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# Arroyo Fresco Community Health Center Feedback Report

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The Arroyo Fresco Community Health Center Feedback Report was prepared for use in the 2006 Malcolm Baldrige National Quality Award Examiner Preparation Course. A consensus team of experienced Baldrige Examiners evaluated the Arroyo Fresco Community Health Center Case Study, using the Stage 2, Consensus Review Process. The case study describes a fictitious nonprofit organization in the health care sector. There is no connection between the fictitious Arroyo Fresco and any other organization, either named Arroyo Fresco Community Health Center or otherwise. Other organizations cited in the case study also are fictitious, except for several national and government organizations. Because the case study is developed to train Baldrige Examiners and others and to provide an example of the possible content of a Baldrige application, there are areas in the case study where Criteria requirements are not addressed.

Arroyo Fresco Community Health Center scored in band 5, showing that the organization demonstrates effective, systematic, well-deployed approaches responsive to the overall requirements of the Items. The organization demonstrates a fact-based, systematic evaluation and improvement process and organizational learning that result in improving the effectiveness and efficiency of key processes. Results address most key customer/stakeholder, market, and process requirements, and they demonstrate areas of strength against relevant comparisons and/or benchmarks. Improvement trends and/or good performance are reported for most areas of importance to the organization's key requirements.

October 25, 2006

Mr. Ramon Gonzalez  
CEO  
Arroyo Fresco Community Health Center  
1345 Desert Bloom Avenue  
Yuma, AZ 85364

Dear Mr. Gonzalez:

Congratulations for taking the Baldrige challenge! We commend you for your commitment to performance excellence and applying for the Malcolm Baldrige National Quality Award.

This feedback report was prepared for your organization by members of the Board of Examiners in response to your application for the 2006 Malcolm Baldrige National Quality Award. It presents an outline of the scoring for your organization and describes areas identified as strengths and opportunities for improvement. The report contains the Examiners' observations about your organization, although it is not intended to prescribe a specific course of action. Please refer to the enclosed "Preparing to Read Your Feedback Report" for further details about how to use the information contained in your feedback report.

We are eager to ensure that the comments in the report are clear to you so you can incorporate the feedback into your planning process to continue to improve your organization. As direct communication between Examiners and applicants is not allowed, please contact me at (301) 975-2360 if you wish to clarify the meaning of any comment in your report. We will contact the Examiners for clarification and convey their intentions to you.

The feedback report is not your only source for ideas about organizational improvement. Current and previous Award recipients can be potential resources on your continuing journey to performance excellence. An Award recipients contact list is enclosed. The 2006 recipients will share their stories at our annual Quest for Excellence Conference, April 15–18, 2007. Current and previous recipients participate in our regional conferences as well. Information about these events and other Baldrige Program-related activities can be found on our Web site at [www.baldrige.nist.gov](http://www.baldrige.nist.gov).

In approximately 30 days, you will receive a customer satisfaction survey from the Panel of Judges. As an applicant, you are uniquely qualified to provide an effective evaluation of the materials and processes that we use in administering the Award Program. Please help us continue to improve the program by completing this survey.

Thank you for your participation in the Baldrige Award process. Best wishes for continued success with your performance excellence journey.

Sincerely,

Harry S. Hertz, Director  
Baldrige National Quality Program

Enclosures

## Preparing to read your feedback report . . .

*Your feedback report contains Baldrige Examiners' observations that are based on their understanding of your organization. The Examiner Team has provided comments on your organization's strengths and opportunities for improvement relative to the Baldrige Criteria. The feedback is nonprescriptive. It will tell you where Examiners think you have strengths to celebrate and where they think improvement opportunities exist. The feedback will not say specifically how you should address these opportunities. The specifics will depend on what you decide is most important to your organization.*

*Applicant organizations read and use feedback comments in different ways. We've gathered some tips and practices from prior applicants for you to consider:*

- Take a deep breath and approach your Baldrige feedback with an open mind. You applied to get the feedback. Read it, take time to digest it, and read it again.
- Especially note comments in **boldface type**. These comments indicate particularly important observations—those the Examiner Team felt had substantial impact on your organization's performance practices, capabilities, or results (either a strength or opportunity for improvement) and, therefore, had more influence on the team's scoring of that particular Item.
- You know your organization better than the Examiners know it. There might be relevant information that was not communicated to them or that they did not fully understand. Therefore, not all of their comments may be equally accurate.
- Although we strive for “perfection,” we do not achieve it in every comment. If Examiners have misread your application or misunderstood your organization on a particular point, don't discount the whole feedback report. Consider the other comments and focus on the most important ones.
- Celebrate your strengths. You've worked hard and should congratulate yourselves.
- Use your strength comments to understand what the Examiners observed you do well and build upon them. Continue to evaluate and improve the things you do well. Sharing those things you do well with the rest of your organization can speed organizational learning.
- Prioritize your opportunities for improvement. You can't do everything at once. Think about what's most important for your organization at this time and decide which things to work on first.
- You may decide to address all, some, or none of the opportunities in a particular Item. It depends on how important you think that Item or comment is to your organization.
- Use the feedback as input to your strategic planning process. Focus on the strengths and opportunities for improvement that have an impact on your strategic goals and objectives.

## KEY THEMES

Arroyo Fresco Community Health Center (AF) scored in band 5 in the consensus review of written applications for the Malcolm Baldrige National Quality Award. For an explanation of the scoring bands, please refer to Figure 6, “2006 Scoring Band Descriptors.”

An organization in band 5 typically demonstrates effective, systematic, well-deployed approaches responsive to the overall requirements of the Items. The organization demonstrates a fact-based, systematic evaluation and improvement process and organizational learning that result in improving the effectiveness and efficiency of key processes. Results address most key customer/stakeholder, market, and process requirements, and they demonstrate areas of strength against relevant comparisons and/or benchmarks. Improvement trends and/or good performance are reported for most areas of importance to the organization’s key requirements.

**a. The most important strengths or outstanding practices (of potential value to other organizations) are as follows:**

- AF’s senior leaders create a focus on results and creating value through the development of the FOCUS (Financial Performance, Organizational Learning, Clinical Excellence, Utilization, and Satisfaction) framework (Figure 2.1-2), which allows the organization to address key strategic challenges and align its efforts on key 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 AF’s strategic objectives through the FOCUS framework. This linkage helps to ensure sustainability, creating an environment of process improvement, learning and innovation, and organizational agility. The automated FOCUS scorecard (Figure 2.2-1), which tracks overall organizational performance, reflects progress toward AF’s strategic objectives and is reviewed by senior leadership, clinic leadership, Clinical Microsystems (CMs), functional groups, and staff members. Practice profiles and scorecards are used to monitor performance and continually improve services and outcomes. CMs and functional work groups provide the framework for promoting cooperation, initiative, empowerment, and culture. These teams share responsibility for goals that are aligned with the FOCUS areas of the strategic plan. This well-deployed approach provides organizational alignment and integrates needs identified in the Strategic Planning Process into the performance measurement system.
- The Chief Executive Officer (CEO) and the leadership team review and reaffirm AF’s vision, mission, and values (VMV) as part of the annual Strategic Planning Process. The VMV are embedded in the Arroyo Fresco Leadership System (Figure 1.1-1) and deployed to all staff members, patients, partners, suppliers, board members, and communities served through the communication methods listed in Figure 1.1-2. AF’s values are prominently displayed in all locations, on its Internet site, and on all

printed materials provided to patients and their families. All displays are presented in English and Spanish. Each quarter, a senior leader champions one of the values, develops a plan for demonstrating that value in the organization's major activities, and discusses the value at the quarterly all-staff meetings. AF supports the VMV through the widespread use of the Baldrige framework, the OASIS Improvement Model, and the balanced measures in the FOCUS scorecard.

- AF demonstrates patient-focused excellence through its mature and well-deployed patient and other customer relationship approaches. These include the development of the CM health care delivery model and the use of multiple approaches to listen and learn from patients. The approaches include the Patient-Family Advisory Boards, the Elders Council, and the Care Connection Kiosk (CCK); the creation of patient-specific Personal Health Plans (PHPs), which are reviewed by caregivers prior to visits; automated prompts for screening and interventions designed into information technologies; and the use of volunteer educators and “health coaches” to support patients and build relationships. The Partners Committee meets with senior leaders four times per year to discuss current and future needs and opportunities for improving relationships, and CMs organize care around patient needs and promote active ongoing partnerships between patients and providers. This approach is effective in managing chronic disease and promoting health literacy and self-management skills. The depth and breadth of AF's activities is especially noteworthy given the strategic challenges associated with enhancing customer and community relations and providing preventive health services.
- AF creates an environment for organizational and staff learning through the creation of an annual workforce development plan that serves as a key input to the Strategic Planning Process and drives the development of the organization's annual training and education plan. Other means used to develop and maintain a learning environment include the use of the Plan, Do, Check, Act (PDCA) process and OASIS design and improvement models. The models include systematic benchmarking and identification of best practices, the development of annual Individual Development Plans (IDPs) for all staff and volunteers, and the offer of multiple educational benefits, such as Work to Learn, tuition reimbursement, and scholarships for staff and their children. In addition, AF participates in multiple national, state, and local associations to gather and share best practices and learning.
- AF utilizes innovative approaches to the management of information and knowledge. These include its interactive CCKs, electronic health record (EHR) system, Web-based PHPs, the online *Staff and Volunteer Handbook*, and computer access for all staff members that includes staff PDAs (personal digital assistants) and the tablet computers used in mobile vans. Annually, AF's cross-location/organization Info Interns team conducts an annual survey as well as focus groups with users throughout the organization. The team also researches internal and external best practices to provide input into the Strategic Planning Process. System availability in the event of

an emergency is ensured through multiple redundancies and mirror servers as well as backup power supplies. AF's emphasis on measurement, analysis, and knowledge management is aligned with and supports its key organizational processes.

**b. The most significant opportunities, concerns, or vulnerabilities are as follows:**

- While AF states that agility is achieved through senior leaders working other staff members' jobs once per quarter and that the Clinical Excellence section of the FOCUS framework addresses the organization's ability to adapt to rapid changes in the clinical environment, it is not evident how these actions create a systematic approach to ensure that the organization is capable of rapid change and flexibility. Further, it is not clear how AF's CM, PDCA, and OASIS models ensure the systematic integration of agility into its work systems or the design and improvement of its key processes. AF may find it difficult to determine how its business and support process designs incorporate new technology and other effectiveness and efficiency factors.
- Although AF focuses on several key strategic challenges through its Strategic Planning Process, action plan deployment, and performance reviews, there is little evidence of approaches to address other key challenges, success factors, changes, and customer/market segments. These include identifying additional sources of revenue, competing for key staff, and meeting the unique needs of certain populations (i.e., Native Americans, veterans, and patients from all income strata). Without systematic approaches to articulate and address all the important factors, challenges, and segments described in the Organizational Profile, it may be difficult for AF to ensure that it creates and balances value for all patients, customers, and stakeholders.
- Although AF identifies communication methods for its key supplier and partner groups, the approaches used to systematically listen and build relationships, create alignment, and facilitate involvement in innovation and improvement activities with others, such as community partners, strategic partners, and vendor partners, are not discussed. Without these approaches, it may be difficult for AF to determine how it will establish requirements for system availability, cost savings, and return on assets with the remainder of its partner groups. Overall, information on the involvement and incorporation of all key suppliers and partners into decision making, including strategic planning (other than the Partners Committee), is absent.

**c. Considering AF's key business/organization factors, the most significant strengths, opportunities, vulnerabilities, and/or gaps (related to data, comparisons, linkages) found in its response to Results Items are as follows:**

- AF presents favorable performance levels and trends against relevant comparisons in a number of key results areas. Some measures of clinical outcomes show favorable trends for the past four to five years, with levels that approach, are equal to, or

surpass the state and/or national comparisons. These outcomes include obesity (Figure 7.1-1a), screening for smoking (Figure 7.1-1b), screening for breast cancer (Figure 7.1-3a), screening for colon cancer (Figure 7.1-3c), and the provision of influenza and pneumococcal immunizations (Figures 7.1-4a and 7.14b). Key financial and market outcomes, such as growth in and total value of AF Foundation funding (Figure 7.3-6), demonstrate improving performance in donations, capital appreciation, and total value from 2002 to 2005. Total value has increased from approximately \$2 million in 2002 to more than \$4 million in 2005. This performance may be particularly noteworthy given AF's strategic funding challenge. Performance in market share by county (Figure 7.3-7) and market share by service (Figure 7.3-8) show improvements from 2002 to 2005 in all segments reported. AF's overall market share (Figure 7.3-7) increased from approximately 14% in 2002 to approximately 17% in 2005. Key human resource results (expressed in the staff turnover data presented in Figures 7.4-9a and 7.4-9b) and key organizational effectiveness results (Figures 7.5-8 and 7.5-9) illustrate strong performance in areas critical to AF. Performance levels from 2002 to 2005 are at or better than the state-best comparisons.

- Results in some areas of importance to AF's strategy and requirements that are identified in Figure P.1-5 are not provided. These include results associated with patient/customer-perceived value, such as loyalty and retention, and building relationships. Results also are lacking for work system performance and effectiveness, specifically budget, cost-control, and productivity and efficiency measures for key health care, business, and support processes. Results for supplier and partner performance for key health care processes and other key processes are not given.
- Most results have comparisons to state-best, top quartile, or top decile performance levels, providing AF with an understanding of its strengths and gaps/opportunities for improvement. This information helps AF determine its progress toward achieving its vision: "the people of western Arizona will become the healthiest in the state." However, while comparative data are provided, competitor data from community-based private medical/dental/behavioral health providers are not given. The lack of competitor data may limit AF's ability to assess its market performance and identify potential areas for growth and revenue capture.
- Results for some key measures are not segmented beyond county or job group levels. These include results segmented by key customer, partner, and stakeholder groups; CM teams; and diversity factors related to staff members and volunteers (Figures 7.6-3, 7.6-4, 7.6-6, and 7.6-7). Without these data, it may be difficult for AF to assess performance levels and trends across different patient, customer, and staff segments; this information may help to drive effective decision making toward strategic goals.
- AF has seven "employer of choice" dimensions (in particular, "positive team relationships") that form the basis of the Staff Satisfaction Survey (Figure 5.3-2).

Trends are positive from 2000 to 2005 for staff satisfaction with key performance dimensions (Figures 7.4-2a and 7.4-2b) in both CM and non-CM work groups as well as for staff satisfaction by county and job group (Figures 7.4-6a and 7.4-6b). These results demonstrate positive trends since 2000, with performance levels meeting or exceeding 80% satisfied or very satisfied for all counties and job groups in 2005. Since 2002, AF also shows improving performance for its training completion rates for both staff and volunteers (Figures 7.4-3a and 7.4-3b), with several core training rates at 100% in 2005. Performance results for staff turnover by job group and by county (Figures 7.4-9a and 7.4-9b) demonstrate improvement trends in all groups and counties from 2000 to 2005, with all job groups meeting or exceeding the state-best CHC levels of approximately 8%.

## DETAILS OF STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

### Category 1 Leadership

#### 1.1 Senior Leadership

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- Senior leaders set organizational VMV as a component of the Strategic Planning Process and, using multiple communication methods, deploy them through the leadership system (Figures 1.1-1 and 1.1-2). Senior leaders’ personal actions reflect their commitment to AF’s values by taking turns championing one of the organization’s values each quarter.
- Senior leaders promote an environment that fosters and requires legal and ethical behavior through a variety of mechanisms. These include an annual overview of legal and ethical obligations for all staff, board members, and volunteers; additional online training courses specifically tailored for certain work areas; and a Code of Ethical Conduct statement signed annually. Information also is made available to staff and volunteers through an online handbook. Questions are encouraged in general and are a component of the Daily Huddle. The commitment to legal and ethical behavior is deployed to partners and suppliers by incorporating a Commitment to Ethical Conduct into signed contracts.
- Senior leaders create a sustainable organization through incorporating a sustainability assessment as a component of the Strategic Planning Process. Sustainability, as well as performance improvement, accomplishment of strategic objectives, innovation, and organizational agility, is supported through the FOCUS framework. To help identify and remove organizational barriers to performance, senior leaders engage in quarterly “front-line rotations.”
- Senior leaders communicate with staff throughout the organization using multiple mechanisms, including the intranet, Daily Huddles, staff meetings, walk-arounds, newsletters, and bulletin boards. Staff members and volunteers are featured as STARS (Superior Teamwork Achieves Results), recognized by a letter of appreciation from the leadership, provided with a food gift for the person’s work group or a small pin, and may receive small token rewards that are linked to specific behaviors in order to reinforce high performance.
- Senior leaders create a focus on action to accomplish AF’s objectives, improve performance, and attain their vision through a variety of performance metrics based on the FOCUS scorecard. These include trend charts, control charts, and the ability to drill down to a specific clinic, CM, group, payor, provider, and /or team. Metrics are

communicated and deployed through cross-functional teams referred to as Data Docs. The senior leadership team reviews and approves all key organizational performance indicators that will be part of the scorecard. The OASIS Improvement Model is utilized to improve performance and accomplish the organization's objectives.

#### OPPORTUNITIES FOR IMPROVEMENT

- It is not clear how the approaches identified in Figure 1.1-2 ensure full deployment of the VMV through the leadership system to all stakeholders, particularly to patients, other customers, and suppliers.
- Although there is a process to promote organizational sustainability, how senior leaders personally participate in succession planning and the development of future organizational leaders is not evident.
- Senior leaders do not appear to have systematic approaches to empower and motivate all staff and volunteers, or to encourage frank two-way communication (Figure 1.1-2). Beyond the STARS program and recognition letters, it is not clear how senior leaders take active roles in staff reward and recognition activities to reinforce high performance and a focus on the organization, as well as on patients and other customers.

## 1.2 Governance and Social Responsibilities

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- The Board of Directors utilizes a six-committee structure to address key governance factors. Annual reviews of the CEO’s performance, regularly scheduled reports of financial and quality performance, and other audits create board-level accountability for management’s actions. The board regularly reviews budgets, financial reports, and capital expenditures on established time frames to ensure fiscal accountability. Results of independent external audits are presented to the board and published in the Annual Report. Although exempt from the Sarbanes-Oxley Act, board members and senior leaders participate in formal training, annually disclose conflicts of interest, and sign the Code of Ethical Conduct to promote transparency in operations and protect stakeholder interests.
- Board members perform annual self-assessments utilizing the Stewart-Hagen model. The individual performance of senior leaders is reviewed using a 360-degree review process. Annual survey results and performance indicators for the system are also used for assessment. Senior leaders and the board use the OASIS model to develop action plans based on these performance reviews to improve both their personal leadership effectiveness and the leadership system.
- AF utilizes a Failure Modes and Effects Analysis (FMEA), facilitated by a subteam involved in the Strategic Planning Process, to identify and address any adverse impacts on society of health care services and operations. Examples are provided of needle-stick prevention, background screening, and additional lighting/escort service to promote safety.
- AF identifies its key compliance processes, measures, and goals in Figure 1.2-2, including fiduciary responsibility, accreditation, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance, licensure, safety, and others. Key processes, measures, and goals for addressing risks associated with health care services and other organizational operations are listed in Figure 1.2-3 and include patient safety and waste management. Goals are set to achieve and surpass regulatory, legal, and accreditation requirements.
- AF identifies and validates the key communities it serves through the Strategic Planning Process; the key communities are currently identified based on geographic proximity and defined as the three counties the organization serves. Figure 1.2-5 lists the methods (grouped by support for the body, spirit, and mind) AF utilizes to actively support and strengthen its key communities. Examples of these methods include assistance with food,

housing, recreation, and service on boards. The multidisciplinary Caring Community subteam uses a Pugh matrix to evaluate and prioritize opportunities based on the VMV and strategic objectives. Employees are provided with three paid days to support identified initiatives.

## OPPORTUNITIES FOR IMPROVEMENT

- Although board members are representative of AF’s stakeholders, it is not clear that there is a systematic, transparent approach for board member identification and selection. Without a systematic, transparent approach, AF may not be fully demonstrating its value of trust and building confidence in its integrity by everything it does.
- Although Figure 1.2-2 lists requirements for AF, along with key processes, measures, and goals, it is not clear that the specific federal requirements noted as key for AF to qualify for Section 330 grant funds as a federally qualified health center (FQHC) are recognized and addressed.
- Although Figure 1.2-4 notes training, monitoring, and investigation processes related to ethical behavior, and the “no blame” environment for identification of problems is coupled with “zero tolerance” for breaches of ethical behavior, it is not clear how these processes (including interactions with patients and other customers to promote and ensure ethical behavior in all interactions) are deployed throughout the organization.
- Although participation and hours are tracked for the identified activities in Figure 1.2-5 that may support the key communities of the organization, it is not clear that the activities listed represent systematic approaches to building community health.

## Category 2 Strategic Planning

### 2.1 Strategy Development

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- Strategic planning is conducted by cross-location teams, members of the Board of Directors, various staff members, and senior leaders who utilize the approach and key steps outlined in Figure 2.1-1. Input from each of AF’s key stakeholder groups, including patients and their families, physicians (both AF’s and private-practice providers), volunteers, representatives from health care and education partners, business partners, and community representatives, is considered in the process. AF’s short-term planning horizon is one year and its longer-term planning horizon is five years, which is aligned with the State Association of CHCs’s strategic planning process. AF uses its OASIS Improvement Model to assess and improve its Strategic Planning Process and provides several examples of improvements based on the use of this model.
- AF uses its Partners Committee to help address blind spots in its Strategic Planning Process. The committee conducts scenario planning, provides an external view of AF’s plans and strategies, and provides perspectives and concepts from outside of the health care industry in support of the Strategic Planning Process.
- AF uses a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, and the results of the analysis are included in the Strategic Planning Process. In addition, it uses a resource-based approach and a series of questions to determine its ability to execute its strategic plan.
- AF presents its key strategic objectives and the timetable for accomplishing them in Figure 2.1-2. It identifies the strategic challenges associated with its strategic objectives.
- To ensure that its strategic objectives balance the needs of all patients, other key customers, and stakeholders, AF uses the Pugh matrix and the FOCUS framework to set priorities.

#### OPPORTUNITIES FOR IMPROVEMENT

- Although AF’s leadership team members are responsible for specific areas of information for the Strategic Planning Process, apart from the Partners Committee and the Info Interns, it is not clear how the information is gathered and analyzed to ensure that it can be used effectively in the process.

- Although AF presents its key strategic objectives and the timetable for accomplishing them in Figure 2.1-2 and performance projections for its action plans in Figure 2.2-1, it is not clear which objectives or goals are most important to the accomplishment of the strategic objectives. Without prioritizing these goals, it may be difficult for AF to ensure that it applies its limited improvement resources to those that are most important.
- Although AF presents its key strategic objectives and their related strategic challenges in Figure 2.1-2, it is not clear how the objectives actually address the strategic challenges identified in its Organizational Profile. For example, it is not clear how AF's strategic objectives address the financial performance strategic challenge (Figure P.2-3) of finding new revenue sources.

## 2.2 Strategy Deployment

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF’s senior leadership team and local clinic managers develop detailed action plans at four levels of the organization: organization-wide, county, point of care, and individual staff member. Plans are deployed to each unit using a “catchball” approach, starting with the involvement of all senior managers in the Strategic Planning Process and cascading to the development of 90-day plans and Individual Development Plans (IDPs). Resources for the action plans are allocated through the budgeting process and validated through the Pugh matrix.
- AF uses regular review meetings to monitor progress of its action plans and assigns a manager as the “single point of responsibility” if a plan requires modification. The manager makes the necessary modifications, and the new plan is implemented following senior manager/leadership team review and approval.
- AF identifies the key measures and indicators associated with the accomplishment of its action plans (Figure 2.2-1). For example, for the action plan “provide current staff the time and resources to expand their skills,” the associated sample measure is the staff proficiency rate.
- AF identifies performance projections for the key measures and indicators associated with the accomplishment of its action plans. Its short- and longer-term projections compare favorably with ten of twelve of its shorter-term “best” comparisons and all of its longer-term “best” comparisons (Figure 2.2-2).

### OPPORTUNITIES FOR IMPROVEMENT

- Although AF assigns a “single point of responsibility” for modifying action plans when required, it is not clear how it supports rapid execution of new plans, especially considering its semiannual review and various approval approaches. Further, it is not clear how AF ensures that any key changes resulting from its action plans can be sustained.
- Although AF presents “Representative Examples” of its FOCUS actions plans in Figure 2.2-1, it is not clear which of these action plans are its key short- and longer-term action plans. Without identifying its key action plans for both the short and longer terms, AF may have difficulty ensuring that it applies its limited resources to its most important action plans.

- Although AF presents one example of a human resource plan derived from its action plans, it is not clear what are the key human resource plans that derive from its short- and longer-term strategic objectives and action plans.
- While a number of leaders and staff are involved in the strategic and action plan development process, it is not clear how their involvement ensures that the action plan measurement system reinforces organizational alignment or addresses all key stakeholders.

### Category 3 Focus on Patients, Other Customers, and Markets

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

Your score in this Criteria Item for the consensus stage is in the 70–85 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

##### STRENGTHS

- Customer groups are systematically identified annually as part of the Strategic Planning Process using AF’s VMV as a focus. By analyzing demographic data from multiple sources, the cross-location Service With Spirit Team (SWST) is able to identify the gaps, look at disparities, and identify potential customers. Deployment of this process through multiple cycles has resulted in the development of several services designed to meet the unmet needs of customers in AF’s service area.
- **AF uses multiple methods to listen and learn about the requirements for multiple stakeholders (Figure 3.1-1). Representatives from each of AF’s facilities meet quarterly with an eight-member Patient-Family Advisory Board in order to obtain feedback on services that are currently delivered, as well as to participate on the design and improvement teams to ensure that patient and family perspectives are incorporated. Feedback is captured using a consistent reporting template across all AF facilities.**
- **AF uses portable, multi-use CCKs across the three-county area to identify community needs, disseminate health information, gather ideas and feedback, and provide enrolled patients with access to their own PHPs and other information. Realizing that CCK utilization among elderly clinic enrollees was low, AF began hosting a monthly evening social hour called Second Time Around, which serves a similar function to the CCKs but in a manner that is more comfortable and personable for elderly patients.**
- AF obtains information from key partners through senior leadership interaction with partner organizations, an annual telephone survey, and quarterly Partners Committee meetings to understand the needs and requirements of key partners, as well as areas where the partnerships can be strengthened. Information from these meetings is used as part of the Strategic Planning Process.
- The methods for understanding key customer needs and requirements are kept current as part of the Strategic Planning Process through the work of the SWST, which aggregates, segments, and analyzes customer listening post data to determine key drivers in satisfaction loyalty and positive referrals. In addition, the SWST uses the Critical to Quality (CTQ) process to identify the factors critical to customer satisfaction. Customer requirements are then embedded into service design and delivery by CMs.

## OPPORTUNITIES FOR IMPROVEMENT

- The process for including local competitor data in the identification of patients and other customers is unclear. Without a clear process, AF may have difficulty attracting patients from all income strata, and this may adversely affect its primary competitive position to guarantee service regardless of ability to pay.
- While AF's SWST analyzes a variety of listening post data and information, it is not clear how the information from current and former patients and other customers is used for marketing, process improvements, and new business opportunities. It also is not clear how AF uses the information gathered from all customer groups to become more patient- and other customer-focused and to better satisfy patient and customer needs and desires.
- It is unclear how AF's listening and learning methods vary for different customers and customer groups. For example, it is unclear whether the Partners Committee includes representation from all partners (e.g., physicians, education partners) and other community representatives noted in the Organizational Profile. This lack of clarity may affect the systematic evaluation and improvement of health care services.

### 3.2 Patient and Other Customer Relationships and Satisfaction

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- **AF builds relationships with customers and key stakeholders through a variety of methods including patient enrollment, which serves as an orientation to enabling services; Patient-Family Advisory Boards, which have recommended and implemented improvements to patient care; CCKs; and high-visibility community health activities. Senior leaders participate on the boards of key partner organizations, which has led to improved discharge planning from the hospital setting, community-wide disaster drills, and training opportunities in culturally competent care. In addition, senior leader participation has led to opportunities for AF to teach the OASIS methodology to community members.**
- AF uses multiple key access mechanisms (Figure 3.2-1) to enable patients and other customers to seek information and services and to make complaints. These mechanisms include CCKs, Web site access, telephone and after-hours voice mail messages, printed materials in English and Spanish, transportation, child care, and interpreter services. At the close of every patient intervention, staff members ask what else they can do for the patient and how they can improve the next intervention. Data obtained from this customer feedback led to the development of the CCK prototype, which has since been deployed throughout the community and has become a key information-gathering and relationship-building methodology.
- AF uses its seven-step Complaint Management and Service Recovery Process (Figure 3.2-2), developed in collaboration with the Saguaro State University (SSU) Graduate School of Business, to manage patient and other customer complaints. Starting at orientation, all staff are trained in the process, which includes resolving problems immediately, if possible, or following up within 24 hours. Complaints are recorded on a short electronic template by site, service, stakeholder, and cultural group, and results are used in rapid cycle improvement efforts and also serve as key inputs in the Strategic Planning Process. Data are reviewed by the executive team and communicated to staff. In addition, top prevention tips are published in AF’s newsletter.
- To determine customer satisfaction and dissatisfaction, AF uses multiple survey tools and methods, including the Packer Satisfaction Survey that is administered to all enrollees. The Service Experience Survey, which gathers real-time satisfaction data, allowing staff to take immediate action to address patient or family concerns, is tracked by CMs and is available on AF’s intranet. To obtain satisfaction data from the community, AF developed and uses the Community Climate Survey, which identifies the community’s unmet needs and prioritizes enabling services.

## OPPORTUNITIES FOR IMPROVEMENT

- It is not clear how AF systematically minimizes patient and other customer dissatisfaction to ensure future interactions; nor is it clear how the complaint management process is deployed to suppliers and partners to further their improvement.
- It is unclear how AF ensures that its measurements capture actionable information for use in securing patients' and other customers' future interactions and gaining positive referrals; nor is it clear how the information is used to drive improvements. It also is unclear how AF differentiates dissatisfaction and complaints among different patient and stakeholder groups, and how these different perspectives are integrated into making improvements.
- Although AF's Service Experience Survey and Service Recovery Process allow follow-up with some of its patients to receive prompt and actionable feedback, it is not clear how the other survey approaches enable AF to receive prompt feedback from its other customer segments, such as the community, partners, and payors.
- It is not clear how AF obtains and uses information from its partners and payors relative to their satisfaction with its competitors and other organizations. In addition, it is unclear whether AF makes any comparisons with other local community providers, which may affect its ability to compare its performance relative to these competitors.

## **Category 4 Measurement, Analysis, and Knowledge Management**

### **4.1 Measurement, Analysis, and Review of Organizational Performance**

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### **STRENGTHS**

- AF utilizes a cross-location team, the Data Docs, to review measures; this helps to ensure that selected measures are aligned and integrated. Data from this team are then used during the annual Strategic Planning Process. In addition, measures are used for tracking daily operations, and the automated FOCUS scorecard tracks overall organizational performance.
- AF uses multiple sources of comparative data, including state CHC benchmarking consortium comparisons that are included on the FOCUS scorecard and reviewed quarterly by senior leaders. These data are utilized to identify performance gaps and define targets for improvement.
- AF works with the State Association of CHCs to re-evaluate measures each year to ensure that operational definitions are current. The Data Docs team routinely evaluates and assesses measures. This systematic evaluation process allows senior leaders to keep current with emerging trends.
- Senior leaders, clinic leadership, CMs and functional groups, and staff members review and analyze the FOCUS scorecard. Progress toward goals is quickly assessed through coded stoplight colors and the use of control charts for some measures to provide early indication of adverse trends. The OASIS Improvement Model is used to address statistically significant performance issues.
- The three “highs” (high cost, high risk, and high volume) are used to prioritize opportunities for continuous improvement, with deployment initiated by a CM, functional group, or senior leaders.

#### **OPPORTUNITIES FOR IMPROVEMENT**

- AF utilizes multiple sources of comparative data to challenge its performance in setting targets for improvement; however, comparative data from community-based private medical/dental/behavioral health providers are not evident. The lack of local community-level data may affect AF’s ability to assess relative performance and provide input into strategic decisions.
- While the Data Docs team evaluates performance in multiple dimensions to keep AF’s performance measurement systems current, it is not evident how the performance

measurement system is sensitive to rapid or unexpected organizational or external changes.

- While AF deploys improvement priorities to staff, it is not clear how initiatives are deployed to suppliers, partners, and collaborators. This may affect AF's ability to provide innovative care given its reliance on key suppliers and partners to deliver health care services.

## 4.2 Information and Knowledge Management

Your score in this Criteria Item for the consensus stage is in the 70–85 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF collaborates with its key Information Technology (IT) supplier to provide an intranet site and 30 portable CCKs that provide needed information to staff, suppliers, partners, patients, and other customers. In addition, the intranet site also uses telemedicine that allows staff to obtain medical consultations remotely and to connect with the SSU Medical Center for complex subspecialty cases. Providing these subspecialty services promotes AF’s efforts in accomplishing its vision: “the people of western Arizona will become the healthiest in the state.”
- AF’s key IT supplier ensures that industry-standard hardware and software are deployed throughout the system with an operating system uptime at 99.9% and help desk support during all hours of operations. To obtain customer feedback, an annual survey related to reliability and user-friendliness is conducted, with results integrated into the Strategic Planning Process.
- The Disaster Plan provides for backup and off-site storage of server data files, uninterruptible power supplies connected to all servers both centrally and remotely, and a mirror system to immediately assume control if a server fails. Mock restoration drills are conducted quarterly to test backups and ensure system recovery within two hours in the event of an emergency.
- The Info Interns team, a cross-location team, conducts focus groups with CMs, functional groups, volunteers, patients, providers, partners, and suppliers for feedback, and then, at least annually, reviews information system needs with its IT partner. Senior leaders decide which requests are urgent and which can wait for the next planning cycle.
- AF transfers knowledge to and from staff members and volunteers through multiple communication methods that include meetings, the intranet, staff rotations, and mentoring. In addition, a search engine scans daily logs for trends that indicate a need for local improvement and/or that identify organizational issues. This automated systematic approach to data abstraction and aggregation enables staff, CMs, and senior leaders to continually improve their daily work.
- Innovations are shared through the intranet via real-time, collaborative tools that enable document exchange and create reminders for specific performance goals. Implementing these tools has quadrupled the number of collaborating cross-organizational teams, with best practices shared through the OASIS Improvement Model, which promotes a focus on performance improvement and organizational learning.

- AF uses a variety of approaches to ensure data, information, and knowledge quality. These approaches include data input control features, firewalls, passwords, automated data checks, and staff training (Figure 4.2-1).

#### OPPORTUNITIES FOR IMPROVEMENT

- While the Partners Committee meets routinely and participates in two-way communication with the organization, it is not clear how AF systematically transfers relevant knowledge from all of its key suppliers, partners, and collaborators.
- While the Info Interns team conducts focus groups to address health care needs, it is unclear how AF keeps abreast of technological changes, which may affect its ability to ensure that its approaches remain current.
- While the electronic health record is the primary source of patient information, the approach for ensuring the accuracy, integrity, reliability, and security of paper records is unclear. In addition, it is not evident how the transfer of information to patients without an Internet connection or CCK access occurs.

## Category 5 Human Resource Focus

### 5.1 Work Systems

Your score in this Criteria Item for the consensus stage is in the 70–85 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- **AF has 25 CMs, each of which is led by a physician or dentist, and functional work groups to promote cooperation, initiative, and its culture. CMs develop practice profiles and monitor performance, sharing responsibility for team goals aligned to the FOCUS areas of the strategic plan. Collaboration and communication among CMs occur through real-time collaborative tools, the intranet, scorecards with common performance metrics, and online communities of practice.**
- AF uses cross-functional teams, its volunteer workforce, active engagement in the community, and the CM delivery structure to capitalize on the diverse ideas, thinking, and cultures of its staff and community.
- AF utilizes multiple methods to achieve communication and skill-sharing methods across health care professions, departments, and work units. These methods include Daily Huddles, CMs, committees and work groups, online learning modules, communities of practice, staff rotations, and liaisons.
- AF’s performance management system supports the achievement of its key action plans by linking staff performance planning to the annual Strategic Planning Process and FOCUS framework. Staff meet semiannually with their supervisor to set priorities, review progress on goals, make any necessary adjustments, and focus on career development. Volunteers also meet biannually with their assigned community educators to exchange feedback on the volunteers’ current activities and to develop plans for future ones. In addition, AF’s STAR recognition program supports its VMV.
- AF identifies characteristics and skills needed by potential staff by working with hiring managers to identify and embed in job descriptions the required characteristics and skills in four competency areas: (1) clinical or technical, (2) team, (3) cultural, and (4) service. These competency areas are a key input on workforce capabilities, as are gaps and anticipated changes in the environment. All are addressed as part of long-term workforce planning.
- Recruitment priorities start with internal staff members, then focus on local community, state, and national recruitment pools, to help ensure that staff members reflect the local communities’ diverse thinking, ideas, and culture. During the hiring process, a panel of volunteers and staff members representing the communities where the new staff will serve conducts behavior-based interviews addressing key characteristics and skills.

Volunteers also go through a matching process. To enhance staff retention, approaches such as the “Rising Stars” and job buddy programs take place during the first 90 days of employment.

- The career progression of all staff occurs through the performance management process, which includes the development of an IDP and a midyear career development review. Each job description has a promotional checklist that outlines requirements for a higher-level assignment and supports staff decision making regarding opportunities for education and training, tuition reimbursement, flexible work arrangements, scholarships, and the Work to Learn program. Volunteers also have development paths that are designed to increase their skills and impact on the community.

#### OPPORTUNITIES FOR IMPROVEMENT

- While AF utilizes both formal and informal recognition methods, such as its STAR program, senior leader thank-you notes, and a formal gain-sharing plan, it is not clear how these actions contribute to the achievement of action plans and support a patient, other customer, and health care service focus.
- While AF identifies skills and characteristics for its staff in four competency areas, it is not evident how skills and characteristics are identified for its volunteer workforce, who are closely integrated members of the CM delivery model and whose actions contribute to AF’s performance and achievement of its VMV.
- While the board and CEO share responsibility for succession planning, and succession plans are developed and revised annually with two qualified individuals identified for each senior leader position, it is unclear (beyond board member selection) how individuals are identified for succession to senior administrative/operational and health care leadership positions, including the position of CM leader.

## 5.2 Staff Learning and Motivation

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF’s workforce development plan is reviewed and updated annually. Key inputs include performance evaluations, education and training results, and satisfaction data. Also input are organizational needs related to strategic objectives, regulatory and technical requirements, anticipated changes in the work environment, and new opportunities through partnerships. In addition, an education and training plan, which is reviewed quarterly and addresses additional training requests, is developed by the Human Resource (HR) Director and the People Potential Team (PPT).
- Key organizational needs associated with new staff orientation, diversity, ethical health care and business practices, and safety are handled through a variety of group and individual training and education activities, such as New Staff and Volunteer Orientation and annual refreshers on HIPAA. Also, specific training is provided for certain roles. This training includes additional safety training for clinical staff, defensive driving for volunteers responsible for transportation, and child and family development for all volunteers.
- On a quarterly basis, AF’s PPT aggregates and analyzes input from staff on education and training. Key sources of data and information include the annual Staff Satisfaction Survey, post-training feedback, post-training knowledge and skills test results, and a volunteer survey that provides input on perceptions of education and training needs, as well as preferred delivery approaches. The results of these analyses are used to adjust the annual education and training plan.
- Primarily, online training programs that include pre- and post-testing and a post-training feedback survey are used to deliver training due to the long distances among facilities, limited coverage for direct patient care staff, and few resources for large group meetings. “Train-the-trainer” programs, mentoring, and live group sessions also are used to deliver training and education. For example, a live group forum is used for new staff and volunteers to allow them the opportunity to hear directly from senior leadership about AF’s VMV and culture, its key communities, and its responsibilities.
- AF reinforces the use of new knowledge on the job through peer mentoring and the “train-the-trainer” approach. In order to demonstrate proficiency with new competencies, high-proficiency staff members are paired with newer staff members, so the newer staff members can learn from the best. In addition, online tests are conducted following training or at 30, 60, or 90 days after the training, as appropriate.

### OPPORTUNITIES FOR IMPROVEMENT

- While workforce development plans are updated as part of the Strategic Planning Process, and education and training plans are formulated annually, it is not clear how key needs associated with technological changes are addressed. Also unclear is how the education/ training approaches balance short- and longer-term organizational objectives with the needs for development, ongoing learning, and career progression. This lack of clarity may affect AF's ability to address challenges associated with staff recruitment and retention, as well as its ability to use technology to reduce waste and increase productivity.
- While AF states that certain staff members are developed to train volunteers in the areas of prevention and chronic disease management, it may be difficult for AF to determine how organizational learning and knowledge assets are systematically incorporated into education and training approaches.
- Although AF responds to its geographically dispersed facilities by delivering most training online, it is not clear how or if it systematically seeks input from staff, supervisors, and managers in determining delivery approaches.
- While AF requires two-to-four weeks notice for voluntary terminations and uses annual supervisor evaluations of employees' likelihood to depart in the next six months, it is not evident how it systematically retains this knowledge for long-term organizational use. Also unclear is how knowledge from departing or retiring volunteers is systematically captured and transferred.
- While AF has implemented the CM delivery model and provides staff opportunities for professional development, it is not evident how these actions create a systematic approach to motivating all staff members, including the more than 200 volunteers, to develop and utilize their full potential. In addition, beyond a midyear review, it is not clear how managers and supervisors help staff and volunteers to attain job- and career-related development and learning objectives.

### 5.3 Staff Well-Being and Satisfaction

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- AF ensures workplace preparedness for disasters or emergencies through the development of a facility-specific safety plan, periodic announced and unannounced drills, competency tests, certification of all direct patient care staff in Basic Cardiac Life Support, defibrillators at each clinic, and participation with local counties’ emergency response agencies’ disaster scenario drills.
- AF utilizes research conducted by an external, national company, with review and approval by its staff members and volunteers, to determine seven out of 12 dimensions that are representative of an “employer of choice.” These dimensions form the basis for AF’s annual Staff Satisfaction Survey that is given to both staff and volunteers.
- AF supports its staff via multiple services and benefits that include a family benefit package to staff working 30 hours or more per week, a 403b retirement plan with employer matching, tuition reimbursement, educational leave, flex time, job-sharing, and scholarships. Further, based on feedback, scholarship benefits are extended to children of staff and volunteers for training in a health care profession. Along with paid holidays and vacation time, staff is given three discretionary days off for community service.
- AF utilizes multiple formal and informal assessment methods to determine staff well-being and satisfaction. These include the annual Staff and Volunteer Satisfaction Survey, monthly breakfast meetings with senior administrators, and quarterly reviews of rates and trends in staff turnover, absenteeism, grievances, safety, and productivity.
- The PPT, led by a member of the senior leadership team, reviews satisfaction assessment findings segmented by functional groups and counties to identify opportunities for improvement. The findings are compared to key organizational performance measures such as productivity, patient satisfaction, and clinical outcomes to identify and set priorities. Results and action plans are shared with staff and serve as a key input into the Strategic Planning Process.

#### OPPORTUNITIES FOR IMPROVEMENT

- **Although staff and volunteers receive safety training; clinics have safety officers, champions, and committees; and clinics conduct biweekly safety and infection-control rounds; it is unclear how staff and volunteers systematically take part in ensuring and improving workplace health, safety, security, and ergonomics. In addition, while performance measures have been identified in Figure 5.3-1, it is**

**unclear how significant differences in workplace factors have been addressed for different staff groups and volunteers or for different work environments.**

- While AF utilizes seven dimensions on its annual Staff and Volunteer Satisfaction Survey, it is unclear how factors have been segmented to address its diverse workforce or its different categories and types of staff and volunteers.
- It is not clear how AF tailors its services, benefits, and policies to meet the needs of its diverse workforce and particularly different categories and types of staff. Also unclear is how services and policies are tailored to support the needs of the more than 200 volunteers participating in its work systems.
- Although multiple formal and informal assessments are used to determine the well-being, satisfaction, and motivation of staff and volunteers, it is not apparent how methods differ across the diverse workforce and different categories and types of staff and volunteers. Without this information, it may be difficult for AF to address the strategic challenge of retaining staff.

## Category 6 Process Management

### 6.1 Health Care Processes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- Key health care processes, focus areas, and measures (Figure 6.1-1) are determined during the Strategic Planning Process. Inputs include a community needs assessment, federal mandates for funded community health centers, and input from partners and other key stakeholders. CMs establish continuous and coordinated healing relationships with care teams and a practice system, which contribute to improved health care outcomes. All of these key health care processes include follow-up procedures.
- AF’s key health care process requirements (Figure 6.1-2, step 2) are based on a set of requirements defined by the Institute of Medicine (IOM). The Medical Director leads the Healing Partners Team (HPT), which keeps abreast of emerging clinical practices and their implications for key health care process requirements. AF’s key customer listening and learning methods (Figure 3.1-1) and its review of the Culturally and Linguistically Appropriate Service Standards during quarterly meetings demonstrate an effort to support its mission.
- **The HPT uses an expanded PDCA model to design its health care processes. The team views the process and desired outcomes from the patients’ perspective and identifies critical inputs for new or improved process designs. Implementation occurs through documenting and sharing the processes in the Staff and Volunteer Handbook, adding appropriate measures to the FOCUS scorecard, and providing appropriate training. An integrated improvement methodology is used to improve health care processes. Standardization, automation, and small tests of change prevent errors and reduce rework.**
- Patients’ expectations and preferences are addressed through the PHP. Enrolled patients and their primary care providers incorporate evidence-based recommendations for care along with individual preferences. The PHP creates the motivation, knowledge base, and skills and confidence for patients to make decisions about and manage their health. Self-management capability is correlated with better health outcomes, higher satisfaction, and more efficient use of services, which are at the core of AF’s VMV.

#### OPPORTUNITIES FOR IMPROVEMENT

- AF states that the HPT designs its key health care processes and meets key requirements; however, although the HPT considers patient feedback at quarterly reviews, it is unclear how input from customers, suppliers, and other stakeholders is used in managing the key

processes, as appropriate. Not including supplier, partner, and collaborator input on key processes may affect AF's ability to improve the efficiency and effectiveness of key health care processes.

- **It is not clear how AF's model for process design (Figure 6.1-2) incorporates new technology, agility, cycle time, and other effectiveness and efficiency factors. This may be noteworthy given AF's principal factors of operational efficiency and the use of IT to reduce waste and increase productivity.**

## 6.2 Support Processes and Operational Planning

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF identifies its key business and support processes during the SWOT analysis step of its annual Strategic Planning Process. Key support and business processes and their requirements and measures are given in Figure 6.2-1.
- Also shown in Figure 6.2-1 are AF’s key business and support process outcome measures. Process owners and team members monitor processes in Daily Huddles, exchange information about process performance, and communicate issues and ideas. Performance tracking is usually managed with simple checklists and check sheets that are recorded in spreadsheets and posted on the intranet. Statistical process control is in place for key process metrics, and staff are trained to intervene when a process signals an out-of-control condition. Results are rolled up to the process owner for reporting overall performance for those measures on the FOCUS scorecard.
- AF minimizes the cost of audits and inspections by training staff to perform work as documented in the online Staff and Volunteer Handbook and by maintaining “audit-ready” status at all times. Teams perform their own quality checks, and checking for accuracy is an embedded step in the work of every staff member in a business or support process. AF has created a “no-blame” environment where staff are recognized for identifying errors that could create significant downstream problems. Any systemic issues identified are addressed with training and counseling.
- AF utilizes the Baldrige framework; its OASIS Improvement Model, which includes Six Sigma and Lean methodologies; and feedback from external and internal customers to improve business and support processes. If process performance, stakeholder feedback, or a strategic priority indicates a need for improvement, a team is formed from the staff and volunteers in impacted areas. The team works to identify opportunities, assess and analyze outcomes, set targets and timelines, and share results.
- AF ensures that adequate resources are available to support operations through a zero-based budgeting process that is linked to the five-year capital and funding plans developed during the Strategic Planning Process. After the strategic plan and associated goals for the upcoming fiscal year are developed, each group prepares a budget to provide planned services.
- AF ensures continuity of operations through an Emergency Management Plan that focuses on preparedness for power outages, desert sand storms, or an influx of illnesses or injuries caused by contagious disease or disasters. Mock evacuation drills are

conducted, and emergency preparations are reviewed monthly. The plan includes the use of alternate sites and transportation. Full mock disaster response drills are conducted unannounced at least annually in conjunction with local partners.

#### OPPORTUNITIES FOR IMPROVEMENT

- Although the PDCA model is used to design business and support processes, and the model incorporates organizational knowledge, the potential need for agility, cycle time, productivity, cost control, and other efficiency and effectiveness factors, it is unclear how this occurs. It also is unclear how other customer, supplier, partner, and collaborator input is incorporated. Without a systematic approach to address these factors, it may be difficult for AF to achieve its success factors related to efficiency and the challenges of shrinking reimbursement and revenue.
- Although frequent monitoring of both in-process and outcome measures, Daily Huddles, checklists, and check sheets are used to manage the day-to-day operations of key business and support processes, it is not clear how the requirements presented in Figure 6.2-1 were defined. This may affect AF's ability to improve the efficiency and effectiveness of key support processes.
- Although AF uses a zero-based budgeting process and develops contingency plans that include actions to temporarily reduce non-mission-critical expenditures as needed to support operations, it is not clear how it ensures that adequate resources are available to support major new business investments. Given AF's intent to use IT to reduce waste and increase productivity, this may be significant.
- **It is not clear how AF's business and support process design incorporates new technology. This may impact AF's principal factor of operational efficiency, as well as its use of IT to reduce waste and increase productivity.**

## Category 7 Results

### 7.1 Health Care and Service Delivery Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- **Favorable trends on a number of screening and prevention measures for lifestyle risk factors, behavioral health, and cancer are demonstrated. These include the following measures: Body Mass Index (BMI) showing improvement from 1999 to 2005, with performance better than that of the state-average CHC from 2003 to 2005 (Figure 7.1-1a); screening for smoking measures improving from 45% in 1999 to more than 80% in 2005, with better than the 90th percentile comparison in 2004 and 2005 (Figure 7.1-1b); and screening for depression and for domestic violence demonstrating improved performance from 2002 to 2005, with both areas demonstrating nearly 60% improvement and recent levels at or near the state-best comparison CHCs (Figures 7.1-2a and 7.1-2b). Screening for colon cancer and for breast and cervical cancers also demonstrate improvement (Figures 7.1-3a, 7.1-3b, and 7.1-3c).**
- Outcomes related to selected acute and chronic conditions (diabetes, asthma, and heart care) show steady improvement over the years reported (Figures 7.1-5, 7.1-6, and 7.1-7).
- In 2005, performance results for communicable diseases—influenza and pneumococcus immunizations (Figures 7.1-4a and 7.1-4b, respectively)—met Arizona’s Healthy People 2010 goals in all three counties. These results link to AF’s efforts to provide preventive services and address challenges related to low incidences in prevention and screening and high incidences of chronic and communicable disease.
- Outcomes related to maternal and child care show improvement over time. Data show decreased numbers of newborns with low birth weight in all three counties, with a favorable trend over the past four years and levels that approach or are equal to the state-best comparison in 2004 and 2005 and approach the Arizona’s Healthy People 2010 goal (Figure 7.1-8a). Other measures related to pregnancy, childbirth, and pediatric care show consistent improvements and, in several cases, are at or near the Health Care Data and Information (HCDI) 90th percentile for the most recent year. These include early prenatal care (Figure 7.1-8b), well-child care (Figures 7.1-9a and 7.1-9b), and appropriate immunizations (Figures 7.1-9c and 7.1-9d). Performance for acute pediatric care (Figure 7.1-9e) and testing for pharyngitis (Figure 7.1-9f) also show favorable trends since 2002.

- AF’s performance for key dental service metrics—dental exam in past year (adults) (Figure 7.1-10a) and 8-year-olds with sealant present (Figure 7.1-10b)—shows favorable trends for all three counties from 2002 through 2005, with performance levels reaching state-best CHC levels in 2005.

#### OPPORTUNITIES FOR IMPROVEMENT

- **There is an absence of measures related to some of the requirements identified as patient and other customer requirements in Figure P.1-5. For example, although many measures for participation in screening and health care delivery processes are presented with favorable results, no results are presented related to patient safety or functional status.**
- **There is a lack of segmentation by customer group for several of the lifestyle risk factors and behavioral health indicators (Figures 7.1-1a, 7.1-1b, 7.1-2a, and 7.1-3c). While AF shows positive results for screening for depression (Figure 7.1-2a), it indicates that persons of Hispanic background are at a higher risk of depression; yet the data are not segmented by Hispanic or non-Hispanic background. There also is a lack of segmentation by county for key measures such as heart care (Figure 7.1-7), asthma care (Figure 7.1-6), diabetes screenings (Figure 7.1-5), patients with self-management goals (Figure 7.1-11), and post-acute myocardial infarction (AMI) beta blocker therapy (Figure 7.1-12). This lack of segmentation may make it difficult for AF to determine opportunities for improvement among county locations.**
- Comparisons with relevant state or national standards are lacking for some key measures of health care outcomes: diabetes care (Figure 7.1-5), asthma care (Figure 7.1-6), and heart care (Figure 7.1-7). In addition, there are no comparisons with competitors. It also is unclear which of AF’s health care and service delivery outcome measures presented in Item 7.1 are mandated by regulatory, accreditor, or payor requirements.

## 7.2 Patient- and Other Customer-Focused Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- Coordination of care, reflected by the percentage of patients who do not feel that their medications are adequately explained, demonstrates a favorable trend for the last three years (Figure 7.2-2). In addition, AF’s levels have surpassed the national norm for the last two years and approach or are equal to state-best CHC performance in 2005.
- Emotional support, measured by family/living situation and questions not addressed (Figures 7.2-3a and 7.2-3b), shows favorable trends for the last four years in all three counties. The 2005 levels surpass or are equal to the national norm and one clinic’s level is equal to state-best CHC performance for family/living situation and questions not addressed.
- From 2002 to 2005, AF demonstrates improvement trends for its key information and education measures of patients with “language problems” (Figure 7.2-4a) and patients who “did not receive enough information” (Figure 7.2-4b). In the “language problems” measure, results show that since 2002 AF’s performance has surpassed the national norm level in all three counties; in 2005, AF’s performance for the “did not receive enough information” measure surpassed the national norm level in all three counties. In addition, for both measures, the 2004 and 2005 performance in two of the sites compares favorably to state-best CHC comparative levels.
- The percentage of patients who perceive a lack of respect for their cultures demonstrates a favorable trend over the last four years, with a 2005 overall performance level approaching 2%, which is best in the state (Figure 7.2-6).
- AF demonstrates improvement trends from 2002 to 2005 in all three counties for its “would-recommend-to-a-family-member-or-friend” patient measure (Figure 7.2-7), with results well above the national norm in 2004 and 2005. In addition, two of the counties have performance levels (approaching 80%) that compare favorably to the state-best CHC comparisons.
- Results for community confidence (Figures 7.2-8a through 7.2-8c) show improving results over the last three years among users and nonusers in all counties, with overall, pediatric, and senior care performance that is the best in the state for 2005. These results demonstrate AF’s progress toward the key customer and stakeholder requirement that AF have a “reputation as a high-quality health center.”

## OPPORTUNITIES FOR IMPROVEMENT

- Access to care, measured by the patients' ability to schedule appointments when wanted, and "waited too long after arrival" at the health care facility (Figures 7.2-1a and 7.2-1b), show favorable trends over the past four years, with levels that exceed the national comparison. However, these levels do not approach the state-best CHC comparison, which may impede AF's accomplishment of its mission to provide residents with easy and timely access to health care services.
- AF demonstrates inconsistent performance trends from 2002 to 2005 in all three counties for its respect-for-patient-preferences measure (not involved in care decisions) (Figure 7.2-5), with declining performance in 2004. Further, a decline in the emotional support measure (questions not addressed) (Figure 7.2-3b) performance level of approximately 40% in 2005 for the La Paz clinic is noted. This performance may affect AF's responsiveness to meeting the needs of its patients.
- Although AF utilizes statewide and national benchmark comparisons for its health care results, use of local competitor data is not evident. Lack of this competitive data may affect AF's ability to identify gaps and evaluate its performance against competing organizations.
- While results from various patient and other customer surveys relative to satisfaction are described, results related to patient- and other customer-perceived value, such as patient dissatisfaction and retention, are absent. Also lacking are results stemming from the service experience survey or complaints from patients and other stakeholders. Without this information, it may be difficult for AF to determine the effectiveness of its patient complaint and relationship-building processes.

### 7.3 Financial and Market Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

#### STRENGTHS

- AF’s performance in revenues, expenses, and collections (Figure 7.3-1), a key measure of its financial solvency, demonstrates improving performance from 2002 to 2005. Collections improved from approximately \$20 million in 2002 to \$25 million in 2005, and total revenue improved from approximately \$25 million in 2002 to nearly \$30 million in 2005. AF’s performance in total revenue is at or better than its state-best CHC comparison in 2004 and 2005. Performance in cost savings from purchasing consortium (Figure 7.3-5) demonstrates improving performance from 2000 to 2005, with total savings increasing from more than \$800,000 in 2000 to more than \$1 million dollars in 2005.
- AF’s performance in accounts receivable by payor type (Figure 7.3-2) demonstrates improving performance in the Medicare, private, and self-pay segments from 2001 to 2005. Also, in 2003, 2004, and 2005, performance in the private segment was equal to the state-best CHC comparison. Performance in these areas may demonstrate the effectiveness of AF’s “Improve Collection Rates” action plan.
- AF’s performance in collection rates (Figure 7.3-3) demonstrates improving performance from 2002 to 2005 in the private, Medicaid, and AF overall segments. AF’s overall performance equaled its state-best CHC comparison for 2004 and 2005. Performance in these areas may demonstrate the effectiveness of AF’s “Improve Collection Rates” action plan.
- AF’s performance in return on assets in clinical units (Figure 7.3-4) improved from 2002 to 2004 and, while declining slightly in 2005, has been at or very near its state-best CHC comparison since 2001. Performance in this area may demonstrate the effectiveness of AF’s “Improve Collection Rates” action plan.
- **AF’s performance in growth in and total value of Foundation funding (Figure 7.3-6) demonstrates improving performance in donations, capital appreciation, and total value from 2002 to 2005. Total value has increased from approximately \$2 million in 2002 to more than \$4 million in 2005. This performance may be particularly noteworthy given AF’s strategic challenge associated with funding.**
- AF’s performance in market share by county (Figure 7.3-7) and market share by service (Figure 7.3-8) demonstrates improvement from 2002 to 2005 in all segments reported. AF’s overall market share increased from approximately 14% in 2002 to approximately 17% in 2005 (Figure 7.3-7).

## OPPORTUNITIES FOR IMPROVEMENT

- Although AF provides comparisons for results in some areas, it does not provide relative comparisons for four of the results areas it reports in Item 7.3 and provides no comparisons for key measures or indicators of health care market performance. In Figures 7.3-1 and 7.3-2, it presents results information for three (expenses, collections, and total revenues) and four (Medicare, Medicaid, private, and self-pay) results areas, respectively; yet comparisons are provided for only one results area in each. The lack of relative comparisons in these key areas may make it difficult for AF to ascertain the relative effectiveness of its improvement strategies and action plans.
- In 2005, the Medicaid segment of AF's performance in accounts receivable by payor type (Figure 7.3-2) declined from its levels in 2003 and 2004. Also, its 2005 performance in collection rates (Figure 7.3-3) declined in its self-pay and Medicare segments from 2004. Declining performance in these areas may call into question the effectiveness of AF's "Improve Collection Rates" action plan.
- Although AF presents some segmented financial and market outcome results, it does not provide segmentation by market, patient, or other customer segments in five of the eight results areas presented. This may make it difficult for AF to understand its performance relative to these key segments.
- AF does not present financial and market outcome results in a number of areas—such as asset utilization, value-added per staff member, performance to budget, and reserve funds—that may be key given its strategic challenge of financial performance.

## 7.4 Human Resource Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF’s cost savings related to CMs (Figure 7.4-1) demonstrate improvement trends from approximately 2% savings in 2002 to near 12% in 2005.
- AF shows improving performance for its training completion rates for both staff and volunteers (Figures 7.4-3a and 7.4-3b) since 2002, with several core training rates at 100% in 2005. Further, improvement trends are demonstrated since 2001 for staff and volunteers enrolled in degree/certification programs (Figure 7.4-5), with performance levels in 2005 exceeding state-best CHC data for nonlicensed staff.
- AF shows improvement trends from 2002 to 2005 for staff satisfaction with key performance dimensions (Figures 7.4-2a and 7.4-2b) in both its CM and non-CM work groups, as well as staff satisfaction by county and job group (Figures 7.4-6a and 7.4-6b). These county and job group results demonstrate performance levels meeting or exceeding 80% of staff being very satisfied in 2005. In addition, AF’s volunteer satisfaction results have improved from just over 60% in 2002 to over 80% in 2005 (Figure 7.4-7). AF’s overall 2005 performance exceeds the Oates Group 75th percentile for North American companies.
- AF demonstrates improvement trends for key safety and security measures, with performance levels in 2005 comparing favorably to Baldrige recipient performance levels (Figure 7.4-8).
- **Performance results for staff turnover by job group and by county demonstrate improvement trends in all groups and counties from 2000 to 2005, with all job groups meeting or exceeding the state-best CHC levels of approximately 8% (Figures 7.4-9a and 7.4-9b).**
- From 2002 to 2005, AF demonstrates improvement trends for its STAR Recognition Program, with over 50% of volunteers and staff receiving recognition in 2005 (Figure 7.4-10). In addition, staff gainsharing payouts have improved from \$20,000 in 2002 to approximately \$90,000 in 2005 (Figure 7.4-11).

### OPPORTUNITIES FOR IMPROVEMENT

- **Although AF has provided results relating to staff and volunteer proficiency rates that result from orientation and training, other measures of staff learning and development are not provided. These might include innovation and suggestion rates, courses completed, learning, on-the-job performance improvements, credentialing,**

**and cross-training rates. In addition, except for the Oates data for the key performance dimensions (Figures 7.4-2a and 7.4-2b), comparative data are not provided for other key measures and indicators of work system, learning, and development performance.**

- While AF provides staff results segmented by county and job group (Figures 7.4-6a, 7.4-6b, 7.4-9a, and 7.4-9b), it is unclear what other types of segmentation are used to capture and understand the diversity of AF’s workforce across the different types and categories of staff and volunteers. For example, other types of segmentation might include segmentation based on specialties, skills, needs, or work assignments. Such information may help AF to determine the effectiveness of its work system performance and education and development efforts, as well as its staff and volunteer well-being, satisfaction, and dissatisfaction.
- Although AF utilizes the Oates 75th percentile and state-best comparisons for its staff and work system results, the use of local competitor data such as community-based private medical/dental/behavioral health providers is not evident. This may affect AF’s ability to evaluate its performance against local competitors and to meet its strategic challenge of addressing workforce gaps.

## 7.5 Organizational Effectiveness Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- AF identifies an important goal as improving access to care, and it uses the OASIS Improvement Model to share best practices across all clinics. The data shown in Figures 7.5-1 through 7.5-4 indicate improvement in patient access and new patient visits. Yuma and La Paz counties are at or very near the goal and the state-best CHC performance levels for open appointment slots (Figure 7.5-1), and all counties’ performance is meeting the goal and equal to the state-best CHC performance levels for office visit cycle time (Figure 7.5-3).
- AF has made significant improvements in patient access over the past four years. For example, its innovative measure, the “third next available” appointment (Figure 7.5-2), eliminates chance occurrences such as appointments that are available because of last-minute cancellations. In 2005 AF’s overall performance was the state-best CHC performance on this measure. Also, the number of AF’s volunteers and the number of hours per volunteer per year have increased over the four years reported. These hours are equivalent to those of the state-best CHC (Figure 7.5-10).
- AF’s medical records accuracy rates indicate steady improvement trends since 2003, with overall performance near the state-best CHC performance in 2005 (Figure 7.5-5). Yuma has steadily performed above the state-best CHC level since 2003 and has been near that of a Baldrige Award recipient benchmark for the same period.
- The systems availability of Desert Data Solutions (DDS) indicates a high level of performance provided by this strategic partner with responsibility for the information technology management process (Figure 7.5-7). Performance levels are equivalent to or above the available Baldrige Award recipient comparisons and equal to the Quality and Productivity Group (QPG) best performer’s results in 2004 and 2005.
- **AF demonstrates strong performance in two areas that it identifies as critical: grant success rate (Figure 7.5-8) and development funds (Figure 7.5-9). Performance in these areas has improved steadily and is equivalent to or better than the state-best CHC comparisons.**

### OPPORTUNITIES FOR IMPROVEMENT

- Although AF states that it is a member of the QPG and that the QPG provides a process framework with access to a benchmarking database and the ability to compare data and best practices from other organizations that perform similar processes, QPG performance measures are not provided for any of the other partner or supplier groups. Without

comparative data for other business and support processes, it is unclear how AF evaluates and improves performance and shares information with other organizational units to drive learning and innovation.

- Although AF utilizes statewide benchmark comparisons for its operational performance of key health care process results, use of local competitor data such as community-based private medical/dental/behavioral health providers is not evident. This may affect AF’s ability to identify gaps, to evaluate its performance against local competitors within the community, and to meet the key requirement of having a “reputation as a high-quality health center.”
- Although AF provides data (Figures 7.5-1, 7.5-2, 7.5-3, and 7.5-4) that indicate improvement in patient access, it is unclear (other than by county) how the data are segmented by health care service types (i.e., transportation, translation, and groups such as home visits and medical and dental care).

## 7.6 Leadership and Social Responsibility Outcomes

Your score in this Criteria Item for the consensus stage is in the 50–65 percentage range. (Please refer to Figure 5, “Scoring Guidelines.”)

### STRENGTHS

- The cumulative percentage of action plans implemented during 2005, a measure of accomplishment of organizational strategy, reached 100% by year-end 2005 (Figure 7.6-1). This shows a trend toward improvement over the accomplishments of 2004 (92% implemented by year end) and 2003 (81% implemented by year end). In addition, various awards and accomplishments are listed in Figure 7.6-2, including that of AF being the recipient of the Baldrige-based state-level award for performance excellence in 2005.
- Results for key measures or indicators of ethical behavior and of employee and volunteer trust in the leadership of the organization are improving (Figure 7.6-3). For example, the staff survey finding related to ethical expectations and motivation to do what is right has improved from 96% in 2002 to 98% in 2005, and it exceeds the 2005 comparison of 67%. Similarly, the volunteer survey responses related to the ethical standards of AF have improved from 87% in 2002 to 93% in 2005, compared with a 2005 level of 71% in the comparison group, which is identified as the “state-best community health clinic.” Positive responses concerning the timeliness and accuracy of AF’s communications have improved from 89% in 2002 to 95% in 2005, and they are near the benchmark level of 96%.
- External audit firms and third-party payors have had no major findings for the past 10 years, and the internal audit team has not identified any major findings during that same time frame.
- Key measures for organizational accreditation, assessment, and regulatory and legal compliance include JCAHO accreditation, licensure of staff, and Occupational Safety and Health Administration (OSHA) and Environmental Protection Agency (EPA) violations. There were no recommendations during the previous JCAHO accreditation, and AF maintains continuous survey readiness. One hundred percent of the staff licenses are current, and there have been no OSHA or EPA violations for the past ten years. All waste volume management trends have improved consistently from 2002 to 2005 (Figure 7.6-5), and AF achieved recognition as the state-best CHC for regulated medical waste and solid waste. Recycling levels also are approaching the state-best level, having improved from 34.8% in 2002 to 53.1% in 2005, with the state-best level consistently in the 54–58% range.
- AF demonstrates favorable trends in the number of volunteer hours and donations over the past four years (Figures 7.6-6 and 7.6-7). In addition, AF’s three-year improvement trend for volunteer hours has now reached 3,000 hours, surpassing the national

comparison (Figure 7.6-6). Examples of contributions for community support shown in Figure 7.6-7 demonstrate the emphasis on “Support for the Body,” “Support for the Spirit,” and “Support for the Mind,” a noted priority in AF’s strategic planning that reflects its vision that “the people of western Arizona will become the healthiest in the state.”

## OPPORTUNITIES FOR IMPROVEMENT

- Although Figure 7.6-1 notes that 100% of AF’s action plans were implemented in 2005 (thus meeting the goal), no information is provided on the results of these plans in terms of the accomplishment of organizational strategy.
- Although Figure 7.6-3 shows that results from the community survey related to questions of trust indicate that AF’s response to the needs of patients has improved steadily from 88% in 2002 to 94% in 2005, and the community perception of timeliness/accuracy of communications improved from 89% in 2002 to 95% in 2005, the results are lagging the 2005 comparisons presented of 97% and 96%, respectively.
- Although Figure 7.6-4 illustrates a trend toward improvement in four questions on the board self-assessment results related to ethical behavior from 2002 through 2005, two of the four questions are below the comparison level, and one is equal. While AF indicates that the ethics committee reviews all potential breaches of ethical conduct, no results of these reviews or other results of key measures/indicators of ethical breaches are presented.
- No data are provided related to nine of the 14 programs to support the key communities identified in Figure 1.2-5. Without such results, it is not clear how AF determines the success of its organizational citizenship efforts and ensures that its resources are being used effectively.
- The results related to leadership and social responsibility presented in Figures 7.6-1, 7.6-3, 7.6-4, 7.6-6, and 7.6-7 lack segmentation by facility, community, or service category. The absence of segmentation may hinder the ability of the organization to identify specific gaps in performance or opportunities for improvement. For example, without segmentation of staff survey results on ethical questions by facility, AF may not be able to identify specific trouble spots.

## **APPENDIX**

By submitting a Baldrige application, you have differentiated yourself from most U.S. organizations. The Board of Examiners has evaluated your application for the Malcolm Baldrige National Quality Award. Strict confidentiality is observed at all times and in every aspect of the application review and feedback.

This feedback report contains the Examiners' findings, including a summary of key themes of the application evaluation, a detailed listing of strengths and opportunities for improvement, and scoring information. Background information on the examination process is provided below.

### **APPLICATION REVIEW**

#### **Stage 1, Independent Review**

Following the receipt of the Award applications, the first step of the Award Process review cycle (shown in Figure 1) begins with Stage 1, the independent review, in which members of the Board of Examiners are assigned to each of the applications. Assignments are made according to the Examiners' areas of expertise and to avoid potential conflicts of interest. Each application is evaluated independently by Examiners who write comments relating to the applicant's strengths and opportunities for improvement and use a scoring system developed for the Award Program. All applicants in all categories (manufacturing, service, small business, education, and health care) go through the Stage 1 evaluation process.

# Award Process Review Cycle

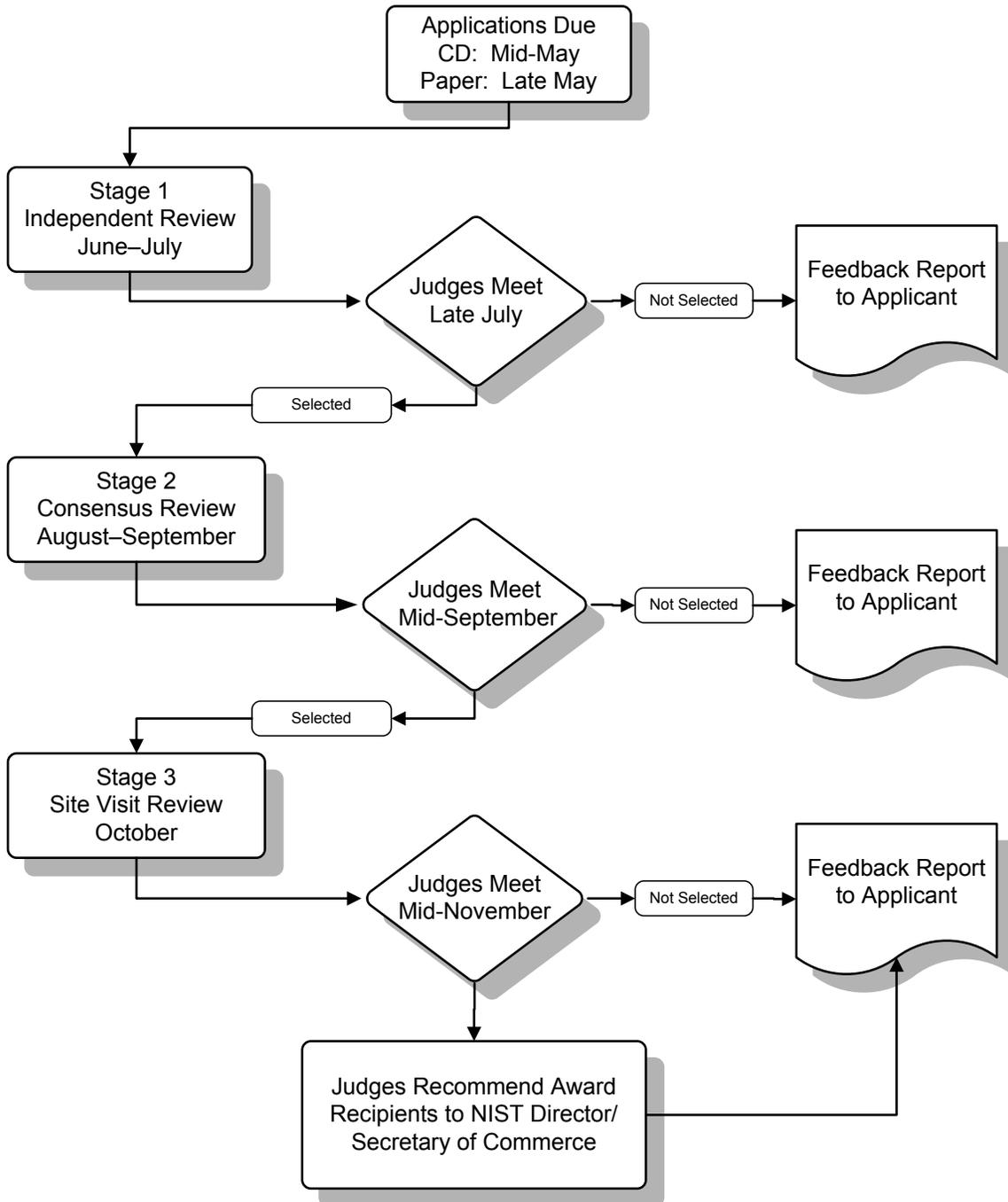


Figure 1—Award Process Review Cycle

## Stage 2, Consensus Review

Based on Stage 1 scoring profiles, the Panel of Judges selects applicants to go on to Stage 2, the consensus review. If an applicant is not selected for consensus review, the comments written by Examiners at Stage 1 are reviewed and used to prepare a feedback report.

For those applicants that do progress to Stage 2, a team of Examiners, led by a Senior Examiner, conducts a series of conference calls to reach consensus on comments and scores that capture the team’s collective view of the applicant’s strengths and opportunities for improvement. The team documents its comments and scores in a consensus scorebook. The consensus review process is shown in Figure 2.

Step 1	Step 2	Step 3
<b>Consensus Planning:</b> <ul style="list-style-type: none"><li>• Prioritize Items for Discussion</li><li>• Assign Category/Item Discussion Leaders</li><li>• Review Findings From the Independent Evaluations</li></ul>	<b>Consensus Calls:</b> <ul style="list-style-type: none"><li>• Discuss Key Business/Organization Factors</li><li>• Discuss Items and Key Themes</li><li>• Achieve Consensus on Comments and Scores</li><li>• Document Findings</li></ul>	<b>Post-Consensus Call Activities:</b> <ul style="list-style-type: none"><li>• Prepare Final Consensus Scorebook</li><li>• Prepare Feedback Report</li></ul>

**Figure 2—Consensus Review Process**

## Stage 3, Site Visit Review

After the consensus review process, the Panel of Judges selects applicants to receive site visits based upon the scoring profiles. If an applicant is not selected for site visit review, one of the Examiners on the Consensus Team edits the final consensus report that becomes the feedback report.

Site visits are conducted for the highest-scoring applicants to clarify any uncertainty or confusion the Examiners may have regarding the written application and to verify that the information in the application is correct. After the site visit is completed, the team of Examiners prepares a final site visit scorebook. The site visit review process is shown in Figure 3.

Step 1	Step 2	Step 3
<b>Team Preparation:</b> <ul style="list-style-type: none"> <li>• Review Consensus Findings</li> <li>• Develop Site Visit Issues</li> <li>• Plan Site Visit</li> </ul>	<b>Site Visit:</b> <ul style="list-style-type: none"> <li>• Make/Receive Presentations</li> <li>• Conduct Interviews</li> <li>• Record Observations</li> <li>• Review Records</li> </ul>	<b>Site Visit Scorebook:</b> <ul style="list-style-type: none"> <li>• Resolve Issues</li> <li>• Summarize Findings</li> <li>• Finalize Comments</li> <li>• Prepare Final Site Visit Scorebook</li> <li>• Prepare Feedback Report</li> </ul>

**Figure 3—Site Visit Review Process**

Application reports, consensus scorebooks, and site visit scorebooks for all applicants receiving site visits are forwarded to the Panel of Judges, which makes final recommendations on which applicants should receive an Award. The Judges discuss applications in each of the five Award categories separately, and then they vote to keep or eliminate each applicant. If more than three applicants remain in a particular Award category, the Judges rank order the applicants and eliminate those that rank lowest. This process is repeated until the top three applicants remain. Next, the Judges decide whether each of the top applicants should be recommended as an Award recipient based on an “absolute” standard: the overall excellence and the appropriateness of the applicant as a national role model. The process is repeated for each Award category; there may be as many as three recipients in each of the categories. The Judges’ review process is shown in Figure 4.

Step 1	Step 2	Step 3
<b>Panel of Judges’ Review:</b> <ul style="list-style-type: none"> <li>• Application Reports</li> <li>• Consensus Scorebooks</li> <li>• Site Visit Scorebooks</li> <li>• Feedback Reports</li> </ul>	<b>Evaluation by Category:</b> <ul style="list-style-type: none"> <li>• Manufacturing</li> <li>• Service</li> <li>• Small Business</li> <li>• Education</li> <li>• Health Care</li> </ul>	<b>Assessment of Top Organizations:</b> <ul style="list-style-type: none"> <li>• Overall Strengths/ Opportunities for Improvement</li> <li>• Appropriateness as National Model of Performance Excellence</li> </ul>

**Figure 4—Judges’ Review Process**

Judges do not participate in discussions or vote on applications in which they have a competing or conflicting interest or in which they have a private or special interest, such as an employment or a client relationship, a financial interest, or a personal or family relationship. All conflicts are reviewed and discussed so that Judges are aware of their own and others' limitations on access to information and participation in discussions and voting. Following the Judges' review and recommendations of Award recipients, the Site Visit Team leader edits the final site visit scorebook that becomes the feedback report.

## **SCORING**

The scoring system used to score each Item is designed to differentiate the applicants in the various stages of review and to facilitate feedback. The Scoring Guidelines for shown in Figure 5 are based on (1) evidence that a performance excellence system is in place; (2) the maturity of its processes as demonstrated by Approach (A), Deployment (D), Learning (L), and Integration (I); and (3) the results it is achieving.

In the feedback report, the applicant receives a percentage range. The percentage range is based on the Scoring Guidelines, which describe the characteristics typically associated with specific percentage ranges.

An applicant's total score falls into one of eight scoring bands. Each band corresponds to a descriptor associated with that scoring range. Figure 6 provides scoring information on the percentage of applicants scoring in each band at Stage 1. Scoring adjustments resulting from the consensus review and site visit review stages are not reflected in the distribution.

<b>SCORE</b>	<b>PROCESS (For Use With Categories 1–6)</b>
<b>0% or 5%</b>	<ul style="list-style-type: none"> <li>▪ No systematic approach is evident; information is anecdotal. (A)</li> <li>▪ Little or no deployment of an approach is evident. (D)</li> <li>▪ An improvement orientation is not evident; improvement is achieved through reacting to problems. (L)</li> <li>▪ No organizational alignment is evident; individual areas or work units operate independently. (I)</li> </ul>
<b>10%, 15%, 20%, or 25%</b>	<ul style="list-style-type: none"> <li>▪ The beginning of a systematic approach to the basic requirements of the Item is evident. (A)</li> <li>▪ The approach is in the early stages of deployment in most areas or work units, inhibiting progress in achieving the basic requirements of the Item. (D)</li> <li>▪ Early stages of a transition from reacting to problems to a general improvement orientation are evident. (L)</li> <li>▪ The approach is aligned with other areas or work units largely through joint problem solving. (I)</li> </ul>
<b>30%, 35%, 40%, or 45%</b>	<ul style="list-style-type: none"> <li>▪ An effective, systematic approach, responsive to the basic requirements of the Item, is evident. (A)</li> <li>▪ The approach is deployed, although some areas or work units are in early stages of deployment. (D)</li> <li>▪ The beginning of a systematic approach to evaluation and improvement of key processes is evident. (L)</li> <li>▪ The approach is in early stages of alignment with your basic organizational needs identified in response to the other Criteria Categories. (I)</li> </ul>
<b>50%, 55%, 60%, or 65%</b>	<ul style="list-style-type: none"> <li>▪ An effective, systematic approach, responsive to the overall requirements of the Item, is evident. (A)</li> <li>▪ The approach is well deployed, although deployment may vary in some areas or work units. (D)</li> <li>▪ A fact-based, systematic evaluation and improvement process and some organizational learning are in place for improving the efficiency and effectiveness of key processes. (L)</li> <li>▪ The approach is aligned with your organizational needs identified in response to the other Criteria Categories. (I)</li> </ul>
<b>70%, 75%, 80%, or 85%</b>	<ul style="list-style-type: none"> <li>▪ An effective, systematic approach, responsive to the multiple requirements of the Item, is evident. (A)</li> <li>▪ The approach is well deployed, with no significant gaps. (D)</li> <li>▪ Fact-based, systematic evaluation and improvement and organizational learning are key management tools; there is clear evidence of refinement and innovation as a result of organizational-level analysis and sharing. (L)</li> <li>▪ The approach is integrated with your organizational needs identified in response to the other Criteria Items. (I)</li> </ul>
<b>90%, 95%, or 100%</b>	<ul style="list-style-type: none"> <li>▪ An effective, systematic approach, fully responsive to the multiple requirements of the Item, is evident. (A)</li> <li>▪ The approach is fully deployed without significant weaknesses or gaps in any areas or work units. (D)</li> <li>▪ Fact-based, systematic evaluation and improvement and organizational learning are key organization-wide tools; refinement and innovation, backed by analysis and sharing, are evident throughout the organization. (L)</li> <li>▪ The approach is well integrated with your organizational needs identified in response to the other Criteria Items. (I)</li> </ul>

**Figure 5—Scoring Guidelines for the Health Care Criteria**

<b>SCORE</b>	<b>RESULTS (For Use With Category 7)</b>
<b>0% or 5%</b>	<ul style="list-style-type: none"> <li>▪ There are no organizational performance results or poor results in areas reported.</li> <li>▪ Trend data are either not reported or show mainly adverse trends.</li> <li>▪ Comparative information is not reported.</li> <li>▪ Results are not reported for any areas of importance to your key mission or organizational requirements.</li> </ul>
<b>10%, 15%, 20%, or 25%</b>	<ul style="list-style-type: none"> <li>▪ A few organizational performance results are reported; there are some improvements and/or early good performance levels in a few areas.</li> <li>▪ Little or no trend data are reported.</li> <li>▪ Little or no comparative information is reported.</li> <li>▪ Results are reported for a few areas of importance to your key mission or organizational requirements.</li> </ul>
<b>30%, 35%, 40%, or 45%</b>	<ul style="list-style-type: none"> <li>▪ Improvements and/or good performance levels are reported in many areas addressed in the Item requirements.</li> <li>▪ Early stages of developing trends are evident.</li> <li>▪ Early stages of obtaining comparative information are evident.</li> <li>▪ Results are reported for many areas of importance to your key mission or organizational requirements.</li> </ul>
<b>50%, 55%, 60%, or 65%</b>	<ul style="list-style-type: none"> <li>▪ Improvement trends and/or good performance levels are reported for most areas addressed in the Item requirements.</li> <li>▪ No pattern of adverse trends and no poor performance levels are evident in areas of importance to your key mission or organizational requirements.</li> <li>▪ Some trends and/or current performance levels—evaluated against relevant comparisons and/or benchmarks—show areas of good to very good relative performance.</li> <li>▪ Organizational performance results address most key patient and other customer, market, and process requirements.</li> </ul>
<b>70%, 75%, 80%, or 85%</b>	<ul style="list-style-type: none"> <li>▪ Current performance is good to excellent in most areas of importance to the Item requirements.</li> <li>▪ Most improvement trends and/or current performance levels are sustained.</li> <li>▪ Many to most reported trends and/or current performance levels—evaluated against relevant comparisons and/or benchmarks—show areas of leadership and very good relative performance.</li> <li>▪ Organizational performance results address most key patient and other customer, market, process, and action plan requirements.</li> </ul>
<b>90%, 95%, or 100%</b>	<ul style="list-style-type: none"> <li>▪ Current performance is excellent in most areas of importance to the Item requirements.</li> <li>▪ Excellent improvement trends and/or sustained excellent performance levels are reported in most areas.</li> <li>▪ Evidence of health care sector and benchmark leadership is demonstrated in many areas.</li> <li>▪ Organizational performance results fully address key patient and other customer, market, process, and action plan requirements.</li> </ul>

**Figure 5—Scoring Guidelines for the Health Care Criteria (continued)**

## 2006 Scoring Band Descriptors

Band	Band Number	% Applicants in Band <sup>1</sup>	Descriptors
0–275	1	0	The organization demonstrates the early stages of developing and implementing approaches to Category requirements, with deployment lagging and inhibiting progress. Improvement efforts focus on problem solving. A few important results are reported, but they generally lack trend and comparative data.
276–375	2	0	The organization demonstrates effective, systematic approaches responsive to the basic requirements of the Items, but some areas or work units are in the early stages of deployment. The organization has developed a general improvement orientation that is forward-looking. The organization obtains results stemming from its approaches, with some improvements and good performance. The use of comparative and trend data is in the early stages.
376–475	3	0	The organization demonstrates effective, systematic approaches responsive to the basic requirements of most Items, although there are still areas or work units in the early stages of deployment. Key processes are beginning to be systematically evaluated and improved. Results address many areas of importance to the organization’s key requirements, with improvements and/or good performance being achieved. Comparative and trend data are available for some of these important results areas.
476–575	4	0	The organization demonstrates effective, systematic approaches responsive to the overall requirements of the Items, but deployment may vary in some areas or work units. Key processes benefit from fact-based evaluation and improvement, and approaches are being aligned with organizational needs. Results address key customer/stakeholder, market, and process requirements, and they demonstrate some areas of strength and/or good performance against relevant comparisons. There are no patterns of adverse trends or poor performance in areas of importance to the organization’s key requirements.
576–675	5	0	The organization demonstrates effective, systematic, well-deployed approaches responsive to the overall requirements of the Items. The organization demonstrates a fact-based, systematic evaluation and improvement process and organizational learning that result in improving the effectiveness and efficiency of key processes. Results address most key customer/stakeholder, market, and process requirements, and they demonstrate areas of strength against relevant comparisons and/or benchmarks. Improvement trends and/or good performance are reported for most areas of importance to the organization’s key requirements.
676–775	6	0	The organization demonstrates refined approaches responsive to the multiple requirements of the Items. These approaches are characterized by the use of key measures, good deployment, evidence of innovation, and very good results in most areas. Organizational integration, learning, and sharing are key management tools. Results address many customer/stakeholder, market, process, and action plan requirements. The organization is an industry <sup>2</sup> leader in some areas.
776–875	7	0	The organization demonstrates refined approaches responsive to the multiple requirements of the Items. It also demonstrates innovation, excellent deployment, and good-to-excellent performance levels in most areas. Good-to-excellent integration is evident, with organizational analysis, learning, and sharing of best practices as key management strategies. Industry leadership and some benchmark leadership are demonstrated in results that address most key customer/stakeholder, market, process, and action plan requirements.
876–1000	8	0	The organization demonstrates outstanding approaches focused on innovation, full deployment, and excellent, sustained performance results. There is excellent integration of approaches with organizational needs. Organizational analysis, learning, and sharing of best practices are pervasive. National and world leadership is demonstrated in results that fully address key customer/stakeholder, market, process, and action plan requirements.

1. Percentages are based on scores from the Stage 1 review.

2. Industry refers to other organizations performing substantially the same functions, thereby facilitating direct comparisons.

**Figure 6—Scoring Band Descriptors**