Ex8, Ex1, Ex4, Ex7, Ex2, Ex5 There is an OFI on the effectiveness of the approached. We will need to review the two comments during consensus to ensure they are actionable.  | b(1) |
|  | The Complaint Management and Service Recovery Process (Figure 3.2-3), is used to capture, manage, and resolve patient complaints. It was developed in collaboration with Saguaro State University (SSU) Graduate School of Business using benchmark data from Baldrige service sector award recipients and practices of the Winding River Casino partner. In a cycle of learning through benchmarking a defense contractor, complaints are now ranked by severity. All complaints are recorded, aggregated and analyzed at the local clinic, site, and across all facilities. The data are used to support rapid cycle improvements and as an input to the SPP.  | Comment 3.2b2 based on comments by Ex5, Ex7, Ex2. Supported by Ex8 | b(2) |

#### Notes

Worded an OFI b2 comment so that it could be included but does not appear to conflict with the strength.

In round two feedback, Ex7 suggests dropping the b2 strength to remove confusion with the OFI. I agree but feel this should be raised at consensus.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | The effectiveness of relationship building approaches to attract and retain patients, meet requirements, and exceed expectations is not apparent. For example, the only mechanism presented to regain patients who received care from an inpatient facility is to make post-discharge phone calls. Although families are described as customers, there is no evidence of approaches to acquire them as patients, nor is there a description how the organization tailors approaches to build relationships with different patient segments. Outreach to patients’ families and all customer segments may help to acquire and retain patients and build their brand. | Comment addresses several aspects of the relationship building model in Figure 3.2-1. It is supported by comments by Ex7 Ex4., Ex2. The strength comment gives credit for the overall approach and the applicants emphasis on patient retention. Further examination of the response in the application also showed limited response to explain how the applicant enhanced the brand. (Ex8) This comment should be reviewed at consensus and might result in a double OFI. If agreed to this is a significant gap.  | b(1) |
|  | It is not evident how the SWST analysis used in the determination of segmentation and identification of potential segments to pursue considers competitors’ patients and other customers. An approach that considers competitors customers in segmentation determination may enhance the applicant’s ability to address the key competitiveness challenge to compete for and attract patients from all income strata.  | Comment based on comment by Ex3 and Ex4. Only comments on this but right on target to support a high score giving the applicant credit of the existing systematic approach but creating and opportunity for improvement. Reworded the relevance statement based on comment by Ex4 during round two feedback.  | a(3) |
|  | It is unclear how the Complaint Management and Service Recovery Process (Figure 3.2-3) ensures that complaints are addressed promptly and effectively. The timeline for complaint resolution is not included, and there is no evidence of evaluating effectiveness of complaint resolution. A systematic approach may help the organization to avoid similar complaints in the future, and demonstrate the core value of relationships.  | Started with comment by Ex3 and added aspects of comment by Ex4 and Ex1. Reworded relevance statement based on suggestion by Ex4 in round two feedback. | b(2) |
|  | It is unclear that there is a systematic process to identify and adapt service offerings to meet/exceed requirements and expectations of patients and other customer groups. For example, it is not evident that the applicant uses analyses and comparisons of data to develop and improve health care services in relation to the strategic challenge of the low incidence of prevention and higher incidence of chronic and communicable disease in the service area. An approach to adapt services to potentially address this challenge may enhance senior leaders’ ability to deliver on the vision of having the healthiest people in western Arizona.  | Based on feedback comment by Ex3. Other examiners that had elements in support include Ex4, Ex7, Ex5 and Ex8. | a(1) |

#### Notes

Need to be sure that the team agrees that the b1 ofi is not in conflict with the strength.

### Scoring

**Score Value: 50**

**Score Range: 50–65%**

**Why shouldn’t the score be in the range above or below the selected one? Did not move the score the next range due to the gap in the relationship-building system. This could be considered a significant gap and hold the applicant back from optimizing performance and business improvement opportunities.**

## Item Worksheet—Item 4.1

## Measurement, Analysis, and Improvement of Organizational Performance

### Relevant Key Factors

1. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
2. Vision: “The people of western Arizona will become the healthiest in the state.”
3. Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.
4. Key customers: Patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as high-quality health center; personal relationships/partnerships..
5. Key sources of comparative and competitive data: National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program.
6. PIF: leaders set directions, focus on action through clearly defined strategies/objectives, regular performance reviews, sharing/spreading best practices, use of performance tools.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | A Performance Measurement System (Figure 4.1-1) is used to align data and information into a FOCUS Scorecard to track Financial performance, Organizational learning, Clinical excellence, Utilization, and Satisfaction to evaluate daily operations and overall organizational performance. Software populates this customizable scorecard (Figs. P.2-3 & 2.1-2), by pulling data and information from the EHR and other systems. Metrics are aligned with the strategic planning process to track progress on achieving strategic objectives and action plans. Measures, frequency of review, and participants in reviews are shown in Figure 4.1-2. | Everyone had strength comments about the FOCUS scorecard, one (Ex7) had a bold. I agree it’s a strength, but not a bold, as it’s simply a commercially available software program, and I don’t see how they use it in any way that would be role model for other users of the program. All of the team members also noted the “Data Docs” as a strength associated with the system—but I decided to give the Data Docs strength under 4.1a(4) in order to keep both strengths “single thought” Revised comment based on Ex5 feedback to include PMS in opening nugget, and removed some other words to make it fit. Reworded slightly based on feedback, in order to clarify and correct a figure reference. Ex7 suggested adding a relevance statement “This helps the applicant leverage its strategic advantages and address strategic challenges,” but there is not sufficient space.  | a(1) |
|  | Measurement agility is accomplished through real-time integration of data into the FOCUS scorecard, with any FOCUS area able to be updated quickly as needs are identified or circumstances change. The process is facilitated by the “Data Docs,” a cross-location team representing all the PCTs and functional groups, who can quickly add measures, such as TB testing compliance as needs are identified. Agility in updating the FOCUS scorecard may help the applicant provide efficient and effective care. | All of the team members noted the “Data Docs” as a strength somewhere in 4.1, three team members (Ex2, Ex5, Ex8) noted in a4. I decided to put this strength here, based on the example given in this section about adding TB testing | a(4) |

#### Notes

“Below the line” information

Although almost all examiners had a strength for 4.1a(2), I didn’t wrote an OFI comment on it because most strengths were centered around the fact that the organization uses comparative data, while the criteria asks for a process for how the comparative data are selected. The application does not address the selection—just notes that P.2-2 lists multiple sources. For example, not clear how Packer or Oates were selected from the various vendors available. Similarly, there is not much information on how voice-of-the-customer data are selected in response to 4.1a(3).

Ex5 suggested making a separate strength comment on this, but I think it would be beyond the scope of the criteria and conflict with OFIs Comment “The FOCUS scorecard enables the organization—including governance—to review performance in each of the areas of importance for organizational success. Trending, variances, internal comparisons, and comparisons with external benchmarks are some of the analyses noted in Figure 4.1-2 used to support reviews and fact-based decision-making.” was removed based on feedback—so is now “below the line.”

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | A systematic approach to track progress on achieving action plans and strategic objectives and close gaps between actual and projected performance is not clearly evident. Some FOCUS data and action plans in Figure 2.1-2 do not include metrics or milestones, and projections are “+/=“ competitors. Some measures are annual, without interim measures, and not clearly aligned with objectives (how immunization rates and screenings will address major health challenges, how grant funding will be secured and used). Alignment and measurement of progress may help to better allocate resources to close gaps and improve health. | Most of the “goals” noted in Figure 2.1-2 are “year over year improvement,” and neither the “goals” nor the “projections” actually have quantifiable data. When the size of the “gap” is not quantified / known, it will likely be more difficult to allocate and prioritize resources to close them. The majority of the measure of success relate to participation in screenings—not treatment of findings, nor health of the people who find their “medical home” in one of the primary care teams at the organization. Screenings without treatment will not move them toward their vision of “healthiest people in the state.” Changed the nugget based on Ex5 feedback, incorporated language from Ex3 comment. I went with the double because I believe this is a key blind spot for the organization, and a major impact on the score for this area—and probably also 2.1 and 2.2 | a(1),c(1) |
|  | It is not clear how the applicant deploys improvement priorities to partners and collaborators. The function of the innovation council mentioned in P.1b(2) as the mechanism to engage key stakeholders in improvements is not described. For example, it is not clear how the service provider for dialysis is included in identifying opportunities for innovation and improvement in the care of the diabetic / obese population, which may help the organization achieve its vision that the people of western Arizona will become the healthiest in the state. | Lack of clear deployment / engagement of suppliers, partners, collaborators. The “innovation council” is mentioned in the profile (without a description) and never referenced again. | c(2) |
|  | It is unclear how the organization assesses competitive performance. For example, it is not clear that the state CHC benchmarking consortium or other comparative data resources inform the applicant about the performance of local competitors, nor that the applicant uses publicly reported data or social media reviews of private providers of similar health care services in the local area. Understanding performance relative to local competitors may help the applicant maintain or increase market share and be successful in the tight fiscal environment by accomplishing the strategic objective of attracting patients from all income strata. | Issues surrounding use of competitive data. Competitive performance is addressed in 4.1b, so I used that for the item reference. | b |
|  | A systematic approach is not evident regarding how the organization selects comparative data and information. For example, it is not clear how comparative data from non-CHC providers in the local area are selected, including publicly reported metrics. A robust process to select comparative data that includes benchmark performance, a mechanism to evaluate the data and information selected, and specifically includes local competitors may help the applicant provide residents with high-quality and safe health care service. | The applicant lists the comparative data resources in P.2-2, but never says how they were selected. Two examiners (Ex4, Ex8) had an OFI about this, another (Ex2) had an a(1) OFI about not having comparisons from the private providers in the area—who are actually the applicant’s competitors. The organization states they “select the best available” information for benchmarking, but not clear how they determine this. Also, specific to complaint information—the description provided in 3.2b(2) about complaints doesn’t reference any aggregation by topic, and the 1-10 scale for severity is not clearly defined. Feedback: Removed portion of the comment about 4.1a(3) in order to clean up comment. I still believe there are gaps in the explanations about a(3), but agree with benefit of the doubt, and don’t want to add another OFI. | a(2) |

#### Notes

There were also OFIs written about sensitivity to rapid changes (Ex2 and Ex1), Use of performance reviews for evaluation, improvement / learning (Ex4), reviews of performance by the governance board (Ex5), and the process to project performance being just based on extrapolation of historic trends (Ex5, Ex7++). I didn’t include these because I think the double OFI incorporates most of these issues—not being well aligned to actually measure the strategic objectives, and not using quantifiable data for results nor for projections. There are 4 OFIs, one double, which seemed like enough.

### Scoring

**Score Value: 35**

**Score Range: 30–45%**

Why shouldn’t the score be in the range above or below the selected one? **Not above: Although most (Ex2, Ex1, Ex5, Ex3, Ex7) scored in the 50-65 range at Independent Review, everyone saw nearly the same strengths and much more varied OFIs. Although I believe the applicant addressed at least the “overall” level of the Criteria, there were a couple of “overall” OFIs identified, and many of the “multiple” requirements were not addressed. Further, there are major gaps in deployment—particularly the suppliers, partners, and collaborators, and general lack of alignment of performance measures with areas of importance for the organization. Not below: Many of the multiple requirements are addressed, and I would say they are “in the early stages” of aligning these processes with the needs identified in the organizational profile. There does seem to be deployment (primarily based on the Data Docs information) of processes to most of the primary care teams.**

**Based on team feedback, propose score of 35 (down from 45)**

## Item Worksheet—Item 4.2

## Information and Knowledge Management

### Relevant Key Factors

1. 3 highly diverse Arizona counties (Yuma, La Paz, Mohave). 11 clinics, 4 mobile service vans.
2. Mission: provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay
3. Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.
4. IT capabilities: support for EHR integrated with billing/scheduling. All staff have access to computers, wide array of data and information on intranet, portable CCK.
5. Key customers: Patients/families: timely/convenient access to care/information.
6. **Drivers of workforce engagement:** Nonmillennials: use of skills/abilities, personal relationships/partnerships.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Through the KMP and associated approaches, both explicit and tacit, the applicant transfers knowledge among key stakeholders and embeds learning in the way it operates. With the Knowledge Management Process (KMP; Figure 4.2-3), the applicant builds knowledge assets and enhances management by fact and evidence-based decision making (Figure 4.2-4). Examples of improvements include engagement with a local university to create the Knowledge and Innovation Center, and increasing reliance on IT systems.  | I think double is appropriate, given the importance of the process, and the description is pretty systematic. | b(1,3) |
|  | Mechanisms to ensure the quality and availability of electronic data and information to the workforce and customers (Figures 4.2-1 and 4.2-2) address requirements and expectations for access to care and information. Numerous management approaches are in place to promote the accuracy and validity, integrity and reliability, and currency of electronically stored data, and information is made available to various stakeholders through a variety of mechanisms.  | Information in Figure 4.2-1 addresses only electronic data and information, while 4.2-2 does have some nonelectronic considerations. This makes this a stronger strength than the third one, but still not much more than what is required to meet minimum legal requirements in health care—nothing particularly high-performance, innovative, or role model. | a |
|  | The applicant uses multiple mechanisms identify high-performing units and encourage them to share, supporting the workforce engagement drivers of use of skills and abilities, and personal relationships. Virtual sharing facilitates the implementation of best practices across the 15 locations. For example, an annual quality summit highlights top performers, and systematic approaches to sharing include communities of practice and the knowledge and innovation center. The intranet promotes document sharing, which has quadrupled the number of collaborating cross-organizational teams.  | There were numerous OFIs identified in how the best practices are identified. I tried to write this so that it would not conflict with the OFI below, but the presence of the OFI certainly pulls down the strength of the strength/impact on the score. \*\*\*\*\* May need some discussion about the specific OFI that Ex3 saw regarding including best practice sharing in communications.  | b(2) |

#### Notes

Two examiners (Ex4 and Ex7) cited a strength for IT integration into the strategic plan, but looking at Figure 2.1-2 (strategic plan objectives and goals and action plans), there is nothing there. Particularly with the impact of the IT “market basket” in health care driving payment, this gap makes me hesitant to write a strength comment about the IT plan—although “benefit of the doubt” probably precludes an OFI comment.

There were also suggestions of having 2 different strengths for “a” and including “super users” in one. Super users are pretty routinely used with EHR platforms—usually recommended by the vendor. I combined the two questions in “a” because I think it deserves a strength mention, but nothing really role model or outstanding (or even totally solid, I think) so I don’t think it warrants 2 strengths.

During consensus, the b(2) strength and OFI were edited to ensure they don’t conflict—but the team agreed they are both valid, and address different aspects of identifying, sharing, and implementing best practices.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is unclear how the applicant ensures the availability of data and information to key partners (such as the dialysis partner) who need access to clinical information, and to the 22% of the population without access to computers. This lack of access may limit the provision of easy and timely access to care in the applicant’s three-county, highly diverse service area. | All examiners had OFI comments about this deployment issue. Based on Ex5 feedback, modified to be more clear, concise, and specific—moved to top spot, as this is a higher concern than the modified b(2) comment. Although there is an increasing emphasis on IT, and the applicant has the Customer Care Kiosks, they still note that nearly ¼ of their customers “don’t have access” to a computer. Particularly with the population they are serving (socioeconomic and language barriers) management of knowledge and information may be particularly problematic. | a(2) |
|  | It is unclear how the applicant identifies the specific best practices yielding the high performance identified through FOCUS scorecard measures, or how it decides where the best practices should be deployed. Nor is it clear how the practices are implemented. Considering the applicant’s highly diverse locations, personnel, cultures, and languages, an approach in this area may help the applicant determine the likelihood of specific best practices having a positive impact in particular areas.  | Three examiners (Ex8, Ex3, Ex4) saw this as an OFI—and I do think it’s valid. Particularly in health care, there are lots of variables that create results—and without validating cause (rather than just correlation), they risk disseminating something with unintended consequences. The “rank ordering” of this OFI and the “a(2)” OFI was changed during consensus.  | b(2) |
|  | A mechanism to ensure the accuracy and validity, integrity and reliability, and currency of nonelectronic data and information is not evident—which may limit information and knowledge management for patients, other customers, and locations without electronic access. For example, many mechanisms presented in Figure 4.2-1 do not have clear applicability outside of the electronic systems, and most of the systems for sharing best practices and transferring knowledge are IT based.  | All examiners cited this OFI, although at various places throughout 4.2. Modified based on Ex5 feedback, removed the “bold” and moved to second spot. | a, b |

#### Notes

The team was pretty well aligned on this item—both strengths and OFIs, so there was not much left “below the line.” The only topic not really addressed in the comments that was brought up by a few examiners were a “theme and variations” about diversity issues.

Ex7 brought up segmentation based on age / socioeconomic status and the (probably) highest-risk populations not having computers, Ex3 brought up about the millennial segment of the workforce and also the ESL segment of the population. I read some information about items being available in Spanish (although not in the Native American languages). I thought the customer communications issues could be addressed in other categories. So, the only loose thread to tuck in, I think, is Ex3’s concern about the sharing of best practices.

Moved the comment “The management of large data, a strategic challenge in population/public health is not evidenced in the organizational knowledge of the organization. Beyond a grant with a partner to develop statistical models to extract data from the databases, there is no discussion of the larger data trends within the three-county area that will impact the long-term planning of the organization. It is also not clear that the organization has the capability to blend and correlate data from internal databases to create new knowledge. Such future-oriented information management may be important to the applicant in adapting to a rapidly changing health care environment.” below the line, based on feedback. Don’t think this impacts the score, but based on feedback suggestions, I have lowered the score to 45.

### Scoring

**Score Value: 45**

**Score Range: 30–45%**

**Why shouldn’t the score be in the range above or below the selected one? Independent Review scores on this item ranged from 50% to 70%, with four people on the team scoring 70%. I believe 70 is too high, because of the deployment issues to 22% of the patient/customer base, concerns about data and information properties when not in an IT system, lack of access for many key stakeholders (particularly the dialysis partner), and not much innovation. I think they’re higher than the 30–45% range, based on addressing most of the Criteria requirements at the overall level—but lots of gaps addressing the multiple requirements.**

**I think 4.2 is better than 4.1 in term of evaluation/improvement/learning, and also alignment/integration—really major deployment gaps, and not much in innovation. I think “just barely” into the 50–65 range, but much of the feedback said 45.**

**Need to discuss during consensus. Even though the applicant is small, there has been a big push for CHCs to “go tech,” and lots of funding support—most are pretty robust at this point.**

At Consensus Review: settled on the top of the 30–45% range.

4.2

**2017 Baldrige Case Study**

**Item lead’s approach to drafting of consensus review worksheet (R1) for item 4.2**

**Purple font indicates the information is also in the scorebook draft**

**Select Key Factors**

BOSS does not report the Key Factors from the Independent Review Worksheets. Therefore, Item Lead began with the key factors from independent review. After determining the strengths and OFIs, the Key Factors were referenced for the relevance of comments, evaluating whether any of the identified factors are not really “key” for this item and should be dropped, or if some of the key factor statements / profile information should be used to provide some “benefit of the doubt,” about any processes. Item lead also used Key Factors to help rank-order the comments, based on priority for the applicant, and for the relevance portion of comments

Since this item (4.2) is information and knowledge management, the key factors **initially** selected were:

1. There is an electronic health record (EHR) integrated with the billing and scheduling system. All staff members have access to computers, a wide array of data and information on an intranet, and an innovative portable, Care Connection Kiosk (CCK). **Data captured in the EHR and other systems flows automatically to the scorecard to manage information and grow knowledge assets. This key factor was retained through consensus.**
2. National data from CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJH; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award for Performance Excellence; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; and Saguaro State Award Program. **Comparative data are used to inform relative performance to convert data to information and organizational knowledge. This key factor was retained through consensus.**
3. Strategic Advantage #2 - the Knowledge Management System. **This key factor was dropped during consensus. Although the first comment (bold) is about the system, the fact that the system was cited as a strategic advantage was not the key focus / relevance of the comment.**
4. Alignment with the FOCUS scorecard - F–Financial Performance, O-Organizational Learning, C-Clinical Excellence, U-Utilization, S-Satisfaction. **This key factor was dropped during consensus, as it was more relevant to Category 2**
5. Use IT to reduce waste and increase productivity, operational efficiency and productivity, decrease expenses, and the expansion and strengthening of access to capital **This key factor was dropped during consensus, as it was more relevant to Category 6**
6. A Performance Improvement Framework aligns and integrates all aspects of performance management throughout the organization, starting with leaders setting directions and focusing on action through clearly defined strategies and objectives, followed by regular performance reviews, the sharing and spreading of best practices, and the use of performance tools. Multiple strategies for performance improvement and organizational learning including the PDCA process, OASIS Improvement Model, CMs, Baldrige Criteria, and Saguaro State Award Program. The organization received the Malcolm Baldrige National Quality Award in 2009, and has followed the changes in the Criteria over time to ensure processes and systems remain current. **The data and information and relative performance are the basis for improvement activities using the Framework. This key factor was dropped during consensus, as it was more relevant to Category 2**

The following key factors were added for consensus, primarily due to the apparent gaps between what the organization is measuring, what they provide, and what they state that the community needs. (*emphasis added)*

1. Applicant is a non-profit, community health center (CHC) providing *primary care, preventive services and enabling services* in three *highly diverse* Arizona counties (Yuma, La Paz, and Mohave). Care is delivered through 11 clinics and 4 mobile service vans.
2. Mission: to provide residents easy and timely access to high-quality and safe health care services, *responsive to diverse cultural and socioeconomic needs*, regardless of their ability to pay;
3. Vision: “the people of western Arizona will become the *healthiest in the state*.”
4. Chronic health problems of patients in the service area include diabetes, *asthma, cardiovascular disease, depression, obesity, and substance abuse/addiction behavior, as well as higher incidence of infectious diseases such as TB and sexually transmitted diseases*. Barriers to care include geography, culture, and income, contributing to the applicant's patients having poorer health than the general population.
5. Key customers include patients and their families. Customer requirements include: *safety; effective, high-quality care; efficient, cost-effective care; timely and convenient access to care and information; patient-centered service; equitable, culturally sensitive care; reputation as a high-quality health center; and personal relationships and partnerships*.

Final key factors selected were

1. Applicant is a non-profit, community health center (CHC) providing primary care, preventive services and enabling services in three highly diverse Arizona counties (Yuma, La Paz, and Mohave). Care is delivered through 11 clinics and 4 mobile service vans.
2. Mission: to provide residents easy and timely access to high-quality and safe health care services, responsive to diverse cultural and socioeconomic needs, regardless of their ability to pay;
3. Vision: “the people of western Arizona will become the healthiest in the state.”
4. Chronic health problems of patients in the service area include diabetes, asthma, cardiovascular disease, depression, obesity, and substance abuse/addiction behavior, as well as higher incidence of infectious diseases such as TB and sexually transmitted diseases. Barriers to care include geography, culture, and income, contributing to the applicant's patients having poorer health than the general population.
5. IT capabilities includes support for an electronic health record (EHR) integrated with the billing and scheduling system. All staff members have access to computers, a wide array of data and information on an intranet, and an innovative portable, Care Connection Kiosk (CCK).
6. Key customers include patients and their families. Customer requirements include: safety; effective, high-quality care; efficient, cost-effective care; timely and convenient access to care and information; patient-centered service; equitable, culturally sensitive care; reputation as a high-quality health center; and personal relationships and partnerships.
7. Key sources of comparative and competitive data within the health care industry are the following: national data from CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award for Performance Excellence; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; and Saguaro State Award Program.

**General Process for Strengths and Opportunity for Improvement topic selection and comment writing**

Item Lead ordered the information in BOSS by item reference number, then downloaded to Word. The “feedback ready comments” were pulled out and saved in a separate document in order to not be confusing as duplicate comments.

The Item lead printed the document, in order to be able to highlight and make notes more easily.

Each comment made by every examiner was read and evaluated to see where examiners had similar or divergent observations – within the strengths, within the OFIs, and across strengths and OFIs.

Item lead selected “around six” **topics** to address as comments – strengths and OFIs combined. Selection was based on how important and actionable the feedback would be for the applicant.

**Strengths**

Strength topics were selected based on relevance / importance to the applicant.

* Some items (such as the innovation center at the local university) were a clear source of pride and addressed the criteria to be recognized as strength comments
* Items that seem to be role model or innovative (helpful to other organizations to emulate) or that had a significant impact on the scoring were “doubled” / bold, such as the knowledge management process.
* The size of the organization, the availability of federal and grant funding to assist with implementation of electronic health records, and “norms” within health care were also considered in the evaluation of this item. For example, the applicant mentioned training “super-users,” which is quite commonplace, and therefore not called out as a strength – but the DataDocs model is not typical, and was called out as a 4.1 strength.
* Anything cited by any examiners that were not included in the “around six” topics were evaluated to see if they should be added, or noted as “below the line.”
* The topics were compared with the Feedback ready comments from individual review to see if any could be used with minor editing. Full feedback ready comments were written for each of the “topics,” and the rationale/evidence column was completed.

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | The organization uses the Knowledge Management Process (KMP), shown in Figure 4.2-3 to build knowledge assets and enhance management by fact and evidence-based decision-making through the many approaches listed in Figure 4.2-4. Examples of improvements include engagement with a local university to create a Knowledge and Innovation Center, and increasing reliance on information technology systems. These KMP and associated approaches, including both explicit and tacit approaches are used to transfer knowledge among key stakeholders and embed learning in the way the organization operates | All of the examiners cited the KMP and many approaches in Figure 4.2-4, with IP noting as a double. I think double is appropriate, given the importance of the process, and the description is pretty systematic. | b(1,3) |
|  | The organization uses the mechanisms presented in Figures 4.2-1 and 4.2-2 to ensure the quality and availability of electronic organizational data and information. Numerous management approaches are in place to promote accuracy and validity, integrity and reliability, and currency of electronically stored data, and information is made available to various stakeholders through a variety of mechanisms. These mechanisms may help address the customer and workforce requirements and expectations for access to care and information. | Five examiners (JJ, JG, MY, LC, DH) had strengths in this area. Information in Figure 4.2-1 only addresses electronic data and information, while 4.2-2 does have some non-electronic considerations. This makes this a stronger strength than the third one, but still not much more than what is required to meet minimum legal requirements in health care – nothing particularly high-performance, innovative, or role model. | a |
|  | The organization uses multiple mechanisms identify high performing units within the organization, and encourage them to share. For example, an annual quality summit highlights top performers, and the communities of practice and knowledge and innovation center are systematic approaches to sharing. The intranet is used to promote document sharing, which has quadrupled the number of collaborating cross-organizational teams. Virtual sharing may help facilitate implementing best practices across the 15-location organization spread over 3 counties. | All of the examiners except one (JG) noted strengths in sharing of best practices, JG had an OFI. There were numerous OFIs identified in how the best practices are identified. I tried to write this so that it would not conflict with the OFI below, but the presence of the OFI certainly pulls down the strength of the strength / impact on the score.  | b(2) |

#### Notes

Two examiners (DH and IP) cited a strength for the IT integration into the strategic plan, but looking at Figure 2.1-2 (Strategic plan objectives and goals and action plans) there is nothing there. Particularly with the impact of the IT “market basket” in health care driving payment, this gap makes me hesitant to write a strength comment about the IT plan – although “benefit of the doubt” probably precludes an OFI comment. There were also suggestions of having 2 different strengths for "a" and including "super users" in one. Super users are pretty routinely used with EHR platforms - usually recommended by the vendor. I combined the two questions in "a" because I think it deserves a strength mention, but nothing really role model or outstanding (or even totally solid, I think) so I don't think it warrants 2 strengths. During consensus, the b(2) strength and OFI were edited to ensure they don't conflict- but the team agreed they are both valid, and address different aspects of identifying, sharing, and implementing best practices.

**Opportunities for Improvement**

The same process was used for the OFIs as was used for the strengths. In this item, there were some potential conflicted comments – also some potential conflicts with Category 2, based on the evaluation of topics for comments. When a similar topic (or item reference) was the focus on both a strength and an OFI comment, the item leads and entire team were attentive to communicate clearly to the applicant why both comments were valid and not conflicted. Usually, the topics were addressing different aspects of the criteria question and/or different evaluation factors.

Specifically for OFI comments, the topic would be bold if it was significant in suppressing the score. There were no bold OFI comments for 4.2

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is unclear how the organization ensures the availability of data and information to all key stakeholders. For example, it is not clear how key partners (such as the dialysis partner) access clinical information, or how the 22% of the population without access to computers can access needed data and information. This may impair the ability of some customers, partners, and other key stakeholders to participate fully in sharing of knowledge and information. | All examiners had OFI comments about this deployment issue. Based on JJ Feedback, modified to be more clear, concise, and specific – moved to top spot, as this is a higher concern than the modified a(1) comment. | a(2) |
|  | While high performing units are identified through the measures on the FOCUS scorecard, it is unclear how the organization identifies the specific best practices that yielded the high performance or decides where the best practices should be further deployed, and how the processes are implemented. Particularly with a high degree of variance and diversity, such as locations, personnel, cultures, languages, etc. processes that yield high performance in one area may not positively impact other areas, and help the organization more efficiently and effectively improve performance. | Three examiners (MY, JG, DH) saw this as an OFI – and I do think it’s valid. Particularly in health care, there are lots of variables that create results – and without validating cause (rather than just correlation), they risk disseminating something with unintended consequences. The “rank ordering” of this OFI and "a" OFI were kind of a “toss up” and the order was changed during consensus.  | b(2) |
|  | A mechanism for the organization to ensure accuracy and validity, integrity and reliability, and currency of data and information for non-electronic knowledge and information is not evident. For example, many mechanisms presented in Figure 4.2-1 do not have clear applicability outside of the electronic systems, and most of the systems for sharing best practices and transferring knowledge are IT based. | All examiners cited this OFI, although at various places throughout 4.2. Although there is an increasing emphasis on IT, and they do have the Customer Care Kiosks, they still note that nearly ¼ of their customers “don’t have access” to a computer. Particularly with the population they are serving (socioeconomic and language barriers) management of knowledge and information may be particularly problematic. Modified based on JJ feedback, removed the "bold" and moved to second spot. | a,b |

The team was pretty well aligned on this item – both strengths and OFIs, so there was not much left “below the line.” The only topic not really addressed in the comments that was brought up by a few examiners were a “theme and variations” about diversity issues. IP brought up segmentation based on age / socioeconomic status and the (probably) highest-risk populations not having computers, JG brought up about the millennial segment of the workforce, and also the ESL segment of the population. I read some information about items being available in Spanish (although not in the Native American languages). I thought the customer communications issues could be addressed in other categories. So, the only loose thread to tuck in, I think, is JG’s concern about the sharing of best practices. Moved the comment "The management of large data, a strategic challenge in population/public health is not evidenced in the organizational knowledge of the organization. While a grant has been funded with a partner to develop statistical models to extract data from the databases, there is no discussion of the larger data trends within the three county area that will impact the long term planning of the organization. It is also not clear that the organization has the capability to blend and correlate data from internal databases to create new knowledge. Such future oriented information management is important in the rapidly changing healthcare environment." below the line, based on feedback. Don't think this impacts the score, but based on feedback suggestions, I have lowered the score to 45.

**Finalizing Strengths and OFIs**

The final step for this Item lead is to rank order the comments. Any that are bold rise to the top, beyond that, the order is determined on how actionable the feedback is for the applicant, and the impact that the specific comment has on the score.

**Scoring:**

**Independent review scores on this item ranged from 50% to 70%, with four people on the team scoring 70%.**

**Preparing for consensus, it seemed that the 70-85 range was too high, because of the deployment issues to 22% of the patient / customer base, concerns about data and information properties when not in an IT system, lack of access for many key stakeholders (particularly the dialysis “partner”), and not much innovation.**

**The initial proposal for consensus was 50%, based on the applicant addressing most of the criteria requirements at the overall level – but lots of gaps addressing the multiple requirements. Much of the feedback during Consensus R1 said they thought 45 was more appropriate. Even though the applicant is small, there has been a big push for CHCs to "go tech," and lots of funding support - most CHCs are pretty robust at this point.**

**It was also considered that 4.2 is better than 4.1 in term of evaluation / improvement / learning, and also alignment / integration. There are pretty major deployment gaps, and not much in innovation. Team felt that the 30-45 range was the “best fit,” but at the top of the range. Team validated that it is primarily a lack of systematic approaches to manage data and information for the 22% of the population without computers, and for the data and information that resides in non-IT repositories holds the organization back from being in the 50-65% scoring range.**

Score Value: **45**
Score Range: **30-45%**

## Item Worksheet—Item 5.1

## Workforce Environment

### Relevant Key Factors

1. Clinics/mobile service serve patients at churches, schools, community centers w/23 PCTs as essential HC delivery unit. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Core competencies: 1. Culturally competent, patient-centered care; 2. Expertise in treatment of diseases prevalent within applicant’s patient population; 3. Collaborative relationships that increase access to specialty care/other services.
3. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
4. 314 volunteers (key stakeholder group): patients/family members, who help build relationships with patients/families, increase efficiency/effectiveness of care delivery.
5. Health and safety requirements: Protection from exposure to communicable diseases, radiation, chemicals, needle sticks, ergonomic injuries, accidents.
6. SC2—reducing workforce gaps, including clinical providers/staff w/specific technical skills; SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package..

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Multiple approaches are used to recruit and hire a workforce representative of the hiring and patient communities. Staff recruiting is done locally first, supporting its communities, and occurs through an employee referral program, scholarship programs, and internet. For clinical staff, the applicant collaborates with the NHSC to provide loan forgiveness and scholarships. Volunteer recruitment occurs through multiple methods including a “Get Involved” link on the Internet, CCks, and Get Involved pamphlets. These approaches enhance the organization’s ability to demonstrate its core competencies of culturally competent, patient-centered care. | Two examiners recommended a double and I am recommending this as well. | a(2) |
|  | The applicant delivers care through 23 Primary Care Teams. Each team is led by a family medicine physician, and includes a physician assistant, a medical assistant, an administrative support staff member, a community educator and one or more volunteers. This model organizes care around the patient needs and promotes active, ongoing partnerships between patients and provides. This structure enables all elements of the workforce (employees, providers, and volunteers) to deliver on the core competency of patient-centered care. | Comment was supported by Ex7, Ex4, Ex5, Ex1, Ex2 and Ex8. | a(4) |
|  | Capacity needs for staff and volunteers are systematically identified and defined during the People Review of the SPP considering trends in patient census and acuity as well as staffing needs identified during the SPP. Competency is assessed around four areas: clinical or technical, team, cultural, and customer service. Strategic objectives aligned with capability and capacity needs are translated into short- and long-term action plans. Defined competencies are embedded in job descriptions, are used in the Performance Planning and Evaluation process, and are integrated with the HR database to help manage career progression. | Capability and capacity (Ex7, Ex5, Ex3, Ex8, Ex1). Comment was developed using evidence provided by these examiners. One examiner recommended a double strength, but I recommend keeping it a single. | a(1) |
|  | A variety of safety and wellness approaches including a “Healthy Living” program, safety training, and infection control enable a favorable workforce climate. The applicant partners with the State Association of CHCs to provide a flexible family benefit package that includes education benefits for children of staff and volunteers, self-insured medical, dental, and vision programs to all staff working 30 hours or more per week and some benefits such as educational support are extended to volunteers. Policies include a fair living wage, flex time and job sharing that address the millennial driver of workforce engagement. | This comment was supported by all examiners. | b |

#### Notes

Below the line comment not included: Ex2 and Ex7 had comments on the performance management system. I did not use this based upon the number of stronger strengths that were supported by the majority of examiners.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is not evident the the competencies identified during the People Review are defined and assessed through a systematic process for individuals, work units or the the organization as a whole. It is unclear how performance results are considered as part of this determination. It is also unclear how competencies are identified for the volunteer and provider segments of the workforce. Systematic processes in these areas, may help the applicant demonstrate its core competencies of culturally competent, patient-centered care and collaborative relationships that increase access to specialty care and other service. | Ex1, Ex8, Ex7, Ex2, Ex5, identified OFIs around this item. I attempted to create an OFI that captured the key thoughts from all examiners.  | a(1) |
|  | It is unclear if the applicant has a systematic, proactive approach to evaluate and ensure workforce safety and accessibility. While the applicant provided measures of healthy and safety, measures were not identified for accessibility. Additionally, how safety is evaluated other than by assessing actual safety events is unclear. Measures do not address possible areas of vulnerability such as exposure to radiation and chemicals, ergonomic injuries and accidents. By clearly articulating leading indicators of health, safety, security and accessibility, the applicant may be able to proactively eliminate potential risks to its workforce. | Comments around this item were included by Ex8, Ex4, Ex5, Ex1, Ex2. Strong agreement on this comment. | b(1) |

#### Notes

I did not include the following comments: Ex5 and Ex2 both had b(2) comments around tailoring of benefits, services and policies to the needs of a diverse workforce. (Considered less important than the 2 OFIs that were included.

Ex4 had an a(4) comment that stated: unclear how workforce is managed to exceed performance expectations. (Considered less important.)

Ex3 also had an a(4) OFI stating “unclear that the organization uses a systematic process to organize and manage the WF to address the strategic challenge of serving needy, vulnerable patient population in remote locations. (I did not include this as we had a strong strength around the PCT structure and I felt that this structure did address the SC.)

Ex4 had an a(3) OFI -- unsure how WF is managed to ensure continuity. (Again, I did not include as I considered it less important and the applicant indicated that the contingency plan would be to close clinics and reassign or outpace displaced staffing. I may not have liked the answer, but I do believe they addressed the issue.)

Ex3 had an a(3) OFI around preparing the WF for changing capability and capacity needs. I did not consider this as important as other OFIs due primarily to the fact that the organization has never reduced its workforce. Ex2 had an a(3) OFI around whether or not the recognition programs contribute to the achievement of action plans. (Agreed with comment, but considered it less significant than included OFIs.)

Ex4 has an a(2) comment that stated processes to place / acclimate workforce into the organizational culture was unclear. (Only comment in this areas -- considered less significant.)

### Scoring

**Score Value: 60**

**Score Range: 50–65%**

**Why shouldn’t the score be in the range above or below the selected one? Based upon comments for this item, I am recommending a score of 65. We have four strengths—one of which was a double and two OFIs. Clearly in this scoring range. I put them at the top of the range. They do answer to multiple requirements, but we had some questions around deployment, so there may be some significant gaps. I also don’t think I could get them to the 70–85 range because I didn’t see real examples of innovation or many cycles of improvement.**

## Item Worksheet—Item 5.2

## Workforce Engagement

### Relevant Key Factors

1. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
2. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
3. 314 volunteers (key stakeholder group): patients/family members, who help build relationships with patients/families, increase efficiency/effectiveness of care delivery.
4. Drivers of workforce engagement: Nonmillennials: senior management communication, use of skills/abilities, comfortable reporting errors or unsafe acts, protection from health/safety hazards, clear sense of what is expected. Millennials: growth opportunities, flexible work schedule, fair pay/good benefits, personal relationships/partnerships, support of mission.
5. SC2—reducing workforce gaps, including clinical providers/staff w/specific technical skills; SC4—establishing/managing mechanisms to provide specialty care/meet service needs; SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package.
6. PIF: leaders set directions, focus on action through clearly defined strategies/objectives, regular performance reviews, sharing/spreading best practices, use of performance tools.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | The organization systematically identifies drivers of workforce engagement and collects workforce and volunteer engagement and satisfaction through on-line surveys. An external company researches and identifies engagement dimensions representative of an “employer of choice.” Factors are segmented for staff and volunteers by generational differences. Survey results are analyzed by workforce segment and location. Turnover, absenteeism, grievances and safety data are combined with survey results, and findings are used to identify improvement opportunities. Such approaches may help to address the strategic challenge to hire and retain staff. | All examiners had an a(2,3) strength statement. I combined several comments into the above strength comment. | a(2,3) |
|  | To reward and recognize high performance, a variety of approaches (Figure 5.2-2) are in place. These approaches include gainsharing, and the STAR program and are deployed to staff and to volunteers. Senior leader personally recognize employees who contribute to innovation and take intelligent risks to focus on patients and enhance the organization’s operational performance. The approaches may strengthen the organization’s strategic advantage of a highly engaged workforce. | Ex4, Ex7, Ex5, Ex2, and Ex8 had comments around performance management. I combined comments about performance management and reward and recognition. | a(4) |
|  | The organization uses multiple approaches to enable learning and development (Figure 5.2-3) to support organizational and personal development needs of staff, managers and volunteers. The workforce development plan is reviewed and updated annually as part of the SPP using a variety of inputs including individual development plans (IDPs), results of the Oates satisfaction survey, regulatory changes, etc. This approach may enable the organization to successfully deliver its core competency of patient-focused care. | All examiners had a b1 comment. I created a consolidated comment capturing the input from all examiners. None suggested a double. | b(1) |
|  | Multiple systematic approaches are used to build a culture of engagement, communication, and high performance as shown in Figure 5.2-1. These include: methods to constantly review performance and expectations such as huddles, town hall meetings, and collaborative IT tools. In support of the core values of performance and accountability, the organization collaborates with area universities, colleges and the State Health Education Center to develop staff and add to community health care resources. The Patient Care Team model emphasizes team performance and empowerment. | All examiners had an a1 strength. I combined several comments into the strength statement above. | a(1) |

#### Notes

There was extremely high consensus among examiners on the strength statements. I used parts of all comment with the exception of a “b” comment by Ex7 that focused on use of new knowledge through mentoring. She was the only examiner who called out this strength and I felt that it did not elevate to the level of other comments. I doubled the a(2,3) comment based upon the recommendations of Ex7 and Ex8. Given the strength of this comment, I agreed with a double.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is not clear how the organization’s learning and development approaches develop managers and leaders, encourage innovation and change, focus on patients and other customers, and enable the organization to address technological changes. Such a focus may help to ensure the applicant’s ability to address strategic challenge related to reducing workforce gaps, including clinical providers and staff with specific technical skills to address the needs of patients and communities. | Ex2, Ex3, Ex2, Ex7 all had comments around this item. I tried to incorporate all the missing elements in the comment.  | b(1) |
|  | It is unclear how the organization’s Performance Planning and Feedback Process includes a focus on engagement, reinforces intelligent risk taking and innovation or supports a focus on patients and other customers. Additionally there is a lack of integration of the Staff Performance Planning and Feedback Process with the organization’s PIF and performance measures. By integrating these important elements into performance management, the organization may be able to meet the challenges of a rapidly changing industry. | Ex5, Ex8 and Ex1 all had comments in this area. I combined the thoughts. | a(4) |

#### Notes

While there was strong agreement among examiners on 5.2 strengths, this was not the case with OFI. There were several stand-alone comments that I chose to put below the line. These included comments from Ex5, Ex4, Ex2, Ex7. Ex4 and Ex3 had comments around drivers of engagement that I felt conflicted with the double strength we gave in this area.

### Scoring

**Score Value: 65**

**Score Range: 50-65%**

**Why shouldn’t the score be in the range above or below the selected one? We had four strengths (one a double) and 3 OFIs. I selected a score at the higher end of this range.**

## Item Worksheet—Item 6.1

## Work Processes

### Relevant Key Factors

1. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Core competencies: 1. Culturally competent, patient-centered care; 3. Collaborative relationships that increase access to specialty care/other services.
3. Requirements of patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as a high-quality health center; personal relationships/partnerships.
4. Key stakeholders: Communities, physicians, staff, volunteers, payers, partners, suppliers, collaborators: information/training on current medical technology/procedures; knowledge, skills tools to do job; fair pay/benefits, recognition/opportunity to serve and develop job skills for staff/volunteers; opportunities for collaboration/innovation for partners, suppliers, collaborators.
5. Suppliers/partners: Inpatient care partners in each county, advocacy providers, strategic/vendor partners, industry partners, education partners, community partner groups/community service organizations, industry/vendor partners. Role in innovation: contribute ideas, new products, tools, technology, best practices; represented on Innovation Council, receive annual training in ethical/legal obligations, MVV.
6. SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | The applicant factors patient preferences into the delivery of health care services through the personal health profile (PHP), supporting the core competency of culturally competent, patient-centered care. The profile is used to account for patient preferences, set encounter goals, and evaluate how well goals were met using a postcare follow-up survey. This PHP, which includes information on patients’ use of traditional healing practices, is integrated into the EHR and is available to patients through Care Connection Kiosks (CCKs) and the web.  | One examiner suggested a double, I chose not to make it a double, seeing that a personalized plan of some nature is a requirement of EHR implementation and funding. During consensus, it was suggested that the PHP is at the heart of what the organization does, therefore consider making it a double. The rationale is that for such a CHC this may be a “best practice” given the financial constraints of such an organization. Was made a double strength. | b(2) |
|  | The Performance Improvement Framework (PIF) helps the applicant fulfill patient requirements for effective, efficient, and equitable care. Integration with the OASIS improvement model and feedback from external and internal customers are used to consistently FOCUS the applicant on its major service areas. Recent improvements include enhancement of the Patient Portal, expanded use of Lean tools for process and cycle time, and a new server room.  | The approaches are integrated throughout the organization and allow alignment with the defined FOCUS areas for the CHC. There are learnings and improvements made to organizational strategy and action plans. | b(4) |
|  | The applicant annually and strategically plans and updates key work processes and requirements based on community needs, SWOT analyses, VOC listening posts, EBP, and monitoring of key process measures and regulatory requirements. A systematic process integrates information from these sources, providing the basis for real-time improvement opportunities and resulting in identification of the interdependent requirements that must be met to provide the IOM’s six aims of care. | Cited in one way or another by all (Ex5, Ex7, Ex4, Ex8, Ex3, Ex1, Ex2). There was little change in this as consensus progressed. | a |

#### Notes

Did not use.... one cited strength of the Innovation Management Process ...conflicted with some OFIs

One cited strength about key business and support processes demonstrating the value of partnership and core competency of collaborative relationships.... the integration of the processes with partnerships was missing.

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | It is not clear how the applicant establishes work process requirements for its numerous health care partners, or how it uses input from these partners and from collaborators in designing, implementing, and improving work processes. Given the applicant’s reliance on partners to provide the full range of health services, an approach in this area—including the use of information on support processes and partner/collaborator relationships gained through the SPP—may strengthen the applicant’s core competency of collaborative relationships. | Supplier and partner information was very vague. It was suggested during consensus that this become a double OFI. It may reflect a rising theme and was thus made a double. | a(1), b(1,4), c |
|  | It is not clear how the applicant has leveraged the Innovation Management Process (Figure 6.1-5) to pursue strategic opportunities determined to be intelligent risks, other than dialysis partnerships, or how pursuit of opportunities is discontinued. In the applicant’s tight reimbursement environment, an approach in this area may help in managing scarce resources toward the effective and efficient delivery of patient-centered care. | Lack of process for pursuing opportunities for innovation. One examiner (Ex7) included the approach of innovation management, but there was no discussion of learning and integration across the organization. This is significant in light of no evidence of how the organization is optimizing its work processes to meet the world of ACA demanded health care such as how the organization is partnering with the competitive health care organizations and acute care organizations to facilitate those transitions of care that provide opportunities of care for community based organizations. | d |
|  | Alignment between the processes and requirements in Figure 6.1-1 and health care offerings that meet identified community needs (e.g., geriatric services, substance abuse treatment, and pharmacy services) is not evident; and it is not clear how the applicant aligns support processes with key operational requirements (e.g., EHR/IT, medical records completion, coding accuracy, billing cycle time, missed appointments transportation services, and use of the mobile service fleet). Without such alignment, decisions related to the process design and to monitoring, and improvement of organizational performance may be difficult.  | Lack of fully integrated work and support processes related to patient care and enabling services. Many gaps in this area. The overall response by the applicant is “we use PDCA”—but the processes related to the multiple requirements in 6.1a (organizational knowledge, evidence-based medicine, health care service excellence, patient and other customer value, and the potential need for agility into these services and processes) are not clearly provided.  | a, b(3) |
|  | Measures for the applicant’s key processes (Figure 6.1-1) do not appear to reflect the quality of health care outcomes, as many relate to screening outcomes, volume, and capacity. Measures of the performance of health care services, including those provided by partners, may help the applicant align its implementation of health care processes with the six IOM aims on which the applicant bases its key health care requirements, and thus to improve those processes.  | As with OFI directly above, there are, but very few actual patient treatment outcomes measures or transition of care outcomes (which relate to partnering activities). As Ex3 said ... measures appear to largely be measures of screening which links to effectiveness, and perhaps patient-centered, other key requirements do not appear to be measured. Many of the measures shown in 6.1-1 appear to be volume-metrics rather than actual healthcare outcomes. Three examiners cited such a lack of metrics (Ex4, Ex3, Ex1). This may be a learning opportunity as the organization moves forward. | b(1) |

#### Notes

Did not use one comment on how the organization deals with poor performers; it was thought that this did not rise to the level of importance of the other OFIs.

### Scoring

**Score Value: 55**

**Score Range: 50–65%**

**Why shouldn’t the score be in the range above or below the selected one?**

Scores on the Independent Reviews ranged from 40 to 70. All or nearly all examiners agreed on the two major OFIs.

What keeps the applicant out of a score of 70 or above is (1) a deployment issue related to the lack of information on the relationship with **partners and collaborators and their involvement in process design and improvement, and (2) an alignment issue—the identified processes (Figure 6.1-1) do not appear to address the full range of health care and enabling services needed by the applicant’s patients and populations.**

## Item Worksheet—Item 6.2

## Operational Effectiveness

### Relevant Key Factors

1. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Patients/families: Effective, high-quality care; efficient, cost-effective care.
3. **Core Competencies** 3. Collaborative relationships that increase access to specialty care/other services.
4. IT capabilities: Support for EHR integrated with billing/scheduling. All staff have access to computers, wide array of data/information on intranet, portable CCK..
5. **Health and Safety Requirements**: Protection from exposure to communicable diseases, radiation, chemicals, needle sticks, ergonomic injuries, accidents.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | Leveraging the applicant’s core competency of collaborative relationships, the applicant and DDS review, standardize, and integrate hardware, software, and clinical devices across a single enterprise-wide system architecture to ensure reliability and security of information systems. | 1 of 2 examples given for collaborative partnerships. Relationships for the outsourcing of support services and specialty care are important if the organization is to meet the CC of patient centered care, and to be financially responsible in its highly constrained financial environment. This was moved up in importance during consensus. | b |
|  | The applicant ensures a workforce focus on safety and business continuity through site Safety Committees, with champions in each PCT responsible for safety and infection control rounds. Each clinic undergoes audits, tests, inspections, and mock drills related to safety rounds, accidents, and near misses. In the applicant’s “just” culture, staff members are recognized for catching errors that may cause safety or process issues. The EOP ensures continuity of availability and security of systems and data during an emergency, and the applicant participates in countywide disaster drills.  | There are multiple approaches for safety awareness. Each site is involved. Community involvement occurs through countywide disaster drills. | c(1, 2) |
|  | The standardization and automation of processes and documentation helps the applicant continuously comply with the requirements of its stringent regulatory environment. To avoid errors and rework, PCTs are trained to perform their own quality checks, and accuracy checking is an embedded step in the work of every staff member. Role clarification enables staff members to work to their full potential and eliminate redundancy.  | This encourages regulatory compliance at all times and helps the applicant assume an agility to continuously be able to meet regulatory compliance, a vital requirement in its stringent regulatory environment. This also reduces rework. | a |

#### Notes

One strength not used: Applicant works with suppliers to establish delivery and cost requirements, and the suppliers are responsible for inspection. Also, cited as an OFI, which I think is stronger

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | It is not clear how the applicant systematically improves the numerous safety drills and safety plans included in its approach to providing a safe operating environment. Systematic evaluation and improvement in this area may help the applicant meet workforce health and safety requirements.  | Limited examples of improvement given. This was moved up in importance during consensus. | c(1) |
|  | The applicant’s approach to business continuity does not appear to account for its reliance on partners, who are identified as key to the applicant’s ability to provide comprehensive care. Including partners in prevention, continuity, and recovery plans beyond basic contract information may help ensure that applicant is prepared to provide the full continuum of care needed in the event of disasters and emergencies.  | May be a larger theme? As one examiner wrote, “The lack of processes to include strategic partners in processes to ensure business continuity may limit ORG’s ability to provide tricounty residents access to health care services in times of emergency or disaster.” Beyond having a list of the names of partners and suppliers as part of the disaster management protocols, there is no information on whether and to what extent partners and suppliers are included in disaster management, and drills. Only two partners, DDS and dialysis, were discussed. Early on, it was discussed that this may be a double OFI, but as the larger theme evolved across the discussion, it was a single. | c(2) |
|  | Cycles of learning and improvement are not evident in the applicant’s security and cybersecurity approaches, including those related to patient portals, the CCKs used across the applicant’s wide geographical coverage area, and the security of data for patients without Internet or CCK access. Ongoing refinement of these approaches may enhance the applicant’s ability to ensure security while providing high-quality, patient-centered services.  | The approaches are present, but there is lack of learning and integration into the larger FOCUS areas which leads to a larger learning opportunity for the organization. The OFI will feed into a potential KT on lack of learning. | b(2) |

#### Notes

Did not use ... Unclear how the requirements presented in 6.1-3 were defined. It is important, but does it rise to the level of significance? The metrics given were standard.

### Scoring

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| --- |
| **Score Value: 55****Score Range: 50–65%**Why shouldn’t the score be in the range above or below the selected one? **Not all approaches are integrated; yes, they are aligned. Gaps with partnering processes especially in areas of business continuity.** |

**6.2**

2017 TST Scorebook

Item Leads approach to Drafting consensus review and final consensus worksheet for Item 6.2

**Key Factors**

Not reported in BOSS from the Independent Review. As the team had previously agreed on the Key factors, there had been some discussion surrounding key factors, so there was an awareness of what the team felt was important. I have worked on some consensus teams that decided upon the key factors very early in the process, so that each team member was working from the same list of key factors as they IR was done.

I initially chose a number of key factors and then eliminated and added based on the comments that occurred during consensus. The initial key factors were chosen by the IL based on what I thought related to the criteria and the organizational preface. As the consensus materials was reviewed, if a key factor did not relate to the strengths and OFIs, I eliminated it.

**Strengths**

The Item Lead printed the IR comments so that they could be read and re-read for themes. It is always surprising that there is considerable consensus with most of the items. I then attempt to place them in order of importance based on multiple/overall and then approach/deployment/learning/integration. I then also think of the key strategic strengths and challenges of the organization.

But depending on the completeness of the IR comments, it gets challenging at times to sense what the examiner was intending. Some examiners write almost everything that then becomes easily transferable feedback ready comments, while other examiners write bullets: such as listing the “safety champions” as a strength. It helps the Item Lead to have more information as to what the individual examiner was thinking. For example, the individual work teams at each locale were seen as a strength. During consensus, it was decided that the work teams was a cat 5 thought, but that the responsibilities of the work teams surrounding the learnings of these teams for a safe operating environment, as well as the manner in which these teams prevent rework and control the costs of inspections really was two strengths. Both were linked to the competency of efficiency and the organization’s commitment to efficiency and effectiveness. Both of these strengths were seen as important given the financial constraints of a CHC. It could have been one overarching strength, but the team during consensus thought that the focus on safety was significant itself, as well as the preventing rework strength.

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| --- | --- | --- | --- |
|  | Site Safety committees, with champions in each Primary Care Team, mobile or site specific are responsible for bi-weekly safety and infection control rounds. Each clinic undergoes audits, tests, inspections, mock drills related to safety rounds, accidents and near misses. The organization also participates in county wide disaster drills. Safety events for the workforce are tracked and root cause analyses are reviewed for learning. In this "Just Culture" staff members are recognized for catching errors that may cause safety or process issues. These actions ensure a workforce focus on safety and dissemination of organizational learning.  | 5 examiners (DH, IP, JJ, LC, MY) cited this as a strength. There are multiple approaches for safety awareness along with learnings occurring from RCA's. Each site is involved. Community involvement occurs through county wide disaster drills. | c(1) |
|  | Work Teams are trained to perform their own quality checks, and checking for accuracy is an embedded step in the work of every staff member to avoid errors and rework. Role clarification enables staff to work to their full potential and eliminate redundancy. Improvements to processes have been made based on lean techniques, and there is an "audit ready" atmosphere at all times. The standardization and automation of processes and documentation enhances the meeting of effectiveness and efficiency goals. | All examiners (JJ, IP, DH, MY, JG, KB, LC) verified this in one way or another. This encourages compliance with regulatory compliance at all times and for the organization to assume an agility to continuously be able to meet regulatory compliance, a vital requirement in their stringent regulatory environment. This also reduces rework. | a |

1. **Opportunities for Improvement**
2. Upon initial review of the IR worksheets, I again attempted to consolidate the comments into major theme areas, and review them based on multiple/overall and then approach/deployment/learning/integration. I then also think of the key strategic strengths and challenges of the organization. This type of decision making was significant in the consensus surrounding the third OFI.

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| --- | --- |
| While the organization has an approach to cybersecurity, it is unclear if there have been cycles of learning and improvement. This is important given the innovative use of patient portals and CCKs across a wide geographical area. Also, given that the EMR and the CCKs are a primary source of patient information, processes for collection of information related to these innovations are not defined. It is also unclear how the organization supports the transfer of information to patients without internet connection or access to CCK access. | 5 examiners (IP JG, JJ, KB, LC) commented on this with 2 (IP, JG) listed it as a strength and three (JJ, KB, LC) listing it as an OFI. The approaches are present, but there is lack of learning and integration into the larger FOCUS areas which leads to a larger learning opportunity for the organization. The decision was made to make an OFI to determine the lack of learning as a larger potential for the organization. |

Initially here, the CCK were identified as a best practice of the organization. But as the comments and discussions continued, the lack of learning was identified as a comment of more “value” to the organization who knows that the CCK are innovative.

Similar thoughts occurred with the first OFI. With only three examiners listing this as an OFI, it was initially placed lower in the OFI rating. But as the discussion about the lack of measures beyond the workforce safety, it was moved up in importance. It was also part of the many comments across the scorebook that also added to the theme about partnering. As the consensus progressed the thought of key themes also led to some of the “value added” in the comments.

|  |  |  |
| --- | --- | --- |
| Despite the numerous safety drills and safety plans there is no evidence of measures /results (other than workforce), goals and improvements made that demonstrate the organizational commitment to patient care outcomes, organizational safety outcomes and other safety outcomes that result from the numerous approaches dealing with safety and emergency preparedness. There is also no discussion of how identified partners are included in these processes and how improvements to these processes result in disaster and emergency preparedness across the tri-county area. | 3 examiners (IP, JG, KB) supported this OFI. Limited examples of improvement given with one examiner saying: " The lack of processes to include strategic partners in processes to ensure business continuity may limit ORG's ability to provide tricounty residents access to health care services in times of emergency or disaster." This was moved up in importance during consensus. | c(1) |

**Scoring**

There was relative ease of consensus here once the comments were in place. Initially the score bands in IR were either 50-65 or 70-85. This reflected the variation of comments within the IR responses. Unlike cat 6.1, there were few consensus comments that were identified by all examiners, with the exception of the above strengths, which were initially cited as one overarching strength. The Item Lead posited that there was a lack of integration and learning and suggested that the 50-65 band was most appropriate. As the discussions evolved, it became clearer that there were significant gaps in partnering approaches, and a lack of integration of the approaches. This brought the score to 50-65, with a score of 55.

## Item Worksheet—Item 7.1

## Health Care and Process Results

### Relevant Key Factors

1. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay.
3. Core competency: 3. Collaborative relationships that increase access to specialty care/other services.
4. Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.
5. Health and safety requirements: Protection from exposure to communicable diseases, radiation, chemicals, needle sticks, ergonomic injuries, accidents include protection from exposure to communicable diseases, radiation and chemicals, needle sticks, ergonomic injuries, and accidents.
6. National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award for Performance Excellence; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program..

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | Improving results for health care screening and vaccination, with some exceeding the benchmark, reflect success in these key functions. Examples are screening results for smoking, depression, and domestic violence (Figures 7.1-3 through 7.1-5), which show consistent improvement since 2012, and diabetes and heart care (Figures 7.1-12 and 7.1-14), which have met or exceeded the DDDI 90th percentile since 2012. Other areas of improvement or benchmark performance are cancer screening (Figures 7.1-6 through 7.1-8) and vaccination rates (Figures 7.1-9 through 7.1-10B, 7.1-19, and 7.1-20).  | Consistent performance clearly aligned with service delivery and FOCUS areas. | a |
|  | Results for timely access to care, a key customer requirement, show sustained performance close to the 25% goal from 2012 to 2016, with one county meeting the goal for open appointment slots in 2016 (Figure 7.1-25). In addition, results for the number of days to the third-next-available appointment and wait time to be seen after the scheduled appointment time (Figures 7.1-26 and 7.1-27) show improvement for all counties. | Shows the applicant’s effectiveness in meeting a cross-county goal of reducing ~15 days to third next available appointment in 2012 to ~5 days in 2016, and ~25 minutes’ wait time in 2012 to ~12 in 2016. | b(1) |
|  | Results for the effectiveness of the applicant’s supply-chain management show good levels and beneficial trends. For example, supply order accuracy (Figure 7.1-34) has been close to a national benchmark since 2012. In addition, cost savings achieved as a member of a purchasing consortium increased from close to $1 million in 2012 to nearly $1.2 million in 2016 (Figure 7.1-35). These results are indicators of the efficiency of the applicant’s operations and its ability to compensate for unreimbursed care | The majority of suppliers are listed as “partners” in the Organizational Profile, and partnerships are reflected in the core competency of collaborative relationships. . Supply chain is an important metric in the collaborative partnerships that allow the applicant to meet patient needs. | c |
|  | Safety and emergency preparedness results show sustained good levels or improvement from 2012 to 2016, supporting a key workforce requirement as well as continued access to care. Examples are performance at or better than the benchmark for lost-time injuries, sharps injuries, and TB test compliance (Figure 7.1-31), and 100% compliance across nine proactive health, safety, and security measures (Figure 7.1-32). Emergency preparedness results (Figures 7.1-31 through 7.1-33) show reductions in security events and 100% compliance in the conduct of tests and drills since 2012. | Results for key measures of workplace health/safety (Figure 7.1-31) show consistent improvement; most measures outperform 2015 Baldrige benchmark. Results for proactive health, safety, and security measures show 100% compliance with nine indicators for training and inspection (Figure 7.1-32). | b(2) |

#### Notes

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| --- |
| Did not use.... Patient and family satisfaction results have been sustained in the top decile level (could be used in 7.2). Did not use comments on effectiveness of care (such as asthma care, Figure 7.1-13, presence of H & Ps etc.). These are health care process outcomes, but not outcomes that speak to improvement in the health status of the population.  |

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Results are not segmented for the Hispanic and Native American populations, which are identified as important to the applicant. Tracking results for these populations may help the applicant deliver patient-centered, culturally competent care across the different groups served by the applicant and contribute to meeting the vision of “making the people of western Arizona the healthiest in the state.” | Missing results, The missing results for the Hispanic population was raised by one examiner and when put forward to the larger group, the lack of cultural competence approaches, metrics and outcomes to the overall cultural groups served by this organizations was agreed as significant. Rose to the level of a double during consensus. | a |
| **X** | The applicant does not report results for health-care-related errors, unsafe events, and near misses related to health care and customer-focused work processes, such as alerts for critical lab value; for measures of process effectiveness and efficiency related to payors’ requirements; or for the effectiveness of collaborative initiatives and standardization of materials, procedures, and requirements across CHCs. With the applicant’s emphasis on error reduction and prevention, such results may help leaders demonstrate the applicant’s value of accountability. | Missing results ... This rose to the level of a double during the consensus process. | b |
|  | No results are provided for the applicant’s numerous key partners and the services they provide, such as transportation, translation, and health education. Nor are results provided for the supply-chain requirements of continuity of operations for providing clinical care, low cost/high value, or on-time delivery. Such results may help the applicant judge the effectiveness of its partners in helping to ensure that patients can access all services across the continuum of care.  | Only one graph for order accuracy, and one for cost savings. No measures/outcomes listed. | c |
|  | Results are not presented for some services associated with identified high-prevalence health issues (Figure 6.1-1), such as substance abuse, addictive behavior, mental health other than depression, and vision and hearing screening; and other than those for maternal and child health, few results are presented for outcomes for treatment services provided by the applicant. | There is a lack of data for some screening services, and other than maternal and child health services, a lack of metrics for the outcomes of treatment services.  | a |

#### Notes

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| --- |
| Did not use.... Use of local competitor data such as community-based private medical/dental/behavioral health providers is not evident ... may be a bit prescriptive seeing that they do use benchmarks. OFI 4 ... does it conflict with OFI 1, the access strength? The strength is about continued improvement. Determined not to conflict—just pointing out some missing results in that area.  |

### Scoring

|  |
| --- |
| **Score Value: 40****Score Range: 30–45%****Why shouldn’t the score be in the range above or below the selected one?** Independent review scores ranged from 55 to 65; this item dropped considerably during consensus review. Key considerations were missing segmentation for key populations with identified, unique health care concerns and needs, missing results related to the safety of health care services, missing **results for identified services being offered, and missing results related to partners and collaborators.**  |

**7.1**

2017 TST Scorebook

Item Leads approach to Drafting consensus review and final consensus worksheet for Item 7.1

**Key Factors**

Not reported in BOSS from the Independent Review. As the team had previously agreed on the Key factors, there had been some discussion surrounding key factors, so there was an awareness of what the team felt was important. I have worked on some consensus teams that decided upon the key factors very early in the process, so that each team member was working from the same list of key factors as they IR was done.

With the results items, it is a bit easier than the process items (or at least I think so!)

**Strengths**

The Item Lead initially consolidated the comments into the major focus areas of the item: health care results for patients and other customer service results; process effectiveness and efficiency results; safety and emergency preparedness results; and supply chain management results. I then checked to make sure that the data presented agreed with the examiner inclusion of the result as a strength or OFI (some results can be very deceiving!). I then reviewed the comments according to favorable levels/beneficial trends/favorable comparisons/benchmark performance. Some of this led to the decision of the importance of the strength.

I then began leveling the results in order of importance to the organization, first based on key factors but later as consensus progressed I added the potential of “value to the organization” as feedback.

As this organization has a major focus and strategic objectives on health care screening, screening activities results were seen as important to the organization. The strength is below:

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| --- | --- | --- |
| A function of this CHC is health care screening and vaccination. Screening results for depression (7.1-4) smoking (7.1-3) and domestic violence (7.1-5) show consistent improvement since 2012. Diabetes (7.1-12) and cardiovascular (7.1-14) screening meets or exceeds DDDI 90th% since 2012. Cancer screening (7.1-6, 7,8) has demonstrated improving results for all clinics. Body Mass Index results for adults (7.1-1) and youth (7.1-2) are significantly lower than state average CHC. Vaccination rates (7.1-9,10, 10A, 10B, 19,20) have been steadily increasing since 2012. Pediatric appropriate immunizations meeting and exceeding benchmark since 2014. | Consistent performance clearly aligned with service delivery and FOCUS areas. All examiners agreed (JJ, IP, DH, MY, JG, KB, LC). | a |

**Opportunities for Improvement**

Upon initial review of the IR worksheets, I again attempted to consolidate the comments into major theme areas of the item, missing results, gaps in segmentation, poor or lacking benchmark performance. Also according to levels/trends/comparisons/integration.

Missing results were significant for this applicant. As consensus moved forward, there was a lot of discussion about the lack of actual patient and safety outcomes. . There were many “volume-metric” and compliance results, but few if any measures/results surrounding error reduction and some specific patient populations. This results in a doubling of the two OFIs listed below.

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| --- | --- | --- |
| **X** | There are no metrics nor results for errors, unsafe events and near misses despite the emphasis on error reduction and prevention. Key areas of 6.2 are not shown in results, such as alerts for critical lab value. Results are also missing for measures of process effectiveness and efficiency related to payors' requirements. No results are provided for the effectiveness of collaborative initiatives and standardization of materials, procedures, and requirements across CHCs. The lack may limit leaders' ability to demonstrate the core value of accountability and CC of collaborative relationships that increase access to care. | Missing results ........ 3 examiners (IP, KB, MY). This rose to the level of a double during the consensus process. |
| **X** | Results are not presented for many screening activities associated with identified high prevalence issues such as substance abuse, addictive behavior, mental health other than depression, vision and hearing screening. There are also missing results for populations identified as important to the organization: Hispanic and Native American populations. This raises concerns about the processes for delivering patient centered culturally competent care, a stated value of the organization | Missing results, Supported by examiners (LC, KB, MY, IP, JJ, JC, DH). The missing exalts for the Hispanic population was raised by one examiner and when put forward to the larger group, the lack of cultural competence approaches,metrics and outcomes to the overall cultural groups served by this organizations was agreed as significant. Rose to the level of a double during consensus. |

**Scoring**

There was relative ease of consensus here once the comments were in place. The two double OFIs dealing with the missing results for key areas of services/safety led the decision to the 30-45 band with a score of 40. Good organizational performance responsive to the **basic requirements.**

## Item Worksheet—Item 7.2

## Customer Results

### Relevant Key Factors

1. Clinics/mobile service serve patients at churches, schools, community centers w/23 PCTs as essential HC delivery unit. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Mission: Provide residents easy/timely access to high-quality/safe health care services, responsive to diverse cultural/socioeconomic needs, regardless of ability to pay
3. Key customers Patients/families: safety; effective, high-quality care; efficient, cost-effective care; timely/convenient access to care/information; patient-centered service; equitable, culturally sensitive care; reputation as high-quality health center; personal relationships/partnerships.
4. SC1—balancing mission to serve all patients regardless of ability to pay against tight fiscal environment, including increasing percentage of uninsured patients and no growth in federal grant payments for uninsured
5. SC4—establishing/managing mechanisms to provide specialty care/meet service needs.
6. Key sources of comparative and competitive data: National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Patient and family satisfaction results show top decile performance or above for the past several years. Aggregate patient satisfaction (7.2-1), medical services (7.2-2), and dental services (7.2-3) have met or exceeded the top decile comparisons starting in 2013. These results are critical to the applicant’s mission to provide easy, timely access to high-quality safe health care services, responsive to diverse cultural and socioeconomic needs, regardless of ability to pay. These results are reflective of the applicants’ positive competitive positions. | Comment based on Ex7’s comment. All had comments related to excellent levels and trends for 7.2 1-1. Two examiners had it as a double strength. Added an additional relevance statement based on round two feedback by Ex3.  | a(1) |
|  | Good to excellent levels and trends are shown for most patient/ other customer results. Figures 7.2-,3-,5 and 7.2-7 (Patient/Family Satisfaction with dental services, school services, mobile van, support services), as well as 7.2-6,8 (Patient/Family,Community Satisfaction by Key Requirement and Patient Satisfaction with Services ) show favorable trends. Levels of payor satisfaction (Figure 7.2-10) exceed state-best CHC from 2012-2016. Beneficial patient and other customer results may enable the applicant to maintain and grow its market share.  | Comment on 7.2-3-5, 6-8 and 10. Comment based on Ex5. Ex7, Ex3 and Ex8 had positive comments that included these figures. Ex2 supported comment on 8 Ex5 and Ex8 had as a double strength. Could consider a double strength during the consensus discussion.  | a(1) |
|  | Measures of customer engagement presented all show positive trends and high levels of relative performance. For example, patients who indicated they would recommend the applicant, those who did recommend, and social media Facebook likes all show beneficial trends and outperform available benchmark comparisons. (Figures 7.2 15,16,and 18) Figure 7.2-17, community perception of which CHC provides the best care is above 90% for the last 4 years and better than the state best.  | Willingness to recommend questions are segregates for engagement. Comment on customer engagement based on comment by Ex8 supported by comment by Ex2. Added figure number for community perception based on feedback from Ex3 in round two. | a(2) |
|  | In support of the organization’s performance value to embrace improvement, results indicate lower percentages of patient/family members who strongly disagree with the organization’s quality and services (Figure 7.2-11). These levels demonstrate better relative performance than the Packer comparison provided, and beneficial trends from 2012-2016. Results for aggregate complaint severity (Figure 7.2-12) show good levels and a beneficial trend from 2014-2016, and results for the organization’s ratio of complaints to compliments (Figure 7.2-14) show a beneficial trend from 2012-2016. | Comment on Figures 7.2-11, 12, 14 based on comment by Ex3. Supported by comment by Ex8 levels and trends for 7.2-11,12,14 show good levels and trends and outperform the lowest Packer decile. | a(1) |

#### Notes

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### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | The applicant lacks comparisons to local or regional competitors for many patient and other customer satisfaction results. For example, Figures 7.2-1 through 7.2-7 (Aggregate Patient Satisfaction, Satisfaction with medical services, dental services, school services, mobile van services, support services and key requirements) lack comparisons. Comparing with competitor data may enable the applicant to more effectively address its competition for patients.  | Comment on local comparisons based on comment by Ex5 and supported by Ex8, Ex2. Ex4 suggested bold in her backup feedback. If needed will discuss at consensus.  | a(1) |
|  | Results are missing for the applicant’s success in acquiring new patients and other customers, and for customer loyalty / retention. With the challenges associated with the recent and anticipated changes in the Affordable Care Act and Medicaid expansion enabling CHC patients to obtain care elsewhere, specifically measuring and monitoring the success of patient acquisition and retention mechanisms presented in Figure 3.2-2 may help the applicant effectively enhance utilization. | Comment on SCs based on comment by Ex7 and supported by, Ex3. Ex4 suggested a double during her backup feedback. We can discuss this at consensus if there is not agreement. Revised comment based on feedback by Ex3 in round two feedback.  | a(2) |
|  | Some results are presented are not segmented by product offerings, customer groups, and market segments. For example, patient/family satisfaction with services such as pharmacy, laboratory, behavioral health, and satisfaction with partners provided only in the aggregate. Analysis by segment may uncover strengths and opportunities for improvement that remain hidden in the aggregate.  | Comment on segmentation based on comment by Ex1 and Ex8 | a(1) |

#### Notes

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| Did not use the comment on access based on comment by Ex3. I think this is a valid and interesting comment but I am not sure that is goes here or should be considered in Category 4 on measurement. The organization reports annual measures from 2012-2016 for patient/family satisfaction with the organization’s ability to address the key requirement of timely/convenient access (Figure 7.2-6); this reporting of annual results does not align with the organization’s quarterly measures of patients’ satisfaction with their ability to get an appointment, and weekly monitoring of appointment lead time (6.1b[1]). This lack of alignment of patient/family satisfaction results with the cycle times of key process and in-process measures may limit leaders’ ability to meet customer requirements.  |

### Scoring

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| **Score Value:** **55****Score Range:** **50–65%****Why shouldn’t the score be in the range above or below the selected one? This score is based on the two double strengths and the sustained levels trends and comparisons for a1. At consensus, this may move the lower range if great weight is given to the OFIs and if any of the OFIs are consider for a double or bolded comment.** **Lowered score to 50 based on comments by examiners Ex3, Ex4, Ex7.** At consensus, raised the score to 55. |

## Item Worksheet—Item 7.3

## Workforce Results

### Relevant Key Factors

1. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
2. 314 volunteers (key stakeholder group): patients/family members, who help build relationships with patients/families, increase efficiency/effectiveness of care delivery.
3. Drivers of workforce engagement: Nonmillennials: senior management communication, use of skills/abilities, comfortable reporting errors or unsafe acts, protection from health/safety hazards, clear sense of what is expected. Millennials: growth opportunities, flexible work schedule, fair pay/good benefits, personal relationships/partnerships, support of mission.
4. SC5—staff recruitment/retention challenges related to remote locations, needy population, compensation package.
5. Key sources of comparative and competitive data: National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | In support of the organization’s strategic advantage of a highly engaged workforce, results for the engagement of millennial and non-millennial staff (Figure 7.3-13) indicate good levels and favorable trends from 2012, with both groups at 95% in 2016, outperforming the Oates top decile. Levels of staff engagement with all key engagement drivers and key requirements (Figure 7.3-14 and 7.3-15) meet or exceed Oates top decile since 2014. Physician satisfaction (Figure 7.3-16) and volunteer satisfaction (Figure 7.3-17) reflect sustained levels approaching 100% from 2012-2016, consistently outperforming the Oates top decile. | Two examiners recommended double (Ex5 and Ex8) but I choose to keep this as a single. | a(3) |
|  | Performance results for Turnover by Employee Group (Figure 7.3-1), for Turnover Rate for Employees <1-year Tenure (Figure 7.3-2) and for Vacancy Rates (Figure 7.3-3) demonstrate favorable trends from 2012 to 2016, with all groups meeting or exceeding the state-best CHC levels. These results may demonstrate success of the applicant’s approaches to reduce employee turnover. | Several examiners (Ex7, Ex3, Ex2, Ex5, Ex1) reflected a similar strength statement. Combined essence of several comments. | a(1) |
|  | Favorable trends were demonstrated in several measures of workforce climate including, Gainsharing Payout (Figure 7.3-9) increasing each year since 2012, and use of Thank You Notes (Figure 7.3-12) from approximately 600 in 2012 to more than 800 in 2016. Results in STAR Recognition (Figure 7.3-11) reflect a favorable trend for both staff and volunteers, significantly outperforming the State-Best CHC benchmark. These results support the applicant’s value to respect every individual. | This strength was referenced by (Ex5, Ex3, Ex8). | a(2) |

#### Notes

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| Below the line comments: I did not include a strength statement from Ex8 for an a(4) strength around proficiency rates for training. Ex3 was the only examiner who noted this strength, and I did not feel that it was supported by other examiners. I also did not include an a(1) strength noted by Ex3 and by Ex8 for staffing levels and productivity. Given the balance of comments, I felt this strength was not needed.  |

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Results are missing for areas of importance to the applicant. For example, results are not provided for recruitment of health care professions and physicians. Results are also missing for drivers of workforce engagement including, comfortable reporting errors or unsafe acts, protection from health and safety hazards and a flexible work schedule. Additionally, no results are provided for measures of workforce safety. Beyond proficiency results and satisfaction with training, results for training effectiveness were not provided. Capturing results in these key areas may help address the strategic challenge of staff recruitment and retention. | Missing results. Numerous examples were provided. I created an OFI statement that captured the essence of several comments. Ex2 recommended a double OFI. By combining several OFI statements, I agree that this warrants a double. | a |
| **X** | Segmentation is missing in several areas of importance. For example, the applicants indicates that it segments its workforce by millennial and non-millennial, yet results segmented in this manner were presented only for Staff Engagement (Figure 7.3-13). Segmented results were not provided for physicians other than Physician Engagement (Figure 7.3-16). Measures of workforce capability and capacity (turnover, vacancy rates, time to fill, overtime) were not segmented at all. Without appropriate segmentation of workforce results, the applicant may be unable to identify needed areas for improvement. | Segmentation. I attempted to write an OFI that captured examples from various comments. | a |
|  | No comparisons are provided to direct competitors such as community-based private medical/dental/behavior health providers. By capturing comparisons to its direct competitors and assessing performance, the applicant may be able to identify opportunities to better leverage it strategic advantages of utilization and strategic partnerships to provide comprehensive care in more innovative ways to increase competitiveness. | Ex5, Ex2 identified this gap. | a |

#### Notes

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| I ended up with three OFIs that cut across all areas of 7.3. I used parts of all comments.  |

### Scoring

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| **Score Value: 50****Score Range: 50–65%**Why shouldn’t the score be in the range above or below the selected one? **During consensus, all examiners agreed on 50–65% scoring range based upon the balance of comments. Based upon the consensus strength and OFIs, I recommended a score of 55%.** **After consensus, the team agreed to a score of 50%. We have three solid strengths and two OFIs with one of those being a double OFI. The comments reflect the scoring guidelines for the 50–65% range. Not below the 50–65% range because the strengths are really strong. Where performance results were presented, however, not in the 70–85% range because we are missing too many results and segmentation.**  |

## Item Worksheet—Item 7.4

## Leadership and Governance Results

### Relevant Key Factors

1. Clinics/mobile service serve patients at churches, schools, community centers w/23 PCTs as essential HC delivery unit. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits..
2. Core values: respect, trust, relationship, performance, accountability.
3. 419 employees (12% part-time), 62% clinical staff (physicians, dentists, physician assistants, nurses, nurse practitioners, medical assistants, dental hygienists); 33% administrative, facility, support staff; 5% managers/senior leaders; no organized bargaining units. Staff represents ethnic diversity of communities served.
4. Regulatory and accreditation requirements: Multiple federal, state, local—including designation as FQHC, qualification for Section 330 grant funds and TJC, recognition as PCMH.
5. Voluntary 15-member Board of Directors, 6 standing committees: Quality, Ethics, Community, Partner Relations, Development, Audit. More than 51% of voting members are recipients of applicant’s services; senior leaders are nonvoting board members.
6. Key stakeholders: Communities, physicians, staff, volunteers, payers, partners, suppliers, collaborators: information/training on current medical technology/procedures; knowledge, skills tools to do job; fair pay/benefits, recognition/opportunity to serve and develop job skills for staff/volunteers; opportunities for collaboration/innovation for partners, suppliers, collaborators.
7. ACA resulted in more stable finances. Increasing demands for care place stress on applicant.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | Excellent performance related to legal, regulatory, and licensure requirements indicate the effectiveness of the applicant’s approaches to addressing these requirements as they relate to operations. The best performance possible is reported for HIPAA measures and licensures since 2012 (Figures 7.4-3 through 7.4-5) and for Percent Staff and Volunteers Trained in Proper Disposal of Medical Waste (Figure 7.4-6). | The nugget sentence came from Ex2’s feedback-ready comment; Ex5 provided the examples; Ex8 provided the relevance statement. Revision for R3: Revised the relevance statement (Ex8).  | a(3) |
|  | Results reported indicate trust in the applicant’s governance and high performance in a complex and highly regulated environment. From 2012 to 2016, clinical and administrative employees’ satisfaction with senior leader communication (Figure 7.4-1) shows beneficial trends and levels beyond the top decile; board members’ compliance with requirements increased from 89% to the 98% benchmark (Figure 7.4-2). | Ex5’s feedback-ready comment provided the nugget. The two examples based on Figures 7.4-1 and 7.4-2 came from the feedback-ready comments of Ex1, Ex3, Ex7, and Ex8. The relevance statement came from Ex7’s feedback-ready comment. Revision for R2: Removed reference to 7.4a(1). | a(2) |
|  | Results for perceptions of ethical behavior and community support—including Staff, Volunteer, and Community Response to Ethics-Related Questions (Figure 7.4-7), Support of Key Communities: Staff Members’ Volunteer Hours (Figure 7.4-8), and AF Community Support of Key Programs—Annually (Figure 7.4-9)—show beneficial trends since 2012. These results show adherence to the core values of trust, relationship, and accountability. | This is a combined strength derived from 5 strengths identified by 3 examiners (Ex2, Ex5, Ex8). Ex2 and Ex8 provided the strengths for 7.4a(4) and 7.4b, while Ex5 provided that for 7.4a(5). The relevance statement is based on the MVV elements that the nugget and examples are most aligned. Decided to combine these strengths into one comment because splitting the strength into two would have resulted in more strengths than OFIs, which would not be consistent with the assigned score for the Item (45%). Revision for R2: Removed references to 7.4b, strategy implementation, and Figure 7.4-10. Added to the relevance statement the alignment with the organizational culture of providing health care for underserved populations. Revision at Consensus (R4): Amend the nugget sentence by changing “Results for ethical behavior” to “Results for perceptions of ethical behavior.” | a(4, 5) |

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### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Results are missing for several identified leadership and governance approaches. Examples are results for the effectiveness of approaches to ensure responsible governance (Figure 1.2-1) and for senior leaders’ communication with customers, board members, volunteers, strategic partners, payors, and the community. In addition, there are no results for 9 of 14 community support programs (Figure 1.2-5), the extent of workforce participation in them, or their impact on community health. Without such results, the applicant may be limited in demonstrating its commitment to accountability or the success of its community support efforts. | Two examiners (Ex3, Ex5) labeled this OFI as a. In the construction of the draft consensus comment, Ex5 provided the nugget; Ex1, Ex2, Ex3, and Ex7 provided examples, but the Item Lead retained 2 examples for the sake of brevity; Ex2, Ex3, and Ex5 provided the relevance statement. Backup Feedback at R1: Separate this OFI into three OFIs—a(1,2,4), a(5), and b—and consolidate “a(5)” and “b” contents of other proposed OFIs into the new “a(5)” and “b” OFIs. Revision at R1: Team Lead decided to combine a(1,2,4) and a(5) into one OFI in order to keep the number of OFIs to four. Separated this OFI into three OFIs—a(2,4), a(5), and b—and consolidated “a(5)” and “b” contents of other proposed OFIs into the new “a(5)” and “b” OFIs. Comment focus revised at Consensus: one on missing results in parts of 7.4(a), one for b, and one for segmentation in parts of 7.4(a). | a(1, 2,4,5) |
|  | Results are missing for outcomes of action plans in alignment with strategic objectives (Figure 2.1-2), such as efforts to secure funding from public and private grants and major gifts, building and strengthening core competencies, and managing risk and taking intelligent risks. Tracking such results may help the organization demonstrate accountability in a highly regulated environment. | This is a new OFI resulting from BU feedback at R1. Four examiners (Ex1, Ex3, Ex5, Ex7) contributed OFIs leading to this comment about strategy implementation results. Although two examiners (Ex3, Ex5) labeled this OFI as a --, Team Lead kept it as a—because the first OFI, which is also about missing results but in different measures, is already a --. Ex7 provided the basic structure for this comment, with Ex1, Ex3, and Ex5 providing examples. Revision at Consensus (R4): Changed item reference to b. Moved the following missing results originally included in Item 6.1: “efforts to secure funding from public and private grants and major gifts.” | b |
|  | The applicant’s leadership, ethical behavior, societal responsibility, and community support results (Figures 7.4-1 and 7.4-7 through 7.9) lack segmentation by facility, community, service category, or workforce segment. Segmented results may help the applicant identify specific gaps in performance or opportunities for improvement. | Three examiners (Ex1, Ex2, Ex8) contributed 5 OFIs leading to the observation about gaps in segmentation. The feedback-ready comments of Ex5 and Ex2 provided the basic structure for the nugget of this OFI. | a(1,4,5) |

#### Notes

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### Scoring

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| **Score Value: 40****Score Range: 30–45%****Why shouldn’t the score be in the range above or below the selected one? There are good organizational performance levels, responsive to the overall item requirements (Le), and beneficial trends evident in areas of importance to the accomplishment of the organization’s mission (T). Le and T are consistent with the 50%-65% scoring range. However, there are several missing results and gaps in segmentation (I). C and I are more consistent with the upper end of the 30-45% scoring range. Overall, the most descriptive scoring range appears to be 30–45% with a score toward the upper end (40%) of that range.**  |

**7.4**

**2017 BALDRIGE CASE STUDY**

**ITEM LEAD’S APPROACH TO DRAFTING OF CONSENSUS REVIEW WORKSHEET (R1) FOR ITEM 7.4**

**Key Factors**

BOSS does not report the Key Factors from the Independent Review Worksheets.

Therefore, Item Lead identified the six Key Factors based on the language of the Item 7.4 Criteria requirements. Starting with the Overall requirements, the candidate Key Factors would include (1) Workforce Profile, (2) Patients and Other Customers, (3) Organizational Structure, (4) Regulatory Requirements, and (5) Stakeholders. Proceeding to the Multiple Requirements, the additional candidate Key Factors would include (6) Health Care Service Offerings (specifically locations), (7) Mission, Vision, and Values, (8) Competitiveness Changes, and (9) Core Competencies. Consideration of the Scoring Guidelines would lead to the addition of (10) Comparative Data as a candidate Key Factor. Can you relate the KFs to the specific Criteria requirement? Not the obvious ones, but for example, why did you feel that #6 or #8 rose to the top of the list? Facilitators will be asked this type of question in class, and they can guess, but we want them to avoid guessing as much as possible.

After drafting the six Strengths and Opportunities for Improvement, Item Lead reviewed the 10 candidate Key Factors and eliminated those candidate Key Factors that are not associated with any of the six comments. Which ones?

**Strengths**

Item Lead first considered the approach of organizing the strength comments around the evaluation factors (e.g., favorable levels, beneficial trends, favorable comparisons or benchmark performance). This approach, however, was not productive because the IR strength comments typically have more than one evaluation factor embedded (e.g., favorable levels and beneficial trends).

Item Lead then pursued an alternative approach of organizing the strength comments around type of results reported. This approach entailed sorting the IR strength comments by multiple requirement by, say, grouping the 7.4a(1) strengths together, followed by 7.4a(2), and so on. This approach initially yielded four draft consensus strengths: 7.4a(1,2); 7.4a(3); 7.4a(4,5); and 7.4b.

The following is my entry for the third strength in the R-1 consensus review worksheet for Item 7.4:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **User** | **++** | **Strength/Description** | **Rationale/Evidence** | **LTCI** | **Item Ref.** |
|  |  | Results for ethical behavior, community support, and strategy implementation show beneficial trends since 2012. These include Staff, Volunteer, and Community Response to Ethics-Related Questions (Figure 7.4-7); Support of Key Communities: Staff members’ Volunteer Hours (Figure 7.4-8); AF Community Support of Key Programs—Annually (Figure 7.4-9); and Achievement of Action Plans (Figure 7.4-10). These results provide evidence of progress toward the organization’s vision of leadership in community involvement and adherence to the core values of trust, relationship, and accountability. | This is a consolidated strength derived from 5 strengths identified by 3 examiners (LC, JJ, MY). LC and MY provided the strengths for 7.4a(4) and 7.4b, while JJ provided that for 7.4a(5). The relevance statement is based on the MVV elements that the nugget and examples are most aligned. Item Lead decided to combine these strengths into one comment because splitting the strength into two would have resulted in more strengths than OFIs, which would not be consistent with the assigned score for the Item (45%). A facilitator may be asked, “Why did the score seem to drive the comments instead of the other way around? Comments should drive the score. Right? | T | a(4,5),b |

**Opportunities for Improvement**

Drafting consensus OFIs for Item 7.4 was relatively more straightforward. Item Lead’s initial scan of the IR OFI comments immediately yielded three organizing themes among the IR OFIs: missing measures, gaps in segmentation, and unfavorable comparisons. Based on my past experience, organizing OFIs in process and results items using the evaluation factors (ADLI or LeTCI) as organizing themes is a productive approach and one that results in actionable OFI comments. Can you speak to why your first listed OFI, and strength a well, were the highest priority?

The following is my entry for the first OFI in the R-1 consensus review worksheet for Item 7.4:

| **User** | **++** | **Opportunity for Improvement/Description** | **Rationale/Evidence** | **LTCI**  | **Item Ref** |
| --- | --- | --- | --- | --- | --- |
|  | X | Results are missing for several areas of importance to the applicant. No results are provided that demonstrate achievement of action plans associated with the organization's approaches to ensure responsible governance (Figure 1.2-1), or for the achievement of action plans related to leadership and governance (Figure 2.1-2). Additionally, while results were provided of activity around support of key communities, there is no information on actual impact on the community. The lack of such results may limit the organization's ability to demonstrate a commitment to accountability and performance or the success of its community citizenship efforts. | Five examiners (KB, LC, JG, JJ, IP) contributed OFIs leading to this comment about missing results. Two examiners (JG, JJ) labeled this OFI as a --. In the construction of the draft consensus comment, JJ provided the nugget; KB, LC, JG, and IP provided examples, but the Item Lead retained 2 examples for the sake of brevity; LC, JG, and JJ provided the relevance statement. | LTI | a(3,4,5), b |

**Scoring**

Item Lead first looked at the IR scores’ range (i.e., 40%-55%) and median (47.5%). Item Lead then treated 30%-45% and 50%-65% as the two candidate scoring ranges for Item 7.4. Applying the Scoring Guidelines, Item Lead felt that Levels and Trends seem to be aligned with the descriptors of the 50%-65% range; however, Comparisons and Integration seem to be aligned with the descriptors of the 30%-45% range. Overall, Item Lead felt that the best-fit scoring range is 30%-45%, with a proposed score of 45%, given that the next best scoring range is 50%-65%. Why did the Item Lead feel that the best-fit scoring range is 30 – 45? And why is the proposed score 45 instead of, say, 35 or 40? This is the real learning point that would really help in the classroom discussion.

**Finalizing Strengths and OFIs**

After scoring the Item (45%), Item Lead determined that having four strengths and three OFIs does not appropriately represent the relative balance between the strengths and the OFIs. Item Lead, therefore, decided to combine the third and fourth strengths into one strength dealing with 7.4a(4,5)b. Here again, it might appear like the score drove the balance of strengths and OFIs, rather than the other way around. Not saying this is incorrect, if could be the right thing to do in this case. But why was this approach chosen rather than going back and saying, based on the balance, is the score right?

## Item Worksheet—Item 7.5

## Financial and Market Results

### Relevant Key Factors

1. Ambulatory medical (obstetric/gynecologic, family medicine, pediatric), dental services, routine laboratory, radiology, vision/hearing screening, pharmacy services, behavioral health/substance abuse screening. Enabling services: transportation, translation, case management, health education, home visits.
2. Vision: “The people of western Arizona will become the healthiest in the state.”
3. Chronic health problems: diabetes, asthma, cardiovascular disease, depression, obesity, substance abuse/addiction behavior, higher incidence of infectious diseases such as TB/sexually transmitted diseases. Barriers: geography, culture, income, contributing to poorer health than general population.
4. Key sources of comparative and competitive data: National: CHCs, AHRQ, BPHC/HRSA, CDC, CMS, HCDI, HEDIS, Healthy People 2020; TJC; data from professional associations; Packer Patient Satisfaction data; Oates Staff Satisfaction data; QPG; Baldrige Award; Healthy Arizona 2020; State Association of CHCs and State CHC Benchmarking Consortium; Saguaro State Award Program.

### Strengths

| **++** | **Strength** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | In support of its mission to provide health care services to the tricounty community it serves, the organization’s financial results show positive trends for actual expenses, revenues, and net collections from 2012 to 2016; total revenues consistently meet state-best CHC; expenses, and collections (51% of total revenue) increase from $20 million in 2012 to $25 million in 2016 (Figure 7.5-1). Further, results for accounts receivable (Figure 7.5-2) show good levels and positive trends for number of days to payment from 2014 to 2016; levels for medicare and self-pay meet the state-best CHC (private) benchmark. | Strength for the organization’s performance outcomes related to revenues, collections, and accounts receivable. I synthesized IR inputs to create the a(1) Strength comment. | a(1) |
|  | In support of the organization’s mission to provide access to health care services to the populations of its tricounty service area regardless of residents’ ability to pay, results for market share (Figure 7.5-5) show positive trends from 2012 to 2016. For example, market share in Y county increased from 21% in 2012 to 23% in 2016, while market share in M county increased from 11% in 2012 to 12% in 2016 and in LP county from 20% in 2012 to 21% in 2016.  | a(2) Strength for the organization’s marketplace performance results. One examiner (Ex7) noted a(2) results as a double. | a(2) |

#### Notes

###  Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Results are missing or limited for key measures of financial and market performance. For example, results are not presented for operating margin, fundraising revenues, cost control, and ACA impact. Additional financial and market performance measures may provide evidence to inform leaders’ decision-making processes to address changes in the financial environment, including the SC of balancing the mission to serve all patients regardless of ability to pay against a tight fiscal environment.  | Missing results for measures and indicators of financial and marketplace performance, including meaningful comparisons. One examiner (Ex8) indicated a double for lack of financial and marketplace results. Using one examiner’s (Ex5) comment as the stem, I refined the comment to reflect details of other examiners’ IR inputs. I did not double the comment, pending CR inputs. TEAM FEEDBACK: In response to one examiner (Ex4), I doubled this OFI and deleted the sentence about comparisons: Comparisons were not presented for market share by county or by service line, and for budget performance to projections. | a |
| **X** | Results for market share segmented by service (Figure 7.5-6) show low market share for dental services (15%) and chronic disease (10%) for the 5-year period from 2012 to 2016. Such results indicate a potential missed opportunity to establish/manage mechanisms to provide specialty care and meet services needs. | One examiner (Ex7) noted a double a(2) OFI for levels of market share by service (Figure 7.5-6). I included this double OFI for CR consideration. TEAM FEEDBACK: In response to two examiners (Ex1, Ex7), I raised the double OFI to first rank. In response to feedback from another examiner (Ex4) I revised the comment to focus on lower market share for dental and chronic disease, and to align the comment with SC4. CONSENSUS: Deleted comparison between market share for dental and chronic disease compared to levels for maternal, infant, child health, and senior care to enhance focus on low levels for dental and chronic disease. | a(2) |
|  | Results are missing for measures and indicators of the effectiveness of the organization’s key partnerships. For example, no results are provided to show the financial and marketplace performance of a strategic partnership with a local provider of dialysis. The lack of actionable data that demonstrate the financial and marketplace effectiveness of key partnerships might limit leaders’ ability to make evidence-based decisions about partnerships that could enhance the organization’s ability to care for individuals with chronic diseases. | Lack of results related to the effectiveness of the organization’s strategic partnerships and new markets. Although an outlier, I included this 7.5a OFI for consideration because a diverse set of key partnerships (see P.1b[3]) enables the organization to provide comprehensive care in more innovative ways--and to more markets--than it could accomplish alone. | a |
|  | Several results lack segmentation. For example, results for return on assets in clinical units (Figure 7.5-4) lack segmentation by county, services offered, and type of clinic (clinical facility, school-based clinic, mobile van, and Women’s Health Center). No segmentation by market, patient, and customer segment is provided for dental, medical, and behavioral health services. The lack of segmentation may limit leaders’ ability to assess the return on clinical services provided per RVUs for each clinical facility and the return on assets per county/community served. | Three examiners (Ex7, Ex2, Ex8) noted an a(1) OFI for lack of segmentation. CONSENSUS: Deleted reference to CCK in first sentence. | a(1) |

#### Notes

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| BELOW THE LINE: One examiner (Ex5) provided an a(1) OFI for unfavorable levels and comparisons of collection rate of private pay (Figure 7.5-3). I did not use this OFI because it did not rise to the level of actionable feedback represented by other comments. Two examiners (Ex1.Ex8) provided an a(2) OFI for lack of benchmarking of market share results (Figure 7.5-4, 5) against local competition. I did not include this OFI because it did not appear to rise to the level of actionable feedback represented by OFIs for missing results and lack of segmentation. |

### Scoring

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| **Score Value: 35****Score Range: 30-45%****Why shouldn’t the score be in the range above or below the selected one?** **NOT ABOVE: Many results are missing for key measures and indicators of financial and marketplace performance. NOT BELOW: Good levels, positive trends, and beneficial CHC comparisons are provided for many of the results that are provided.** **TEAM FEEDBACK: At the suggestion of one examiner (Ex7), and because two OFIs are now doubled, I lowered the score to 35%.**  |

### Consensus Review—TST2017—Final

| **Summary of Criteria Items** | **Total Points Possible** | **% Score** | **Score** | **Scoring Band** |
| --- | --- | --- | --- | --- |
| Category 1—Leadership |
| 1.1 Senior Leadership | 70 | 60% | 42 |  |
| 1.2 Governance and Societal Responsibilities | 50 | 65% | 33 |  |
| Category Totals | 120 |  | 75 |  |
| Category 2—Strategy |
| 2.1 Strategy Development | 45 | 55% | 25 |  |
| 2.2 Strategy Implementation | 40 | 50% | 20 |  |
| Category Totals | 85 |  | 45 |  |
| Category 3—Customers |
| 3.1 Voice of the Customer | 40 | 50% | 20 |  |
| 3.2 Customer Engagement | 45 | 50% | 23 |  |
| Category Totals | 85 |  | 43 |  |
| Category 4—Measurement, Analysis, and Knowledge Management |
| 4.1 Measurement, Analysis, and Improvement of Organizational Performance | 45 | 35% | 16 |  |
| 4.2 Information and Knowledge Management | 45 | 45% | 20 |  |
| Category Totals | 90 |  | 36 |  |
| Category 5—Workforce |
| 5.1 Workforce Environment | 40 | 60% | 24 |  |
| 5.2 Workforce Engagement | 45 | 65% | 29 |  |
| Category Totals | 85 |  | 53 |  |
| Category 6—Operations |
| 6.1 Work Processes | 45 | 55% | 25 |  |
| 6.2 Operational Effectiveness | 40 | 55% | 22 |  |
| Category Totals | 85 |  | 47 |  |
| SUBTOTAL Cat. 1-6 | 550 |  | 298 | 4 (261-320 pts) |
| Category 7—Results |
| 7.1 Health Care and Process Results | 120 | 40% | 48 |  |
| 7.2 Customer Results | 80 | 55% | 44 |  |
| 7.3 Workforce Results | 80 | 50% | 40 |  |
| 7.4 Leadership and Governance Results | 80 | 40% | 32 |  |
| 7.5 Financial and Market Results | 90 | 35% | 32 |  |
| SUBTOTAL Cat. 7 | 450 |  | 196 | 3 (171-210 pts) |
| GRAND TOTAL | 1000 | TOTAL SCORE | 493 |  |

1. These sources are included in the scorebook to allow the team and technical editor to check the accuracy of the key themes. They will be removed in the feedback report sent to the applicant. [↑](#footnote-ref-1)