RESULTS

The Great Health Center

Meanings. Pathways. Impacts.

by Hal Williams

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PREFACE

World Class. Excellence. The Best. ***GREAT.***

For centuries, individuals, organizations, and entire movements have pursued both the concept and the actual practice of true greatness. Some have attempted simply to understand it, others to achieve it. Some have sought this pinnacle of achievement simply to gain recognition, while others have seen perfection as its own highest reward.

The National Association of Community Health Centers (NACHC) has long sought to promote real excellence within all of the nation's community health centers (hereafter referred to as "health centers"*****), in large part through its Training and Technical Assistance Department. As NACHC expands its work to help health centers become ever more efficient and effective, we remain keenly interested in two foundational questions:

- What **defines** a truly great health center?
- What are the **attributes and practices** associated with the highest levels of success – in organizational sustainability as well as in health services and related outcomes for health centers?

**** NOTE: In this document, unless otherwise noted, the term "health center" is used to refer to organizations that receive grants under the Health Center Program as authorized under Section 330 of the Public Health Service Act, as amended (referred to as "grantees") and FQHC Look-Alike organizations, which meet all Health Center Program requirements but do not receive Health Center Program grants. It does not refer to FQHCs that are sponsored by tribal or Urban Indian Health Organizations, except those that receive Health Center Program grants.***

The answers to these questions will clarify the relationship between the next incremental gains in any given process or procedure and the long-term capabilities that health centers are striving to achieve. Continuous improvement is tactical; aligning improvements to create great health centers is strategic. Greatness and the pathways to it are especially important given the number of new health centers to be created if health reform investments continue to be made nationally. For such centers, it will clearly be more advantageous to start with key elements that forecast high achievement than to try to build in these elements later.

To help explore perceptions and insights about greatness in health center organizations, NACHC engaged nationally-respected Outcome Guide Hal Williams and asked him to read, listen, and then formalize not just what health center professionals and others think greatness *is*, but also what paths have been shown to be helpful in getting there.

NACHC has already begun to apply one fundamental finding – that great organizations are defined less by what they do than by what *others gain* from what they do. Accordingly, NACHC is now moving from self-assessment based on specific activities (such as number of attendees, number of workshops offered, etc.), to focusing on how many participants actually *did* something differently – and better – as a result of NACHC's assistance. This report represents Mr. Williams' findings and resulting recommendations. We invite you to join us in the active pursuit of true greatness. While we will likely begin the journey at different starting points, I believe we will celebrate together at a common destination.

Julie Bodën Schmidt
Associate Vice President, Training and Technical Assistance
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APPROACH

Since search results depend in large part on where one looks, we started with a broad scan of inquiries about "greatness" in many kinds of organizations, then focused in on health care and health centers. Five main sources of information were used for this report:

1. Literature on what defines and creates greatness in organizations. Some of the reading brought back old favorites – such as *In Search of Excellence*, the 1982 book by Peters and Waterman that launched a spate of research on high performing businesses. And, of course, Jim Collins' *Good to Great* (2001) and its 1994 predecessor, co-authored by Jerry Porras, *Built to Last: Successful Habits of Visionary Companies*.

2. Writings on high achieving health centers, including work by Deborah Ann Gurewich and her colleagues at Brandeis University. This also involved reviewing efforts to define quality standards, such as the 2001 report from the Institute of Medicine (IOM) entitled *Crossing the Quality Chasm*. Research specific to key themes, such as publications by Susan Hubbard and her colleagues on patient activation, was also conducted.

3. Interviews with thought leaders in the field of organizational excellence. Included was a cross-section of researchers and practitioners including Peter Shin, director of the Geiger Gibson Program in Community Health Policy at The George Washington University; Dr. David Stevens, former Director of the NACHC Quality Center; and Bruce Gray, CEO of the Northwest Regional Primary Care Association in Seattle. Personal and group discussions were also held both with staff and with Board members of health center organizations. More than 50 individuals attended focus groups addressing such vital functional areas as clinical services, operations, finance, and governance.

4. Follow-up contacts with specific high-achieving health centers, in order to study them more closely.

The complete list of persons who served as respondents is displayed at the end of this report.

We will attempt to be clear in this report about whether we are referencing a significant number of respondents, via literature and interviews, or just one (or several). We also attempt to sort out personal conclusions from the contributed observations.

A final note is in order. The pronoun "we" is used to reflect that this was, in the best sense, a truly collaborative work. In particular, my appreciation goes to Julie Bodën Schmidt and the staff of NACHC's Training and Technical Assistance department for their help, insight, and curiosity. They are perfect examples of George Bernard Shaw's observation that the greatest reformers the world has ever seen began first with themselves.

Hal Williams
Outcome Guide

SUMMARY FINDINGS

The primary areas studied for this report were as follows:

- Greatness at the core of health centers
- Greatness in the health centers' parts
- Greatness attributes, both seen and heard
- Assumptions shaping the view of "greatness"
- Paths to greatness
- NACHC's role in encouraging truly great health centers

People often quibble with the term "great." Some prefer "excellence", others "world class" or "best in class", and others "outstanding." But a common notion underlies all of these terms.

One international center dedicated to defining the *world class* organization refers to *greatness* when it describes, *"An organization which is as good as anyone, anywhere in the world, and greater than any organization in the locality."* Here, one term is even used to define another. So perhaps the path to greatness is like a circular staircase. Let's start climbing!

GREATNESS AT THE CORE

Virtually all health center respondents suggested that the best place to locate greatness is at the organizational core, rather than in the health center's component parts. They spoke first to descriptors of the overall organization, and only then addressed operations, finance, and other specific functional areas to *illustrate* those central organizational tendencies. The seven core attributes noted most frequently are a mix of values, capabilities, and practices, are:

1. **The patient is the organization's focal point.** The great health center dives below the abstraction of "patient satisfaction" to understand and continually improve the actual patient *experience*, which is seen as crucial to positive health outcomes. Genuine respect goes deeper than surface pleasantries, and real cultural understanding goes far deeper than language alone. True access to care, by hours and location, is critically important, and the yardstick is not what is good for staff, but what is good for patients.
2. **Patient health is the whole point.** The great health center ultimately defines itself by health outcomes for those it serves, rather than by compliance with service delivery standards – even strong quality-based standards. The expression "whatever it takes" signifies actively dealing with housing, jobs, and anything else that stands in the way of positive health outcomes. A great health center need not offer all of these services itself, but it will at least have strong relationships with other organizations that provide them effectively.
3. **Improvement is a constant quest.** Good health centers are satisfied, while great ones are restive. Great centers show constant urgency to reduce waiting times, address sedentary lifestyles, drive screenings and vaccinations to 100%, and so forth. They spend less time talking about issues and more time trying new approaches. Advancing is more about achieving full organizational potential than it is about remediating faults.
4. **Systems and data guide behavior.** Data use trumps databases. Great clarity prevails regarding what information all staff can use to actively track and improve results. Selected software offers specific decision prompts and provides relevant information in real-time dashboard format.
5. **Partnerships and connections are both plentiful and productive.** Good health centers connect with other entities through cooperation, coordination, and communication. Great health

centers actively *collaborate*, achieving greater results through partnership than they could generate on their own.

6. **Great people are selected, supported, and retained.** Many health centers hire for credentials, degrees, and number of years' experience. The great health center selects and "grows" people with attributes (such as the ability to engage, and the capacity to learn) that enable full expression of core competencies. The great health center does not see people within a given category as interchangeable, and it believes that *selecting* well ultimately has more payoff than simply training well.
7. **Growth and adaptation capacities are very high.** Most nonprofit organizations are adept at meeting basic requirements and writing successful grants to fund their ongoing services. The corollary, however, is that organizational adjustments are often primarily responses to funding or regulatory changes. The great health center is both proactive and focused on changes that truly improve health gains, whether or not funders or regulatory agents require them. One seldom hears that the reason a service is not offered is that the government won't pay for it.

GREATNESS IN THE PARTS

Respondents were then asked to speak to the idea of greatness in the organization's component parts, with respondents representing specific functions addressing what differentiates average from great departments. Focus groups and follow-up interviews were held with thought leaders in each of five functional areas, as follows:

1. **Operations** is seen as what is done to support patients, as opposed to meeting staff or organizational needs. Those in operations are at their best when they function in the background, quietly supporting the steady daily flow of patients, staff, technology, and information.
2. **Clinical practice** focuses on patient experience (seen as more than simply "satisfaction") and addresses not only what physicians know, but also how they communicate that knowledge to create both understanding and effective patient initiative and compliance. Importantly, clinical work is seen as the arena of *all* staff, not just doctors and nurses.
3. **Governance** adds strong positive value to the organization by connecting the center to community resources, overseeing outcomes, and providing stewardship of the center's mission. In taking their fiduciary responsibilities seriously, Board members focus on how they can personally as well as collectively improve health outcomes for the patients served. Both consumer and professional Board members generally spend little time "educating" those in the other category, and more time actually applying their respective strengths.
4. **Leadership** begins with a strong, highly collaborative CEO who continuously "pushes the envelope" and relies on the Board to rein him or her in as appropriate. Partnerships created by these leaders are both external (connecting with other entities that can add value) and internal (especially managing the differing perspectives of clinical and administrative staff). Rather than trying to eliminate staff differences, the great CEO *harnesses and utilizes* those differences to the center's advantage.
5. **Finance** sees itself less as "counting the numbers" than as making those numbers better before they are counted. This function engages with all other functional areas, including the front desk (to ensure accuracy of patient numbers for billing and tracking purposes). It also makes all

needed data available to decision makers so that both costs and gains are appropriately considered.

GREATNESS SEEN AND HEARD

Respondents were asked whether different things are seen and heard in a great health center than in a good or fair one. The answer was a resounding "Yes." With surprising ease, respondents were able to identify what was observable in organizations where greatness ran deep. And they could readily give examples of how what is observed reflects the seven attributes described above in "Greatness at the Core."

With respect to patient centeredness, for example, in high-achieving health centers one sees substantially more smiles than frowns on the faces of both patients and staff. There are no obvious indicators of relative status when staff and/or Board members interact. One hears clarity from patients when asked how long they are likely to be waiting; more comments about solutions than about problems from staff and Board; and cogent questions alongside assertions and opinions.

Most respondents found significant merit in efforts to create and use checklists to build a picture of what is really happening, as well as to uncover helpful contrasts between the organization *on paper* (*e.g.*, plans, logic models, policies, procedures, protocols, etc.) and the organization in *day-to-day reality*.

ASSUMPTIONS FOR GREATNESS

Since "greatness" is fundamentally an abstraction, we wanted to learn what actually shapes our practical view of it – both generally, and specifically as applied to health centers. From our research and interviews, the five questions below appear to frame fundamental assumptions regarding a great health center organization:

1. **Is greatness absolute, or relative to other organizations?** Most respondents had no clear view of the *absolutely* "great" health center; rather, they defined greatness in terms of relative location on multiple continua that are seen as important.

2. **Is greatness best defined by what goes in, or by what comes out?** Most respondents felt that greatness lies very much in achievement (*i.e.*, results), and that no amount of perfecting of structures, processes, or other inputs can serve as a credible surrogate for great outcomes. Most felt that a health center simply cannot "comply" its way to greatness.

3. **Is greatness achieved incrementally, or does it require breakthroughs?** Respondents were split on this question. Some felt that continuous improvement from a current baseline will gradually carry a health center to greatness; others saw a need for innovation and transformation in order to make quantum leaps forward.

4. **Is greatness a singular condition, or can it take multiple forms?** While many respondents spoke of the need to honor differing health center contexts (*e.g.*, small and large, urban and rural, special populations, etc.), when it came to actual health outcomes, little variation was

evident on what constitutes greatness. Interestingly, most respondents *resisted* the long-prevailing adage that "If you've seen one health center, you've seen just one health center."

5. **Is greatness best explained by systems and structures, or by people?** While most respondents spoke of organizational attributes, the examples they described were most often about specific individuals whose personal characteristics prompted, if not caused, the organization's success.

PATHS TO GREATNESS

Luck, fate, chance – there is no room for these phrases on the path to health center greatness, according to the respondents. The starting point is *intentionality*, with a high degree of *purposeful thinking and action*. No one suggested that a health center achieves greatness by even highly effective reactions to crises, or that simply going through organizational phases (for example, from start-up to mature) or adopting new models necessarily produced anything great.

Most respondents felt strongly that the two most critical "pins on the map" of the path to greatness are those locating the starting point and the destination. Respondents noted that without a clear goal line, incremental improvements could easily lead in different, even contradictory, directions. They also suggested that the *comparative* perspective of "We want to be better than the others" keeps organizations looking sideways rather than ahead. And most felt that the ultimate goal should be specific, so that any center would know when it had arrived at greatness.

Regarding current location on the path, respondents noted that health centers, like other organizations, may not always know what their shortfalls are, especially when viewed by their patients or through patient outcomes. Respondents also addressed the role of *strategy* in finding a path to greatness, citing strong value in setting interim milestones and tracking to their accomplishment through a few key metrics. Others added that *rate of change* was actually more critical than current level of achievement; that is, an organization more distant from greatness but with a steep improvement curve (or rate of change) will often eclipse a currently higher-performing health center with a flatter improvement curve.

Some respondents focused on critical transition points that they felt predicted success, such as moving from hiring people on the basis of credentials and certifications, to hiring people who are highly effective at engaging patients and other staff. Others focused on overcoming major challenges, such as avoiding complacency once they see themselves as "good", or dealing effectively with physicians who desire a better work/life balance.

EXPANDED FINDINGS / DISCUSSION

GREATNESS AT THE CORE

Research on high performing organizations, most from the for-profit sector, generally finds that a handful of core characteristics is associated not only with high achievement, but also with its explanation.

Authors Thomas Peters and Robert Waterman, Jr. were seminal figures in this type of inquiry, as reflected in their 1982 book *In Search of Excellence: Lessons from America's Best-Run Companies*. They concluded that eight factors explain excellent companies *(please refer to the original text for a more detailed explanation of the factors)*:

1. **A Bias for Action**
2. **Closeness to the Customer**
3. **Autonomy and Entrepreneurship**
4. **Productivity through People**
5. **Being Hands-On and Value Driven**
6. **"Sticking to the Knitting"**
7. **Simple Form and Lean Staff**
8. **Simultaneous "Loose-Tight" Properties**

One important theme in their work is that greatness is neither obscure nor complicated, and indeed that it has an underlying premise of simplicity. Being good requires nuance, explanation, and qualification; greatness speaks for itself.

In 2001, James Collins published *Good to Great,* describing additional research attempting to define the characteristics of great companies. He refined the research methodology in order to get as close as possible to a truly controlled experiment, by pairing great companies with other corporations having similar characteristics but which achieved much lower return to shareholders. Collins' research found seven core traits which are summarized below:

1. **Level 5 Leadership.** Leaders in great companies do not aspire to be larger than life or irreplaceable. They are seemingly ordinary people producing extraordinary results. If you see extraordinary achievement with no one stepping up to claim ownership, you have greatness in action.
2. **First Who . . . Then What.** Get the right people on the bus. They don't need to be tightly managed or externally fired up – they do that for themselves. Selecting well is much more effective than training well.
3. **Confront the Brutal Facts.** The great companies look squarely at reality and change course as often as necessary to stay on the path to greatness. They do not explain away problems, but see and respond to them.
4. **The Hedgehog Concept.** Great companies know what they are really good at doing, what drives their engine, and what they feel passionately about. They put this into a simple framework that drives all action.
5. **A Culture of Discipline.** Great companies change their plans but not their intended results. They always look at what they accomplished relative to what they said they would accomplish and do not lightly explain away shortfalls.
6. **Technology Accelerators.** Hardware, software, websites, data systems, and other technologies are not seen as the creator of momentum but, rather, as its accelerator. Great companies use technology purposefully, but do not thoughtlessly rely on it.

7. **The Flywheel.** Great companies do not look for the "killer innovation", lucky break, or life-defining breakthrough. They develop momentum and often do not even see transformation until they are well into it.

As did Peters and Waterman, Collins speaks not to the mastery of complexity, but rather to the discovery and use of simplicity.[1]

As noted previously, our own inquiry into health center greatness also produced a common core of attributes cited repeatedly as essential. When we asked respondents, "What do you see as the differences between a great health center and one that is fair or good?", respondents could have gone to the component parts of the organization ("They have a great financial system", or "They have a first-rate clinical set-up," etc.). Instead, responses clustered around core organizational factors; as we have noted, some are values (*e.g.*, patient-centeredness), some are capabilities (*e.g.*, to adapt to the future), and some are practices (*e.g.*, seeking partnerships.) Let's now expand upon our earlier summary (in "Findings", above) to address in greater detail the seven attributes our study's respondents said were present in great health centers.

1. **The patient is the organization's focal point.** Most organizations say they put the customer first. Health centers have even more reasons to do so, including their community heritage and the Federal requirement that half of their Board members be community residents reflecting the center's client base. But writing something is not the same as living it. In great health centers, the value of patient-centeredness is acutely seen in respect, cultural sensitivity, and positive relationships – not just between staff and patients, but among staff, Board members, and everyone else.[2]

   No one needs to be reminded that this is important. In fact, we were told that the stronger the patient-centered premise, the less need there was for programs, campaigns, or slogans to *make* it important. Patients are simply the default priority. Patient perspectives are actively considered in every decision and action. Follow-up calls to patients are made by people who can answer questions, not just deliver news. And doctors record their messages such that patients can listen to them as often as they wish.

   Patient *experience* in great health centers goes far deeper than simply patient "satisfaction" and is seen as a key to health outcomes. The focus is not on pleasing people, but on helping them. Further, there is no sense that the patient is any part of the problem. You do not hear, "Mrs. Johnson just won't lose any weight." Instead you hear, "We have so far failed to find a way to help Mrs. Johnson lose weight, and we have to figure that out."

   The patient as focal point is also reflected in service delivery location. Within the center, services come to patients whenever possible; outside of the health center walls, services are provided in schools, housing projects, work sites, and other locations where patients already go.

2. **Patient health is the whole point.** Good health centers report on units of service. Great ones report on units of *gain*. They do not equate seeing patients, or dispensing scripts, or giving advice as equivalent to health outcomes. They allow no other accomplishments to substitute for actual patient health gains.

Most health centers report on a *sample* of patients, a practice allowed by HRSA. Great centers choose to report on *all* persons they serve. At the same time, they are realistic. They focus more on improvements for their patients than on changes in population statistics they cannot fully control.[3]

To the great health center organization, health improvement compels getting into the behavior change business. At the very least, these centers follow up to ensure that patients "take their medicine" – be it a pharmacy script or a prescription for exercise. They find ways of using all staff, not just clinicians, in follow-up and patient support.

The expression "whatever it takes" is taken seriously as great centers look to deal directly or by linkages with social and other factors that influence health – jobs, housing, education, environment, and so on. Some health center organizations go directly into these areas, opening related businesses or expanding existing programs. Others select and partner with groups that are already successful in providing these services. In either approach, the great health center doesn't cite lack of money or expertise for not doing what's necessary to help people who need a house, educational support, a job, or anything else with a clear influence on health.

3. **Improvement is a constant quest.** Good health center organizations celebrate their accomplishments and work to make everyone feel positive about them. Great ones constantly focus on the next step forward and make everyone feel restive that they are not there yet.

   Simply put, the will is backstopped by a way. In many cases, according to the respondents, that way is to generate a constant flow of projects – each with a defined starting and ending point, as well as a clear focus on improving a specific metric from *x* to *y*. For instance, operations is driven to get patient waiting time from 30 minutes down to 20. Or finance is determined to reduce by 10 its "days in accounts receivable." Or clinical services is concentrating on getting 100% of patients to fill, refill, and take their medications. Ask staff members at a great health center if they are working on improving anything specific – they will say "Yes" and tell you what it is. They can tell you the target, and they can tell you where they are right now relative to that target.

   Many approaches used in both formal and informal projects are termed "innovations." The great health center was seen by respondents as constantly trying new approaches and building on what has been shown to work. While the staff may not be doing one big thing that produces a quantum forward leap, the accrued effect of many smaller changes relentlessly made over time is just as substantial.

4. **Systems and data guide behavior.** In many organizations, when you ask people why they are collecting information, they respond by saying that someone else wants it. In the great health center, the response is different: "How could I make the best decisions *without* that information?" Data is used to improve outcomes long before it is used for reports.

   Great data systems were described as being truly interactive, with prompts for what to do next. Patients are prompted to call the center, to show up for appointments, to follow up on findings from tests, and to get and take their medications. At the center, information is used to guide a smooth flow of people and resources throughout the day, and staff is prompted to make needed follow-up calls and/or visits.

Many respondents noted that the sophistication of a database was not a strong predictor of data use. In a similar vein, simplicity was reported to trump complexity. Key data points were limited to those making the most difference in efficiency and effectiveness.

Good systems, according to respondents, ensure that everyone does the same things in the same ways. At their best, these systems help nudge *all* employees toward emulating the practices of the best ones, which are used to norm procedures and expectations. Great systems even go a step beyond, enabling more personal choice and creating more, rather than less, flexibility.

5. **Partnerships and connections are both plentiful and productive.** Strong linkages with other entities are seen as a hallmark in virtually all studies of high performing organizations. Rosabeth Moss Kanter, in her book *World Class*, notes that the best corporations are regional or even global in outlook. According to her, they have "connections." Other researchers have come to similar conclusions. Few great organizations retain fierce independence.

   We were told that great health centers indeed have a view of being "global" within their own communities. Rather than seeing themselves as one isolated provider serving a niche of people others don't or can't help, these centers look at how they fit within the broad ecology of health-promoting factors, including social determinants.

   An oft-mentioned explanation for this perspective is the disposition of a health center's leaders. Often, respondents reported, critical groups fail to work together well because of the personalities of their leaders – usually CEOs, but sometimes Board chairs. The great health center organization has leaders who give and share credit and who look to create gains that may not be readily attributable to his/her own group.

6. **Great people are selected, supported, and retained.** Traditionally, organizations hire for degrees, credentials, and experience. Great health centers hire for attributes, such as energy, empathy, stamina, and resourcefulness. The great health center organization does not believe that individuals with the right background are interchangeable. And they believe that hiring well is even more critical than training well.[4]

   Once the right people have been hired, the focus is then on providing supports that enable all staff members to achieve at their highest level. Mentoring and training opportunities abound, and performance appraisal is seen less as a point of assessment than as a factor of growth. As one respondent put it, being patient-centered begins with being staff-centered.

   The great health center actively differentiates between high and low performers. On the one hand, it knows who to retain and takes active steps to accomplish that. At the opposite end of the spectrum, a great health center identifies and parts company with those who are not high performing, much more quickly than do health centers that are simply good.

   Here are some staff-related specifics that were mentioned frequently by respondents as leading to greatness in health centers:

   - Encouraging robust professional networks and learning, both for clinicians and for all support staff[5]

- Providing an incentive system that puts both money and non-monetary rewards behind high achievement[5]
- Paying competitive salaries (for example, to avoid losing great nurses to hospitals over a $2-$3 pay differential)
- Providing significant professional development, including mentoring.[6]

7. **Growth and adaptation capacities are very high.** All health centers face the same turbulent times. However, according to respondents, they can differ greatly in their response to those times. Some centers hunker down and move with caution. A few get reckless and overreact. Great health centers do neither. They are simply proactive, spending little time bemoaning factors they cannot control. Their underlying premise is that there is always some way forward.

   We asked what capacities enabled this attribute, and two were cited repeatedly. One is the ability to **be nimble**, giving up a present position or program if something better takes shape. The other is the capacity to **do things quickly** – to reduce cycle time from planning to action. Indeed, the great centers know how to essentially plan and act simultaneously.

   Respondents also cited two specific organizational practices that enable growth and adaptation in great centers. One is a continual, systematic **scan of the environment** – in particular, potentials for alliance, and clarity on how others view the center. Adaptation, these centers believe, comes hard when the only view considered is your own.

   The second organizational practice is a **focus on opportunity** more than on problems. Peter Drucker is among the management experts who believe that the ability to shift from a comfortable focus on durable, widely understood, and externally created problems to the search for time-bound, hidden, and internally-generated *opportunities* is a huge distinguishing factor in an organization's level of greatness.

A point the respondents made repeatedly is that these seven attributes run deep. While all organizations have characteristics, one respondent noted, the great ones have *character*.

One caution: We have no way of knowing whether these seven attributes started at the organizational core or at the periphery. Most likely it is a combination of both, with some starting as organizational priorities, and others beginning in a specific function and gradually spreading, first to other functions and then to the organizational center. What we can say is that these attributes are unlikely to appear in *any* location without the intention to put them in place.

GREATNESS IN THE PARTS

While the conversations generally took us first to organization-wide factors, we also looked at greatness in five specific health center functional areas: operations, clinical practice, governance, leadership, and finance. We started by listening to what people from each area selected as important achievements, using a focus group format.

One insight from these conversations provides a critical backdrop. This is simply that greatness may mean *optimizing* rather than maximizing gain in any given functional area. If each area were encouraged to focus solely on its own issues without regard to those of the other areas, greatness at an

organizational level would be unlikely. Optimal balance and supportive interplay among functional areas is perhaps the most critical part of internal collaboration.

Operations. Two practices were seen as highly developed in the operations function of great health centers. One is **flow management**. Operations in all elements is viewed through the lens of what can be done to insure the steady flow of patients, staff, information, and technology through the daily life of the center. The foremost priority for flow management is the patient, not the staff. Flow is considered critical in a positive patient experience.

The second highly developed practice in the operations area of a great health center is constant **translation of strategy into behavior**. As with great companies in the retail sector, strong latitude is given to all staff to do "whatever it takes" when an issue arises.[7]

Specific points of greatness:

- Little time is spent putting out fires. The center routinely runs in such a way that everyone can concentrate on the services and relationships that actually create health.
- Systems are developed to prompt behaviors by staff and patients that increase both engagement and health.
- Operations trains and encourages staff and volunteers on how to adjust behavior based on data, including productivity and payer mix reports.
- There are clear top-line metrics that are actively tracked, with interventions pre-defined whenever something goes off-track.

Clinical practice. The core premise reported here was a broad definition of the term "clinical." It included prevention as well as all other services delivered to the patient, not simply those services provided by a physician or nurse. Several persons suggested the need for a new term so as not to pigeonhole "clinical" issues. This broader definition also enables a focus on dental and behavioral issues as integral parts of health (rather than being seen as separate services).

Specific points of greatness:

- Patient self-efficacy is a priority. A trusting provider-patient relationship is important but doesn't necessarily lead to change. There is a recognition that even a satisfied patient may not necessarily have the self-confidence or skills to change behaviors in needed ways.
- Harnessing multiple perspectives is vital. Rather than eliminating or minimizing tension between clinicians and administrators, great health centers see both viewpoints as useful, and both perspectives are harnessed in making the best possible decisions in achieving patient health. Customary role prerogatives are not held sacred.
- Quality standards should be prioritized. The focus on quality goes well beyond funder and regulatory compliance and gives priority to standards that best predict both clinical outcomes and organizational viability. An example offered by many respondents was the framework found in Dr. Donald Berwick's *User's Manual for the IOM's "Quality Chasm" Report*. (The Institute of Medicine, or IOM, is one of three bodies comprising the National Academy of Sciences.)[8]

Also in the clinical arena, everyone both works to the highest level of their licensure and also seeks cross-training opportunities to ensure that all staff members own responsibility for continuous and coordinated care. And in a great health center, training on patient tracking and customer relationships is always in place.

Governance. Two themes were described in conversations regarding the great health center's Board. One was that Board members let their **passion shine through to action**. The health center's Board connects the clinic to community resources, ensures funding, and provides active stewardship of the center's mission and results for patients. Simply sitting in Board and committee meetings is far from enough for these Board members.

The second theme is the attention paid to **interpersonal relationships** – both those among Board members, and the relationship between the Board and the CEO. These relationships were seen as being just as important as the structural issues of Bylaws, agendas, etc.

Specific points of greatness:

- In great health centers, the Board has an outstanding relationship with the CEO. The CEO does not lecture the Board or feel the need to spend significant time educating its members. For its part, the Board does not manage the center or get involved with management decisions. As several respondents put it, a great relationship avoids both excessive coziness and excessive separation.
- Board members provide strong links to community resources. They are not only the "eyes and ears" of the community, but they also actively look for ways to forge new connections and to imbed the health center into the community context.
- Board members respect and actively listen to each other. Individual egos and prerogatives do not get in the way of effective discussion and decision making, and the interests of patient health are always put first.
- The Board sees stewardship of health center *results* to be equally as important as stewardship of finances and compliance issues. Board members continually ask questions about health outcomes for the people served, and each Board meeting includes a review of critical successes and shortfalls.
- The Board has an effective annual review with the CEO, based on clear targets for achievement that are set at the beginning of each year. The Board effectively "rehires" the CEO at the end of each contract period and routinely has a succession plan in place.
- There is also a succession plan for Board leadership, as well as a rotation schedule sufficient to getting new Board members involved and younger members into different roles (such as representing the center at community and professional meetings). In great Boards, no form of "the old guard" dominates.

Leadership. The CEO (top leader) position is clearly important in a merely proficient health center, but it is critical in a great one. Two CEO-based themes continually arose in respondent interviews: 1) the ability to **bring people together**, both inside and outside of the organization; and 2) the ability to continually put **positive and sustained energy** into the organization.

Specific points of greatness:

- The leader in a great health center organization is highly collaborative, guiding but not dictating, and setting a tone of strong mutual respect. He or she also knows how to empower a consumer-driven Board.
- Rather than ignoring tensions between clinical and administrative areas, the great CEO harnesses differences in staff perspectives to make optimal broad-based decisions that benefit the entire organization.
- A great leader knows when to move from listening to decision-making when the cost of inaction would be high. For example, he/she might move to terminate or change the roles of staff members who are performing poorly or contributing to negative morale.
- The great CEO spends more time on strategy than on operations, actively considering change and taking proactive steps to exploit opportunities and deal with problems.

Finance. Respondents noted two practices as critical. The first is a shift from simply "counting" to **making the numbers better *before* they are counted**. This brings help to other functional areas rather than imposing control, and it includes making data available to everyone regarding decisions in which they have a stake. The second (and related) theme is that **costs are not viewed in isolation**; rather, costs are continuously put into the context of *gains* that do or do not justify them.[9]

Specific points of greatness:

- Finance builds and maintains excellent systems, including selection of optimal accounting software. The finance function views accounting processes as clear predictors of staff ability to control costs and use funds to optimal effect.
- The accounting system is flexible (especially in reporting formats and scenario building), and it is prompt. Books are closed and statements are ready within five days of each month's end.
- The great CFO views clinicians – as well as all others in the organization – as his/her customers. Controlling cash is seen as a matter of implementing effective systems, not as control over the people who use them.
- A great CFO takes a broad view of organizational success and is a full partner with the CEO in the use of resources to achieve optimal results.

GREATNESS SEEN AND HEARD

During the interviews, respondents were asked if they thought greatness in a health center could be actively observed. To a person they answered in the affirmative, and they were very clear on what would be seen and heard in a great health center that might not be observed in other centers. Additionally, respondents were asked if at least some signs of greatness would likely be seen within 10 minutes of walking into a health center; again the answer was affirmative.

The respondents stated that in a great health center, an observer would <u>see</u> the following:

- An environment that is warm and welcoming (within the limits of space and budget)
- Human energy, a sense that staff actively want to be present and are positive about their work
- Active staff and patient engagement, with no one seeming "lost" in time or space
- More smiles than frowns on the faces of both patients and staff
- No clear way to know who has higher status in interpersonal interactions

- Patients and caregivers talking/listening with mutual respect
- Patients and caregivers at the same eye level, interacting as partners in health.

The same observer, according to the respondents, would hear the following:

- Clarity by patients on how long they will be waiting
- More discussion about solutions than about problems
- As many questions being asked as there are assertions being made
- Respect in words and the way in which they are delivered, both among staff and between staff and patients
- More enthusiasm and "life" than pessimism and listlessness
- Little or no blaming of patients (for anything).

Simple observations were often cited as deeply telling. One is the ratio (in conversations both formal and informal) between statements about problems speakers can't control and ones they *do* control. And in those same conversations, another simple but powerful observation is the ratio of statements about problems to statements about *opportunities and solutions*.

One respondent suggested that in observing staff meetings, one should look at the number of opinions stated versus the number of questions asked. In an organization which is always seeking to improve, questions are essential to continued learning.

That said, it is also worth noting that in his book *Blink*, Malcolm Gladwell asserts that genuinely smart people do not need to know 100 things in order to act. Rather, they instinctively look for just a few factors that can tell them what they need to know to predict success. An excellent example is a group of professionals at the University of Washington whose members can listen to a tape of two marriage partners and predict, with unnerving accuracy, the longevity of their relationship based on a single factor.[10]

ASSUMPTIONS FOR GREATNESS

What criteria do people use to label something "great?" In many cases, the answer appears to be anchored in unspoken, and sometimes unexamined, assumptions about what greatness is and what it means. Previously, we posited five questions whose answers appear to be central to this issue; here we will expand on these questions and their ramifications for what is assumed about greatness.

1. **Is greatness absolute, or relative to other groups?** One approach to greatness starts with an ideal and then asks if we are living up to it. Absolute definitions often originate in a visionary starting point that defines the highest achievable end state in communities, organizations, and/or individuals. Plato envisioned the ideal republic, utopians define ideal communities, and religious leaders and philosophers envision the ideal code of ethics. In this view, there is little room for *relative* merit. The Stradivarius is a "great" violin not because it is simply better than other violins, but because it achieves an incomparable sound that could be considered ideal.

   Similarly, a great school could be defined as one in which 100% of students achieve at or above grade level. And a great health center could be one that has no undetected, untreated, or chronic conditions within its service area. In this world of the ideal, 90% is not good enough.

Another absolute definition of greatness could be the "line drawn in the sand" by such declarations as:

- *If our patients all had choices, they would all still come to us.*
- *I would gladly have my own family treated at our health center.*

A second approach is greatness as *relative* to others within a category. Greatness is the high end of a continuum, regardless of the specific value of achievement. Ratings and rankings use this approach, as do "best in class" descriptions.

When Peters and Waterman wrote *In search of Excellence*, they defined excellence as relative high performance within a given industry. Most studies of this nature, including *Good to Great* by Jim Collins, pair a high-performing group with a low-performing one and look for differences. Unlike the theoretical limit that defines the farthest edge of greatness, this view is empirical and practical. We do not need to know much about the true essence of greatness; we just need to know which groups are farther along on the low-to-high continua used to gauge organizational performance.

Some approaches to greatness contain elements of both absolute and relative thinking. A surprising pick for "best of show" at the 2011 Westminster Kennel Club dog show was a Scottish deerhound named Hickory. Judge Paolo Dondina had to pick a winner. On the one hand, he could not say that no dog measured up to true greatness; on the other, when asked why this dog was selected, he said it was because Hickory most conformed to the standard for that breed as determined 150 years ago. So in effect, an absolute standard was used to decide relative merit.

Of course, each of these two approaches raises valid questions. For example, is absolute excellence always the goal? The U.S. Environmental Protection Agency has found that with some pollutants, the cost to get a 95% reduction in pollution was reasonable, but the cost to get out the last 5% was incredibly high. So does greatness lie in spending more resources to reach perfection, or in knowing when to shift limited resources to other areas having greater return on investment?

A primary question for the relative approach is just how and why specific ranking factors were selected beyond simply their ability to array performance among a cohort. The variables used to create the frequent lists of "10 Best" colleges, livable cities, and so forth may or may *not* be ones that matter most to any given consumer.

And for both approaches, is greatness a destination, or a journey? In some ways, the answer seems counterintuitive. The absolute definition, while a long way out, constitutes a clear destination; that destination may take a lifetime or more to reach (or may in fact be unreachable), but it is defined clearly in binary terms. You either reach it or you don't. Relative definitions can better gauge positive progress; however, the journey may appear to be an endless quest, since someone can always run a faster mile, or help more people lose greater amounts of weight.

In practice, roughly 80% of the respondents for this report favored a *relative* view; they had no overarching theory or construct regarding "ideal greatness." Rather, they saw it as achievement

relative to other groups, and they felt strongly that selecting the right sorting factors was crucial.

The roughly 20% of respondents who considered greatness *absolute* had a vivid and compelling sense of what a deeply patient–centered perspective could mean to people whose health is at risk, and they wanted nothing short of "ideal" health services and optimal health gains for all their patients.

2. **Is greatness best defined by what goes in, or by what comes out?** One view is that we should specify the factors that "go in" to greatness, then look to verify their presence or absence. Much of the quality movement, as well as many related awards (such as the Baldrige Quality Award) take this view. More broadly, it is the basis for many certification programs, in which a checklist of items is used to actively certify – from policies on this, to contingency plans for that; from degrees and experience of staff members, to Board attendance at official meetings. In this approach, the gold star goes to those who can show these inputs as being present.

   The alternate view, which revolves around output/outcomes, is that "greatness is as greatness *achieves.*" Don't look at standards, values, practices, systems, or policies. Instead, look at the extent to which the health center's services have actually improved lives and health status. From this perspective, one cannot "comply" one's way to success. Standards and systems, policies and plans – these simply constitute the floor, not the ceiling.

   These differing perspectives hinge in part on a view of how people actually improve their lives. From the "what goes in" perspective, people get better because appropriate services are delivered to them efficiently. Count the number of people receiving such services, then consider the answer as reasonably approximating the number of people receiving actual health gains. Focus on the standards for delivering care, making sure these standards are evidence-based, vetted by appropriate professionals, etc.

   From the "what comes out" perspective, the underlying belief has to do with return on investment, whether in schools or health centers. It's not about conformance, but rather about *achievement*. This is a difference with which many organizations struggle mightily. For a Legal Aid Society, as an example, is the "right" outcome the number of people given proficient legal advice on how to avoid housing foreclosure, or is it the number of clients who actually *use* that advice and keep their homes? For those who believe primarily in outcomes, purpose sets the bar for greatness.

   One clear difference between a focus on "what goes in" and a focus on "what comes out" is that inputs are generally far more durable than outputs. Once in place, standards, policies, etc. are likely to stay there, at least for a good while. Outputs, however, are more likely to vary over time. Retrospective reviews of how organizations deemed "excellent" (that is, great) fared over time suggests that inputs can be retained long after outcomes have declined.

   At the same time, a health center focus strictly on outcomes has a beguiling and potentially dangerous simplicity. Why bother with any given input measure when we can simply count the people who get healthier? Two issues arise here. First, multiple factors influence health status, and health outcomes may rise or fall for reasons having little or nothing to do with the health

center. Second, many outcomes are easier to achieve than to maintain. Do we call a residential drug treatment facility, for instance, "great" because 90% of its graduates come out clean, even though research clearly shows that the hard part is *staying* clean?

With government funding (including for health centers), grants generally go to those organizations with the best scores on their funding proposals. The numbers of points awarded for needs assessments, plans, and operational factors often dwarf those given for actual results the grant seeker proposes to achieve. What, then, is the relationship between a great proposal and a great project? And when we perfect the proposal document, are we also perfecting the project? Recently, the state of Utah failed to receive federal education funding through the Race to the Top initiative because state officials provided the wrong year's budget data, thereby losing just enough points to slip out of the group of top contenders. For many people, the relationship of that mistake to actual improvements in academic achievement for Utah children seems close to non-existent.

For health centers, HRSA's "19 program requirements" (which include such mandates as having a conflict of interest policy) are not all strong predictors of real health outcomes. As with most such requirements, while they are excellent prerequisites (*i.e.*, the "floor"), they do not, in themselves, predict success.

A sports analogy can help make the point. For years, some sports fans scoffed at a certain basketball player for a major NBA franchise. He was awkward and almost ponderous on the floor. From the *input* perspective, few would pick him for greatness. But from the outcome perspective, Larry Bird had little trouble winning games for the Boston Celtics.

For this report, most respondents focused on the input variable of quality standards, along with systems and people to achieve them. But when pressed, very few respondents suggested that perfect compliance with known standards was equivalent to perfect outcomes for patients. When asked why they believed this was so, two significant points came out. First is the simple fact that **no organization can be guaranteed to address all the "right" rules and regulations**. And second, **compliance does not ignite innovation and energy**, which is required in order to achieve breakthroughs at the intersection of medicine and patient health.

In sum, both inputs and outputs clearly have a place in a health center's approach to "greatness", just as a finished house needs both a floor and ceiling. And in a health center organization committed to excellence, both constructs must be continuously monitored and improved as needed.

3. **Is greatness achieved by an incremental process, or does it require breakthroughs?** The idea of continuous quality improvement contains a premise that small changes add up over time. That is, a 5% improvement here and a 6% improvement there will lead to profound improvements in the long run. This is an incremental approach that keeps building, with great continuity, on what is done *now*. The path to greatness is known: take small steps, and get better and better. The quality movement sits squarely in this arena, as does an impressive body of literature on the theory and practice of "small wins."

The alternative view is that greatness is more than simply a refinement of the present, and that at some point something discontinuous must happen – that is, a breakthrough or a quantum leap

forward needs to occur. In many enterprises, this often originates with a new leader. In other cases, it comes from an environmental shift such as modified funding rules or new funding opportunities. Most of the resulting changes are seen as innovations – new approaches that outperform rather than simply refine current practices. In this view, disruption plays a significant role, and greatness is about change and transformation.

Both views have their strengths. Slow and steady improvement does in fact lead to substantial accrued performance gains. Alternatively, organizations that foster a continual stream of bold innovations can indeed achieve faster rates of change.

And both views also have their drawbacks. Continuing to build on a faulty base or false premises leads to unsupportable organizational structures, while constant innovation can bring a continual churning that may make action more frenetic than purposeful.

Here again, the best answer is probably "both/and." However, a preoccupation with steady improvement often does not find an easy relationship with restive high-level change within the same organization (or the same people).

Slightly more than half of the respondents for this report, including most of those who provide any form of technical assistance or support, felt that continuous and steady improvement is the pathway to greatness. They saw little need for transformation or major leaps forward; indeed, they worried about the risks that could accompany too rapid adoption of change. Those respondents who did look for faster and deeper ways to improve focused both on the present and on the organization's capacity for speed and adaptability when future environmental shifts occur.

4. **Is greatness a singular condition, or can it take multiple forms?** Much of the resistance to the terms often used when describing greatness (world class, excellence, etc.) seems to have a common basis – resistance to anything suggesting a uniform and potentially arbitrary meaning. Related points made by the respondents include the following:

    - *Greatness varies by context.* What's great in a rural context may be different from what is great in an urban context. Excellence can vary by ethnicity, organizational size, the community's cultural heritage, and so forth.
    - *Greatness must allow for the unexpected.* We can't really imagine the full set of factors that define our universe.
    - *Greatness varies by observer.* A customer of any given social program may define greatness quite differently than do Board members, staff, or funders. A single view of greatness cannot encompass that variation.
    - *No one can specify all of the factors that go into greatness.* As noted previously, quality standards are the floor, not the ceiling.

    One related conclusion is that everyone has the right to their own view of greatness. This view is reflected in the familiar adage, "The customer knows best" – in other words, greatness lies in the eyes of the beholder.

An alternative view is that greatness is in fact a uniform condition (or must at least be standardized in order to have true rigor and real value). In this perspective, once you allow multiple definitions, you are on a slippery slope.

Most respondents preferred a hybrid view, in which some core measures of greatness (particularly with respect to outcomes) coexist with variations in meanings and approaches. Most agreed that variation is, and should be, much more pronounced in means than in ends. And no respondent asserted the extreme perspective that all health centers are already great, just in different ways.

5. **Is greatness best explained by systems and structures, or by people?** Many forms of organizational development assume that the "right" structures and processes are what predict success. If the organization has the correct policies and programs in place, it is presumed that all that is then needed is a leader to manage them. This assumption is seen in many procurement documents, in which only minimal standards define the specific people who should carry out the plan. The idea is also reflected in the grant application for new Section 330 (Public Health Service Act) health center sites, which requests a listing of personnel but no description of how they will work together to achieve the goals and objectives described in the application.

   The alternative view is that *people* matter as much, if not more, than all of the organization's structural elements. This view is held by venture capitalists and others who invest in start-ups and turnarounds. These investors are essentially betting on a few research studies rather than on hard market surveys.

   The strength of relying on structural elements such as business approaches and organizational systems is that this perspective is open to ongoing assessment and evaluation. All of the factors are clear and predictable. We can replicate and scale factors that are known and which have been shown to be predictive of success. When idiosyncrasies of individuals – especially any extreme characteristics (whether in energy and vitality, divergent thinking, or anything else) – enter the picture, it becomes much more difficult to make these predictive links.

   Yet for most organizations, the *person* does matter. More elementary school students are on appropriate grade levels when taught by teachers with compelling energy and engagement ability than by instructors who simply have advanced degrees and many years of experience.

   Most respondents for this report spoke both of approaches/systems and of people, but rarely in any integrated way. Some interview triggers – such as discussions of standards, regulations, proposals, and site visits – led the respondents to focus on systems. Other triggers – such as requesting examples of high achieving health center organizations – tended to start and end with a discussion of human sparkplugs. Specific ways in which the right people and the right structures *interact* to achieve greatness, however, were not generally discussed. In itself, this is likely an opportunity to find new ways to help build health center greatness.

PATHS TO GREATNESS

As noted previously, luck, fate, happenstance, or natural organizational evolution have little place on the path to greatness for health centers, according to the respondents. Instead, what was seen as needed is *intentional and sustained work* that is as likely to change habits and traditions as to continue them. The degrees of planned thinking and resulting action were seen as the strongest predictors of greatness. Further, greatness was believed to be proactive; one cannot reach it, most respondents thought, by even highly effective reactions to crisis.

Interestingly, two factors which have been cited in other fields as forms of progression to greatness were rarely mentioned by the respondents for this study. One is **group longevity**. None of the respondents felt that the maturation cycle from organizational infancy to great maturity was a strong indicator of progressive greatness. Indeed, more respondents actually *questioned* the relationship between long organizational life and greatness than supported it. The other cited factor not considered influential by the respondents for this report was **scale**. While larger health center size was seen as predicting better systems, few thought that large health center organizations had any monopoly on greatness. Some respondents felt instead that large size could in fact mask fundamental problems.

In the view of the respondents, the first real challenge in achieving greatness is simply **defining the path**. In Ivan Doig's novel *Ride with Me, Mariah Montana*, Mariah is asked, "How good are you going to get?" She replies, "How good is there?" It's a fundamental question. As the old saying suggests, "If you don't know where you're going, any road will do."

Without clarity regarding the desired end state, the respondents suggested, incremental improvements will often go in different, even contradictory, directions. And as noted previously, a "comparative" view – wanting to be better than others – was seen as keeping organizations looking sideways rather than ahead.

So part of the necessary work lies in anchoring aspirational intent to specific targets for achievement. Most respondents felt that a view of greatness involving actual metrics (or other concrete ways to know when greatness has been achieved) is vastly preferable to simply having general visions or goals.

The second challenge cited by respondents was **identifying current organizational location on the path to greatness**. Most felt that organizations (including their own) often had a hard time facing realities squarely and promptly. Research on "capacity mapping" and related assessments by nonprofits underscores this problem. The use of clear metrics – favored by high-performing health centers, as we have seen – helps greatly in fostering objectivity.

Respondents also felt that while greatness can contain some uniform elements, paths to actually achieving it can vary greatly. Among their key points regarding the path to greatness were the following:

- As noted previously, rate of improvement can be more critical than present location on the path to greatness. An organization with a steep improvement curve but lower current achievement may ultimately surpass a currently higher-performing center with a flatter improvement curve. The respondents went on to note, however, that in most cases health centers do not have a good way to gauge their actual rate of change. Scorecards and dashboards were suggested as holding promise for providing this measure as technology improves.
- Some health center organizations focus on incremental improvements, while others focus on transformational or quantum leaps. As we have already seen, both can be effective. With

incremental approaches, the question is how long it will take to get to greatness with (for example) a 5% annual improvement. For quantum leaps, the question is less about boldness than about effectiveness. That is, will such a "breakthrough strategy" have the power to actually make the intended big difference?

- Both incremental and quantum leap approaches require *innovation*. Neither approach will work by simply redoubling efforts around current practices. Both require trying new methods and building on what is found to work. And both require a definition of "innovation" not as what is new, but as what is *better*.[11]
- An important distinction is between organization-wide approaches and smaller prototypes that lead change by example. The problem with the organization-wide approach was reported to be that it often bogged down in planning and documentation. The problem with the approach of smaller prototypes has to do with effectiveness in spreading the results even when they were successful.
- Milestones are critical. A multi-year path to greatness absolutely requires annual (if not quarterly) markers of progress. The path is best seen in terms of long-term project management and the concrete tools that go with it, rather than in terms of any sort of metaphorical journey.
- Two additional factors were considered important in laying out a path to greatness. One is **readiness**, including clarity regarding threshold prerequisites for setting forth on the path. The other is **capacity** – the combined elements that predict success once on the path. It is not useful, respondents noted, to confuse these factors.
- Most respondents felt that a "rubric" (*i.e.*, protocol-based) approach could be used to sort health centers on a continuum of progress toward, and distance from, greatness. While some resisted this idea, others felt that a rubric could be developed showing present health center location on the path to greatness by quartile. This could involve defining health centers making *early progress*, making *substantial progress*, *closing in* on greatness, and *arriving* at greatness (by mapping health center location relative to the attributes of greatness described in this report).

RECOMMENDATIONS

We asked respondents what NACHC, Primary Care Associations, and individual centers could do to help build great health centers and related organizations. Four critical recommendations emerged. Below is a summary, following by an expanded discussion of each specific recommendation.

1. **Bring greatness into constant view.** Move the focus from remediation and compliance, to a continuing quest for true excellence and the achievement of full potential.

2. **Develop a "Greatness Seen and Heard" audit.** Create a tool that organizations can use to generate feedback on where they are relative to their desired "greatness" destination.

3. **Harness and build patient activation.** Develop methods for moving patients from being passive recipients of services to becoming active managers of their own health.

4. **Shape "Knowledge Management" as a critical tool for greatness.** Spread evidence-based best practices, clinical and administrative, that predict progress toward greatness.

Let's look more closely at each of these important recommendations:

1. ***Bring greatness into constant view.*** Virtually all workshops, conferences, and other trainings can relate even the most compliance-driven discussions to greatness in health centers. This overarching view of the ultimate goal line – no matter how distant – is what gives even small improvements direction and force. It generates energy and identifies gaps between present location and the finish line on the path to greatness.

   We suggest that all health centers begin by asking themselves a fundamental question: *What constitutes "wild success" in this organization?* This can be the basis for anything from a two-hour meeting to a week-long conference, and it moves everyone from the current paradigm to what they will specifically do in order to constantly ramp up achievement. In preparation, ask, "Exactly what must be accomplished for this meeting to be a complete success?" Don't initially discuss what topics will be covered – that's just an activity. Instead, decide specifically what must be accomplished through the planned discussion. The meeting will become a milestone on the organization's way to greatness.

2. ***Develop a "Greatness Seen and Heard" audit.*** Given that greatness is believed by our respondents to be readily observable, a checklist that will provide health centers (and related organizations) with feedback on where they are relative to greatness makes a good deal of sense. This tool could be administered either by staff or by an outside party, for greater objectivity. In either case, this cannot be an approach that relies on inferences; it must focus on *observed behavior*. Individual health centers can do this just as readily as can NACHC (although this recommendation could offer NACHC an excellent opportunity for a new way to be of significant assistance to member centers). This exercise will force out the right questions for the organization to begin asking itself.

   For health centers, this "Seen and Heard" tool will create real data about real situations impacting real patients. What the patient sees and hears will be what shapes his or her health center experience. Patients will not likely care about the agency's logic model, or organization chart, or plan for cultural sensitivity, or long-term business strategy, or anything else that is strictly an organizational construct. Rather, what patients see and hear is what they actually *process* in terms of service and experience, and this can easily have an impact on changes in health.

   Retail businesses have long used this approach. Banks, for example, have learned through observation that for the frequent patron, whether the teller remembers his or her name is far more consequential than internal policy memos from a senior vice president.

   Here are some guidelines for performing a "Seen and Heard" audit:

   - Make phone calls and send mailings in advance to patients, then review the center's intake processes as patients walk in. Expectations are set early and are not readily changed.

- Treat the audit as an opportunity for learning, not as a form of assessment (at least initially).
- To ensure reasonable consistency among auditors, use a forced end point. That is, something is either definitely seen/heard, definitely *not* seen/heard, or of uncertain observation. Finer gradations (such as a 1-10 scale, or even a 1-5 scale) reflect variation in raters more than variation in what is actually being observed.
- For observations which must be heard, a second level of data can be generated by asking questions. For example, "Do you know approximately how much time you will be waiting to see the doctor?" However, be careful not to prompt choices the subject had not actually considered.
- Once the audit instrument is refined, it can be used annually with enough different entities to give a health center an ongoing look at its ratings compared to other organizations considered to be its peers. In most fields, organizations are eager for that type of continuous feedback.

3. ***Harness and build patient activation.*** Most health care organizations know far more about medicine than they do about behavioral change. Yet the personal choices people make in areas such as exercise, diet, smoking, and alcohol use are seen by many as just as consequential to health as is medical technology. In an even more focused way, what patients choose to do with their prescriptions and provider suggestions – whether to get and take pills, start walking 30 minutes a day, etc. – have a significant impact on health status, especially in management of chronic conditions.

   One of the first major impacts of the Affordable Care Act involved financial consequences for hospitals with high readmission rates. Many hospitals engaged social workers and others to follow up with patients in order to ensure that those patients did what *they* needed to do to stay out of the hospital – and it worked. A number of hospitals found that focusing directly on patient behavior was the key.

   Great health centers have been noted as supporting individuals before and after their clinic visits. While part of that focus is to ensure compliance (a term with the unfortunate drawback of implying passivity – just comply with what we tell you and you will get better), part is also clearly focused on helping get patients to self-management and taking ownership of their own health. This is another opportunity area in which NACHC could potentially help add significant value to health centers.

   The literature (especially work done at the University of Oregon by Dr. Judith Hibbard, who was interviewed for this report) regarding what is termed *patient activation* suggests indicators that may predict a patient's move from the passivity of simply receiving services to the active construct of helping manage his/her own health, especially when the patient's self-confidence is low. One specific instrument, the Patient Activation Measure (PAM), based in the work of Dr. Hibbard and Dr. William Mahoney, appears highly promising. It is based in the premise that patient activation seems to involve four stages: 1) believing that the patient role is important; 2) having the confidence and knowledge necessary to take action; 3) actually taking action to maintain and improve one's own health; and 4) staying the course, even under stress. NACHC may wish to consider a possible relationship with the organization (Insignia Health) that is refining this tool, as both a developmental partner and a distribution channel.

A number of approaches to behavioral change can be used by health centers, either directly or in alliance with other organizations. While some of these approaches focus on personal self-help, many bring in the social dimension of *peer support*. A report from the Blue Cross/Blue Shield Foundation of North Carolina, for example, showed that programs for weight control and healthy eating led by "community spark plugs" clearly outperformed those provided as professional services, and at a fraction of the cost. The fabric of neighborhoods indicates that people are often more energized to pursue optimal health when they work with others to accomplish the goal. NACHC could potentially help form strategic alliances at both national and state levels with organizations that work in these important areas.

4. ***Shape "Knowledge Management"*** *as a critical tool for greatness.* Greatness compels us to actively learn from others, not just by ourselves. Virtually all fields actively encourage the sharing of proven models and best practices, as well as dedicating time at conferences, in social media, and through interactive web-based forums to sharing learnings. But evidence of actual importation of specific models and practices is sparse.

   One reason is that the approaches used to identify and formalize best practices have limitations. Respondents for this report pointed out three:

   - Best practices are often stated at such a high level of generalization (for instance, "involve staff", "engage the media", etc.) that they are virtually meaningless.
   - While we know that these practices have attracted both people and money, we often don't know if they actually worked to improve health.
   - Scientific studies showing the validity of some treatments or approaches often fail to hold up well when the number of people actually helped is considered – especially when the cost is compared to the gain. Statistical significance is often different than practical significance.

   Other problems lie in access:

   - Many web sites purporting to offer knowledge bases of what does and doesn't work simply provide additional web links. There may be good information available, but it is often just too many clicks away for busy practitioners.
   - Many presentations at conferences are long on reporting what was done but short on defining the actual fundamentals of a given best practice (which must of course be replicated in order to achieve successful implementation).
   - Too often we hear of a "best practice" only from those who provide it. The view of actual (such as patients at health centers) may be quite different.

JUMP-STARTING GREATNESS

Finally, here are five practical ideas for beginning the quest to achieve health center greatness:

1. ***The value of this report is not in its content, but in what you choose to do with it.*** If you want genuine impact, you must decide to intentionally create it.
2. ***Start immediately.*** Ask, "What is one thing we can do to pursue greatness in our center *right now*?" If you initiate something – anything – within two weeks of reading this report, the chances soar that it will actually make a difference.
3. ***Start anywhere.*** Set a high target, then go for it. Greatness achieved in virtually any part of your organization will prove infectious. The key is to set the bar well above where you are now, to ensure that you will have to do things differently to reach it.
4. ***A great place to start is with the "Seen and Heard" audit described above.*** What would you see and hear in your health center which signifies that it is moving toward the greatness you do not see or hear now? This approach "keeps your boots muddy" – that is, it will keep you grounded in the realities patients and staff experience every day.
5. ***Whatever you make of it and however you pursue it, greatness comes with one indispensable advantage: energy.*** How much enthusiasm is created by being average (or even good)? Greatness is far more compelling.
6. ***Let NACHC help.*** The Training and Technical Assistance Department would love to hear from you and can help your health center discover further insights into any aspect of organizational greatness. Contact NACHC at (301) 347-0400.

However one frames it – World Class, Excellence, The Best – there is obviously a common idea at the core that everyone recognizes and most people aspire to. As we have seen throughout this report, while not everyone agrees on exactly what it is or how to precisely measure it, this "greatness" clearly has a number of identifiable characteristics. And just as clearly, there are common markers on the path to reaching it.

As is so often the case, Shakespeare provides sage insight on the subject. In *Twelfth Night*, the Bard suggests that real excellence *is* in fact achievable, and he offers this admonition: "Be not afraid of greatness…" And Ralph Waldo Emerson adds an important behavioral truth when he notes, "Nothing great was ever achieved without *enthusiasm*."

We hope that you and your team will heed the wisdom of these perceptive authors and will dedicate the intentional and positive effort to reach the true greatness that is, without question, waiting to be unlocked at <u>your</u> health center.

NOTES

Since the publications referenced in this report are generally well-known and can readily be found on the Internet, formal publication notations are not shown here. The notes below are provided as supplements to primary points made in the main narrative of the report, on the specific pages shown in parentheses at the end of each note.

1. The literature on great organizations in virtually every field underscores that these organizations became successful by discovering simplicity rather than pursuing or embracing complexity. Jim Collins in *Good to Great* puts it this way:

> *"It soon became abundantly clear that all the great companies attained a very simple concept that they used as a frame of reference for all their decisions, and this understanding coincided with breakthrough results."*

While a long list of goals, strategies, or anything else may look impressive and comprehensive, the organization with just three to five priorities has a much easier time getting to alignment and shared action than one with, say, 20. **(Page 10)**

2. Respondents in most cases believed that being patient-centered means more than just providing a medical home. It also means dealing with non-medical factors that influence health. This is a way of thinking mirrored in many fields, including fund-raising. In this field, the old approach is gift-centric. Track the money and don't worry much about shifts in those who provide it. The new approach is donor-centric and focuses on individual donors and what it will take to change their levels of support. For a health center, the comparison might be a focus on population-level outcomes. **(Page 11)**

3. This is a major outcome tension in all human and social services. On the one hand, organizations are expected to "move the needle" on broad populations. On the other, the only domain they can really control is what happens for the clients they actually see. One useful strategy developed at Robert Wood Johnson Foundation is what the Foundation calls the "denominator exercise." Two hundred persons achieving a gain in a neighborhood of 3,000 residents is far more impressive than 200 people out of a city of 30,000. **(Page 11)**

4. The shift from focusing on skills and experience to focusing on attributes is now a major movement in corporate hiring. Organizations believe they can teach people the content they need but cannot teach them drive or compassion. In an opinion article in the *New York Times* entitled "Doctor, Shut Up and Listen," Nirmal Joshi, Chief Medical Officer for Pinnacle Health System writes:

> *"A doctor's ability to explain, listen, and empathize has a profound impact on a patient's care. Yet, as one survey found, two out of every three patients are discharged from the hospital without even knowing their diagnosis. Another study discovered that in over 605 cases, patients misunderstood directions after a visit to their doctor's office. And on average, physicians wait just 18 seconds before interrupting patients' narratives of their symptoms."* **(Page 13)**

5. Greg Brandenburg, CEO of Columbia Basin Health Association in Othello, WA, is a case in point. He begins the conversation with providers by asking them how much money they want to make, then discusses the number of patients they will need to see in order to realize that

income. It is a strong incentive-based approach and one that readily accommodates quality and outcome metrics, as well. **(Page 13)**

6. Swope Health Services in Kansas City is an example of a health center with a very strong human development program. Then-CEO Frank Ellis reported that all staff have a coach who helps them in professional and personal development. All coaches come from outside the organization, and the person being helped (not the organization) is their client. Coaches are changed every three years or so to encourage fresh thinking. (Swope is also an example of an unusually entrepreneurial health center organization. Swope developed an insurance company that became the largest health insurer in Kansas, then sold it for $92 million; this enabled the organization to get into housing and other areas that Swope sees as strong determinants of health.) **(Page 13)**

7. A common denominator in all great organizations is the presence of "raving fans." Customers (patients, consumers, participants, clients, etc.) are not just satisfied but *highly* satisfied. In business, this predicts far more re-purchase of goods or services and far more active recommendations to other consumers. In the nonprofit world, studies suggest that participants who report high satisfaction are much more likely to use the program to get to high gain than those who say they are merely "satisfied." High satisfaction is far less a product of policies and procedures than of individuals who interact with customers and who are empowered by the organization to do whatever is necessary to resolve issues. Fat rulebooks bow to personal discretion. **(Page 15)**

8. This article, published in *Health Affairs* (Volume 21, number 3), was referenced as "the bible" for excellence by many respondents. It explains the Institute of Medicine's publication, *Crossing the Quality Chasm,* and its focus on six Aims for Improvement: Safety, Effectiveness, Patient-centeredness, Timeliness, Efficiency, and Equity. **(Page 15)**

9. Historically, program directors and "bean counters" have considered themselves masters of separate domains. In recent years, many organizations have made breakthroughs by seeing the interrelationship between money and services. Cost accounting has led to highly useful insights on the price of such activities as meetings, strategic planning, and so forth. More recently, the focus has moved to cost per unit of gain. If a health center has a smoking cessation clinic, for example, which costs $5,000, and 100 persons attend, the cost is $50 per participant. But if the real outcome is that only 10 persons stop smoking, the cost per unit of gain is $500. Another major trend is the shift from finance as a control to finance as a *helping* function. In this approach, the customers of the finance department get to decide its value based on timeliness, accuracy, and explanation of financial information. **(Page 17)**

10. The key is to look at just one element – the tone used by the husband and whether or not it reflects real respect for the spouse. Nothing else is needed to predict divorce. *Blink* is full of examples of how experts in diverse fields instinctively know something that takes others weeks of study to learn. In virtually all cases, that instinct is tied to things that are readily apparent – if one knows to look for them and what their presence means. Malcolm Gladwell speaks even more directly to greatness in his book *Outliers*. Among his findings is that in any field, the only way to become great at something is to practice incessantly; he has concluded that whether the subject is a violinist or a basketball player, roughly 10,000 hours are needed to become truly

outstanding. The clear lesson is that the great organization works at excellence with both intensity and perseverance. **(Page 18)**

11. Innovation is a method of planned change. Unlike plans, studies, organizational committees, and edicts, it leads by example. The key is to move from having an idea (inventing) to putting that idea to actual use (innovating). The book *Ideas are Free*, by Robinson and Schroder, is among the publications noting the value of having all employees generate ideas on a weekly basis that they can put to real use. Innovation comes not from big plans, large committees, or substantial budgets – it generally comes from individuals and small teams. **(Page 25)**

CONTRIBUTORS

(NOTE: Roles/titles and organizational affiliations were current at the time of the interviews.)

About the author

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Outcome Guide is a resource for foundations, governments, and nonprofit organizations that seek to define, track, verify, and communicate the results they achieve.

His clients for increasing results include the Bill and Melinda Gates Foundation, American Express, Greater Kansas City Community Foundation, the Duke Endowment, and Verizon Foundation. He has worked with over 20 community foundations both small and large nationwide.

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Hal is lead author of Outcome Funding: a New Approach to Targeted Grantmaking. Now in its 4th edition, the book is widely used in the US and the UK as a framework for allocating and spending money to improve human lives and conditions. Hel has served as lead consultant to a U.S. Presidential Commission. He shares articles and tools on www.halwillguide.com.