# 2017 Arroyo Fresco Case Study

# Consensus Review Scorebook

# Final

### June 2017

In this version of the scorebook, the initials of the Training Scorebook Team (TST) members have been replaced by “Ex1” (Examiner 1), “Ex2,” and so on.

## Key Factors Worksheet

#### P.1a Organizational Environment

**Organization Description** Nonprofit community health center (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. Senior leaders’ focus on the applicant’s vision, mission, and values (VMV) promotes its core health care business, contributing to organizational, financial, and societal performance. The VMV create the applicant’s culture and permeate strategic planning and daily operations. Identification of key communities and their needs embeds societal responsibilities into the applicant’s strategies, strategy implementation, action plans, and daily operations. Examples include the Care Connection Kiosks (CCKs), the option of English or Spanish messaging for individuals without computer access, the provision of transportation and child care, and health education outreach. To meet the vision of a healthy population, the applicant organizes its workforce into Primary Care Teams, creates personalized health plans, and sets goals for care. Efforts to engage the community include recruiting volunteers and members from the communities the applicant serves. Collectively, these approaches define the applicant’s organizational culture and form 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 align with the applicant’s core competencies of patient-centered care and expertise in treating diseases prevalent in its population. [Sources of Data/Examples: 1.1b, STR#1; 1.1a(1), STR#2; 1.2c, STR#2; 3.2a(2), STR#1; 5.1a(4), STR#2; 6.1b(2), STR#1] [[1]](#footnote-1)
2. The applicant’s use of the FOCUS (Financial Performance, Organizational Learning, Clinical Excellence, Utilization, and Satisfaction) framework (Figure P.2-3) 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 on patient satisfaction and engagement through various methods feed into the FOCUS scorecard. The FOCUS framework promotes organizational alignment between strategic and operational considerations, and it 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(1,2) STR1; 2.2a(3,4), STR3; 3.1a, STR1; 3.1b(1), STR2; 3.1b(2), STR3; 4.1a(1), STR1; 4.1a(4), STR2]
3. The applicant’s systematic, comprehensive approach to employee hiring, development, engagement, and support aligns with its values of respect and performance while supporting its communities. The applicant systematically identifies and defines workforce capacity and capability needs during the People Review in the Strategic Planning Process; collects and analyzes workforce engagement data to improve; 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 workforce development. The applicant’s workforce practices support its communities by recruiting from their members. A variety of workplace health, security, and wellness approaches are offered to the workforce, and education benefits are available to employees and to the 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 its strategic challenges around reducing workforce gaps and recruitment and retention. [Sources of Data/Examples: 2.2a(3,4), STR3; 5.1a(2), STR1; 5.1a(1), STR3; 5.1b, STR4; 5.2a(2,3), STR1; 5.2a(4), STR2; 5.2b(1), STR3; 5.2a(1), STR4]

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

1. There are gaps in the applicant’s approaches to providing the range of treatment services aligned to its mission and to its core competency of expertise in treating diseases prevalent in its patient population (e.g., mental health issues, alcohol and substance abuse, obesity, diabetes, and heart disease). For example, alignment between the processes and requirements in Figure 6.1-1 and health care offerings that meet identified community needs is not evident, and some FOCUS measures do not clearly align with objectives (e.g., how immunization rates and screenings will address major health challenges). In addition, measures for the applicant’s key processes do not appear to reflect the quality of health care outcomes, as many relate to screening outcomes, volume, and capacity. Leveraging the applicant’s core competency of expert treatment, as well as its core competency of collaborative relationships, to align services provided and measures tracked with its stated objectives may help the applicant move toward its vision of a healthier population. [Sources of Data/Examples: 6.1a, b(3), OFI3; 6.1b(1), OFI4]
2. The applicant has opportunities to enhance its relationships with key partners, including inpatient hospitals and other health care providers, who are identified as important to the applicant’s ability to provide comprehensive care. For example, it is unclear how the applicant communicates with key partners beyond their inclusion in strategic planning or how the applicant systematically determines which key processes will be accomplished internally and which by partners. Nor is it clear how action plans and improvement priorities are deployed to most key partners. In addition, an approach for establishing work process requirements for partners or for using their input in work process management is not evident. Finally, the applicant’s approach to business continuity does not appear to account for its reliance on partners. Deployment of key approaches to key partners may strengthen the applicant’s core competency of collaborative relationships and better address patient and community needs for effective, high-quality care. [Sources of Data/Examples: 1.1b, OFI1; 2.1a(4), OFI2; 2.2a(2), OFI2; 4.1c(2), OFI2; 6.1a(1), b(1, 4), c, OFI1; 6.2c(2), OFI2]
3. It is not clear how the applicant improves its performance and manages innovation in a wide range of areas. For example, financial objectives do not appear to align with action plans to improve collection rates and relative value units. In addition, it is not clear how the applicant identifies strategic opportunities in its Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis; leverages the Innovation Management Process to pursue strategic opportunities determined to be intelligent risks; or discontinues pursuit of opportunities. For action plans, it is unclear how the applicant addresses gaps in performance against competitors and comparable organizations in these plans or implements modified plans when necessary in response to regulatory, legal, and customer changes. Furthermore, an approach for closing gaps between actual and projected performance is not evident; nor is an approach evident for assessing and then improving performance against local competitors. In the applicant’s tight reimbursement environment and rapidly changing market, a focus on learning and innovation in these areas may 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), OFI1; 2.1a(2), OFI3; 2.2a(6), OFI3; 2.2b, OFI4; 4.1a(1), c(1), OFI1; 4.1b, OFI3]

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

1. The applicant’s results for screening and access to care, as well as customer-focused and some financial results, contribute to fulfilling the mission of providing residents easy and timely access to high-quality and safe health care services. In particular, the applicant reports good levels, beneficial trends, and favorable comparisons for screening outcomes and measures for access to care, with some results exceeding the state average for community health centers (CHCs). In addition, aggregate patient satisfaction and satisfaction with medical and dental services meet or exceed the top-decile comparisons. Revenues, expenses, and collections, as well as accounts receivable, 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. [Sources of Data/Examples: 7.1a, STR1; 7.1b(1), STR2; 7.2a(1), STR1; 7.2a(1), STR2; 7.2a(2), STR3; 7.2a(1), STR4; 7.5a(1), STR1]
2. Good-to-excellent results for employee satisfaction, engagement, and retention; support of its workforce (including volunteers); and senior management communication with the workforce indicate the success of the applicant’s focus on its values of respect, trust, and relationship. Results for staff engagement, satisfaction with key engagement drivers, physician and volunteer satisfaction, and recognition programs outperform the Oates top decile. Furthermore, retention-related results show improvement from 2012 to 2016, with all workforce groups meeting or exceeding the state-best CHC levels. These results provide evidence of the applicant’s strategic advantage of a highly engaged workforce, which may help overcome the applicant’s strategic challenge of staff recruitment and retention related to its remote location. [Sources of Data/Examples: 7.3a(3), STR1; 7.3a(1), STR2; 7.3a(2), STR3]

### 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 for key health care outcomes across the continuum of care. For example, results are lacking for health-care-related errors, unsafe events, and near misses, as well as for services provided by the applicant’s key care partners. Results are also missing for the impact of many of the applicant’s community support programs. Also not reported are results for some services associated with identified high-prevalence health issues, such as substance abuse, addictive behavior, mental health other than depression, and vision and hearing screening, as well as for the outcomes of many treatment services provided by the applicant. Results in these areas may help the applicant understand its progress in providing the full range of safe, effective, and 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 unmet service needs. [Sources of Data/Examples: 7.1b, OFI2; 7.1c, OFI3; 7.1a, OFI4; 7.4a(1,2,5), OFI1; 7.5a, OFI3]
2. The applicant does not provide some important business and financial results. Examples are missing or limited results for operating margin, fundraising revenues, cost control, and ACA impact; results for action plan outcomes; and results for the success of patient acquisition and retention mechanisms. In addition, the applicant does not report comparisons to local or regional competitors for many patient and other customer satisfaction results or for workforce results; nor are results provided related to the applicant’s strategic challenge of staff recruitment. Tracking such business results may contribute to ensuring financial and organizational sustainability in a rapidly changing health care environment. [Sources of Data/Examples: 7.2a(1), OFI1; 7.2a(2), OFI2; 7.3a(1,2,4), OFI1; 7.3a, OFI3; 7.4b, OFI2; 7.5a, OFI1]
3. The applicant has opportunities to gain additional insight into its performance and market position by segmenting results in several areas. For example, health care results are not segmented for the Hispanic and Native American populations, which are identified as important to the applicant. In addition, most workforce results are not segmented by the applicant’s millennial and nonmillennial groups; nor are results provided for physicians, other than for physician engagement. Leadership and societal responsibility results are not segmented by county, facility, community, or service; and several financial results lack segmentation by service areas and services provided. Reporting results by important patient, workforce, and service groups may help the applicant focus strategic responses on key areas and identify high-performing areas and best practices to help meet its strategic challenges. [Sources of Data/Examples: 7.1a, OFI1; 7.2a(1), OFI3; 7.3a, OFI2; 7.5a(1), OFI4; 7.4a(1,4,5), OFI3; 7.5a(1), OFI#4]

## Item Worksheet—Item 1.1

## Senior Leadership

### Relevant Key Factors

1. Nonprofit community health center (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** | By using and improving a variety of mechanisms (Figure 1.1-2) to communicate with the workforce and community, senior leaders deliver on a key driver of workforce engagement. The mechanisms share and reinforce the organization’s vision, mission, and core values. Several cycles of learning have resulted in 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. | 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 community.” Further support for double ++ is provided by Figure 7.4-1 Employee Satisfaction with Senior Leader Communication. | b |
|  | Senior leaders set, review, and validate the applicant’s Vision, Mission, and Values (VMV), which are embedded in the Leadership System (Figure 1.1-1). In 2010, respect was added as a value, reflecting the provision of culturally competent care. In recognition of the cultural diversity of the workforce and community, the VMV are displayed in English and Spanish to remind everyone about expectations; 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 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) |
|  | Through policies that promote an environment requiring legal and ethical behavior among staff members, volunteers, board members, suppliers, and partners, senior leaders demonstrate the importance of such behavior to the workforce and community. Senior leader processes include an annual overview of the applicant’s legal and ethical obligations; role modeling of values; training on ethics, HIPAA, and medical ethics (Figure 5.2-3) for the staff, board, and volunteers; a “no-blame” environment and just culture; and the “two-challenge” rule for any member disagreeing with a decision.  | 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) |

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| Notes |

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
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| **X** | It is unclear how the applicant communicates with key partners other than by including them in strategic planning. For example, leaders’ communication methods (Figure 1.1-2) do not appear to address key physician requirements (Figure P.1-7); and a systematic approach is not evident for communicating with other clinical partners, such as inpatient hospitals, or to encourage two-way communication (Figure 1.1-2) and engage patients in culturally competent care. Without such mechanisms, the applicant may miss 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’s communication approaches (Figure 1.1-2) and the Performance Improvement Framework (Figure P.2-5) deploy the VMV to some patient and customer groups, such as physicians, the Native American population, or the “snow birds.” Systematic deployment of the VMV to all stakeholders may 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 R2: 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 “some patient and customer groups” in recognition that the organization clearly communicates with some patient and customer groups. In contrast, there is little evidence of communication with the physician segment of the workforce, and the organization seems to only minimally connect with the Native American population or the “snow birds,” with both groups making up a sizable share of the population in the applicant’s service area.  | a(1) |
|  | It is unclear how senior leaders create an environment for success now and in the future. For example, full deployment, as well as evaluation and improvement, of the Leadership System (Figure 1.1-1) is not evident. Nor is it evident that senior leaders participate in succession planning or new leader development or that the Innovation Management Process (Figure 6.1-5) guides intelligent risk taking. Fully deploying these mechanisms may enable the applicant to address its strategic challenge of balancing its mission with fiscal constraints. | 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

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| 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 conflict with the strengths about senior leaders’ promotion of ethics in items 1.1a(2) and 7.4a(4).  |

### Scoring

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| **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 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 Process (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 most descriptive 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 community health center (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** | The applicant’s evaluation of the board’s and senior leaders’ performance promotes accountability, one of the applicant’s values. Methods 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. | 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) |
|  | Leveraging its core competency of patient-centered care, the applicant 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. A variety of programs focus on Support for the Body, Support for the Spirit, and Support for the Mind.  | In 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.  | c |
|  | The Board of Directors’ use of six committees to review and achieve aspects of responsible governance reinforces the applicant’s values of trust and accountability. Regular reports of financial and quality performance and other audits ensure board-level accountability for the management’s actions. Regular reviews of budgets, financial reports, capital expenditures, and external audit findings ensure fiscal accountability. Among other ethics practices, board members and senior leaders participate in scenario-based ethics training and annually disclose conflicts of interest. | 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 applicant’s approach. Moved comment from fourth position to third position.  | a(1) |
|  | Systematic approaches ensure the applicant’s legal, regulatory, and accreditation compliance (Figure 1.2-2) and address risks associated with health care delivery and other operations (Figure 1.2-3). For example, the use of Failure Modes and Effects Analysis (FMEA) to identify and address adverse impacts on society of health care services and operations has enabled the applicant to address needle-stick risk for diabetic patients’ family members and ensure patients’ safety 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; 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. (1.1b[1] OFI deleted at Consensus.)Revision at Consensus (R4): Moved comment from third position to fourth position. | b(1) |

#### Notes

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| 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, the staff, the board, and volunteers are required to complete online, interactive courses, with each person signing a Code of Ethical Conduct upon completion of training; 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 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.** |
| --- | --- | --- | --- |
|  | A selection process and criteria for identifying and selecting board members are not evident beyond the requirement that 51% of voting members must be recipients of the applicant’s services. Nor is it evident what stakeholder groups are represented, what disclosure policies in place, and how these relate to efforts to improve the governance system. A systematic approach in this area may help the applicant build confidence in its integrity and transparency. | 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 contributions enriching the comment with 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 is not a Criteria requirement. | a(1) |
|  | A systematic process to promote and ensure ethical behavior in all interactions is not evident. For example, it is not clear how the applicant investigates and responds to potential breaches of ethical behavior or how it communicates the means of access to the board’s Ethics Committee to the workforce across all locations, as well as to partners and stakeholders. A systematic approach may allow the applicant to better demonstrate its core values 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 are strengths about senior leaders’ promotion of ethical behavior [1.1a(2)] and a strength for results for perception of ethical behavior in 7.4, the OFI on missing results for actual ethical behavior [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 Consensus (R4): Eliminated expectation for the governing board to investigate and respond to potential ethical breaches. There is no longer a b(2) strength, so no concern about a conflict. | b(2) |
|  | The applicant’s key processes, measures, and goals for addressing risks (Figure 1.2-3) do not appear to align with the risks identified, which may increase the applicant’s risk exposure. For example, processes for the identified health care risks of exposure to communicable diseases, exposure to radiation and chemicals, ergonomic injuries, and accidents are not identified. In addition, the measures provided do not relate to outcomes; for example, Health Insurance Portability and Accountability Act (HIPAA) measures include compliance with training but not HIPAA violations or penalties. | This OFI for a “what” question highlights gaps and lack of alignment with identified health care risks and health care services. 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 [approach/integration], while the 1.1b(1) strength highlights the deployment and learning aspects. (That STR deleted at Consensus.)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

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| OFI NOT USED: 1.2c(1,2): It is unclear how the applicant 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 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

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| **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** | The well-deployed, systematic Strategic Planning Process (SPP; Figure 2.1-1), used since 1996, evidences the applicant’s core competency of collaborative relationships. Key SPP elements are organized by calendar year. Senior leaders participate in all SPP activities; a cross-location team ensures that staff members in all services, functions, and locations provide input. Community members provide input, and key stakeholder groups provide input and review. In a 1998 improvement, external stakeholders, payors, volunteers, and patient-family advisory boards were added 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 of improvement to 1998 (per Ex7). | a(1) |
|  | Multiple methods to collect and analyze relevant data for the SPP ensure that all key elements are covered. Data sources include board retreats, as well as regular meetings with the staff, volunteers, and other partners and stakeholders. Strategic advantages and challenges are evaluated in relation to the applicant’s competitive position and performance vs. benchmarks. 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).  | a(3) |
|  | The applicant’s SPP systematically incorporates innovation. The organization engages 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

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| 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** | The applicant’s strategic objectives and action plans (Figure 2.1-2) do not appear to 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 applicant’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) |
|  | A systematic approach to determine which key processes will be accomplished by the applicant’s workforce and which by external partners is not evident. For example, the decision-making process does not appear to include data and information from the SPP People Review (Figure 2.1-1, May) or evidence to support decisions related to improving or augmenting work systems and core competencies to meet future needs. Without an approach in this area, the applicant may be limited in leveraging its core competency of 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 an 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 applicant’s success now and in the future. | a(4) |
|  | A systematic, aligned approach to identify strategic opportunities is not evident. For example, it is not clear how strategic opportunities are identified in the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis (Figure 2.1-1, July), and the key strategic opportunity to partner with a dialysis service to provide a more comprehensive approach to the medical home model does not appear to be reflected in key areas for innovation (Figure P.2-1). The lack of such an approach may limit leaders’ ability to fulfill the applicant’s vision. | While the applicant’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 applicant’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 giving direct feedback to applicants is preferable-- “while” and “although” prefaces might mix the message. | a(2) |

#### Notes

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| 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. A third strength was added during R2. |

### 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? 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% 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. 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.
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. ACA resulted in more stable finances. Increasing demands for care place stress on applicant.
5. 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.
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; 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 value of performance, the applicant uses the FOCUS balanced scorecard to identify and organize short- and longer-term action plans, strategic objectives, strategic advantages, and strategic challenges (Figure 2.1-2). Leaders develop plans at four levels, and the Senior Leadership Team and local clinic managers deploy them to work units after the strategic plan is validated and budgets are developed. The Pugh matrix is used to validate resource availability, and it subdivides annual plans at organizational, county, and point-of-care levels into 90-day plans. | 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 of the applicant. | a(1,2) |
|  | In support of its vision, the applicant identifies key performance measures and indicators for the achievement of many strategic objectives and performance projections. Short- and long-term projections consider state and national comparisons. For example, targets for clinical results incorporate the Healthy People 2020 objectives, which reflects 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 applicant 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, 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), which includes the assessment of workforce capability and capacity. | 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) |

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### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | The applicant’s action plans do not appear to align with its strategic objectives and longer-term planning horizons. For example, the strategic objectives (Figure 2.1-2) do not address leadership and governance, including key short- and longer-term action plans associated with achieving results, and only one of three longer-term action plans addresses expansion of services, which usually involves partnering. This lack of alignment may limit leaders’ ability to demonstrate accountability and meet service needs. | 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) |
|  | A systematic approach to deploy action plans to the applicant’s partners is not evident. For example, key performance metrics for the achievement of strategic objectives and goals (Figure 2.1-2) do not appear to include measurements related to the performance of partners and suppliers. Because the applicant uses partners to provide inpatient care, advocacy, and education, integrating supplier and partners into action plan deployment may help improve patient outcomes toward the applicant’s vision. | I synthesized IR inputs for this a(2) OFI comment. | a(2) |
|  | A systematic approach is not evident for addressing gaps in performance against competitors and comparable organizations in action plans. For example, clinical excellence action plans (Figure 2.1-2) do not appear to reflect priorities for closing gaps; nor do action plans appear to reflect changes related to the Affordable Care Act (ACA) in patients and revenues. Aligning action plans with priorities for improvement may help address the challenge of the low incidence of prevention and screening and higher incidence of chronic and communicable diseases, as well as the impact of the ACA on the applicant’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: The a(4) OFI (Ex8) may be addressed as a 5.1a(1) OFI. The 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) |
|  | The applicant’s SPP (Figure 2.1-1) does not appear to incorporate the implementation of modified action plans in response to changes in the regulatory environment, federal law, and customer base, especially regarding leaders’ semiannual review and approval processes. The lack of such an approach 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

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| BELOW THE LINE: a, b OFI for learning (Ex4)—waiting for consensus 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

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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? 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 community health center (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 used to capture the voice of current, former, potential, and competitors’ patients help the applicant identify their key requirements (Figure 3.1-1). Approaches include the Care Connection Kiosks (CCKs), an innovation that aids community outreach; Patient Family Advisory Boards; and Personal Health Profiles. To ensure that the information is actionable, the Service with Spirit Team (SWST), formed in a cycle of learning, aggregates and analyzes customer and market data. | 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 are R2 feedback.  | a |
|  | Various methods of measuring patient and community satisfaction and engagement help the applicant gauge its response to their diverse needs. The Packer Patient Satisfaction Survey, covering all aspects of the intervention, is mailed after visits, with 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, and a short version of the survey is used to measure community satisfaction.  | 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 R2 feedback suggested by Ex5 and Ex3 have been made. | b(1) |
|  | To obtain data on satisfaction with other organizations for use in the SPP, the applicant uses responses to six questions that correlate with identified patient requirements, ensuring that requirements are addressed and performance against them is 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.  | b2 comment based on Ex5 and Ex2. Based on R2 feedback by Ex5, I have made minor grammar changes.  | b(2) |

#### Notes

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| Comments not used: a(2) 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 R2 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. The phrase was retained, as the difference in the comments seems clear. |

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | It is not clear how the applicant tailors listening and learning approaches to its identified patient segments (Figure 3.1-1), how it obtains feedback from patients’ families, or how it reaches out to the Native American patient segment, which represents a major market segment in one county. The examples given appear to cover only the addressing of Spanish language barriers and the provision of alternative feedback venues for older patients. Obtaining information from these segments and communities may help the applicant meet their needs and therefore enhance market share.  | 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 R2 feedback.  | a |
|  | It is unclear how the applicant obtains the voice of the customer relative to partners and competitors that do not participate in the Packer Survey or are not represented in the Community Climate Survey, such as partners providing ambulatory and specialty care and health care providers in Mexico. Capturing such information may enhance the applicant’s 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 these mechanisms may help the applicant better leverage its core competency of culturally competent, patient-centered care.  | Comment based on feedback-ready comment by Ex5. Made wording change suggested by Ex3 in R2 feedback. Made wording changes suggested by Ex3, Ex4 and Ex7 in R2 feedback. | b(1) |

#### Notes

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

### 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? 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 an approach/deployment/learning OFI for limited approaches and learning in improving customer satisfaction addressing dissatisfaction and enhancing engagement.**  |

## 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. The mechanisms are determined by the Service with Spirit Team using data and information from the customer listening posts. Approaches include patient profiles, the establishment of goals with each visit, after-hours voicemail for patients without online access, an option of English or Spanish messaging on all phone systems, CCKs, and print materials.  | The mention of the increased use of the website and social media 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 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 3.2 may be discussed at consensus. Changes made as result of R2 feedback include deleting culturally competent care (Ex1) and replacing “enable to seek information” with “access mechanisms” (Ex7). Split first sentence into two based on comment by Ex3.  | a(2) |
|  | The applicant identifies current customer groups and market segments and anticipates 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 applicant on gaps in services and health care disparities to determine which new market segments and opportunities to pursue. Determinations are based on the accomplishment of the applicant’s VMV and support the vision of making the people of western Arizona the healthiest in the state.  | Changes made after R2 feedback include rewording of the first sentence based on comments by Ex3 and Ex4 and the strengthening of the rationale suggested by Ex7. | a(3) |
|  | The applicant systematically builds engagement through the four phases of the Relationship- Building Methods (Figure 3.2-2), which begin 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 Personal Health Profile (PHP) information to support patient satisfaction and engagement. Engagement is evidenced by patient involvement on teams and councils, which may help the applicant retain patients.  | Comment 3.2b1 Comment supported by aspects of comments by Ex8, Ex1, Ex4, Ex7, Ex2, Ex5.There also is an OFI on the effectiveness of the approach. Reviewed the two comments during consensus to ensure they are actionable. Worded the OFI b2 comment so that it could be included but does not appear to conflict with the strength. In R2 feedback, Ex7 suggested removing the b2 strength to remove confusion with the OFI. Ultimately retained both.  | b(1) |
|  | The Complaint Management and Service Recovery Process (Figure 3.2-3) is used to capture and manage 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 3.2b(2) based on comments by Ex5, Ex7, Ex2. Supported by Ex8. | b(2) |

#### Notes

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### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | Relationship-building approaches to attract and retain patients, meet requirements, and exceed expectations are not deployed to all patient and stakeholder groups or for all types of health care services and contexts in which they are provided. 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 applicant tailors its approaches to build relationships with different patient segments. Ensuring outreach to patients’ families and all customer segments may help the applicant acquire and retain patients and build its brand. | Comment addresses several aspects of the relationship-building methods 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’s analysis (used to determine segmentation and to identify potential segments to pursue) considers competitors’ patients and other customers. An approach that considers competitors’ customers in determining segmentation may help the applicant address the key competitiveness challenge to compete for and attract patients from all income strata.  | Comment based on comments by Ex3 and Ex4. Only two comments on this, but right on target to support a high score by noting an opportunity for improvement of integration in the systematic SWST. Reworded the relevance statement based on comment by Ex4 during R2 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. Ensuring timely and effective resolution of complaints may help the applicant avoid similar complaints in the future and demonstrate the core value of relationship.  | Started with comment by Ex3 and added aspects of comment by Ex4 and Ex1. Reworded relevance statement based on suggestion by Ex4 in R2 feedback. | b(2) |
|  | A systematic approach to identify and adapt service offerings to meet the requirements and exceed the expectations of patients and other customer groups is not evident. 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.  | Based on feedback comment by Ex3. Other examiners that had elements in support include Ex4, Ex7, Ex5, and Ex8. | a(1) |

#### Notes

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| Need to be sure that the team agrees that the b(1) OFI is not in conflict with the strength.  |

### 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? Did not move the score to the next range due to the gap in the deployment and integration/segmentation of 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.** |
| --- | --- | --- | --- |
|  | Use of the Performance Measurement System (Figure 4.1-1) to evaluate daily operations and overall organizational performance helps the applicant leverage its strategic advantages and address strategic challenges. The customizable FOCUS Scorecard (Figures P.2-3 and 2.1-2) aligns data and information pulled from the electronic health record (EHR) and other systems. Metrics are aligned with the Strategic Planning Process to track progress on achieving strategic objectives and action plans. | Everyone had strength comments about the FOCUS scorecard; one (Ex7) had a double. I agree it’s a strength, but not a double, as it’s simply a commercially available software program, and I don’t see how the applicant uses it in any way that would be role model for other users of the program. All the team members also noted the “Data Docs” as a strength associated with the system—but I decided to give the Data Docs a strength under 4.1a(4) 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 to clarify and correct a figure reference.  | a(1) |
|  | Real-time integration of data into the FOCUS scorecard enables measurement agility, with the ability to update any FOCUS area quickly as needs are identified or circumstances change. The process is facilitated by the “Data Docs,” a cross-location team representing all the Primary Care Teams (PCTs) and functional groups, who can quickly add measures, such as tuberculosis (TB) testing compliance, as needs are identified. This agility may help the applicant provide efficient and effective care. | All team members noted the “Data Docs” as a strength somewhere in 4.1; three team members (Ex2, Ex5, Ex8) noted it in 4.Ia. I decided to put this strength here, based on the example given in this section about adding TB testing. | a(4) |

#### Notes

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| “Below the line” information Although almost all examiners had a strength for 4.1a(2), I wrote an OFI comment on it because most strengths were centered around the fact that the applicant uses comparative data, while the Criteria asks 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 was 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. The following comment was removed based on feedback—so is now “below the line.” “The FOCUS scorecard enables the applicant—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.”  |

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | It is not clear how the applicant systematically tracks progress on achieving action plans and strategic objectives and closes gaps between actual and projected performance or how some measures align with objectives or the vision. For example, some FOCUS data and action plans (Figure 2.1-2) do not include measures or milestones, and projections are “+/=” competitors. In addition, some measures are annual and do not clearly align with objectives (e.g., how immunization rates and screenings will address major health challenges or how grant funding will be secured and used). Alignment and measurement of progress against stated objectives may help the applicant better allocate resources to close gaps and improve the health of its patients. | 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. Most the measures 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 the applicant toward its 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 applicant and a major factor in 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. For example, the use of the Innovation Council (P.1b[2]) is not evident, and it is not clear how the service provider for dialysis is included in the deployment of opportunities for innovation and improvement in the care of the diabetic/obese population. Deploying such priorities to partners and collaborators may help the applicant achieve its vision for the people of western Arizona. | 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) |
|  | How the applicant assesses its performance against that of local competitors is not evident. For example, it is not clear how the state CHC benchmarking consortium or other comparative data resources inform the applicant about local competitors’ performance; nor is it clear how the applicant uses publicly reported data or social media reviews of local, private providers of similar health care services. Understanding its performance relative to local competitors may help the applicant maintain or increase market share and be successful in its tight fiscal environment. | Issues surrounding use of competitive data. Competitive performance is addressed in 4.1b, so I used that for the item reference. | b |
|  | It is not clear how the applicant selects comparative data and information—such as comparative data from non-CHC providers in the local area, including publicly reported metrics. An approach in this area may help the applicant provide residents with high-quality and safe health care service. | The applicant lists the comparative data resources in Figure 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 applicant 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) 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

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| 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, 1 double, which seemed like enough. |

### 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: 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: Some 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, I 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 Knowledge Management Process (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 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 information technology (IT) systems.  | I think double is appropriate, given the importance of the process, and the description is 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 identifies high-performing units and encourage them to share, supporting the workforce engagement drivers of use of skills and abilities and of 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. Revision at Consensus (R4): Discussed the specific OFI that Ex3 saw regarding including best-practice sharing in communications and rejected the idea.  | b(2) |

#### Notes

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| 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 that 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, it still notes that nearly ¼ of customers “don’t have access” to a computer. With the population’s socioeconomic and language barriers, management of knowledge and information may be particularly problematic. | a(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(1) |
|  | Once having identified the best practices of high-performing teams, it is unclear how the applicant selects which of these to disseminate and to which units and contexts to disseminate them, as well as to what extent these new practices are implemented. A systematic approach in this area may help the applicant effectively disseminate and implement best practices as appropriate to its highly diverse locations, personnel, cultures, and languages. | 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), the applicant risks disseminating something with unintended consequences. The “rank ordering” of this OFI and the “a(2)” OFI was changed during consensus.  | b(2) |

#### Notes

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| 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

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| **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 it’s 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 it’s “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. |

## 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 used to recruit and hire a workforce representative of the hiring and patient communities demonstrate the applicant’s core competency of culturally competent, patient-centered care. Staff recruiting is done locally first, supporting the applicant’s communities, and occurs through an employee referral program, scholarship programs, and the Internet. For clinical staff, the applicant collaborates with the National Health Service Corps (NHSC) to provide loan forgiveness and scholarships. Volunteer recruitment occurs through multiple methods, including a “Get Involved” link on the Internet, CCKs, and pamphlets.  | Two examiners recommended a double, and I am recommending this as well. | a(2) |
|  | The applicant’s care delivery structure enables all elements of the workforce (employees, providers, and volunteers) to deliver on the core competency of patient-centered care. Each of 23 Primary Care Teams 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 patients’ needs and promotes active, ongoing partnerships with patients. | Comment was supported by Ex7, Ex4, Ex5, Ex1, Ex2, and Ex8. | a(4) |
|  | Capability and capacity approaches help the applicant mitigate its workforce-related strategic challenges. Capacity needs for the staff and volunteers are systematically identified and defined during the People Review of the SPP, considering patient census and acuity trends as well as identified staffing needs. Competency is assessed around four areas. Strategic objectives aligned with capability and capacity needs are translated into short- and long-term action plans. Defined competencies are embedded in job descriptions, used in the Performance Planning and Evaluation process, and 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 workforce security and wellness approaches, including a “Healthy Living” program 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 members and volunteers, as well as self-insured medical, dental, and vision programs to all staff members working 30 hours or more per week. Policies include a fair living wage, flex time, and job sharing, all of which address the millennial driver of workforce engagement. | This comment was supported by all examiners. | b |

#### Notes

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

### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
|  | A systematic process is not evident for assessing the four competencies identified during the People Review for individuals, work units, or the applicant as a whole; nor is it evident how the applicant identifies competencies of volunteers and physicians. In addition, it is unclear how performance results are considered as part of this determination. Assessment of competencies and deployment of identification approaches to all workforce members who interact with patients may strengthen the applicant’s core competencies of culturally competent, patient-centered care and collaborative relationships. | The a(1) strength is for the identification of the competencies; the OFI, for lack of information that the applicant is assessing them and using this information and for a deployment issue—to volunteers and physicians. Ex1, Ex8, Ex7, Ex2, and Ex5 identified OFIs around this item.  | a(1) |
|  | It is unclear how the applicant systematically evaluates and ensures workforce security and accessibility. Measures are not identified for accessibility, and the measures given do not address possible areas of vulnerability such as exposure to radiation and chemicals, ergonomic injuries, and accidents. By clearly articulating leading indicators of 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, and Ex2. Strong agreement on this comment. | b(1) |

#### Notes

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| 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 it is unclear how workforce is managed to exceed performance expectations. (Considered less important.) Ex3 also had an a(4) OFI stating “unclear how the applicant systematically organizes and manages the workforce 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 regarding how the workforce 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 the applicant addressed the issue.) Ex3 had an a(3) OFI around preparing the workforce 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 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 area—considered less significant.) |

### Scoring

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| **Score Value: 60****Score Range: 50–65%****Why shouldn’t the score be in the range above or below the selected one? Based on comments for this item, I am recommending a score of 65%. We have four strengths—one a double—and two OFIs, so clearly in this scoring range. I put it at the top of the range. The applicant does 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 to the 70–85% range because I didn’t see real examples of innovation or many cycles of improvement.** Deployment gaps for the physician workforce and volunteers caused the score to drop to 60% at consensus. |

## 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** | Systematic identification of drivers of workforce engagement, as well as collection of workforce and volunteer engagement and satisfaction data, address the strategic challenge to hire and retain staff members. 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.  | All examiners had an a(2,3) strength statement. I combined several comments into the above strength comment. | a(2,3) |
|  | A variety of approaches to reward and recognize high performance (Figure 5.2-2) support the applicant’s strategic advantage of a highly engaged workforce. These approaches include gainsharing and the STAR program and are deployed to staff and volunteers. Senior leaders personally recognize employees who contribute to innovation and take intelligent risks to focus on patients and enhance the applicant’s operational performance.  | Ex4, Ex7, Ex5, Ex2, and Ex8 had comments around performance management. I combined comments about performance management and reward and recognition. | a(4) |
|  | Multiple approaches to enable learning and development (Figure 5.2-3) support the 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, such as individual development plans, results of the Oates satisfaction survey, and regulatory changes.  | All examiners had a b(1) comment. I created a consolidated comment capturing the input from all examiners. None suggested a double. | b(1) |
|  | The applicant builds a culture of engagement, communication, and high performance through a variety of systematic approaches (Figure 5.2-1). Examples 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 applicant collaborates with area educational institutions to develop staff and add to community health care resources. The Patient Care Team model emphasizes team performance and empowerment. | All examiners had an a(1) strength. I combined several comments into the strength statement above. | a(1) |

#### Notes

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| There was extremely high consensus among examiners on the strength statements. I used parts of all comment except for 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 applicant’s learning and development approaches help develop managers and leaders to encourage innovation and change and enable staff at all levels to remain current with technological and health care system changes. Such a focus may help ensure the applicant’s ability to address its strategic challenge of 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 applicant’s Performance Planning and Feedback Process reinforces intelligent risk taking and innovation and a focus on patients and other customers; nor is it clear how it is integrated with the applicant’s Performance Improvement Framework (PIF) and performance measures. By integrating these elements into performance management, the applicant 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

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| While there was strong agreement among examiners on 5.2 strengths, this was not the case with OFIs. 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

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| **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 2 OFIs (a third OFI about drivers of engagement was deleted). We selected a score at the higher end of this range,** in recognition of systematic approaches with good deployment. What keeps the score out of the higher range are some gaps in deployment, less evidence of multiple cycles of learning and innovation, and some areas lacking integration (e.g., adapting training to rapid technology changes and a changing health care environment).  |

## 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 its 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. 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, considered 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, voice-of-the-customer (VOC) listening posts, evidence-based practice, 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 Institute of Medicine’s (IOM) six aims of care. | Cited in one way or another by all (Ex5, Ex7, Ex4, Ex8, Ex3, Ex1, and Ex2). There was little change in this as consensus progressed. | a |

#### Notes

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| Did not use.... one cited strength of the Innovation Management Process as it conflicted with some OFIs. One cited strength about key business and support processes demonstrating the value of partnership and core competency of collaborative relationships because 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 is 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 manage 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 in 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 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 health care 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

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

### 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?** 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 its partner DDS review, standardize, and integrate hardware, software, and clinical devices across a single enterprise-wide system architecture to ensure the 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 and workforce safety training. 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 emergency operations plan (EOP) ensures the continuous 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 be continuously 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. Additionally, how safety is evaluated other than by assessing actual safety events is unclear. 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 the 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, are 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 a 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 are defined. It is important, but does it rise to the level of significance? The metrics given are 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.** |

## 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 screenings and vaccinations, 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, as well as 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 by the applicant 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. | Most 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), as well as 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 a 2015 Baldrige Award recipient 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.** |
| --- | --- | --- | --- |
|  | 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.” | The lack of segmentation for the Hispanic population was raised by one examiner and the larger group agreed that the lack of cultural competence approaches, metrics, and outcomes to the overall cultural groups served by this organization is significant. | a |
|  | 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 its leaders demonstrate the organization’s value of accountability. | Missing results. | 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 it 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

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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?** Independent review scores ranged from 55**%** to 65**%**; this item dropped 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.**  |

## 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—such as aggregate patient satisfaction, satisfaction with medical services, and satisfaction with dental services (Figures 7.2-1 through 7.2-3)—have equaled or exceeded the top-decile level since 2013. These results reflect the applicant’s positive competitive position and support its 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. | Comment based on Ex7’s comment. All had comments related to excellent levels and trends for 7.2-1. Two examiners had it as a double strength. Added relevance statement based on R2 feedback by Ex3.  | a(1) |
|  | Good-to-excellent levels and beneficial trends for most results for patient and other customer satisfaction with services may enable the applicant to maintain and grow its market share. Patient and family satisfaction with dental services, school services, mobile van, and support services (Figures 7.2-3, 7.2-5, and 7.2-7), as well as patient and community satisfaction related to key requirements (Figures 7.2-6 and 7.2-8), has improved over the periods shown. Payor satisfaction results (Figure 7.2-10) exceeded those of the state-best CHC from 2012 to 2016.  | Comment on Figures 7.2-3 through 7.2-5, 7.2-6 through 7.2-8 and 7.2-10. Comment based on Ex5, Ex7, Ex3, and Ex8 had positive comments that included these figures. Ex2 supported comment on Figure 7.2-8. Ex5 and Ex8 had a double strength. Could consider a double strength during the consensus discussion.  | a(1) |
|  | Measures of customer engagement all show beneficial trends and favorable comparisons. For example, patients who indicated they would recommend the applicant, those who did recommend it, and Facebook likes (Figures 7.2-15, 7.2-16, and 7.2-18) all show beneficial trends, with the two former levels outperforming available benchmarks. In the community’s perception of which CHC provides the best care, the applicant has been named by more than 90% of respondents over four years, better than the state-best CHC (Figure 7.2-17).  | Willingness-to-recommend questions are aggregates for engagement. Comment on customer engagement based on comment by Ex8 and supported by comment by Ex2. Added figure number for community perception based on feedback from Ex3 in R2. | a(2) |
|  | Dissatisfaction results support the applicant’s performance value to embrace improvement. Increasingly lower percentages of patient/family members indicate that they strongly disagree regarding the quality of the applicant’s services (Figure 7.2-11), with levels well below the Packer lowest decile. In addition, results for aggregate complaint severity (Figure 7.2-12) show good levels and a beneficial trend from 2014 to 2016, and results on the applicant’s complaints versus compliments (Figure 7.2-14) show a beneficial trend from 2012 to 2016. | Comment on Figures 7.2-11, 7.2-12, and 7.2-14 based on comment by Ex3. Supported by comment by Ex8 levels and trends for Figures 7.2-11, 7.2-12, and 7.2-14 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 does not report comparisons to local or regional competitors for many patient and other customer satisfaction results (e.g., aggregate patient satisfaction, satisfaction with medical services, dental services, school services, mobile van services, and support services and key requirements; Figures 7.2-1 through 7.2-7). Comparing these results with those of competitors may enable the applicant to identify areas in which it might more effectively compete for patients.  | Comment on local comparisons based on comment by Ex5 and supported by Ex8 and Ex2. Ex4 suggested bold in her backup feedback. If needed, will discuss at consensus.  | a(1) |
|  | Results are missing for the success of the patient acquisition and retention mechanisms presented in Figure 3.2-2. Given 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 such results may help the applicant 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 R2 feedback.  | a(2) |
|  | Patient/family satisfaction with services such as pharmacy, laboratory, and behavioral health, as well as satisfaction with partners, are not segmented by product offerings, customer groups, or market segments. Analysis by segment may uncover strengths and opportunities for improvement that remain hidden in aggregate results.  | 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 applicant reports annual measures from 2012 to 2016 for patient/family satisfaction with the applicant’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 applicant’s quarterly measures of patients’ satisfaction with the 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 a(1). At consensus, this may move to the lower range if great weight is given to the OFIs and if any of the OFIs are considered for a double.** **Lowered score to 50% based on comments by Ex3, Ex4, and 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** | Engagement and satisfaction results that outperform the Oates top decile support the applicant’s strategic advantage of a highly engaged workforce. Examples are millennial and nonmillennial staff engagement results (Figure 7.3-13), with both groups around 95% in 2016; satisfaction with key engagement drivers and the meeting of key requirements (Figures 7.3-14 and 7.3-15); physician satisfaction (Figure 7.3-16); and volunteer satisfaction (Figure 7.3-17), with the latter approaching 100% from 2012 to 2016. | Two examiners recommended a double (Ex5 and Ex8), but I chose to keep this as a single.The comment was doubled at consensus. | a(3) |
|  | Turnover results (Turnover by Employee Group, Turnover Rate for Employees <1-year Tenure, and Vacancy Rate (Figures 7.3-1 through 7.3-3) demonstrate beneficial trends from 2012 to 2016, with levels for all groups at or better than the state-best CHC levels. These results demonstrate the 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) |
|  | Some workforce climate results show beneficial trends and favorable performance against benchmarks. For example, Gainsharing Payout (Figure 7.3-9) has increased each year since 2012, and use of thank-you notes (Figure 7.3-12) increased from approximately 600 in 2012 to about 800 in 2016. STAR Recognition (Figure 7.3-11) results significantly outperform the state-best CHC benchmark. These results support the applicant’s value to respect every individual. | This strength was referenced by Ex5, Ex3, and 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. Only one examiner 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 related to the applicant’s strategic challenge of staff recruitment and retention. For example, results are not provided for recruitment of health care professions and physicians; for some drivers of workforce engagement, including comfort with reporting errors or unsafe acts, protection from health and safety hazards, and a flexible work schedule; and for measures of workforce safety. In addition, beyond proficiency results and satisfaction with training, results for training effectiveness are not provided. | 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(1,2,4) |
| **X** | Most workforce results are not segmented by groups indicated as important to the applicant. For example, other than Staff Engagement (Figure 7.3-13), results are not segmented by millennial and nonmillennial employees, and other than Physician Satisfaction (Figure 7.3-16), results are not provided for physicians. Without segmentation of workforce results, such as capability and capacity results, the applicant may be unable to identify areas for improvement. | Segmentation. I attempted to write an OFI that captured examples from various comments. | a |
|  | For workforce results, the applicant does not provide comparisons to direct competitors, such as community-based private medical, dental, and behavior health providers. Capturing such comparisons may help the applicant identify opportunities to better leverage its strategic advantages of utilization and strategic partnerships to increase its 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 the 50–65% scoring range based upon the balance of comments. Based on 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 too much 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, results for clinical and administrative employees’ satisfaction with senior leader communication (Figure 7.4-1) show beneficial trends and levels beyond the top decile; in addition, 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(1,2) |
|  | 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 Applicant’s 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 it 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 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, 2,5) |
|  | 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 applicant 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 7.4-9) 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.**  |

## 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 its tricounty community, the applicant’s financial results show beneficial trends for actual expenses, revenues, and net collections from 2012 to 2016 (Figure 7.5-1). Total revenues consistently meet the level of the state-best CHC. In addition, expenses and collections (51% of total revenue) increased from $20 million in 2012 to $25 million in 2016. Furthermore, results for accounts receivable (Figure 7.5-2) improved from 2014 to 2016, with levels for Medicare and self-pay meeting 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) |
|  | The applicant’s market share (Figure 7.5-5) increased from 2012 to 2016: in Y county, from 21% to 23%; in M county, from 11% to 12%; and in LP county, from 19% to 22%. These results support the applicant’s mission to provide access to health care services to the populations of its tricounty service area regardless of residents’ ability to pay. | a(2) Strength for the applicant’s marketplace performance results. One examiner (Ex7) noted a(2) results as a double. | a(2) |

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### Opportunities for Improvement

| **--** | **Opportunity for Improvement** | **Rationale** | **Item Ref.** |
| --- | --- | --- | --- |
| **X** | Results are missing or limited for operating margin, fundraising revenues, cost control, and ACA impact. Such financial and market performance measures may help leaders address changes in the financial environment, including the strategic challenge 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 are not presented for market share by county or by service line, and for budget performance to projections. | a |
| **X** | Results for market share by service (Figure 7.5-6) show low market share for dental services (15%) and chronic disease (10%) from 2012 to 2016. Such results may indicate a missed opportunity to establish and manage mechanisms to provide specialty care and meet service needs in the tricounty area. | 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 applicant’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 such results may limit the applicant in making evidence-based decisions about partnerships that enhance its 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 financial results lack segmentation by service areas and services provided. For example, results for return on assets in clinical units (Figure 7.5-4) are not segmented by county, services offered, or type of clinic. In addition, results for dental, medical, and behavioral health services are not segmented by market, patient group, or other customer group. Without such segmentation, the applicant may be limited in its ability to assess the return on assets per county/community served and relative value units provided by each clinical facility. | Three examiners (Ex7, Ex2, Ex8) noted an a(1) OFI for lack of segmentation. CONSENSUS: Deleted reference to CCK in first sentence. | a(1) |

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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, beneficial trends, and favorable CHC comparisons are provided for many of the results 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 | 55% | 22 |  |
| 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 |  | 300 | 4 (261-320 pts) |
| Category 7—Results |
| 7.1 Health Care and Process Results | 120 | 50% | 60 |  |
| 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 |  | 208 | 3 (171-210 pts) |
| GRAND TOTAL | 1000 | TOTAL SCORE | 508 |  |

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