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The Guidelines for Authors may be found printed at the end of this volume. Alternatively, you may request the standard contributors' guidance from the editor at chronicle@baldrigefoundation.org or access it online at baldrigefoundation.org/what-we-do/thought-leadership/ before submitting manuscripts. The *Chronicle of Leadership and Management* neither offers nor makes compensation for articles or perspectives, and it assumes no responsibility for the return of manuscripts, although every effort is made to return those not accepted. In submitting work the sender warrants that it is original, that it is the sender's property, and that neither it nor a similar work by the sender has been accepted or is under consideration elsewhere.

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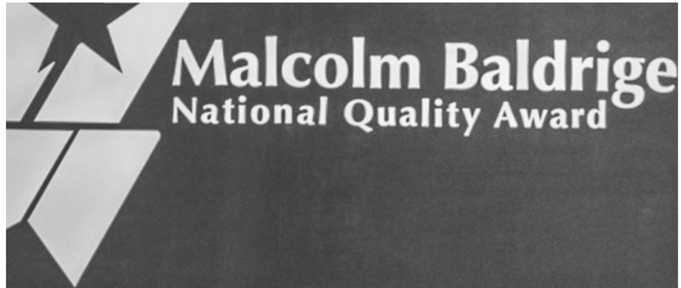
Malcolm Baldrige
National Quality Award

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FROM THE EDITOR-IN-CHIEF

The goal of the Chronicle of Leadership and Management is to facilitate sharing of knowledge by providing insightful and practical perspectives for leading and managing performance excellence in business, health care, education, government, non-profit organizations, and in communities and cybersecurity applications. The journal consists of Feature Articles intended to provide original and useful information of interest and practical significance to organizational leaders, which are grounded in experience, innovative thought, and appropriate literature research. Executive summaries of feature articles are provided as brief overviews of these articles to assist readers. Leadership and Management Perspectives provide specific points of view designed to support understanding or to provide insights about current issues, emerging issues, Baldrige challenges, implementation strategies, best practices, and similar topics. Please refer to the Guidelines for Authors printed at the end of this volume.

As with any new journal, interest often peaks when the call for papers for the first issue is announced. This is what I saw in 2020 when we had over a dozen submissions. However, in this past year, we had far fewer, and it has been quite difficult to identify potential authors. Thus, I plead with our readers to seriously consider contributing to the journal and encouraging colleagues to write articles; this will allow the Chronicle to thrive and continue to support the Baldrige philosophy.

It is perhaps not surprising that each article in this issue deals in some way with COVID and the pandemic; we can rightly call it "The COVID Issue." We have three Feature Articles and one Leadership and Management Perspective.

Feature Articles

- *A Model for Transforming Health Care Using the Baldrige Excellence Framework* by Mountasser Kadrie explains the relevance of the Baldrige Excellence Framework (BEF) to the healthcare industry, focusing on how it facilitates change and innovation and promotes

performance excellence in the environment created by the COVID pandemic. The case study's findings affirm the BEF as a strategic framework that facilitates performance excellence, transformation, innovation, competitiveness, and agility in the healthcare industry.

- *The Agility and Resilience of Health Systems and Response to the COVID-19 Pandemic Crisis* by Rulon F. Stacey, Jiban Khuntia, Xue Ning, and Amit Pradhan examines the links between agility and resilience to four crisis response action-relevant measures: retrenchment, preservation, innovation, and exit. The article also provides practical takeaways that can be applied in health systems with different agility and resilience levels. These lessons will benefit any health system in the United States wishing to increase its agility and resilience in any crisis.

- *Key Success Factors in Communities of Excellence: Innovation and Inclusivity are Proving to be Valuable Threads* by Christel Gollnick addresses the importance of the Baldrige framework in building stronger communities of connection, courage, creativity, and character, particularly in the face of challenges presented by the COVID pandemic.

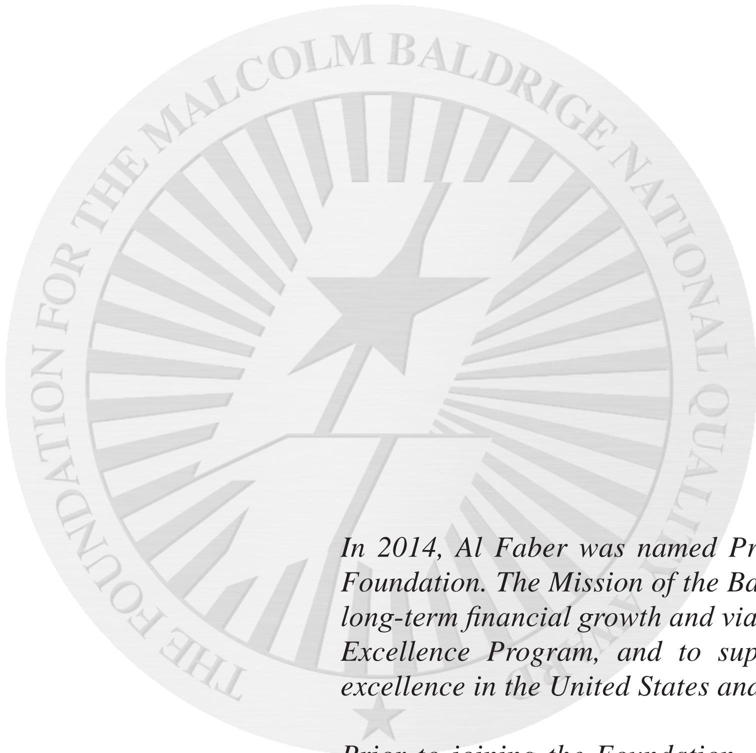
Leadership and Management Perspectives

- *From Hurt to Healing – A New Perspective to Improve Workplace Ecosystems* by Read G. Pierce, Sherry Bright, and Gigi Dunn proposes that it is time to rethink our concept of organizations, our thinking, behaviors, and strategic efforts in healthcare, particularly as a result of the stresses and anxieties resulting from COVID, and advocates looking at workplaces as healing ecosystems.

- *Balancing Strategic Stability and Operational Agility in a Volatile Environment* by Dr. Jennifer Strahan and Dr. KaiLonnie Dunsmore uses structured interviews with C-Suite leaders to explore how inculcation of frameworks of performance excellence, like the Baldrige Excellence Framework or the Integrated Performance Model, in day-to-day operations, help position an organization to adapt to environmental volatility while maintaining the commitment to ongoing performance excellence.

James R. Evans
Professor Emeritus
Lindner College of Business
University of Cincinnati

Editor's note: Dr. Mark Wayda has stepped into the role of interim editor-in-chief following Dr. Evans' decision to step down earlier this year. If you have questions or comments about this issue of the *Chronicle of Leadership and Management*, or to submit articles for consideration for Volume 3, please contact Dr. Wayda at mwayda@baldrigefoundation.org.



In 2014, Al Faber was named President and CEO of the Baldrige Foundation. The Mission of the Baldrige Foundation is to ensure the long-term financial growth and viability of the Baldrige Performance Excellence Program, and to support organizational performance excellence in the United States and throughout the world.

Prior to joining the Foundation, Al served as President & CEO of The Partnership for Excellence (TPE), the premier Baldrige-based state program for the promotion of performance excellence in all sectors of the economy. As of 2014, TPE had served more than 324 organizations that represent more than 1.7 million jobs at 1,769 work locations with revenues in excess of $139.2 billion and more than 226.4 million customers.

Al also served in federal and state government culminating in executive positions and leading more than 11,500 employees, with 65 major facilities, a $250 million operating budget, and real property exceeding $2.1 billion.

He has provided executive leadership, establishing policies, priorities, and oversight of federal budgets, operations and training, personnel, logistical operations, and infrastructure management to include numerous construction programs. He is driven to create winning organizational results with a deep sense of commitment to public service. He led his teams to two consecutive national awards in the Army Communities of Excellence competition using the Baldrige Criteria and also achieved both "Silver" and "Gold" status in The Partnership for Excellence State Program. Al has led department-wide organizational restructuring initiatives to meet the demand for greater efficiency and process optimization, while institutionalizing Lean Six Sigma, Balanced Scorecards, Strategy Maps, and numerous supporting professional development programs.

PRESIDENT AND CEO FORUM

> *"If you are going to achieve excellence in big things, you develop the habit in little matters. Excellence is not an exception; it is a prevailing attitude."*
>
> — Colin Powell, My American Journey

On behalf of the Baldrige Foundation's Board of Directors, it is a privilege to introduce this year's issue of the *Chronicle of Leadership and Management* published by the Baldrige Foundation's Institute for Performance Excellence. The *Chronicle* is the Institute's flagship publication and central to the Institute's purpose: *helping people and organizations learn and grow in the pursuit of performance excellence*.

Over the past two-years, the Institute has afforded quality professionals the opportunity to learn, grow, and network online, from any workplace. The numerous training and education programs offered by the Institute are practical, meaningful, and lead to credentials and certifications at the most affordable prices in the marketplace. Institute Partner organizations receive deep discounts on all of the Institute's training, plus many other exclusive benefits and discounts in collaboration with The George Washington University, Walden University, the University of Charleston, and others.

The Institute also affords Partner organizations an extensive collection of webinars, videos, and best practice sharing break-out sessions from conferences held throughout the United States and globally. Busy professionals, from first-line leaders to CEOs can learn at their own convenience from any device including their smartphone. In addition to the Chronicle, the Institute continues to develop and publish impactful White Papers covering contemporary issues of interest in the areas of leadership and management.

Our Leader Dialogue® program offers a wide array of podcasts from thought leaders and industry experts from every sector. The topics covered in podcasts serve as focus areas for webinars and CEO Roundtable events, as well as agenda items for our CEO Innovation Council meetings, all hosted by the Institute.

As Colin Powell observed, these building blocks, or "*habits*" help our Partners "*achieve excellence in big things*" by creating a "*culture of excellence,*" driven by a passion for personal growth and integrated professional development, to increase an organization's workforce engagement and results. The Institute has uniquely positioned itself as a thought leader, and premier resource for achieving excellence!

I would like to thank Dr. James Evans for his service as the *Chronicle*'s editor-in-chief for the first two issues. He was instrumental in helping us get the *Chronicle* up and running. Dr. Evans is a nationally renowned leader, author, and academician. We are grateful for his leadership and service over the past two years, along with all of our volunteer editorial board members who reviewed the numerous submissions we received.

As always, I want to sincerely thank the Baldrige family, Midge, Molly, and Megan, as well as the Institute's Trustees who form the Mac Baldrige Society, Adventist Health, Stellar Solutions, MidwayUSA, ABOUT HealthCare, Freese and Nichols, Tata, Mid-America Transplant, and the Center for Organ Recovery & Education (CORE). Their generous gifts have made the Institute a reality.

As President Ronald Reagan said of Secretary Baldrige in his eulogy on July 29, 1987, at Washington's National Cathedral, "What I'm saying about Mac Baldrige adds up to a simple but extraordinary quality that I would call, more than anything else, American. In his directness, in his honesty, in his independence, in his disregard for rank, in his courage, he embodied the best of the American spirit."

It is that American Spirit, embodied in Mac's personal leadership style, that serves as his legacy and our inspiration for the future of Baldrige.

Wishing you all the best!

Al Faber
President and CEO

FEATURE ARTICLES

Executive Summaries

Stacey, et al: Agility and Resilience

The authors of this article believe that the operating system contained in the Malcolm Baldrige National Quality Award framework is the single best such framework in the world today. One of the Core Values and Concepts of the Baldrige Excellence Framework is Agility and Resilience (Ogden et al. 2010). As stated in the criteria, agile and resilient organizations have a proportional ability to increase "capacity for rapid change and flexibility in operations…" and resilient organizations are better able to "anticipate, prepare for and recover from disasters…". However, Agility and Resilience is a core value employed by relatively few health care organizations today, even though when facing a crisis such as COVID-19, health systems needed the capacity to change rapidly and respond accordingly. For practitioners interested in finding specific ways that implementing one of the Core Values of the Baldrige framework will help their organization, this article links agility and resilience to four crisis response action-relevant measures: retrenchment, preservation, innovation, and exit.

The information for this research came from interviews with C-suite level executives in eight health systems with aggregate total revenue of more than 61 billion dollars and more than 56,700 employees. The interviews were conducted in July 2020 and focused on the health systems' response to the COVID-19 pandemic. Analysis of the variations and mapping the responses into the low, medium, and high agility and resilience levels led to several observations relating to the crisis responses in the four crisis response measures groups. This article presents these observations to practitioners searching for ways to improve their organizations' agility and resilience. Additionally, we provide practical takeaways that can be applied in health systems with different agility and resilience levels. These lessons will benefit any health system in the United States wishing to increase its agility and resilience in any crisis.

Kadrie: Transforming Health Care with Baldrige

The health care industry has responded to significant reform initiatives, evolving socio-economic and business forces, and most recently, the COVID-19 pandemic. The U. S. health care sector is vast, complex, unique among advanced industrialized countries. and provides fragmented care and services spread across many providers. As a result, the health care delivery system is not as efficient, reliable, and consistent in meeting consumers' expectations and creating performance outcomes as other industries. Major health care stakeholders have a big push to improve and sustain patient care and organizational performance outcomes. Implementing the Baldrige Excellence Framework (BEF) has helped various organizations to generate outstanding performance excellence results.

There is a well-established strategic need for health care organizations to implement BEF to improve excellence performance, competitiveness, and facilitate innovation in clinical and operational functions. In recent years, BEF has become an increasingly common performance transformation framework used by top-performing health systems and hospitals. Health care has become one of the dominant industries represented in the national annual quality award competition administered by the U.S. Department of Commerce's National Institute of Standards and Technology (NIST).

In this paper, the BEF and its relevance to the health care industry are described, and the implementation of the BEF in the health care delivery system is examined through a compelling case study. The target audience includes Boards of Directors, health care executives, and clinical leaders. An in-depth analysis of how BEF facilitates change and innovation and promotes performance excellence in the health care industry is investigated. It assesses the path forward for how health care organizations and their leaders use BEF to deliver reliable and consistent value-based care services. The case study's findings affirm the BEF as a strategic framework that facilitates performance excellence, transformation, innovation, competitiveness, and agility in the health care industry.

Gollnick: Communities of Excellence

Community leadership structures are comprised of people in public and private entities who have agreed to come together and take action to help their communities become better places to live, learn, work, and play. Although they are enthusiastic in the early stages of their collaborative

efforts, the groups often lack the lines of accountability, communication, and organized processes they are used to in their respective workplaces. These groups also discover the need to be inclusive of more perspectives than are typically in formal community decision-making roles. Community development and collaboration efforts are complex.

Drawing from the proven effectiveness of the Baldrige Performance Excellence Framework in helping to solve complex leadership and management challenges, Communities of Excellence 2026 (COE), a 501(c)(3) nonprofit, has innovatively adapted the Baldrige criteria for cross-sector and cross-boundary communities, counties, and regions of varying sizes throughout the United States. The Communities of Excellence Framework is an approachable systematic guide for leaders to strengthen the effectiveness of their efforts towards the maximization of community potential. COE has found success in supporting collaborative community excellence groups at varying levels of readiness to advance improvement efforts, learn from each other through an online multi-community learning collaborative, and share promising practices to accelerate the results of their community's efforts to improve the health, safety, educational attainment, economic vitality, and quality of life of its residents and stakeholders. Evaluation results, primarily qualitative and process-oriented at this early stage, show that systems leadership thinking and the inclusion of a wide range of diverse perspectives are critical keys to building and sustaining more thriving communities in America.

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THE AGILITY AND RESILIENCE OF HEALTH SYSTEMS AND RESPONSE TO THE COVID-19 PANDEMIC CRISIS

Rulon F. Stacey, Ph.D., FACHE;
Jiban Khuntia, Ph.D.,
Xue Ning, Ph.D., and
Amit Pradhan, BE

Agility and resilience is a core value and concept in the Baldrige Performance Excellence Framework. According to the Framework, "agility requires a capacity for rapid change and flexibility in operations." Agility is a concept that encompasses the practices and methods that facilitate quick responses (Boehm 2002). The agile process involves quick releases, evaluations, and improvements of software products and versions originating from the software development area (Dima and Maassen 2018). Business and organizational research adopted agility to explain fast responses to customers, competitors, and regulations while maintaining organizations' structure, scope, and scale (Overby et al. 2006). Agile businesses facilitate timely responses to changes in the environment, like changing customer needs and technology developments (Tallon et al. 2019, Rigby et al. 2016). Additionally, agile businesses develop the culture and collaborations to achieve higher adaptiveness to an uncertain environment or change (Mergel et al. 2018) and can scale up approaches effectively to reap substantial benefits (Rigby et al. 2018). Today's key is to adapt quickly (i.e., be agile) and then sustain those changes into the future. Absent a larger "systems" approach, any agile changes that respond to an imminent crisis will become the focus themselves. These quick "tactical" changes will be viewed in-and-of-themselves and not in the concept of a whole systems approach. As a result, the more critical sustainability of an agile response will be lost and the more significant benefit compromised (Stacey and Goonan 2017).

Resilience is "the ability to anticipate, prepare for, and recover from disasters, emergencies, and other disruptions; and —when disruptions occur—to protect and enhance workforce and customer engagement, supply-networking and financial performance, organizational productivity, and community well-being." Resilient organizations can build on their ability to quickly adapt to a crisis and sustain those changes to ensure the long-term utility of the organization and its

customers. Absent this additional focus on resiliency, short-term goals become acceptable to an organization, and long-term improvement is sacrificed for the appearance of a "quick win."

Leaders in any organization would be wise to learn these traits that can be used to prepare their organization better. The BaldrigeCoach suggests that "Organizational agility [and resilience] requires that its leaders can rapidly detect shifts in market trends, customer preferences, emerging technologies, societal expectations, regulations, political climates, economic indicators, and even employee engagement factors. However, it is more than the ability to detect. Senior leaders can respond to those shifts rapidly and to align their entire workforce and key suppliers, partners, and collaborators in the execution of that response" (BaldrigeCoach 2017).

The Value of Agility and Resilience in Health Care

Agility and resilience became critical when the fast spread of the COVID-19 pandemic created significant uncertainty and undefinable disruptions for hospitals and health systems in the United States beginning in the first quarter of 2020. While the virus hit some areas harder than others, all were forced to prepare for the worst. Given the pandemic's speed and scope, health systems responded to the COVID-19 pandemic with an urgency never before seen in the industry. Accordingly, the crisis required that health systems respond quickly and nimbly to the urgency. Unfortunately, these are traits for which the health system in the United States has often received criticism.

Health systems in the United States continue to this day to find solutions to the many disruptions brought on by COVID-19. As one would expect, some organizations have responded better than others. During the pandemic, researchers and practitioners suggested developing agility to outlast the pandemic for all sectors, including health care (Rigby et al. 2020). This article posits agility and resiliency as an underlying explanation for the variance in health systems' responses to the COVID-19 pandemic and highlights the importance of this core value.

Against the value proposition for agility and resilience, most health care organizations are criticized for being neither agile, transformative, or able to sustain their changes (Sindhwani et al. 2019). Health care providers in the United States have grappled with the changing business environments even before the pandemic. For example, many organizations could not keep up with the adoption and transformation of health information technologies. Their agility, therefore, was limited. Similarly, hospitals have done a poor job using digital approaches to streamline workflows. As such, health care business decisions are not driven by sophisticated analytics, although a plethora of data is available (Khuntia et al. 2021).

Furthermore, health care has not been able to keep up with artificial and machine-driven intelligence and transforming the legacy practice models to patient-convenient and patient-centric care models

(Humphreys et al. 2020, Lee et al. 2020). Plausibly, some health systems have taken steps to be agile, while others have not (Kruk et al. 2018). To this end, the central focus of this article and message to senior health care leaders is that we assert that a factor in creating agile and resilient health systems during the COVID-19 (or any) crisis can be better understood through the measures as proposed in recent management research (Wenzel et al. 2020) and as described below.

Measures for Leaders to Create Agility and Resilience in Their Organizations

Retrenchment involves positive and negative decisions, such as cost-cutting, complexity reduction, performance-reducing, and similar decisions, to manage the crisis while formulating plans for short-term and long-term recovery efforts (Benner and Zenger 2016). It is vital to ensure efficient resource use and preserve the broad company culture and direction, as evident in other industries (Ndofor et al. 2013).

Preservation includes steps and decisions to maintain an organization's ongoing operations. These steps may consist of the pause-plan-start process for selective operations. In other words, some functions can be paused during the crisis. These processes can start after the crisis. This preservation concept aligns with how a crisis unfolds while trying not to buckle under the duress of a prolonged crisis duration (Stieglitz et al. 2016).

Innovating measures would entail sustainable solutions for a better future—for example, new ways of creating revenue through telehealth for health systems. Additionally, a strategic renewal process can incrementally decrease marginal strategies with a limited benefit over time while replacing them with more robust strategies. This process allows for a better evolution of specific products or services for particular value creation activities. However, it is essential to remember that these innovative measures will be deterred by the low liquidity and outside pressure present in a crisis.

Exit measures are the ultimate reactions an organization can take when everything else fails. Conversely, renewals happen for a completely new system or firm. For example, when a business or a business division exits a market, resources are made available and often create fresh opportunities. Nevertheless, business exits from any industry are often a stark reality particularly, as we have seen, in the pandemic. Perhaps the best example in health care is that during the last decade, more than a hundred rural hospitals in the United States were unable to adjust to the changing health care environment and were forced to exit the market entirely (Kaufman et al. 2016).

We assert that agile/resilient health systems have responded decisively and quickly to the ongoing pandemic by, for example: (1) Implementing appropriate strategies to secure personal protective equipment, (2) Shutting down redundant or unproductive activities, and (3) Taking measures to identify and continue delivering crucial services. While some of the decisions were agility-

driven to respond to the short-term goals of surviving the pandemic, other decisions could have been taken, keeping the long-term consistency or business sustainability in perspective (Coleman 2017); that needs to be understood at a granular level.

Our objective in this research was to provide a nuanced and more in-depth understanding of these factors related to hospitals and health systems during the pandemic. Additionally, we aim to distinguish between short- and long-term responses that would have been different across agile and non-agile systems and resilient and non-resilient systems within the earlier identified four crisis response measures.

Our Methodology

We followed an exploratory qualitative design approach. We started with the objective to "broadly understand" the issues and challenges faced by health systems during the COVID-19 scenario. As we progressed with our understanding, we correlated the responses to both a degree of agility/resilience and the four crisis response measures outlined previously.

A process of purposive sampling, interview, and coding, as illustrated in Figure A1 of the Appendix was followed (Lavrakas 2008). A solicitation email invitation to participate in an interview was sent to 15 health systems and hospital C-level executives. We conducted semi-structured interviews with a sample of eight health systems and hospital executives who responded to our invitation during June-July 2020; i.e., during the current peak of the crisis in the health systems under observation (see further information of the eight health systems, and the data sources are provided in Appendix Tables A1 and A2). The qualitative interview approach allowed us to capture the executives' subjective experiences during the pandemic. The respondents were senior leadership team members (e.g., CEOs or COOs) or the responsible area managers such as the crisis management head or command center heads for managing COVID-19 (Guest, Bunce, and Johnson 2006, Morse et al. 2002). The health systems are located in several states of the United States, represent four time zones, and have some variations in the period and progression facing the COVID-19 situation. We also learned about the cultural and structural settings while conducting the interviews and collecting secondary relevant data. After a guiding conversation during the interview, the respondents spontaneously discussed (Eisenhardt and Graebner 2007) their experiences and reflections on challenges and solutions faced during the COVID-19 pandemic. Table A3 provides the unstructured interview questions examples. An iterative and robust coding and analysis followed to derive insights from the transcribed interviews. (Sousa 2014). Data from American Hospital Directory (www.ahd.com) was used to categorize retrenchment, preservation, innovation, and exit measures, along with the short- and long-term-oriented decisions with agile and non-agile health systems.

Categorizing Agility and Resilience

First, our effort was to categorize the health systems as relatively low, medium, or highly agile and resilient. We determined that "agile and resilient" health systems have both higher cost-effective and revenue-oriented attributes as identified for this research. Cost-effective health systems will minimize cost per employee, cost per patient day, supply chain expense, and other meaningful cost measures that drive a system toward having cost equal Medicare reimbursement. Revenue-oriented health systems will differentiate themselves through revenue cycle enhancing outcomes such as increasing the inpatient revenue per patient day, outpatient revenue per-patient day, on-site collections, a state-of-the-art revenue cycle to include payer contracts, chargemaster, and cycle improvements.

This inference is then 'outcome-based rather than 'agile practice' based categorization. This becomes crucial for this research because, due to the COVID-19 crisis, most health systems' revenue decreased by as much as 40 percent in less than two weeks. Accordingly, it is reasonable to suggest that organizations that had their cost and revenue in control were, by definition, more agile and resilient, and this measure, therefore, becomes increasingly important.

Table 1: Agility/Resilience Categorization of Health Systes Based on Cost-Efectiveness and Revenue Orientation Atributes

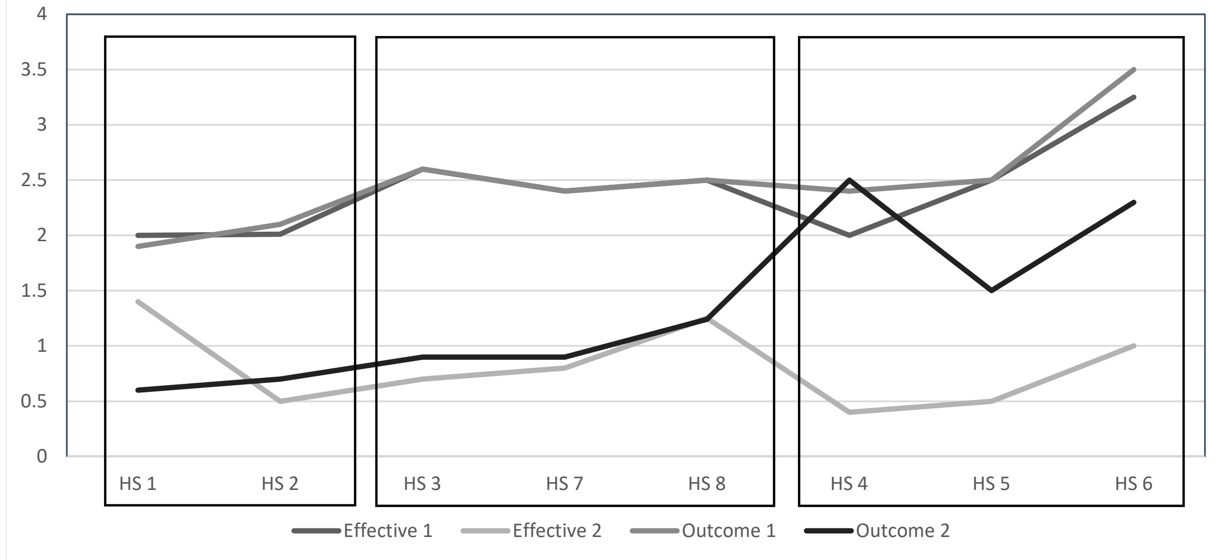
		Cost-Effectivness		Revenue Orientation		Agility/Resilience
	Health System (HS)	Cost Per Employee	Cost Per Patient Day	Net Patient Revenue Per Employee	Inpatient Revenue Per Patient Day	
1	HS 1	2,00	1.5	1.88	0.7	Low Agility/Resilience (LA/R)
2	HS 2	2.06	0.5	2.14	0.8	
3	HS 3	2.58	0.7	2.58	0.9	Medium Agility/Resilience (MA/R)
4	HS 4	2.37	0.8	2.45	0.9	
5	HS 5	2.42	1.3	2.44	1.2	
6	HS 6	1.94	0.3	2.3	2.5	High Agility/Resilience (HA/R)
7	HS 7	2.62	0.5	2.55	1.5	
8	HS 8	3.25	1	3.46	2.3	

Notes:
- *All revenue, operating expense, and operating income numbers are in billions of USD ($bn).*
- *Total Employees of the Health System and Inpatient Days, in Ten Thousand.*
- *The total volume of outpatients in millions for 12 months of duration treated by the Health System.*

This categorization is not comprehensive but an indicator of the relative positioning of the eight health systems based on the data, above rationale, and the researcher's interpretations. We note that this is just a starting point, and much deeper dimensions are needed to establish agile and resilient health systems and their orientations.

As shown in Table 1, we use cost per employee and cost per patient day as standardized measurements for the first perspective; and net patient revenue per employee and inpatient revenue per patientday are standardized measures to measure the second perspective. The last column of Table 1 presents the low, medium, and high agility/resilience categorization derived from the information presented in earlier columns. More detailed indicators of the health systems are provided in the Table B1 in Appendix B.

Figure 1: Illustrative Plot of Health Systems Based on Cost-Effectiveness and Revenue Orientation Traits Across Agility and Resilience Groups



As illustrated in Figure 1, Health Systems HS1 and HS2 have a relatively low level in both effective and outcome measurements, so they are in the low agility/resilience group. HS3, HS7, and HS8 have a medium level of effectiveness and outcomes to be grouped as medium agility/resilience. HS5 and HS6 have a high level of two measurements. Although HS4 has a relatively low level of effectiveness, its outcome performance is very high. So, HS4, HS5, and HS6 are in the high agility/resilience group.

Results

Through interpreting the interviews, we summarized the decisions and responses by health systems during the COVID-19 pandemic crisis in Table 2. This table has both short-term and long-term decision examples.

Table 2: Short- and Long-Term Response Decisions During COVID-19 by Health Systems

Note: HS = Health Systems; LA/R = Low Agility/Resilience; MA/R = Medium Agility/Resilience; HA/R = High Agility/Resilience

Short-Term Decision Examples in the Sample	Long-Term Decision Examples in the Sample
● Cutting down on elective procedures (All HS) ● Sending noncritical staff to home (LA/R2, HA/R2, MA/R2, MA/R3) ● Furloughs and compensation reduction of the staff to offset the financial loss (HA/R2, HA/R3, MA/R2) ● Temporarily shutting down facilities such as ambulatory service or hospitals (LA/R1, LA/R2, HA/R1, HA/R2, MA/R2) ● Addressing the scarcity of ventilators (LA/R1, LA/R2, HA/R1, HA/R2, MA/R2)	● Augment use of Tele Clinic and Telecare facilities (HA/R1, HA/R2, HA/R3, MA/R3) ● Developing in-house testing of COVID (LA/R1, MA/R1, HA/R2, HA/R3, MA/R2, MA/R3) ● Command centers were already in place to deal with various types of crises before the pandemic. They were activated to deal with a pandemic situation such as Covid (HA/R2, HA/R3)
● Develop in-house testing for quick turnaround of results and promote quick decision-making (MA/R2, MA/R3) ● Collaboratively invest with a local manufacturer for PPEs (LA/R1, MA/R1, MA/R2) ● Restricting visitor access and finding ways to communicate updates on COVID status (All HS) ● Creation of command center to address pandemic (LA/R1, LA/R2, MA/R3)	
● Identifying procedures that have various levels of exposure to COVID and aligning the supply of N95 Masks accordingly (LA/R2, HA/R1,HA/R3, MA/R3) ● Moving of IV pumps to hallways to reduce the burn rate of PPEs (LA/R2) ● Able to keep running all the facilities (LA.R1, MA/R1, HA/R1, HA/R2, HA/R3) ● PPE reuse, such as the washing of gowns and masks (LA/R1, HA/R1, HA/R2, HA/R3) ● Changes to the visitor policy to minimize the spread of contamination (ALL HS)	● Identify and develop procedures for reuse of materials wherever possible (HA/R1, HA/R2, HA/R3) ● Collaborated with other health systems to invest in local manufacturing companies for sustainable and on-demand supply of PPEs and reduce dependency on foreign suppliers (MA/R1) ● Use of an established, robust, and integrate supply chain based on a collaborated IT platform to monitor and manage inventory during the pandemic (LA/R2)

Observations of Leaders' Actions

The authors first observed that leaders in each health system involved in our research activities identified four challenges that presented themselves. Those include:

1. Managing the logarithmic increase in demand and associated limited supply of personal protective equipment (PPE) and ventilators.
2. Creating and managing COVID-19 testing facilities to address the unexpected and overwhelming increase in demand for testing facilities, personnel, and supplies.
3. Health systems were forced to quickly prioritize critical operating systems and safeguard those for the community's health. At the same time, most of the public focused on COVID-19, the agile and resilient health systems that needed to flex the short-term while simultaneously protecting for long-term success. This included meeting the immediate COVID-19 needs while ensuring the mandatory services to their community continued.
4. Command structure varied from location to location, but the concept of incident command never wavered. Agile and resilient organizations ALWAYS were able to implement a command center structure immediately. These centers addressed issues such as leadership, command center creation, authority, and responsibility allocations. We summarized those observations and mapped them with the four crisis response measures in Table 3.

Table 3: Observations and Crisis Response Measures

<table>
<tr><th>Observations</th><th>Crisis Response Measures</th></tr>
<tr><td>Observation 1: High-agile/resilient health systems have more readiness to face a crisis such as a pandemic than low agile/resilient health systems.</td><td>Retrenchment (R): Positive and negative decisions, such as cost-cutting, complexity reduction, performance reducing, and similar decisions, manage the crisis while formulating plans for long-term recovery.</td></tr>
<tr><td>Observation 2: Low- and medium-agile/resilient health systems have a higher affinity for short-term preservation measures.</td><td rowspan="2">Preservation (P): Include steps and decision to maintain a firm's ongoing operations--may be aligning with the pause-plan-start process of some parts of operations aligned to the way crisis unfolds.</td></tr>
<tr><td>Observation 3: High- and medium-agile/resilient health systems have a higher affinity for long-term strategic preservation measures than low-agile/resilient health systems.</td></tr>
<tr><td>Observation 4: High-agile/resilient health systems would move towards more risky and uncertain investments, such as technology investments, even when they are facing the crisis.</td><td>Innovating (I): Strategic renewal through the coping mechanisms that have sustainable effects for a better future.</td></tr>
<tr><td>N/A</td><td>Exit (E): Reactions when everything falls apart, shaping a completely new system and exploring entirely new, fresh opportunities.</td></tr>
</table>

Discussion

This study categorized health systems' responses and action-relevant decisions during COVID-19 into four measures postulated in crisis management literature that link and highlight the salience of the core values of the Baldrige Framework of Agility and Resilience. Our observations lead to a set of takeaways that will guide leaders in any health care organization to follow a process better to develop their core values of agility and resilience. Moreover, the authors believe any such effort will ALWAYS improve the ability of any health care organization to move quickly toward improvement and sustain that success.

We observed that health systems have been able to safeguard them by following a set of *retrenchment crisis measures,* such as cost-cutting, complexity, and performance activity relevant decisions while making plans for long-term recovery. A detailed list of these actions is provided in Table 2, categorizing them into short- and long-term decisions taken by low-, medium-, and high-agile/resilient health systems. The observation is that high agile/resilient systems would be proportionately more ready for retrenchment measures, be incrementally more nimble and proactive at times of crisis, and appropriately align their short- and long-term decisions during said crisis.

However, the authors further observed that low-agility/resilience systems are not prepared from a leadership or operational perspective to alter course and sustain long-term improvement promptly. Instead, we observed that low-agility/resilience organizations quickly reverted to "survival-mode," hoping to exist without focus toward excelling. This process would inevitably lead toward making an increased number of short-term decisions rather than a longer-term focus.

Accordingly, for the immediate benefit of health care leaders, we note our initial findings:

1: Health systems with higher agility/resilience would have a higher affinity for both short-term and long-term strategic retrenchment measures, whereas low agility/resilience-driven health systems comparatively focus more on short-term tactical retrenchment measures during a crisis. Additionally, the preservation activities that were described above were less likely to be implemented by low or medium agility/resilience organizations. Rather, the low agility/resilience systems were less likely to make a quick decision and focus on a long-term benefit. Instead, their decisions were more "day-to-day" based, with less focus on the organization's future development.

2: Health systems with high agility and resiliency would have a higher affinity for both short- and long-term strategic preservation measures until the situation is clear, whereas low agility-driven health systems tend to focus more on tactical and short-term retrenchment measures during a crisis. Innovation during the crisis was much more difficult for health systems than it would have been during even a normal operational cycle. Still, our findings indicate that the most successful, most agile, and resilient organizations continued to make innovation an essential part of their

process even during the pandemic. For example, one major innovation across health systems has been using technology in meaningful and different ways during the pandemic than ever before (i.e., starting from tele- and virtual- health care deliveries to tracking and surveillance activities). Nevertheless, only the highly agile/resilient organizations found themselves in a position to be willing and able to take the more risky alternative to move their organization from survival to thriving. We believe that the organizations which excelled during the pandemic tend to follow the Baldrige Excellence Core Value of Agility and Resilience more than others.

3: Health systems with higher agility and resilience affinity for short- and long-term innovations driven by transformative IT during a crisis. Lower agile and resilient health systems have a higher affinity for innovative short-term measures with a less positive impact on their organizations. However, none of the health systems closed completely—which is admirable given that many firms in other sectors such as retail had to exit the market during the COVID-19 pandemic. This leads to a simple finding:

4: Health systems may not immediately focus on any exit strategy during the crisis.

Implications for Health Care Executives

Prior research suggests several factors explaining organizational differences in crisis responses (Bundy et al. 2017). Studies mention that the nature of crisis (Runyan 2006, Park, Hong, and Roh 2013), learning, and adaptation from past experiences (Veil 2011) prepared organizations to respond. Similarly, organizational preparedness for rare events (Wooten and James 2008) and flexible and open working approaches to see the crisis as opportunities to make something right or new (Brockner and James 2008) are precursors for crisis responses.

Furthermore, intuitive but non-emotional decision-making (Dane and Pratt 2007), activating appropriate leadership and human resources (Wooten and James 2008), and an affinity towards resiliency in the crisis is essential (Williams et al. 2017). The crisis would require fast and decisive strategic decision-making--that is not feasible for rigidly structured health systems that are not amenable to behaving flexibly through fewer formalizations and procedures.

As we observed, the agile/resilient health system significantly differed in the approach to the COVID-19 situation with a higher level of confidence, following balancing and combination of short- and long-term approaches and making decisions (Coleman 2017). In stark contrast to low or medium agile/resilient systems that are pretty short-sighted in the approach, highly agile/resilient systems have confidence about how the decisions will weigh all their prior and current scenarios. These experiences can help them make swift and informed decisions. We note that ALL OF THE EXECUTIVES of the agile and resilient organizations knew precisely when and by whom critical decisions could be made. Specifically, the responsibility and accountability associated

with decisions were delineated, and the designated responsible members to implement the crisis-relevant actions were easily identified.

In contrast, there was more chaos in a non-agile/resilient health system, no specific plans, missing critical perspectives, and a lack of clarity on decision-making, responsibility, and accountability. In fact, in our research, we learned that non-agile/resilient health systems tend to create a process where the same topic is discussed multiple times in multiple meetings, often being held at the same time and yielding different conclusions. The result is that this short-term and transitory approach leads to inefficiency and redundancy when the organization and its patients can little afford such redundancy.

The contrast in the approaches of high and low agile/resilient health systems demonstrates the power of agility and resilience. Our research has shown that agility/resilience makes organizations more responsive rather than reactive in a crisis and keeps the organization with its long-term perspective consistent as a goal (Coleman 2017). Further, the quick and decisive response allows the organization to leverage the crisis's opportunities toward the relevant, rapidly changing external environment. This process allows the agile and resilient organization to keep long-term strategies intact while aligning revised short-term decisions.

Ideally, any organization should have some degree of agility and resilience. However, specific to health care, legacy approaches, institutionalized health care practices, businesses, and systems have not been able to keep up with developments seen in other industries. In short, they have been lagging in embracing agility compared to other sectors (Rigby, Sutherland, and Takeuchi 2016). This has increased the concerns that health care can even match the speed of change and respond to situations like COVID-19. Undoubtedly, an optimal combination of the stable core processes and the dynamic agility-driven approaches are needed. Organizations may not adapt and survive in the pressures of changing market, stakeholder, and customer demands. We believe that no operating system in the world will better drive an organization and its leaders to be so well prepared for this exact solution to a crisis as will the Baldrige Excellence Framework.

A few noteworthy reflections need to be stated, derived from our observations. As we learned from the secondary observations, some health systems had flexibility associated with decision-making. For example, in HS2, the chief executive could quickly decide to participate with other health systems to invest in a collaborative supply chain premier organization that would source PPE and other supplies. Similarly, for another health system, the supply chain management structure was standardized and integrated with several other health systems to build enough resiliency to face and respond to any crisis relevant to disaster or pandemic. These observations lead us to state that agile/resilient organizations have developed an internal organizational culture and framework for decision making and leadership (Moore et al. 2020). Agile and resilient organizations have a specific process to make decisions, but they also have an effective internal communication

structure that drives those decisions through the entire organization.

Further, health systems' financial discipline allows their decisions to meet short-term crisis-related issues while maintaining their long-term goals. This process makes the organization more resilient and sustainable yet able to meet the current needs. These findings from the current study can be investigated with more detailed data collection and advanced empirical analyses to rigorously establish the value of agility and resilience for health systems.

Conclusion

The authors believe that the criteria of the Baldrige Excellence Framework constitute the basis of the single best operating system in the world. While the framework is exhaustive and cannot be fully explored in this article, we have researched in great detail the outcomes of organizations that have focused, either intentionally or not, on the Baldrige Excellence Core Value of Agility and Resilience. We stipulate that this is just a small portion of the overall framework. Nevertheless, we believe that even this small component has shown to be of great worth to organizations disciplined enough to create a culture of improvement and success.

Leaders of all health care organizations should realize that:

1. Organizational agility and resilience are a distinguishing factor for the most successful organizations during the COVID-19 pandemic.
2. No operating framework is better prepared to help organizations create agility and resiliency in their organizations than the Baldrige Excellence Framework.
3. The most agile and resilient organizations have developed an internal organizational culture and framework for decision making and leadership. At the time of the crisis, this culture had been well established and proved successful at the moment. Agile and resilient organizations had a specific process to make decisions and an effective internal communication structure to drive those decisions.

To assist senior leaders, we suggest they consider the following questions:

- What is the difference between agility and resilience? How do each of these terms impact our organization?
- How can we become more agile and resilient? What processes can we use?
- Had our organization focused on being more agile and resilient as discussed in this article, what would (or could) our organization have done differently during the begging of the pandemic? Would we have done differently in the past six months?

- What role doe the CEO and Senior leadership in our organization play in ensuring that the Core Value of agility and resilience is fully adopted in our organization? What role do they play with supporting performance excellence as a whole?
- Are we confident that employees in our organization feel comfortable adapting quickly and sustainably to change? Can we measure how comfortable they are? What can we do as senior leaders to improve their ability to drive rapid change in our organization?

Agility/resilience in health care is a concept that has been under-evaluated. Because of the unprecedented focus on hospitals and health systems in the United States during the current pandemic, this study aimed to explore how organizational agility/resilience would impact these organizations in this crisis and help them better prepare for a future crisis. While the COVID-19 pandemic has been a tragedy for millions, it did provide a unique opportunity to study and quantify the areas of agility and resilience for health systems in the United States. As the *Baldrige Excellence Framework* highlights, agility and resilience need to be ingrained as a core value for higher-performing organizations. Organizations that have the internal discipline and leadership acumen to focus and pursue the Baldrige Excellence Framework can create a meaningful Baldrige-based "Leadership System" as part of a long-term organizational transformation. These organizations eventually will find themselves (we can prove) more able to address the impact of a crisis or an emergency and (we believe) more able to adjust their entire organization toward quality and financial improvement.

Key Takeaways

- Agility and Resilience is an important core value and concept in the Baldrige Excellence Framework. Data show that organizations actively pursuing the Baldrige Excellence Framework are inherently better prepared to perform at a high level of agility and resilience than their contemporaries. Specifically, high agility/resilient health systems are better prepared to face a crisis such as a pandemic than low agile/resilient health systems.
- Effective ways to improve agility and resilience include implementing appropriate strategies, shutting down redundant or unproductive activities, and taking measures to identify and continue delivering crucial services.
- Organizational agility and resilience can be categorized into three levels: low, medium, and high, based on cost-effective and revenue-oriented attributes. Low and medium agility/resilient health systems have a higher affinity for short-term preservation measures.
- High and medium agility/resilient health systems have a higher affinity for long-term strategic preservation measures than low agility/resilient health systems.
- High agility/resilient health systems remain more willing to move toward more risky and uncertain investments, such as technology investments, even when they face a crisis.

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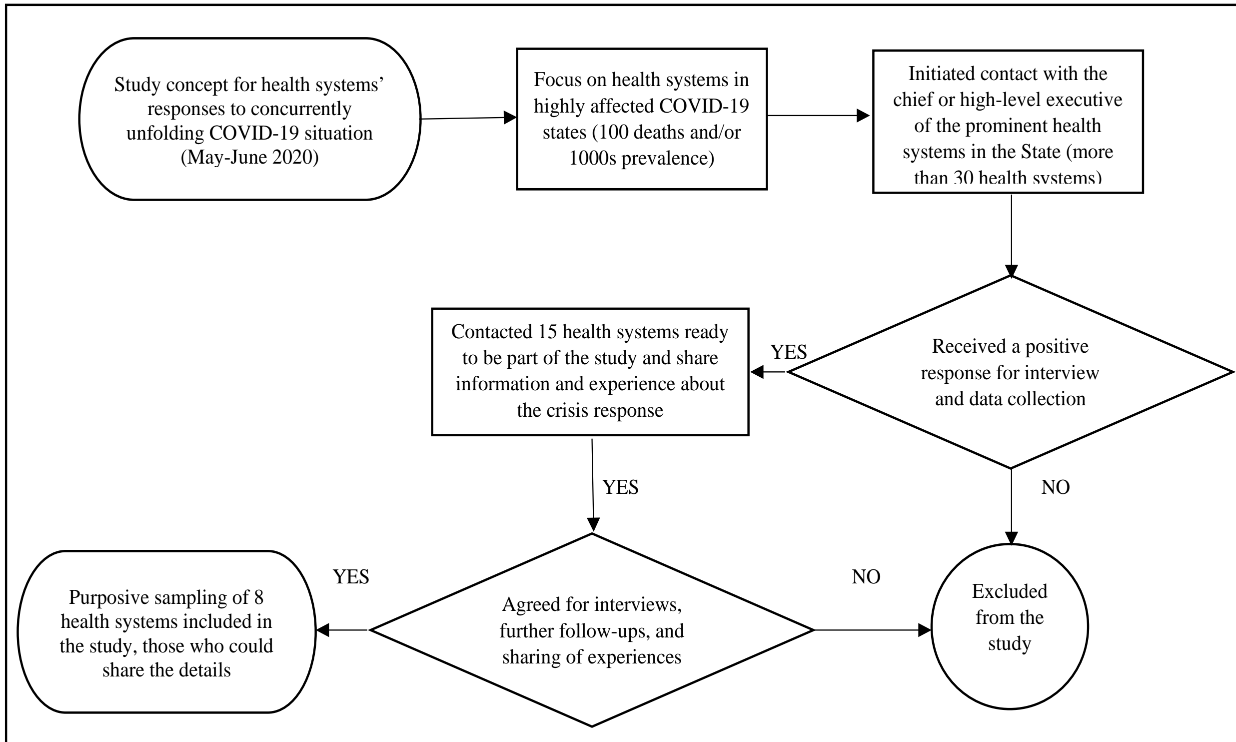
Appendix A: Sampling Process Used in this Study

As illustrated in Figure A1, this study chooses the health care systems by following a stepwise inclusion process.

Figure A1: The Process of Health Systems Sampling Followed in this Study



We provide the brief profile and status of the COVID-19 situation the eight health care systems were facing in Table A1:

Table A1: Location and COVID Situation of the Health Systems at the Time of Data Collection

Health System	Location in the United States	COVID-19 situation in the State by the first week of June, Cumulative cases (per 100,000)	The first case in the health system
HS 1	Northwest	50	March 13, 2020
HS 2	South	859	Early March
HS 3	Middle	601	March 08, 2020
HS 4	Southeast	267	March 12, 2020
HS 5	Northeast	573	March 10, 2020
HS 6	Southwest	257	March 17, 2020
HS 7	Northeast	583	March 10, 2020
HS 8	Northwest	176	March 13, 2020

We provide information on the executives who responded from each health system. We also received information support from other sources, as shown in Table A2:

Table A2: Data Collection: Interview Respondents and Other Sources

Health System	Key Executives Interviewed	Other information or secondary information sources
HS 1	Director of Quality and Safety, COVID-19 incident command lead	Director of Marketing and Communications System, County-level public health sources
HS 2	Director of Supply Chain Strategy, supply chain commance center lead	public health sources
HS 3	Chief Executive Officer	public health sources
HS 4	Chief Executive Officer	public health sources
HS 5	President and Chief Executive Officer, Senior Vice President and Chief Nursing Officer, Senior Vice President and Chief Medical Officer	Digital Communications Manager, public health sources
HS 6	Chief Executive Officer, Senior Vice President an Chief Administrative Officer, Director for Strategy, Enterprise Architect of IT	public health sources
HS 7	Chief Financial Officer	public health sources
HS 8	Vice President of Operations	public health sources

Table A3: Unstructured Interview Questions Examples

- Main Question: What are the challenges your organization is facing?
    - Follow-up questions:
        - What are the challenges in testing?
        - Why is testing so important?
        - Any difficulties in supplying PPE?
        - How to provide high service quality while reducing exposure?
- What changed? How do you adapt to the changes?
    - Follow-up questions:
        - Was there a task force?
        - How was it assembled?
        - What PPE options were there?
        - What other policies were incorporated or adjusted, e.g., whether visitation has had to be adjusted several times?
- What and how guidelines were made available?
    - What communication issues? How did you do that?
    - What prioritization occurred, how?
    - What did you do to keep the trust?
    - How was staff taken care of?
- What new care delivery models were adopted? For instance, how was telemedicine expanded? What techniques, for instance, was Facetime included?
- Where to get the testing equipment?
- How to make decisions for the limited supply allocation? What are the results of the adaptation?
- What technology was embraced that normally would have been more difficult to employ?
- What are the key takeaways?

Appendix B: Detailed Information on the Agility/Resilience Categorization of Health Systems

Table B1 provides an overview of the characteristics of the health systems collected from publicly available sources:

Table B1: Detailed Information on the Agility/Resilience Catagorization of Health Systems Based on Cost-Effectiveness and Revenue Orientation Traits

System	# of Hospitals	Total Patient Revenue	Net Patient Revenue	Operating Expenses	Operating Income	Total Employees	Inpatient Revenue	Beds	Inpatient Days	Operating Revenue	Outpatient Volume	Agility/ Resilience	Code
HS 1	2	0.54	0.3	0.32	-0.02	0.16	0.16	87	2.23	0.37	0.2	**Low**	**LA/R1**
HS 2	7	8.26	2.32	2.24	0.08	1.09	3.97	2471	46.91	4.26	1.24		**LA/R2**
HS 3	5	1.53	0.48	0.48	0.002	0.19	0.62	706	7.32	0.85	0.22	**Med.**	**MA/R1**
HS 7	15	7.48	3.26	3.15	0.11	1.33	3.64	2146	41.71	3.3	1.13		**MA/R2**
HS 8	10	5.46	2.31	2.3	0.01	0.95	2.27	989	18.27	2.74	1.23		**MA/R3**
HS 4	15	29.35	2.87	2.42	0.45	1.24	18.37	3825	73.97	10.97	0.38	**High**	**HA/R1**
HS 5	5	6.53	1.4	1.44	-0.04	0.55	3.99	1263	26.9	2.54	0.55		**HA/R2**
HS 6	1	1.84	0.57	0.53	0.04	0.16	1.23	286	5.37	0.17	0.17		**HA/R3**

Note:

- All revenue, operating expense, and operating income numbers are in billions of USD ($bn).
- HS4 and HS6 are in disaster-prone areas that include hurricanes, storms, and earthquakes.
- Total Employees of the Health System and Inpatient Days, in Ten Thousand.
- The total volume of outpatients in millions for 12 months of duration treated by the Health System.

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A MODEL FOR TRANSFORMING HEALTH CARE USING THE BALDRIGE EXCELLENCE FRAMEWORK

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Using the Baldrige Excellence Framework (BEF) is one of the greatest opportunities health care leaders can leverage to enhance and improve patient care quality outcomes and the overall organizational performance of our nation's health care organizations. The assessment of many organizations from different industries, including health care organizations that implemented BEF, indicates that they achieved stellar and consistent performance results, facilitated cultural transformation, and overcame complex organizational challenges (ACHE, 2021).

Today's health care is usually a complex, highly regulated, and adaptive system, meaning that the system's performance, behavior, outcome, and viability change over time and cannot be understood entirely by assessing only the individual and often fragmented components. It is a fact that no other system is mor complex than health care: not banking, education, manufacturing, or the military. The question that always comes up is why the health care delivery system is not as reliable and consistent in generating patient care and organizational performance outcomes as other industries. In recent years, various health care stakeholders (consumers, providers, payers, and government) have demanded that health care organizations improve patient care outcomes, adopt a systematic approach to support sustainable organizational performance. As a result of the demand to improve outcomes, an increasing number of health care organizations are adopting BEF to answer these demands (Table 1). The percentage of Baldrige National Quality Applications submitted by sector over the past 10 years shows that health care has represented over 50 percent of total applications.

The Baldrige Performance Excellence Program is housed under the U.S. National Institute of Standards and Technology (NIST) and manages the Malcolm Baldrige National Quality Award. The Baldrige National Quality Award examines organizational self-assessments in the form of applications to identify and recognize role models in six sectors through cultural and performance accomplishments. Applicants use the BEF, which provides a systematic framework to structure and align strategies, methodologies, and measurements across different criteria. The BEF criteria

encourage the entity to define and evaluate its business within an internationally recognized and proven framework. According to NIST (2020), BEF "helps organizations evaluate performance, assess where improvements or innovation are most needed, and get results."

Table 1: Baldrige National Quality Award Applications by Sector

Year	Manufacturing	Service	Small Business	Education	Health Care	Nonprofit	Health Care %
2021	0	2	0	3	5	4	36%
2020	0	0	2	1	11	6	55%
2019	0	1	3	1	16	5	62%
2018	0	0	2	5	14	6	52%
2017	0	0	3	5	12	4	50%
2016	0	2	3	5	21	4	58%
2015	0	0	2	4	16	4	62%
2014	0	2	0	0	12	6	60%
2013	0	0	0	2	15	5	68%
2012	1	3	2	3	25	5	66%
2011	2	3	2	8	40	14	70%

Source: (https://www.nist.gov/baldrige/malcolm-baldrige-national-quality-award-application-data)

The Baldrige Excellence Framework is an evidence-based approach to support quality and performance improvement successes. BEF helps organizations reach goals, improve results, and become more competitive by aligning plans, processes, decisions, people, actions, and results. Health care organizations (HCOs) manage their performance outcomes in a complex health environment. In this environment, key stakeholders facilitate sharing knowledge by providing meaningful and practical perspectives for leading and managing performance excellence about organizational outcomes. The BEF is a systematic approach to performance excellence, and includes:

- The Criteria for Performance Excellence, consisting of seven categories.
- A set of interrelated core values and concepts (*visionary leadership*, *patient-focused excellence, organizational learning, valuing people, agility and resilience, focus on success and innovation, managing for innovation, management by fact, societal responsibility, delivering value and results, and systems perspective)*
- A scoring system that gauges the organization's maturity across multiple dimensions of process and results.

Readers should consult the framework on the Baldrige web site.

Implementing the Baldrige Excellence Framework

Over the years, the U.S. health care industry has been active in responding to major reform initiatives and evolving socio-economic trends. These trends range from the Patient Protection and Affordable Care Act (PPACA), the transition to value-based care (VBC) and population health, patient safety, the rise of health care consumerism, and increasing complexity in clinical care settings during the COVID-19 pandemic. These forces compel and motivate HCOs to seek better medical care coordination inside and outside their walls. Many HCOs have learned that they can benefit tremendously from embracing BEF to identify and manage forces, trends, and dynamics, and address anticipated needs. The critical goal for HCOs is to ensure they are doing everything they can to improve care outcomes and experiences for patients, their families, and the communities they serve.

As the health care industry manages the COVID-19 pandemic and sets its target to improve its readiness to support and sustain patient care outcomes and organizational performance targets, it has a clear but challenging mission to achieve. This industry needs a strategic shift, organizational culture alignment, and commitment to invest more resources and efforts to meet population health care needs and survive and grow post-COVID-19. The BEF becomes mission-critical for HCOs to address current and future population health care needs. The implementation of BEF in health care provides a structured and systematic framework to achieve performance excellence. It creates impressive and sustainable improvements in the following outcomes: *organizational effectiveness, organizational efficiency, health consumer satisfaction, risk and compliance, health care quality and patient safety, and organizational culture*. Achieving consistent and reliable patient-centered care outcomes and sustainable organizational performance results should be a shared vision and a common destiny.

BEF implementation also encourages health care organizations to transform their organizational aim and focus from providing safe and good quality care for one patient at one time (an individual clinical care interaction) to also focus on a whole system of safe and quality medical care for all patients, target population, and workforce. This transformation helped some organizations to earn and maintain the Joint Commission's Gold Seal of Approval™, a symbol of quality recognized nationwide that reflects an organization's commitment to meet demanding performance standards. The Greater Baltimore Medical Center (GBMC) in Baltimore is a Malcolm Baldrige National Quality Award 2020 Award Recipient–Health Care, demonstrated its commitment to support patient-centered medical home model and increased access to care, maintained industry and benchmark leadership with 100 percent of its Health Partners (its physician group practices) offering extended hours for weekdays, weekends, and holidays since 2014 and during the COVID-19 pandemic. GBMC achieved a 5-star rating (the highest) from the Centers for Medicare and Medicaid Services. This outstanding result is a clear indication of the senior leadership team's commitment to the organization's mission, vision, and values, and ongoing active participation

in Lean Daily Management, through which senior leaders visit all hospital units, hospices, and medical practices to have frank, two-way discussions with frontline leaders and staff regarding their performance against GBMC's Four Aims of better health, better care, least waste, and more joy (NIST, 2021). GBMC results affirmed its ability to address BEF's core value in patient-driven excellence, societal responsibility, and systems perspective.

Furthermore, implementing BEF has helped health care leaders to prepare their organizations to anticipate and prevent potential problems and deal effectively with adverse events. HCOs that implemented BEF are significantly more likely to display a faster pace of agility and performance improvement over five years. They outperformed non-Baldrige health care organizations in practically all individual performance measures used in the 100 Top Hospitals composite score. The Wellstar Paulding Hospital (WPH), the Malcolm Baldrige National Quality Award 2020 Award Recipient- Health Care, achieved IBM Watson Health Top 100 Hospitals® top 10 percent performance in its inpatient complications index, maintaining 0.50 in 2018–2019 and increasing to only about 0.60 in 2020 (YTD). Achieving this positive result despite the pandemic, WPH adopted BEF *Strategic Planning* and *Workforce* Criteria and reassessed its workforce capability and capacity needs, partnering with the health system and other business units, recruiting new team members, augmenting the training and education of team members, and reprioritizing the use of resources (NIST, 2021). WPH results affirmed its ability to implement BEF core values in organizational learning, delivering value and results, and demonstrating agility and resiliency.

A common question among health care leaders new to BEF implementation is, is it an accurate gauge of performance excellence? The answer overwhelming is yes, according to the American Hospital Association (AHA, 2016) findings that compared Baldrige hospitals (award winners and applicants receiving site visits) to 100 Top Hospitals award winners and found these results presented in (Table 2).

Table 2: Baldrige Health Care Award Recipient Rankings

Baldrige Award recipients are significantly more likely to win a 100 Top Hospitals national award.
Baldrige hospitals were significantly more likely to display a faster pace of performance improvement over five years.
Baldrige hospitals were 83 percent more likely to win a 100 Top Hospitals national award for excellence in balanced organization-wide performance.
Baldrige hospitals outperformed non-Baldrige hospitals in practically all individual performance measures used in the 100 Top Hospitals score.

Dynamic Transformation of Health care

The U.S. economy has been in a historic transformation phase, undergoing significant structural changes in the last decade. These changes are manifested in the growing aging population and baby boomers, the rise of consumerism, digital technology transformation, globalization, and the COVID-19 pandemic. These are just a few examples. The health care industry also is no exception, and it has been going through a constant rapid transition and dynamic change. To address the challenges and opportunities this continuous change has presented, HCOs must adapt to demanding and incremental societal and demographic shifts and the social *determinants* of health elements (such as health disparity and equity, public transportation, safe and secure housing, education, healthy living and food security, public safety, social support, etc.) that profoundly modify and impact the population's health status by the rising health care consumerism and evolving consumers' expectations. Now more than ever, health care innovation is a strategic choice to assist HCOs in responding to societal and demographic shifts. Embracing and prioritizing innovation today is a key to unlocking performance and growth opportunities, especially pandemic crises. By utilizing BEF criteria to embrace innovation advances in the patient care setting and the day-to-day operations, HCOs now and in the future will be better positioned to manage the significant disruption challenges to innovate and transform their clinical and business processes. The health care industry has made noticeable strides and improvements over the last decade. However, the performance results achieved do not quite simply justify or support the investment, resources, and efforts made. In other words, the health care industry is not where it should be when it comes to being competitive (O'Shea, 2018; Geffner, 2020). Many industries in the U.S. economy are expected to reinvent themselves as a result of the COVID-19 pandemic. Will the health care industry do the same?

Transformation Implications

The health care industry is going through a dynamic transition from volume- to value-based reimbursement, promoting and implementing a population health care delivery model. This transition will certainly be accelerated by the scope and impact of the COVID-19 pandemic (Slotkin, Murphy, & Ryu, 2020). The U.S. health care industry has recently shifted rapidly into telehealth-based care delivery necessitated by the COVID-19 pandemic disruption to access to care. This very sudden and dramatic shift into telehealth-based care delivery was cited as the top initiative for helping medical practices get through COVID-19. The Adventist Health White Memorial, a Malcolm Baldrige National Quality Award 2019 Award Recipient–Health Care, in response to COVID-19, improved its virtual visit technology-enabled platform to enable patients to receive virtual and in-person care to visit health care providers by video using a phone, tablet, or computer, instead of going to the clinic and exposing patients and the workforce to unnecessary virus exposure. This initiative aimed to support and facilitate a seamless care experience at home, combining technology, innovation, and clinical expertise to ensure that patients' needs come first

and are addressed. This initiative is aligned with the BEF criteria and the core values in patient-driven excellence, focus on success and innovation, and societal contributions and community health.

For many health care organizations, the overarching goal must be improving the value proposition for patients, where the patient-centered value is defined as high-quality outcomes that matter to patients relative to the cost of reaching those clinical outcomes. To leverage this impactful change and manage its requirements, health systems should embrace BEF (ACHE, 2020). Post COVID-19 pandemic, health care organizations and their leaders must change the status quo and become more competitive and agile. They are expected to create a post-COVID health care delivery system that supports patients and health care workers. An essential component of changing the status quo is understanding the organizational culture alignment and requirements to adopt BEF and its criteria and practices from other industries that have achieved consistent and improved performance results.

Using the Baldrige Excellence Framework to Facilitate Competitive Advantage

The BEF empowers an organization to reach its goals, improve results, and become more competitive. Competitiveness and innovation are essential DNA components of the BEF, and they are critical to supporting and sustaining HCOs as the health care industry prepares for the next normal after the COVID-19 pandemic. Well-managed health systems see their implementation of BEF as a conduit to promote a culture of transformation that embraces innovation as an essential component of their competitive advantage strategy and long-term survival. For instance, an increasing number of forward-looking, integrated health systems may use this time to materially scale virtual health offerings or offer a safe operating environment and ensure that the organization is prepared for disasters and emergencies in ways that create a competitive advantage. GBMC quickly responded to evolving patient needs during the COVID-19 crisis. Patient feedback on technology was capitalized on to offer telemedicine visits and expand access to care (over 10,000 virtual visits in March - June 2020). Also, GBMC developed in early 2020 a six-step Health care Emergency Operations Plan (EOP), and during COVID-19, the EOP was activated, resulting in staff feeling educated, empowered, safe, and supported and having the tools they needed to do their jobs. To stay competitive during the early dark days of COVID-19, GBMC minimized furloughs and layoffs for its workforce during the COVID-19 crisis and instead implemented an alternative workforce solution center to retrain and redeploy staff as the number of COVID-19 cases increased sharply. These results from GBMC demonstrated commitment to BEF criteria related to the organization's objectives, such as patient-focused excellence, citizenship, performance management, information and knowledge management efficiency/effectiveness processes. The results have enhanced the GBMC competitive advantage in various BEF categories and affirmed

that it supported approaches, deployment, learning, and integration (ADLI).

The compelling case for the health care industry to embrace BEF is starting to pay off in incremental successes. These successes in recent years affirm the establishment of the relationships between BEF Criteria and the desired clinical and organizational behaviors of a competitive, high-performing health care organization. The Methodist Healthcare (MHC) of San Antonio is the largest health care provider in South Texas, with 27 facilities, including nine acute care hospitals serving more than 80,000 inpatients and 350,000 outpatients annually. It has used BEF for years to redefine its values and mission for the community and region it serves. As a result, MHC was recognized for best practices for the 2017 Malcolm Baldrige National Quality Award—Health Care. The award recognized the organization's commitment to sustainable excellence through innovation, improvement, and visionary leadership (Methodist Healthcare, 2017).

MHC used various innovative techniques to become more competitive by identifying high-risk patients through clinical data and helping them stay out of the hospital setting. So did medical home primary care, multispecialty clinics for patients, and integrating behavioral health into primary care.

Table 3: Benefits, Honors, and Recognition: Methodist Healthcare

Recognition Area	Outcomes
Five of the seven eligible Methodist Healthcare hospitals received "A" grades from the Leapfrog Group.	Receiving an "A" grade in the Leapfrog Hospital Safety Grades means these hospitals rank among the safest hospitals in the United States.
Medicare.gov's "Hospital Compare" named Methodist Stone Oak Hospital, a Five-Star Hospital with over 4000 hospitals.	Methodist Stone Oak Hospital ranked sixth in the entire nation and was the only five-star hospital in San Antonio.
All Methodist Healthcare hospitals were recently designated as Top Performers by the Joint Commission.	No other acute care hospitals in San Antonio were given this distinctive quality designation.
Methodist Texan Hospital, Methodist Ambulatory Surgical Hospital, and Metropolitan Methodist Hospital are among Modern Healthcare Magazine's Best Places to Work in Healthcare for 2017.	They are the only San Antonio hospitals and three of 150 healthcare entities in the nation to receive this distinction.

Integrating pharmacy, nutrition, and lifestyle coaching into primary care visits generated some of the most significant savings for Methodist Healthcare. MHC was recognized by the Medicare.gov's "Hospital Compare" is the most respected and preferred health care provider in the region. Table 3 presents some of the benefits, honors, and recognition MHC achieved from implementing BEF. MHC results affirmed its commitment to support BEF's core value in organizational learning, focus on success and innovation, agility and resilience, and systems perspective.

MHC's outstanding competitive advantage results show its commitment to excellence, establish best practices that save lives, and position it to become "net positive" — giving more to the community they serve than they take. It has achieved high and sustainable approaches, deployment, learning, and integration (ADLI) in implementing BEF.

By focusing on the tenacious pursuit of quality improvement and improving communication with patients and providers, Adventist Health Castle (AHC) improved its competitive advantage. It boasted rates below 1 percent to zero for common hospital-acquired infections and patient falls, significantly improving financial results and lowering legal risks. AHC is a community hospital system that provides inpatient and outpatient care to people who primarily live on the Hawaiian island of O'ahu. It is one of 20 hospitals within the nonprofit, faith-based Adventist Health System. AHC was the Malcolm Baldrige National Quality Award for 2017 Award Recipient-Health Care. Aligning the AHC's mission-focused and accountable leadership with the BEF criteria, senior leaders reinforced that mission and demonstrated the organizational values of integrity, respect, compassion, and excellence (NIST, 2017). AHC achieved multiple advanced levels of approach, deployment, learning, and integration (ADLI) in implementing BEF, and considerations for role modeling include applying continuous improvement practices at an individual level (unit, department, program).

The Baldrige Excellence Framework and Information Technology

For most health care systems, current central focus performance targets are reducing patient readmissions, managing care transitions, and addressing COVID-19 pandemic requirements. These systems work diligently to improve performance outcomes in population health, enhance the patient experience, and reduce overall costs (Nash, Fabius, Skoufalos, & Oglesby, 2021). To achieve these targets, HCOs must have a mature culture of innovation, a process for efficiency, effectiveness, and capable information technology infrastructure to leverage big data analytics to help decision-makers execute plans and achieve results. Integrated health systems have recognized that BEF adoption catalyzes innovation in digital technology, data analytics, and information technology infrastructure and promotes innovation opportunities in much of the other health care delivery continuum of medical care (PwC, 2019).

In Jasper, Indiana, the Memorial Hospital and Healthcare Center (MHHCC) provides inpatient and outpatient care through an acute care community hospital, including 32 outpatient primary and specialty care clinics and medical practices and an ambulance service. MHHCC uses its clinical and information technology infrastructure to achieve outstanding performance results. It has leveraged its investments to improve competitive advantage in patient outcomes, increase efficiency and quality, and reduce health care costs. The commitment to BEF core values is a mission-critical innovation expected to support and shape the rising at-risk population (NIST, 2019). This commitment allowed MHHCC to be the 2018 Malcolm Baldrige National Quality Award Recipient- Health Care. MHHCC achieved a high approach, deployment, learning, and integration (ADLI) in implementing BEF. Each of the outcomes and behaviors impacted is supported by creating and maintaining organizational focus. Connecting that focus to operations is how high-performing BEF winners achieve the envisioned goals. The MHHCC implemented an advanced clinical decision support software system to track results to improve medical care transition and, ultimately, reduce costly readmissions. Also, MHHCC, in recent years, deployed substantial enhancements to its telehealth program. Due to COVID-19, MHHCC implemented a comprehensive cloud-based platform to facilitate virtual care visits to chronic diseases (MHHCC, 2020). MHHCC results affirmed its commitment to support BEF core values in organizational learning, focus on success and innovation, management by fact, and delivering value and results.

Change Management using the Baldrige Excellence Framework

Leaders of health care organizations are dealing with unprecedented levels of patient care demand, societal and business environments uncertainty, and internal complexities in their organizations. These organizations have been grappling with questions about providing optimal value-based patient care with limited and dwindling resources. For many organizations in various industries, the implementation of BEF has helped them to deal with the challenging dynamics mentioned above. In particular, HCOs that have adopted and implemented BEF gained the meaningful knowledge and competencies to enhance their strategic viability and operational capabilities to manage emerging paradigms for care settings, demand for operational excellence, and the emergence of new growth opportunities. These leaders know that BEF is a change-based journey, and they acknowledge that the biggest mistake in this journey is underestimating the magnitude of the organizational culture change, alignment, and shift needed to implement BEF Criteria. To ensure a successful BEF adoption, organizational culture change must start at the top and proliferate throughout the organization's rank and file. Of course, many successful health care leaders are thriving at managing organizational culture change, but this may not be the case for the entire workforce dealing with change consequences. A change management model is needed to implement BEF.

The implementation of BEF begins with defining a strategy, but it does not end there. BEF implementation extends from strategy development through execution to realize measurable results supporting and sustaining competitive advantage. This process needs to be aligned closely with a change management model that moves the organization to its target goal. A systematic review of change management models currently adopted in health care and their implications to support the implementation and performance improvement methodologies that bring about change in health care teams, services, and organizations is provided in the Appendix.

The dominant change management model HCOs used to implement BEF is Kotter's 8-Steps Process for Leading Change, presented in Table 4 (Kotter, 2016). This model guides organizations and leaders through the transformation process and serves as an effective conduit for executing organizational strategies to ensure their organizations become more resilient and viable in the long run.

Table 4: Kotter 8-Step Process for Leading Change

Transformation Journey	Step	Description
	Create	Create a Sense of Urgency
	Create	Create the Guiding Coalition
	Develop	Develop a Change Vision and Strategy
	Communicate	Communicate the Change Vision
	Empower	Empower Broad-Based Action
	Generate	Generate Short-Term Wins
	Consolidate	Consolidate Gains and Implement More Change
	Anchor	Anchor Change in the Culture

Harrison et al. (2021) synthesized the many applications of the Kotter change model used in hospitals to address, adapt, and transform the health care delivery system. They pointed out that this model is used to create transformative change at all levels (staff-led, single unit, or site, and an entire integrated system-wide) with a significant increase in quality and performance outcomes in the clinical setting related to (a) triage systems of patients' flow in the continuum of care delivery, (b) bedside handoffs in intensive care and surgical orthopedic trauma units, (c) provide timelier access to inpatient and urgent outpatient specialist care for emergency-based patients, and (d) influence the adoption, growth, and sustainability of medication management services.

The Kotter and other change models (Lewin's Change Model, ADKAR and CLARC Change Model, Advent Health Clinical Transformation (ACT) Cycle, Riches Four-Stage Model of Change, McKinsey 7S Model of Change, C.A.P. Model) applied in the health care setting help health care organizations implement BEF and recognize the many issues, challenges, opportunities, and actions arising through the stages of pre-change, stimulus, consideration, validated need, preparation,

commit, do-check-act, results, and into the new normal. Conclusion: there is no doubt that BEF is all about learning and adapting and a critical realization of health care organizations, including those mentioned in this article. They operate as dynamic and intelligent systems that consider everyday clinical work as learning and improvement opportunities and ensure BEF is woven with the chosen change model as a systematic and integrated continuous quality improvement as business as usual for health care.

One of the biggest challenges in implementing BEF is the *sense of urgency* present in an organization. To support the business case internally and build momentum within the entire organization, an effective change agent must appeal and influence both *Thinking* (rational) and *Feeling* (emotional). GBMC's senior leaders introduced the workforce's mission, vision, and values beginning with the employment application process. This continued through hiring and onboarding, which included the personal participation of the CEO in all new employee orientations, and through the senior leaders' active participation in the daily Lean Management walks. GBMC reinforced its suppliers and partners' mission, vision, and values through negotiations, contract language, quarterly meetings, and performance reviews.

Effective change can only come about with the right leaders *building a coalition* with the power to lead change. The Wellstar Paulding Hospital (WPH) is a community hospital in Hiram, GA, Malcolm Baldrige National Quality Award 2020 Award Recipient-Health Care. WPH provides inpatient and outpatient care and emergency services through an acute care hospital. WPH's senior leaders are committed to supporting and reinforcing their "Neighbors Caring for Neighbors" (NCN) culture that guides the workforce in delivering world-class health care to neighbors. Senior leaders actively build a coalition with stakeholders, participate in daily safety and voice-of-the-customer (VOC) huddles, and visit frontline leaders and staff (i.e., leadership rounding). In addition, the hospital president personally leads WPH's biannual town hall meetings and discusses the NCN culture and WPH's mission, vision, and values during new employee orientation.

Another step in Kotter's change model used effectively by HCOs implementing BEF is to *anchor change in the culture*. The Mary Greeley Medical Center (MGMC), a Malcolm Baldrige National Quality Award 2019 Award Recipient-Health Care, is a public, nonprofit, 220-bed hospital offering inpatient, outpatient, emergency department, home health care, and hospice services in central Iowa. MGMC's leaders set the vision and ("to be the best") and values (PRIDE: "People, Respectful, Innovative, Dedicated, Effective") and ensure that they reflect the organizational culture to serve patients and their families. Leaders personally and regularly share the vision and values with the workforce, medical staff, and key suppliers and partners. MGMC fosters a just culture focusing on open communication, high performance, and patient safety; these are emphasized in the onboarding process, rounding, shared decision making, daily huddles, and participation in rapid improvement events (NIST, 2020).

The BEF journey is long, and the required transformation is hard, with many barriers and challenging dynamics throughout the process. With the Kotter 8-Step Process for Leading Change or any other change model, HCOs can gain agility and confidence to facilitate steps required to manage a wide organizational transformation and have a framework to communicate and discuss the transformation vision with the right stakeholders to bring it about.

The Road forward

Implementing BEF in the health care setting is not easily achieved; it is an ongoing journey and a long-term commitment to ensuring organizational culture alignment and shift is accounted for to achieve excellence in patient care outcomes and organizational performance. The COVID-19 pandemic has affected various aspects of life and caught many organizations, including health systems and hospitals, by surprise. It challenged many hospitals in many areas, from workforce staffing and resource shortages, staff burnout, rapid workflow and influx of patients, fragmented coordination of care, overstretched capacity and logistics, worsening financial position, and less than optimal and cohesive and unified organizational culture to manage the pandemic. According to the American College of Health Executives (2021), hospitals and health systems that have pursued performance excellence through BEF had excellent leadership and robust processes executed consistently by informed, engaged, and motivated staff. These success factors allowed these hospitals to navigate these pandemic challenges by supporting, facilitating, and providing patient care and service to the community and targeted population.

As HCOs are working diligently through the recovery phase of the COVID-19 pandemic and become more resilient and agile post-pandemic, they need to reposition their organizations to maintain excellence performance and growth. This repositioning is focused on these areas to (a) ensure alignment of their activities with the strategic plan, (b) enhance board and leadership shared governance and accountability, (c) sustain consistent and agile leadership to drive continuous improvement, (d) engage in clear and transparent communication to internal and external stakeholders, (f) invest in the workforce upskilling and support their wellbeing and psychological safety and needs, (g) build big data and digital tools infrastructure, h) empower innovation champions, (i) and invest in a culture of performance improvement. This forward-thinking repositioning should allow HCOs to (1) Become more agile and capable of delivering consistently high-quality, safe patient care that patients and health consumers value and feel engaged in. This opportunity is also extended to the health care team and staff members to feel appreciated and valued, and the organization can manage staff stress, burnout, and turnover. (2) To thrive now and in the future and become "net positive" — giving more to the community they serve than they take. (3) Communicate better across all populations and communities to build a culture of trust, support, and awareness. BEF is truly the right framework to help HCOs manage the strategic repositioning

and implement an evidence-based road map for excellence performance, transformation, and continuous improvement during the COVID-19 recovery and post-pandemic.

Key Takeaways

- Implementing the BEF creates organizational improvement performance opportunities, and BEF serves as a successful systematic approach for health care transformation and performance excellence.
- The catalyst for organizations that have implemented the BEF was to change and align the organizational culture needed to facilitate BEF implementation. They revamped their internal structures (clinical and business processes) throughout the care delivery system within the organization and aligned them with their vision, mission, and values.
- The path to success in adopting the BEF depends on dedicated and relentless leadership, which puts performance excellence as the central focus to achieving strategic success. Agile, engaged, and capable leadership that embraces a culture of performance and transformation plays a pivotal role in health care organizations' journeys toward performance excellence.
- The goal of transforming health care is to manage successfully these forces and dynamics: (a) ongoing changing population health and health care needs, (b) the demands of increasing life expectancy, baby boomers, and an aging population, (c) evolving complex health conditions and the prevalence of chronic diseases, and (d) the need to support health care workers' psychological needs, well-being, retention, and motivation.
- Recurring BEF themes include building an excellence culture, engaging in active communication and collaboration with patients, workforce, and communities, and striving for success and achieving competitive advantage. By integrating these themes into daily practice, leaders have inspired and motivated their workforce and stakeholders to achieve transformational change, leading to superior and consistent performance excellence results.
- The BEF helps HCOs thrive now and in the future and become "Net Positive" — by giving more to the community they serve than they take.

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Appendix

Change Management Models to Transforming Health Care

Change Model	The Objective in Transforming Health Care
Lewin's Change Model	Reduce nonsurgical trauma admission rate and better align resources to provide care for injured children. Encourage a new culture of clinical care. Improve patient-centered care.
Kotter's 8-Step	Address problems and inefficiencies with the triage system and meet the latest Emergency Department quality clinical indicators. Understand and evaluate significant organizational change. Improve preventive care service deliver, close care gaps, and reduce health disparities among its patients.
ADKAR and CLARC Change Model	The transition from primary to team nursing. Achieve a successful gainsharing culture which capitalizes on creativity, knowledge, and problem-solving ability.
Advent Health Clinical Transformation (ACT) Cycle	Develop a clinical pathway for the management of adults with chest pain in the Emergency Department.
Riches Four-Stage Model of Change	Describe the successful move of the radiation therapy department to its new site.
McKinsey 7S Model of Change	Use cultural and structural elements to support change management for sage opioid prescribing and opioid use disorder treatment.
Roger's Diffusion of Innovation Theory	Implement a successful bronchial thermoplastic program while maintaining patient safety and ensuring staff competency.
C.A.P Model	Transition a large health care organization from an old, non-standardized clinical information system to a new, user-friendly, standards-based system.

Source: Harrison, et al., (2021)

Christel Gollnick is founder and president of JUPER Communications, LLC, is a servant leader and collaborative manager with executive experience in several multi-faceted businesses and local/regional/national nonprofit organizations. She earned her Bachelor of Arts degree, doubling in English and journalism, from Augustana (College) University in Sioux Falls, South Dakota in 1994. After graduating, she worked at Media One Advertising/Marketing, Siouxland Heritage Museums, and Aerostar International/Raven Industries before moving to Kansas City, Missouri in 1999. She spent her first decade there as the CEO/Executive Director of Angel Flight Central and national spokesperson for Angel Flight America. She then bought and merged River City Studio, a small marketing company of 15 team members, into Trozzolo Communications, a much larger Kansas City marketing agency. She continued her relationship with client Heartland Foundation/Mosaic Life Care in St. Joseph, Missouri, to write and publish the book Come Together, Think Ahead: Inspiring People, Organizations & Communities to Thrive as well as serve as their Regional Relations Team Leader for two years.

KEY SUCCESS FACTORS IN COMMUNITIES OF EXCELLENCE

The Value of Innovation and Inclusivity

Christel Gollnick, MSOL

Innovation can mean creating something brand new out of nothing. It can also be defined as applying a proven idea in a new way to solve a different problem or the same problem in a different setting or context. This second description is what is happening in the national nonprofit organization Communities of Excellence 2026 [COE]. This article is a case study of COE's progress to date and may be of interest to any leader in a community, experienced Baldrige practitioner or not. The tried-and-true principles of Baldrige that have helped many organizations over several decades (Blazey and Grizzell, 2019) are now being applied to the unique and complex characteristics of communities in placemaking and revitalization initiatives (Kim, et al., 2021; Low and McClure, 2020).

The need for a new approach to problem-solving is urgent in America's communities. Health, wealth, and well-being indicators have been on the decline for decades long before the COVID-19 global pandemic further challenged the nation's systems. There are significant education disparities. The average performance levels for students in the least socioeconomically advantaged districts are at least four grade levels below students in the most socioeconomically advantaged districts (Rabinovitz, 2016). Public health is deteriorating. The life expectancy of Americans is now below the Organization for Economic Development and Cooperation average and the United States has the highest prevalence of obesity in the developed world (NCHS, 2018). Inequalities in economic opportunity impact nearly all social determinants of health indicators. There are 40-45 million Americans who live in poverty (Fontenot, Semega, and Kollar, 2018), and smaller cities, towns, and rural areas are particularly suffering, with average annual incomes about $54,000 less than larger metropolitan areas (Brainard, 2017).

A collective of performance excellence, leadership, strategy, process improvement, and communications experts, practitioners, and learners has been testing and tweaking an evolving adaptation of the Baldrige criteria for leaders who are interested in improving the health care, education, economic, and quality of life outcomes of communities. The Communities of Excellence Framework [COE Framework] is focused on guiding leaders from all sectors to discover how

to best work together on shared priorities to improve the overall performance of communities. Cross-sector and cross-boundary collaboration that considers many different perspectives and coordinates a wide range of resources is proving to be the innovative difference-making key to uncovering root causes of problems and finding practical and effective solutions in communities of place.

Communities of Excellence 2026 is focusing its performance improvement and quality excellence efforts on the people who lead within geographic places where many different organizations, businesses, groups, and individuals have chosen to live, learn, work, and play. There are now more than two dozen community excellence groups serving communities of a wide range of population and geographic sizes involved across the United States. According to their 2021 Annual Report, the COE leadership team is applying its COE Framework, multi-year National Learning Collaborative, and other community leadership development programs to help ensure "every American is living their best life in communities that are thriving." Best lives cannot be pursued in places where quality education, health care, economic opportunity, and quality of life is compromised, absent, or declining. The organization has begun to establish a pathway for role-model communities to share their promising practices with others and be recognized at the nation's highest levels of influence (Blazey and Grizzell, 2019, 2). COE is working with the Baldrige Foundation to solicit Congress to establish "community" as an official category for the Baldrige Award by 2026 to publicly uplift the essential and challenging work of leaders committed to working together to improve lives in their communities. The foundational statement driving the work of all those involved in this cross-sector and cross-boundary effort is "For America to sustain its vitality, promote opportunity, and create a more equitable society during its second 250 years of existence, we must improve the performance of communities and the people who lead and live in them" (COE, 2020). COE believes an innovative adaptation of the integrated Baldrige approach to quality excellence is the best model for encouraging and empowering many diverse perspectives and existing programs and processes in America's communities, small and large.

Why Baldrige as a Basis for Community Performance Excellence Improvement

There is no single line of accountability, chain of command, or hierarchy that encompasses the whole of geography-defined communities. There is not even a single governmental entity that presides given that local, county, state, and federal bodies have departments, laws, regulations, and guidelines that impact day-to-day activity in small rural towns and large cities alike. "Community issues are so complex that we need an approach that can help us get at the complexity," said co-founder of Communities of Excellence 2026 Lowell C. Kruse when asked about the longitudinal and innovative growth mindset required for improving life in America's communities.

There are many well-researched approaches for facilitating collaboration and strategic project

implementation available to businesses and other entities. Just a few of them include the National Institute of Advanced Technology's [NIAT] Community Resilience Program, the National Trust for Historic Preservation's Main Street America, WealthWorks, Strategic Doing, FSG's Collective Impact, and the Aspen Institute's Community Strategies Group. While they are all valuable programs producing measurable and meaningful outcomes, nearly all of them address only specific areas of interest or projects instead of the entire diverse and interconnected network of stakeholders in a community that simultaneous priorities that must be addressed. Systematically pulling all betterment efforts and stakeholders together for a sustained period of time is rare.

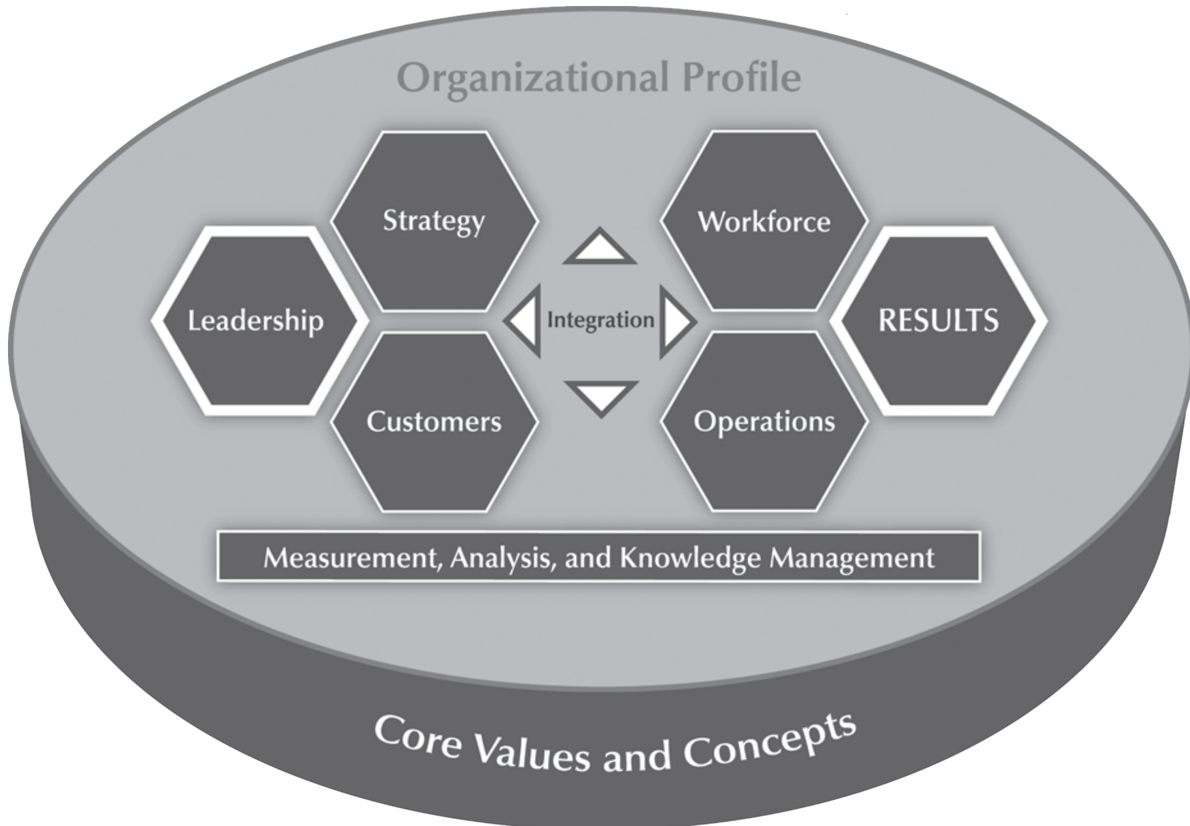
COE's co-founders, both former chief executive officers of Malcolm Baldrige Quality Award-winning health care systems, recognized more than a decade ago that a coaching system for addressing systemic problems and long-term priorities is needed that goes beyond convening people, making plans, and implementing short-term projects. All of these activities are critical to making positive change, however, the present's significant challenges and opportunities require more effort and long-term vision and commitment from leaders.

Today's world requires being comfortable with the uncomfortable exhilarating and scary changes that must be made to not only keep up with what three-time Pulitzer Prize recipient Thomas Friedman calls "The Age of Accelerations" (2016) but to also protect the deep-seated values people hold most dear. Doing the same things in the same way as leaders have always done them is not producing desired results as evidenced in social determinant, population, and other key indicators. W. Edwards Deming's wisdom, first published in 1986, has been brought forward for today's relevance by The MIT Press in their 2018 republication of *Out of Crisis,* highlighting thoughts such as, "Every system is perfectly designed for the results it gets" and "The greatest waste in America is failure to use the abilities of people." Communities need a different system to produce different – and improved – results for all sectors. What that means is engaging many residents and other customers of communities to "sequence and synchronize their work" (Atkins, 2021), utilizing the combined strengths of each entity and individual leader in a way that respects their many unique experiences while also discovering commonalities that, if leveraged, can maximize the potential of communities. A systems approach can help leaders deal with communitywide crises, gaps in key services, and desired amenities that uplifts what is working and gives permission to move on from what is not.

The Baldrige Excellence Framework depicted in Figure 1, is our nation's top-level criteria for quality excellence in manufacturing, business, health care, education, government, and nonprofit organizations. Itis a proven approach for addressing the many complexities of traditional hierarchal organizations with multiple internal and external stakeholders (Blazey and Grizzell, 2019). Since the 1980s, departments of corporations and other entities have discovered the value of working together through the common language of Baldrige's questions around leadership, strategy, customers, measurement, workforce, operations, results, and core values. Doing so highlights the

interdependence, influence, and impact each department has on the others within their "system" or full organization.

Figure 1: The Baldrige Excellence Framework



From Baldrige Performance Excellence Program. 2021. *2021–2022 Baldrige Excellence Framework: Proven Leadership and Management Practices for High Performance (Education)*. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige.

Communities of Excellence 2026's board of directors hypothesized that the Baldrige Performance Excellence Framework "could be modified to achieve performance excellence in communities to benefit the health and well-being of all residents with a primary focus on education, health, economic vitality, and safety." They wanted to find a way to help communities improve their interconnected quality of life key performance indicators. Over the past dozen years since forming in 2010, their hypothesis has been proven correct based on feedback from the communities piloting the Baldrige principles adapted in the COE Framework (Gollnick, 2020). While the results are still process-oriented and qualitative in most cases, some participating communities are starting to see new businesses sprout in areas where economic vitality and entrepreneurship are the focus of their community excellence group. In others, high-speed broadband projects are finally getting the attention they need to connect all households. Policy changes are also being discussed and approved to remove roadblocks to ensure available childcare is available to the workforce.

Other community collaboration researchers are coming to similar conclusions and recognizing that helping leaders get out of their comfort zones to discuss their shared interests and how they do or do not consider or communicate with each other is a huge undertaking (De Jong, 2021). Collaborating on shared priorities with organizations and people that are typically considered competitors requires consideration for the interdependent nature of communities alongside the independent operations, cultures, and goals of each organization, entity, and individual. One group cannot do much of anything without impacting others somehow, so the first step for many of the communities involved in COE is to know and understand their current reality of connectedness. Recognizing the interdependence and being non-political and non-threatening has been an effective coaching strategy that opens the door to building stronger communications channels and relationships. A comprehensive Baldrige-adapted approach has opened up conversations that are leading to the solving of root-level problems. One of the participants in COE's first year of programming, Josh McKim, Maryville Missouri Economic Development Director, said, "We are getting out of our traditional thinking and seeing things happen across organizations. I give credit to this approach [COE2026] for that. We're busy working on the priorities we identified."

Innovations in Communities of Excellence 2026

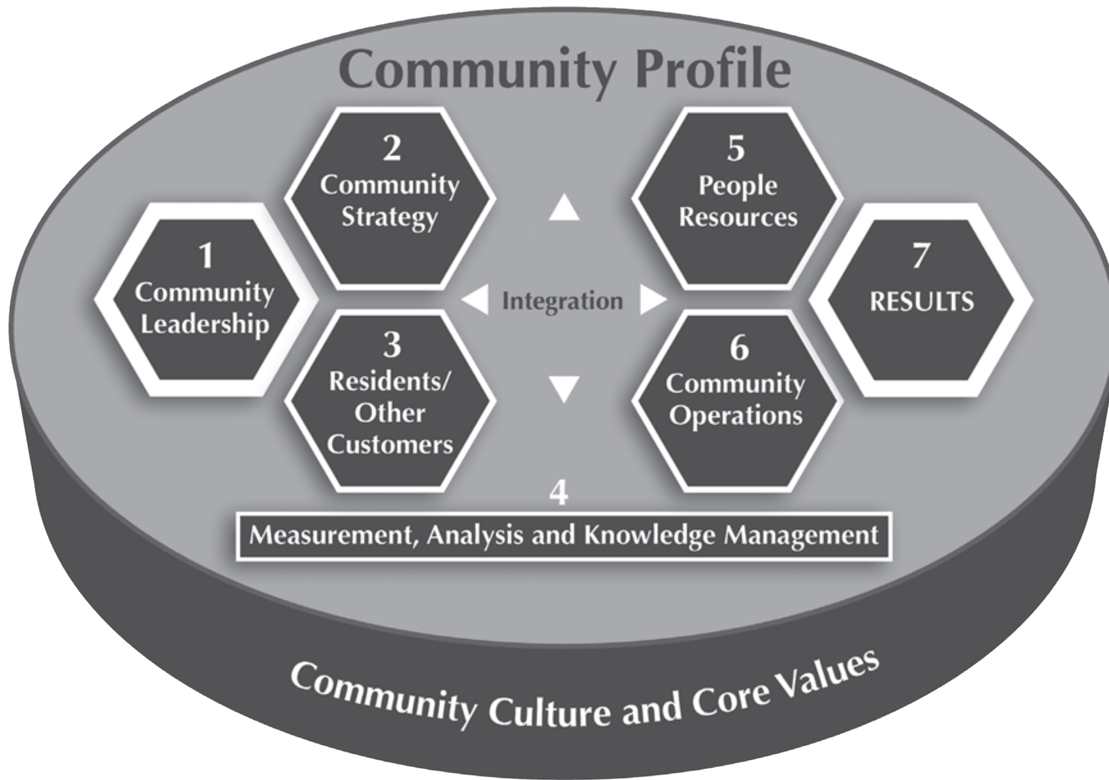
Supporting communities on their journey to community performance excellence requires building on innovation and inclusivity as foundational values. The organization has embraced these concepts itself in the development of its Communities of Excellence Framework and National Learning Collaborative programming for leaders working in collaborative initiatives. Establishing a common language, considering communities of different sizes and locations, and the inclusion of many diverse perspectives are key innovations that establish the COE approach as a comprehensive continuous improvement guide for informal and formal community leaders.

A Common Language

Initially, participants in the National Learning Collaborative, COE's flagship program, who have had no prior experience with continuous improvement or performance excellence language were challenged to see how the probing questions of the profile and seven categories pertained to their work. The categories of Baldrige and questions had to be adapted to pertain to community excellence group members to give the criteria context. The organizational profile has been renamed the Community Profile, and the categories for COE include (1) Community Leadership, (2) Community Strategy, (3) Residents and Other Customers, (4) Measurement, Analysis and Knowledge Management, (5) People Resources, (6) Community Operations, and (7) Results. Community Culture and Core Values underpin the Framework (Figure 2.). For those who had been

through a similar integrated management process in their professional roles, it seemed natural to think about the criteria through the lens of community.

Figure 2: The Communities of Excellence Framework



Adapted from the Baldrige Performance Excellence Program, 2015. *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance*. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology. http://nist.gov/baldgrige. - UPDATED 6.2020

For example, Residents and Other Customers fill the role of the customers of the community excellence group within the COE Framework. They are the community's shareholders and stakeholders. Resources are the people who show up to help with their time, talent, and financial contributions. The Operations category is how all of the sectors in the community work together through the community excellence group of leaders who serve as diverse representatives of the community at the intersection of shared priorities and common goals. How they put aside their personal and organizational agendas and pool assets to address the priorities that are bigger than any one of their organizations defines the decision-making and task implementation processes of operations. True to Baldrige principles, the COE Framework is not prescriptive in telling users how to operate. Through the National Learning Collaborative, participants are exposed to many promising practices to help guide them to the processes and tool that are right for their unique

situation, vision, priorities, and resources. What legal structure or strategic planning model works in one community may not be appropriate for another. Participants are simply taught the best questions to ask to help them make those important decisions.

Shifting the language of Baldrige to word choices that are more familiar to leaders volunteering in communities has been the relatively easy part of piloting the idea of applying proven Baldrige principles (Wright, 2018). The principles, however, are typically applied within existing organizations and hierarchal leadership structures. Communities have less defined layers of responsibility than top-down entities. Shifting the mental models of community leaders to the integrated approach of Baldrige is more complicated than just suggesting new language and talking about systems leadership. Innovative thinking is about more than cooperative partnerships. It is about collaboration that compels people to work together for and with each other's benefit. Learning these principles experientially over time is critical. People have to practice believing in the possibilities. The shift can take several years of using the new language, a timeframe that can try the patience of people used to directing all of their energy towards projects, grant cycles, annual activities, and elected terms of office. However, participants have reported that the journey is worth the wait once the "aha" moment happens for a leader and the purpose of the criteria becomes a useful decision-making, planning, project management, and alignment tool (JUPER, 2021). Communities of Excellence 2026 Executive Director Stephanie Norling shares, "Taking the time necessary to build trust and leadership capacity while learning a framework that includes all parts of a community can contribute to transformational results."

Considering Communities of Different Sizes and Locations

Communities of all sizes are facing systemic challenges, but not all of them have the same challenges. For instance, depopulation over decades and the cascading impact of fewer people on the economy, health care, and education is a serious root cause of many problems Rural America faces daily (Atkins et al., 2021). Conversely, most urban areas face challenges resulting from rising population density (De Jong et al., 2021). While seemingly opposite, the founders of COE suspected they would find that both community sizes have many things in common as they balance the reality of too many people who do not having enough resources nor opportunities to make healthier choices for themselves. The human needs and dynamics are the same, making the COE Framework applicable to all sizes and locations of communities.

To test their initial theory, the organization aimed to involve communities of varying size and geographic location in an online learning experience that teaches and discusses how communities coast-to-coast might answer the questions of the framework. This experience is what has become the National Learning Collaborative. The first year introduced San Diego County's South Region in California (pop. 500,000) to the Baldrige-adapted principles right alongside community excellence

groups representing populations such as West Virginia's Kanawha County (pop. 190,000), Toledo, Ohio (pop. 280,000), West Kendall, Florida (pop. 390,000), Kings County, California (pop. 150,000), Excelsior Springs, Missouri (pop. 11,000), and the primarily rural 18-county region if Northwest Missouri with communities ranging from populations of fewer than 1,000 to 100,000. Participants report their enjoyment of being able to learn from each ther. While there are 26 community excellence groups in 14 states participating in COE 2026 learning programs, these groups represent more than 150 unique communities plus 57 incorporated municipalities in the State of Delaware (Delaware.gov, 2021) and four parishes comprising a third of the State of Louisiana's population (lma.org, 2021). These groups are bringing many voices to the roundtable of collaboration (Figure 3.).

Figure 3: Community Excellence Groups Participating in the Communities of Excellence 2026 National Learning Collaborative Over Five Years

Including Many Diverse Perspectives

The very definition of innovation within COE efforts is a nod to the importance of diversity: "Making meaningful change to improve your community's health, educational status, economic vitality, quality of life, operational processes, and mode of operation, with the purpose of creating new value for residents, other customers, and stakeholders. The outcome of innovation is a

discontinuous or breakthrough change (COE Framework, 2020).” The definition does not single out any specific demographics. It is inherently inclusive of all who reside, do business within, travel through and serve the defined geographic place.

Creating new value and making meaningful changes to improve are the key phrases that apply to all definitions of innovation. The mention of health, education, economics, and life quality deems this definition unique to COE. Inclusion of these elements recognizes the growing desire for greater inclusivity and equity, improved life experience for the greatest number of people, and more sustainable community environments and economics. At the same time, this inclusive approach to community improvement and development is respectful of everyone’s position, is non-political/partisan, and neutral in taking extreme sides. It seeks to find shared values, needs, and desires in a pursuit of excellence through compromise and collaboration.

Organizations applying the principles of Baldrige are forced to think about all of the diverse perspectives within their shareholder and stakeholder groups, including different internal departments and external vendors, suppliers, and target customer markets, to name a few. In communities of place, the diversity of perspectives grows from one organization’s list to a much broader circle of life experiences, positions of power and influence, and expectations from the place they have chosen to live, learn, work, and play. To help people come together to lead a community and not get overwhelmed by this extensive definition of inclusivity, the COE Framework focuses on the geographic place in the Community Profile. The categories, then, primarily focus on the community excellence group that has gathered to serve the community collectively without prescribing how they decide to carry out that service.

The COE Framework’s guidance of encouraging groups to practice the values of diversity, inclusion, and equity is evident in the leadership structures that community excellence groups have put into place. While most have smaller core teams and larger partner groups within their structure for practicality reasons, all COE communities are conducting their decision-making and work activities in ways that inform, consult, involve, collaborate, and empower many diverse perspectives (iap2, 2022).

Those involved in providing residents with health care, quality of life services, education, and economic vitality opportunities are used to working within their individual organizations, businesses, and entities. They may be proficient at networking within their specific silos of interest and expertise and possibly even partnering with others outside their lane to support community events and youth activities. Based on the findings of researchers such as Robert Putnam (2000), Putnam with Shaylyn Romney Garrett (2020), Rosabeth Moss Kanter (2007), Margaret Wheatley and Deborah Frieze (2011), and many others who have examined the rise and fall of trends and challenges in community can-do spirit and organizational leadership, it has become rare over the past 100 years for community involvement to go beyond the surface of needed projects and

desired events. Addressing more deeply rooted challenges and higher-reaching opportunities that cannot be solved or leveraged without systems-thinking and strong relationships requires a greater volunteer commitment to advanced citizenship. Community development that improves the community through its processes beyond the treadmill of repetitive activities and funding cycles requires a more organized and integrated approach that the COE Framework answers.

In addition to the diversity of sectors mentioned in COE's innovation definition, the description of diversity as it applies to community collaboration efforts in the pursuit of progress and excellence is: "Personal differences among community members that enrich the community environment. The differences address many variables, such as race, religion, color, gender, national origin, language, disability, sexual orientation, age and generation, education, socioeconomic status, geographic origin, and skill characteristics, as well as ideas, thinking, academic disciplines, and perspectives (COE Framework, 2020). One of the first processes that the COE Framework addresses is how leaders come together, who they are and why they are coming together. To help catalyze the recognition of the diversity of perspectives that exists within a community, COE developed a "Community Round Table" tool (Figure 4.)

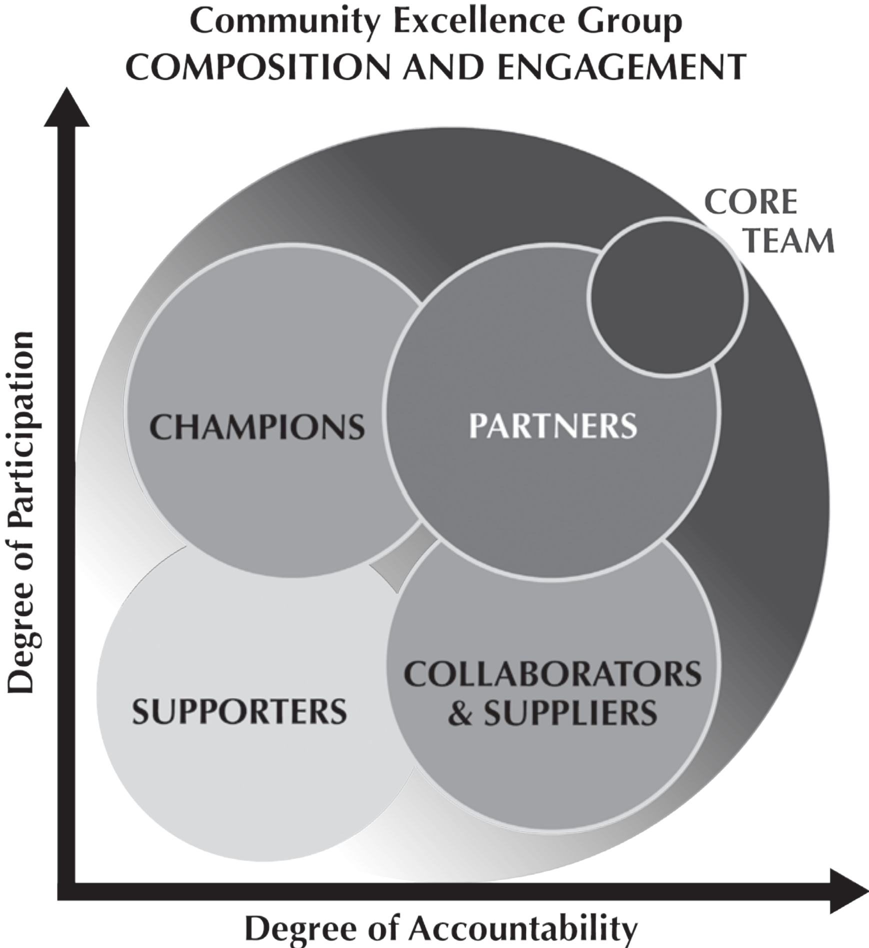
Figure 4: Sample of Diverse Community Perspectives

Listening to, considering, and involving leaders and other volunteers that represent the perspectives of many sectors and interest areas included in this graphic, as well as the more recognized labels of diversity, are proving to be key elements of community collaboration success (Rohd and Lord, 2021).

Solving Community Challenges

The challenges that are being addressed in communities are as diverse as the communities themselves. The following two communities are examples of the 26 community excellence groups across the country that are applying the COE Framework to their community collaboration efforts. They have discovered the importance of moving away from past chaotic reactive activities, projects, and events towards new proactive aligned and integrated plans and implementation that involve many organizations. In one case, San Diego County, South Region, California, over 400 organizations are involved as partners, collaborators and suppliers, champions, and supporters (Figure 5.). Everyone plays an important role when and where they desire and are most needed.

Figure 5: Participation and Accountability Expectations of Various Collaboration Roles



> Building off our prior history and successes allow us to implement the COE Framework and propel the collective work of our partners to advance the vision of Live Well San Diego. Specifically, our enhanced strategic planning process has enabled us to further respond to the community's changing needs and allowed for innovative ideas. The governance structure ensures that we're advancing our collective work. – *Barbara Jiménez, MPH, Live Well San Diego, San Diego County, South Region, California*

> In the past, we often focused on our challenges, without necessarily considering our many strategic advantages. We've also learned that the key requirements of residents in the different geographic areas of our county are very different. We are also thinking about customers beyond our residents. They are employees of businesses in the region, legislators, [visitors], and key stakeholders in our contiguous counties that benefit from our efforts. To be excellent, we need to consider all of our customers and their requirements. – *Judy Crabtree, The Kanawha Coalition for Community Health Improvement, Kanawha County, West Virginia*

Both of these initiatives are looking at their strengths and going about their work differently by opening their discussions to new ideas (Deming, 2018). Kanawha County has moved from addressing topics primarily around wellness and chronic disease prevention to understanding the interconnectedness of all sectors. Through listening to residents and leaders outside of the health care institution that is serving as their effort's backbone organization, this West Virginia County is now prioritizing additional issues such as road safety; access to affordable and adequate childcare options; barriers to employment; and access to safe and adequate recreation, exercise, and play opportunities.

In describing the development of their Community Improvement Plan that is now being implemented through Kanawha County's experience in applying the COE Framework, Crabtree shares how important a systems approach is to engaging residents in a more meaningful way, "We now have new systems and processes in place to help us make decisions that are informed by the input from diverse customer groups and across all the areas of social determinants to health. As we strive for Kanawha County to be a great place to live, learn, work and play, we do so collectively. We look forward to improvements in our offerings, including systems, policy, and environmental changes that will result in long-lasting change."

Another health-focused initiative in West Kendall, Florida has also expanded is work beyond the partnership between West Kendall Baptist Hospital and the Florida Department of Health. The leaders of the group were recently recognized in their State Capitol for their participation in Communities of Excellence. "Looking at our community through the lens of education, economic

vitality, safety and quality of life [in addition to health] is a shift in approach that has allowed us to tap into key stakeholders and create a sustainable initiative. Our new vision statement is 'To be a blueprint for a healthy and thriving community.'" – *Michelle Mejia, West Kendall Baptist Hospital, West Kendall, Florida*

Mejia tells stories of how helpful it has been to have stronger relationships with the Florida Department of Transportation, for instance, to better understand pedestrian and cyclist traffic in their community. Promoting safe walking and cycling for wellness requires knowing the road, sidewalk, and bike path conditions and usage data. Adopting a systems view with participation by many leaders has contributed to a more robust culture of trust and camaraderie.

The Impact of COVID-19

Perhaps the most disruptive challenge other than a natural disaster any community has faced within the last 75 years is the COVID-19 global pandemic of 2020-2022. The virus has served as a pivotal testing ground for the effectiveness of the COE Framework and the innovative and inclusive work of the community excellence groups. For those community excellence groups comprised primarily of health care providers, leading community collaboration efforts all but ceased for a time. Hospitals serving as the action network coordination and administrative support backbone had to reallocate time to patient care. However, that was not the case for those that had taken the time ahead of the crisis to build strong cross-sector relationships. Mejia has shared that West Kendall Baptist Hospital's strong relationship with their local business community has literally opened doors during the COVID-19 global pandemic allowing the hospital to partner with a nearby hotel for patient overflow. Other communities found that having a wide range of sector types already involved was a key to their ability to respond to COVID while also continuing their work on other priorities as much as possible. Following are several direct quotes shared by participants:

> This is when working together has legs, in a crisis like this…This [Communities of Excellence] isn't just something you do when you have time, this is how you solve problems. – *Quentin Wilson, Community Leader, St. Louis County, Missouri*

> Our experience using Communities of Excellence and Baldrige-based principles in the community positioned us to naturally approach the COVID-19 pandemic through a collaborative and inclusive lens. Work Groups for all sectors in the community were quickly formed and now communicate weekly through well-attended robust digital

sessions, ensuring all stakeholders are current on the latest developments and can get their questions answered. We swiftly and collaboratively moved to protect vulnerable populations, taking steps that have been recognized by the state governor during his daily news conferences. We worked side by side with all our health care community to creatively expand medical capacity well in advance of the expected surge. Our experience with COE and Baldrige has allowed us to collectively and collaboratively ensure our community remains healthy, safe, and thriving. – *Nick Macchione, Director, County of San Diego Health and Human Services Agency, San Diego North Regions, California*

The networks, communication channels, and relationships established through our COE work over 2 ½ years are proving extremely beneficial to community leaders during this time. As we move into [COVID-19] recovery, these same channels will be used to coordinate a long-term response and recovery effort. We have a common strategic planning process that can be replicated to develop a community-wide response. Our shared processes and network would not exist without the work we've put in because of COE. The systems approach provided in the COE Framework is an asset to communities anytime, but especially in times of crisis and instability. – *Kim Halfhill, Community Coach, Excelsior Springs, Missouri*

Right after the COVID-19 crisis began, the chair of our Community Success Panel, which coordinates our Communities of Excellence efforts, called a meeting to bring together city leaders, county leaders, our health system, and pretty much all the major players in our community. We formed a coalition, that really came out of Communities of Excellence, that meets twice a week to strategize and work together across the community around this crisis. Communities of Excellence provided a great way for us to get started with this coalition, which is now doing some excellent work. – *Sharon Mortensen, President and CEO, Midland Area Community Foundation, Midland County, Michigan*

It is not just densely populated areas with existing collaboration efforts that are benefitting from the application of the COE Framework. Micropolitan and rural communities that are gathering leaders to begin a community collaboration effort are also finding value in asking the questions of the community profile introductory section of the Framework. While it is difficult to answer many of the questions without an entity or initiative in place, the questions along with an asset-based community development [ABCD] approach (Nel, 2018) are guiding these groups by helping them discuss the topics that will empower them to lay a strong and sustainable foundation for their future work together.

> Slow depopulation over many decades is the root cause of many of the challenges we have throughout our rural region but going around and talking just about the data wasn't getting us anywhere in starting a regional vitality initiative. Once we started asset-mapping and analyzing gaps and opportunities throughout our 18-county region of just over 250,000 people spread across 9,300 square miles, we began to gain a little traction. An uplifting brand story for our collaboration efforts along with a sincere attempt to support many volunteers coming together to better connect and promote what we do have that already helps keep and attract talent to the area are the key factors that are convincing leaders from many sectors that there is value in cross-sector strategic action planning. There is hope! – *Steve Wenger, Maximize NWMO Navigation Team and The Community Foundation of Northwest Missouri*

Hope along with a can-do attitude and a willingness to invest in themselves financially and through leadership development are the ingredients of success in community collaboration efforts (Macke, 2021). In the process of answering the COE Framework questions, several community excellence groups have decided to implement and or expand support for community leadership programs that build the capacity for systems leadership, innovative ideas, managing by fact, and including as many perspectives as possible in decision-making. "Our game plan of building the capacity and capability of leaders is an application of the infinite mindset of investing in long-term generational transformation starting with those informal and formal leadership positions today," said Wenger.

Driving Results from Improvement Mindsets

Opposite of hope and very real and present in early collaboration efforts is the emotion of fear. A lesson for Communities of Excellence 2026 leaders who are mentoring and coaching community collaboration efforts, and any other Baldrige practitioner, is that many of the people involved in each community are unfamiliar with the principles of Baldrige. These leaders are uncomfortable with what they do not yet know about the COE Framework. While those with experience know that the questions within each category are designed to enhance systems thinking and drive quality excellence, the probing can quickly put performance excellence novices on the defense if they do not understand the intentions. Even with the adapted language now in place specific to communities, an orientation to the Framework's innovative interconnectedness and inclusivity along with a strong sense of urgency and shared vision among members of each community excellence group can be helpful. Another key lesson learned is the importance of starting from a place of positivity and willingness to invest in themselves (Macke, 2021).

Starting from conversations focused on strengths that can be built upon versus a spirit of unhelpful

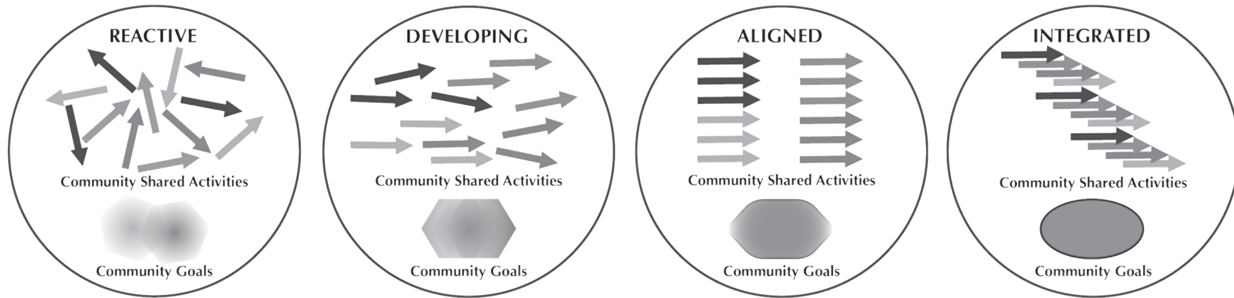
criticism is an especially helpful mindset. Starting with attention to assets instead of deficit and fear balances the essential role of facts in cognitive (logic and information-based) decision-making with the affective (emotional and intuitive) dreams that feed strategic visioning as well as the conative (striving action) for implementation of plans (Kolbe, 2021) (Figure 6.).

Figure 6: Three Stages Mirror the Three Mental Functions of Humans

At its simplest and highest level, COE's approach is described as seeing, believing, doing, and then repeating the cycle. It is a human-centered design mirroring the way human brains operate. Too often, people jump to emotions of overwhelming hopelessness by focusing only on negative realities such as rises in obesity, a decline in population, troubled economies, and crumbling infrastructure as examples. They forget or fail to acknowledge all their strategic advantages, existing assets, and incremental progress. Both the negative and positive facts are essential for driving a sense of urgency to transform outcomes (Kotter, 2012). Leaders involved in these efforts benefit from having a guiding framework that helps them first understand their community situation or story, including many diverse perspectives in envisioning a new and improved story; and take action together to make their strategic plans a reality. One of the elements that set the COE Framework apart from the many other public and private investments made to help communities over the past couple of decades is the focus on sustainability and moving away from reacting to solve surface

problems to developing closer relationships, aligned efforts, and integrating resources where it makes the most sense (Figure 7.).

Figure 7: Assessing Processes and Progress to Meaningful and Measurable Long-Term Outcomes



The guiding questions focus collaborative leaders on documenting their decisions and actions in a way that motivates them to keep an eye on the big picture. They help identify and address the key opportunities for improvement and celebrate the progress of wins along their journey. The COE Framework supports a continuous cycle of considering and engaging the community's residents and other customers/stakeholders instead of focusing only on stand-alone or short-term projects and the siloed agendas of specific sectors and individuals.

> "We developed big audacious goals of where we think we'll be over time. We also developed specific initiatives where we either created additional senses of urgency, additional collaboration, or where we're better together. Of these, universal Pre-K [education] has been implemented in our city, and we're really proud of that. We have not made sustainable progress in infant mortality, although ProMedica continues to do a better job in that. Achieving national ranking as a vibrant art community is in process. We're trying to achieve that objective right now. We did bring several programs to support local tech startups and small business and minority owned businesses. It is definitely a journey.
>
> Social Justice and Reform is the sixth pillar we added. While we spoke about diversity, equity, and inclusion among our pillars, we did not feel our efforts called that out in the way that we feel it needed to be honored in the City of Toledo. When we are thinking about education and a socio-economically depressed areas, are we really thinking about… 'opportunity is not equal to talent that's distributed.' Not everyone has the same opportunity for the resources that are available. So, we created that as a call to action within our community.
>
> I'm proud to say that Communities of Excellence is on the strategic plan for the City of

Toledo, it is on the strategic plan for ProMedica, it is on the strategic plan for our regional growth partners, and several other companies that have been at this conversation for a long period of time." *–Angela Brandt, President, ProMedica Senior Care, Toledo, Ohio*

Over the past four years, additional COE faculty members with experience gained while working in communities have been welcomed to the team. They bring the practical application insight of what is working and what is not that is needed in COE's groundbreaking program. Mentors have been recruited for each participating community to serve as coaches, objective sounding boards, and sources of encouragement throughout the process of adopting the COE Framework. Evaluators have also been secured to review communities' applications for objective feedback and recognition. The Framework itself, and approach to covering its elements in the curriculum, have also been updated several times. The organization has modeled the way (Kouzes and Posner, 2012) for others by listening and learning from participant feedback compiled each year gathered for COE's performance improvement. The most recent program evaluation revealed:

- 100 percent of the participants either strongly agreed or agreed that COE 2026's National Learning Collaborative's content is relevant to their community collaboration work. One survey respondent said, "It brought us together."
- Nearly all indicated that new knowledge is being learned throughout the experience.
- Applying the learning takes time, yet many participants state that they see the benefits of systems-thinking and the Framework's values in their daily personal and professional lives and their community interactions.
- 93 percent said the Framework is a useful approach to support continuous improvement for community collaboration efforts – a benefit they haven't experienced in applying other models – listing the major benefits as:
    - Helping community excellence groups develop a common language across different sectors,
    - Fostering cross-sector collaboration by "shaping the discussions without the need for 'control'" by any one entity or individual;
    - Building a systems approach that focuses efforts on achieving outcomes beyond just planning for them.

A summary of what the faculty feels participants can accomplish as they apply the systems leadership principles of the COE Framework over time include:

- Higher rates of community engagement,

- Measurable outcomes across many sectors,
- Ability to anticipate issues in advance,
- Build resiliency and become less reactive and more proactive,
- Make better decisions by managing by fact, and
- Improve communication that builds stronger and more trusting relationships critical to success.

Key performance indicators in the early stages are as simple as tracking how many people are showing up consistently, how many sectors are represented in conversations and data gathering, and how many voices are participating in surveys and listening session. These process indicators reflect the necessary resources (inputs) and activity (outputs) that must preface short-, mid-, and long-term outcomes.

Conclusion

Throughout its first decade of serving communities, COE's leaders have learned that when it comes to making meaningful change in communities, each community's leaders and key stakeholders must first take ownership and trust the process. They must look to each other and include as many of their residents and other customers as possible to find new and better answers to legacy and systemic problems. To be successful once they have shown up to collaborate, they need guidance, mentorship, and coaching that allows them to thoughtfully and systematically make progress through the interconnected complexity of their community. The systems leadership and integrated management approach inspired by Baldrige and translated into inclusive community language developed by COE is helping to build stronger communities of connection, courage, creativity, and character. It is an innovative approach that is helping leaders think differently about the potential of their communities and value all people and assets. Communities of Excellence 2026 is bringing the light of hope to community leaders who have dedicated themselves to improving the places they live, learn, work, and play.

Key Takeaways

- The interconnected nature of the innovative Baldrige-adapted Communities of Excellence Framework's criteria categories helps community excellence groups better understand themselves as a whole through answering questions of why, who, what, and how related to their collaborative efforts.
- Being inclusive of diverse perspectives in a community context helps community excellence groups solve challenges and cross traditional boundaries towards progress over time.
- The COE Framework can be applied in communities of all sizes and locations to build innovative thinking skills, systems leadership, and more inclusive cultures.
- Considering the strengths and perspectives of many voices helps communities address root causes of problems and more wisely use resources.
- COVID-19 has proven how valuable the cross-sector relationships that are encouraged within the COE Framework are to communities facing shared challenges that need innovative solutions.

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LEADERSHIP AND MANAGEMENT PERSPECTIVES

FROM HURT TO HEALING

A New Perspective to Improve Workplace Ecosystems

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Simple Wisdom for the Journey

It is time to rethink our concept of organizations, particularly in health care where the most important focus of our work is on healing and health. A number of longstanding trends, many of them exacerbated by the COVID-19 pandemic, are revealing that our thinking, behaviors, and strategic efforts in health care are often moving us away from these noble goals, rather than toward them. In this article, we describe a new conceptual model for how we can increase organizational – and personal – resilience (a new core concept in the Baldrige criteria), accomplish less suffering and more healing in our places of work, and we provide examples of how this can be done.

The COVID-19 pandemic has generated extraordinary stress, anxiety, and suffering, but in many ways, it is simply a crescendo on a much longer refrain. At this writing, the Delta variant is ravaging many parts of the country despite hopes that effective vaccines would quell the pandemic, and it is unclear what the future will hold. There is a yearning for a "return to normal" but it is now clear

that desire is unlikely to be fulfilled. This raises an important question: do we really want to just go back to the way things were in 2019 – or to take what we have learned and build our lives, our communities, and our organizations back better?

Put simply, the ways many organizations have worked and are continuing to work -- and the environments thus created -- have become increasingly toxic to a large proportion of human beings. Within the workplace this fact shows up in numerous media stories: frustrated workers imparting poor service and experience to customers and patients, low employee engagement, high turnover rates, levels of burnout that range from 20-80 percent and leaders regularly stepping down from their roles after increasingly shorter tenures.

What has emerged is "The Great Resignation" – people deciding not to return to their old work in unexpected numbers, despite an abundance of open jobs. A Microsoft survey of more than 30,000 global workers showed that 41 percent of workers were considering quitting or changing professions this year (Microsoft, 2021). Reasons for these decisions are as diverse as the people themselves, but they tend to fall in three areas. First, the digital revolution has definitively arrived, and many people are much more comfortable engaging in it, providing more opportunity for non-traditional work. Second, many people have re-centered their lives around family, personal interests, and relationships to sustain themselves during the pandemic, and don't want to return to a structured work environment where relationships are continuously compromised to accommodate work. Third, people who were unhappy with their jobs or their employers – for whatever reason – are deciding to look elsewhere. Conventional wisdom is that this will resolve, and most people will return to a regular paycheck. New jobs may be found in new locations – but people will still need jobs. What seems consistent, however, is a sense among many people that something important has been missing in daily work.

For over three decades the Baldrige Excellence Framework has provided a unique and powerful lens for examining leadership and management systems and the performance they achieve. Using the Framework can identify potentially pivotal opportunities for change that create improvement in key areas of organizational focus. This has served as a powerful mechanism for understanding performance drivers and for shining a spotlight on the leadership, culture, methods, and structures Baldrige award winners utilize to achieve outstanding results, in hopes of inspiring others to emulate them. We believe much benefit has come from this focus on factors that drive performance and outcomes and that a new dimension of our organizations deserves attention to address current challenges.

The Organizational Profile (O.P.) documents the context in which leaders lead and manage the organization. The O.P. asks the organization to describe its internal characteristics and its external environment. One can think of this as the organization's ecosystem - a community interacting with its environment to produce outcomes. Within the Baldrige process, the key facts identified

in the O.P. are accepted as organizational "givens" and all other ADLI descriptions [Approach, Deployment, Learning & Integration] of the leadership & management processes are assessed against them. That makes sense for a Baldrige-based assessment of management and leadership processes, but a key insight is missing.

What if, instead of just accepting organizational givens – the "as is" foundation of what makes an Organization Profile - we re-conceptualize its foundational elements? We believe there is another vital facet of organizations that succeed in the Baldrige framework, which has gone un-named: their conceptualization (conscious or not) of their places of work, the people they employ, and the communities they serve as an ecosystem that produces something positive and beneficial for all parties.

Workers in many industries and in many settings need something different and better than what is too often offered in today's workplaces: a role, a paycheck, benefits, a hierarchical system in which to do one's work, and an opportunity to contribute to products or services that create economic and social benefit. One work setting of great concern is health care. Even before COVID there was a high degree of burnout among health professionals and support staff. Approximately one-half of all U.S. physicians experience burnout – with higher rates among those physicians at the front line of patient care. Burnout rates are nearly twice as high as that of other U.S. workers. Medical students and nurses, in all settings, have higher rates of burnout and depression as well (Dyrbye, Shanafelt, Sinsky, Cipriano, Bhatt, Ommaya, West, Meyers, 2017). Medscape's annual physician burnout survey (Kane, 2021) of 12,000 physicians across 29 specialties collected data during the last half of 2020. The overall burnout rate of 42 percent was not significantly higher than in 2019, but the specialties at the forefront of pandemic response (critical care and infectious disease) registered two of the three highest rates, well above 50 percent. It also found the greatest gap ever between male and female physicians reporting burnout – 36 percent to 51 percent. The prevailing theory for this gap is the disproportionate role women play in child, home care, and the simultaneous collapse or retrenchment of many parts of their support systems at work, school, and home due to COVID-19.

Most organizations, whether utilizing the Baldrige Framework or not, have strategies to improve performance through focus on specific work systems and processes and on benefits offered to employees, customers, and stakeholders. While these efforts are well established parts of our organizational management models, they are missing the mark in terms of workforce experience and suffering. We need to think about our workplaces as being sources of well-being that provide a holistic set of avenues to generate well-being at and through work. To make this leap, we believe a key shift is required in our mental model: Conceiving of workplaces as a healing ecosystem. This may appear too ambiguous, as an ecosystem can seem large, amorphous, and un-ending in its reach. What we mean when thinking about organizations as ecosystems is that they are complex networks of interconnected systems that need to be viewed more holistically – rather than broken

down into their component parts, as we often do today.

W. Edwards **Deming** described the purpose of an organization "is for everybody to gain – stockholders, employees, suppliers, customers, community, the environment – over the long term." What has often occurred since Deming's time and the advent of Total Quality Management is that a subset of stakeholders has gained preference: specifically, customers, shareholders, and – in some instances - communities. The workforce typically receives much less emphasis. Gary Hamel described the current paradigm as taking care of the organization and its shareholders, so there is a company to provide a good or service to customers, and a workforce to employ (to achieve those aims).

We believe we need a new and different paradigm, one that fundamentally alters our mindset about the purpose of the organization. A new paradigm for consideration is to think of an organization as a potential place of "healing" – one that facilitates well-being for those within the organization and for its customers and stakeholders — in addition to or even more so than as a source of profit or a mechanism for matching labor with consumer demand in pursuit of selling something. In other words, an organization that is a reinforcing cycle where everyone wins.

Making this leap requires organizational leaders to look at key aspects of their profile and the leadership processes and systems linked to them and question whether their design is truly benefiting people who reside inside those systems. Breaking a workplace ecosystem into its component parts might look like this: 1) its Structure: physical, digital, economic and political elements in which we do our work and serve our customers; 2) its Climate: the way things feel – the emotional and social temperature humans quickly pick up on – in any given part of the workplace; 3) its Individuals & Teams: the people, who come with individual traits, preferences, and experiences; and 4) its Leadership: the interactions between individuals, groups, and their leaders.

Figure 1 represents this concept of the organization as ecosystem, and the key components described above. Examining these components with an eye on how, individually and in combination, they produce an ecosystem that enables both high performance and human healing may be the strategic work of leadership.

Attending to Structure's Role in Well-Being

We tend to view structures as just the way things are. The O.P. tends to group structures in Assets (P.1.a(4)) and in our organizational and governance structures (P.1b(1)). Investments in our physical plants, our digital/IT systems, our governance and management structures and our response to economic "realities" and regulatory requirements seem beyond our control. We often conceptualize these as constraints we must deal with. But is that really true? It may be true at a macro level – the size of the building dictates the interior size – but not how the space is used.

Figure 1:

Those decisions are choices. Allocation of office space and parking places, compensation design, work schedules or perks are decisions that affect the well-being of the workforce at large. This is, in part, because of something all leaders understand intuitively: structures drive how and where the work is organized and executed. In other words, workflows and processes we manage to help organizations succeed are extensions of structure. Difficult as it may be to change structures, doing so tends to have significant impact on the way work gets done, and thus on the nature of human interactions and the range of human emotions experienced in daily work.

Often, changing structures to support a healing ecosystem begins with a simple, honest, self-assessment:1) what can we modify, 2) if we rethought this component of structure with a focus on workforce thriving, what might we do, and 3) what is the trade-off within the underlying principle of the current design – maximizing efficiency or workforce thriving? In the healing ecosystem model, it is worth holding both goals and working on them concurrently, in addition to placing one (efficiency) above the other (thriving). Health care did that with patient safety and effectiveness. Consider whether extracting maximal financial performance in the short-term has a

negative impact on longer-term sustainability and growth. Area to Address 5.1a(4) asks "*How do you organize and manage your workforce?*". Clearly, there are many ways to organize and even more options for managing. The key point is to shift our thinking about structure as solely related to efficiency and financial performance, and rather to focus on what impact organizational design and management "rules" have on creating an environment of healing for the workforce.

Two simple examples may clarify the potential opportunities to improve the structures within where work is done. Many hospitals have worked to improve throughput in their Emergency Departments. Lean, a common improvement method (P.2c) begins with an understanding of the work site and mapping the work process. A surprising finding has frequently been the inefficiency of the layout, requiring staff to walk literally miles in a day because equipment and support areas are not readily accessible to treatment bays, causing delays in care and frustration for staff.

Another example where technology was the culprit comes from a UCSF primary care clinic where high burnout and stress were reported by clinicians due to daily workload. Instead of hiring more people or shifting work to other departments, the team looked at some of their workplace structures, and sought to change them to move toward a more healing workplace environment. They changed the schedule for taking after-hours urgent phone calls and the structure for how electronic messages sent via the e-health record were reviewed, triaged, and resolved. As a result, they created more time in the actual patient visit schedule allowing more time for all activities and reduced workforce burnout by nearly half and stress by a third at the same time (Berg, 2019).

Even more impressive and important is that they achieved these gains without asking the workforce to take better care of themselves, imploring leaders to lead differently, or focusing on team climate and dynamics. Simply attending to ways in which they could improve the structures designed for daily work was enough to make a difference in well-being metrics. In doing so, they shifted their workplace down the spectrum, from a place of distress toward a healing ecosystem.

The Role of Climate in Well-Being

The second element of a healing ecosystem is climate. Climate is a broad term, and variably has been used to refer to aggregate weather patterns, how teams relate to one another, and the degree of psychological safety a particular leader creates with direct reports. Here, we define it as the way humans feel when interacting with components of the organization in doing their work, or – more simply, the emotional temperature people perceive in any part of the organization. We think this reframing is important because many current models, including the O.P., carry an assumption that the direction leaders set – through values, mission, and vision – define the organization sufficiently well to assume that culture then follows. Indeed, the O.P. asks about the organization's Mission, Vision, Values, and the characteristics of Culture beyond values (P.1a(2)); Item 1.1 is all about how leaders lead and create an organization that engages the workforce, creates an environment

for success and a focus on action to achieve the Mission. In Item 5.1b the Baldrige Framework identifies how the workplace environment, benefits, and policies show up as factors within the Workforce Climate. Item 5.2b asks how the organizational culture is fostered. The Baldrige Core Value *Valuing People* identifies requirements for an engaged workforce. While not a checklist, this may stimulate dialog within the organization about how the way leaders lead creates and supports the desired culture.

In this sense, the organization's actual culture creates and reinforces its climate. It is the way people feel about *being* in the organization. Do they feel energized or debilitated? Valued or disposable? Invested in or depleted? Their voices taken seriously or ignored? Engaged or looking for a way out? This is not a theoretical set of questions, as people tend to ascertain quite accurately and quickly what the climate is, without having to be told – and they lean into or out of their work in response.

Typical employee satisfaction surveys don't really touch on the climate within a team, function, or department. Satisfaction surveys may indicate where there is a problem, but don't go deep enough to identify satisfaction drivers or whether people feel healed, energized, and made better and more whole through their work. Lean improvement has a phrase – "go to the Gemba" – the place where value is created in your organization – and see. It is important to look beyond the process map and the performance data for indicators of climate: does the work flow from one handoff to another; do people look happy or stressed; do staff reach out to help; is their discretionary effort imbued with joy and positivity; does the climate change when managers are present? What do your Values say about the importance and worth of the individual? Of teams? How do your espoused values line up with formal policies and procedures?

A relatively large clinical group and their leaders at an academic medical center in Colorado undertook a 4 -year effort to focus largely on climate as a way to address burnout. This effort was underway even as major structural change proved challenging and during leadership transition between chiefs of the service line. Additionally, there was rapid clinical growth and the group expanded by nearly two dozen members during this time, creating turmoil in terms of team relationships and group identity. In short, the group faced major sources of turbulence that could add stress to work and negatively impact climate.

A number of our first steps focused explicitly on the emotional experience of work. We developed a formal mechanism, which we called "Something Awesome", for any group member to share the experience of positive emotions during daily work (e.g., gratitude, amusement, inspiration, and awe while seeing patients or leading meetings) for five minutes at the beginning of monthly group meetings. This marked a major shift, as previously we started those meetings with a review of group workload and financial performance for the prior month (topics that did not always provoke positive emotions). We also created a Collaborative Case Review process, which allowed our

members to 1) submit clinical cases that had generated a concern for them or others working in the hospital and 2) engage in a supportive, non-punitive discussion and coaching session among a group of peers. And we created Above and Beyond Awards, a mechanism through which members could call out a peer for doing something that positively impacted a colleague at work, write a paragraph about how the nominee created that positive impact, and distribute to the entire group an email naming each award winner and what that person's nominator had written.

By focusing on co-designing a more healing workplace climate amidst these changes, the group achieved the highest quality and safety performance of all service lines in the hospital over the 4-year period, reduced physicians' and advanced practice providers' burnout by 27 percent and increased measures of psychological safety by 70 percent. These efforts also produced a 50 percent reduction in turnover, producing substantial cost savings (Pierce, Diaz, Kneeland, 2019).

The Role of Individual Behavior in a Healing Ecosystem

The third component of a healing ecosystem is a focus on the individual people within the ecosystem, with intent to increase their sense of well-being in the workplace through the work they do. Again, the O.P. is instructive: in P.1a(3) Workforce Profile criteria ask to identify the key drivers of engagement. Item 1.1c(1) asks how leaders create and reinforce the organization's culture – including one that fosters engagement, along with other descriptors of the workforce composition. Item 5.2a is all about Workforce Engagement, how drivers of engagement are determined and how the level of engagement is assessed. Obviously, the climate's "temperature" has a direct effect on individual engagement. Engagement is necessary for sustained high performance, but an exhausted, burnt-out, and stressed individual may be emotionally engaged but unable to perform well. For example, there is no question that today's health care workers are engaged in the work they do, giving patients everything they've got. But at some point, there is nothing left to give. Recent data showing that hospital-acquired infections have risen sharply during the pandemic are a prime example of this phenomenon. (Weiner-Lastinger, et-al, 2021)

Many companies have implemented wellness programs for their employees: on-campus fitness centers, day care for employees' children, or coffee bars and healthier cafeteria food. Generally, these are add-ons: sprinkles on frosting that have no real impact on the substance or taste of the cupcake they cover. These initiatives may help people build resilience – the ability to better manage their energy, time, or personal health so they can engage in work—but they do not alter the work environment or work experience itself. Wendy K. Dean, M.D., president and co-founder of Moral Injury in Healthcare, made an important point in Medscape's 2021 physician burnout and suicide report: "Anti-stress/burnout programs focus on individual approaches to much larger problems. The programs offer temporary symptomatic relief rather than lasting systemic change." These programs treat the symptom, not the disease. Indeed, this is one of the complaints many

employees lodge today: their employers are spending money to help them recover from toxic work situations or deal with workplace stress with fewer sick days, rather than making the work and workplace something fundamentally different—a healing ecosystem.

There is now abundant, well-designed research in health care linking burnout to almost every measure of human, organizational, and clinical performance one can conjure (Reith, 2018; Lu, et al, 2015; Scheepers, Boereback, Arah, et al., 2015; Cooper, et al, 2019). Burnout makes patient harm go up, due to individual-level clinician and team-based mistakes, in every venue we choose to measure. Patients and families know when their care team members are burned out, and, strikingly, they are less likely to follow carefully developed, scientifically supported recommendations on their health when the person providing the diagnosis and treatment plan is burned out. Burned out physicians order more un-necessary diagnostic tests and provide unwarranted medications more often, directly undermining both the high-value care movement and every economic principle of value-based reimbursement. Burnout makes turnover worse, even as organizations strive to keep talented people. While there is not yet a definitive published study that links burnout among health care professionals to overall hospital rating, given the breadth of negative impacts of stress and burnout on the workforce, it is likely research will show that burnout—and its opposite, workforce thriving — is a key part of the special sauce in low vs. high performing organizations.

Leadership for a Healing Ecosystem

The fourth component of a healing ecosystem is Leadership and the relationship between leaders and those being led. The data are clear that positive leadership practices impact performance across multiple measures. Workforces deliver value to the end user, but leaders set the direction, priority, and work systems within which they perform. They choose which areas to resource and how much support to provide. They develop and enforce the policies that govern the everyday work environment and role-model values-in-action. P.1.b(1) asks *"What structures and mechanisms make up your organization's leadership system?"*. In essence, leaders establish or mold the structures and play a dominant role in climate through what behaviors they promote – or permit. The Baldrige Framework clearly recognizes this, as Leadership is Category 1…and *"How do your senior leaders lead the organization?"* is the first Item. Organizations on the Baldrige journey are forced to consider their leadership approaches in terms of their impact on the organization. We believe that thinking of their approaches in terms of their effect on structure, climate and the well-being of their workforce may provide a new and powerful perspective for improvement.

Leaders own well-being plays a role in and of itself. Study findings, from a survey conducted in 2019 at Stanford University School of Medicine, indicate a correlation between leaders' own well-being scores and subordinates' assessment of leadership effectiveness (Shanafelt, et al, 2020). Indeed, recent research from the Mayo Clinic suggests leaders' well-being and subordinates'

conclusions about it may be one of the most powerful single causes of whether employees burnout or thrive in their work – i.e., whether the organization can serve as a healing ecosystem. (Shanafelt, et al, 2015)

Final Thoughts

This way of looking at an organization – a lens for examining how the structures and leadership systems create a climate of well-being for workers, which translates directly into how individuals "team" for performance and interact with customers – is different from describing the organization's departments or their characteristics and situation, accepting them as irreversible or absolute and then considering its management systems from that context. Our historical concept of organizations is built around the idea that leaders impart direction and culture within a constrained set of fixed assets and silos. Then, management controls process, policy, and the workforce within those silos in pursuit of efficiency within the physical and psychological space defined by the leaders, assets, and market forces. We believe a fundamentally different paradigm is needed: seeing organizations as ecosystems and recognizing the power leaders have to shape the organization directly, while proactively making healing and well-being important deliverables, not simply enabling factors for "engagement". No two organizations or situations are the same. Stepping back, as leaders, and thinking differently about the structure, climate, individual and team effectiveness along with how leaders – at all levels – lead, could be the first step in redesign that can address some of the operational and engagement problems faced today.

Of course, organizations face multiple challenges from the external market, competition, regulations and reimbursement. We argue that the capacity and capability needed to overcome those challenges starts with the strength of the operation which is dependent on its workforce. Table 1 looks at those challenges, the risk they carry for high performance and the evidence-based potential of focusing on shifting leadership focus. Were leaders to think differently about how they are spending their time and acknowledge the impact of their interactions and behaviors on those who work in their organizations they can begin this shift. A healthy, engaged workforce may be the most critical driver of sustainable operational performance and financial results and deserves leadership attention.

When we look at work this way, several insights emerge. First, relying on well-being interventions that primarily focus on individual people is too narrow a focus to hope for any sustained progress. A person might exercise, eat right, sleep well, meditate, and regularly access therapy, but simply could not be expected to overcome the combined impact of structures, communal climate, interpersonal interactions, and leadership on day-to-day experience. What is the sense in providing free access to fitness programs if staff are too exhausted and depressed to go? Resilience training may be great, but wouldn't it be better if the workplace required less resilience to do one's daily

work? Even if they take advantage of programs offered, if people return the next day – or next hour – to a workplace that depletes their new-found strength, the cycle begins again. Second, why have we focused so much on individuals, assuming that structures, climate, and leadership are not also sources of well-being? Third, if our places of work conceived of the ecosystem and all its elements as viable avenues for producing less hurt and more healing, we wouldn't be so stymied in our efforts to address stress, anxiety, and burnout.

Table 1:

Current Challenges Facing Organizations	Risk	Benefits of Healing Ecosystem
Individual/Team: Burn Out Exhaustion Stress Anxiety	● Lack of Attention to detail	● Higher Quality ● Improved Safety
	●Turnover ● Leaving the field entirely ● Suicide	● Lower Turnover ● Positive Energy (Joy) at Work
	● Lack of engagement	Increased engagement: ● more discretionary effort ● more natural innovation ● Better customer/patient experience
Organization: Lower quality Poor safety Turnover Disengagement	● Poor reputattion ● Wokforce shortages	● Higher market share ● Gain in marketing power to negotiate prices ● Higher financial return

Instead, we argue that organizations and leaders should look at the foundational conditions that exist and have been codified through structure, policy and history and ask whether they support well-being and positive experience at work. What do leaders have the power to change? How might we increase well-being? What is the ROI of doing it? The good news is that a healing ecosystem is possible, and robust scientific research illustrates that interventions focused on each of the ecosystem domains above measurably reduce stress, mitigate burnout, and promote well-being at work as well as improve organizational performance metrics. The current system of work is under immense strain and challenge. We believe it needs course correction rather than building a bridge back to a previous "normal." Conceptualizing our workplaces as healing ecosystems is a way forward.

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BALANCING STRATEGIC STABILITY AND OPERATIONAL AGILITY IN A VOLATILE ENVIRONMENT

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How an organization responds to crisis and volatility can impact its overall market relevance and longevity. This requires organizations to rapidly recognize indicator signs of a market change, accurately assess the breadth and depth of the market impact, and appropriately respond to ensure the organization does not overreact or underreact to the market stimulus. If organizations respond too slowly, they may miss a critical market opportunity. If they respond too quickly, they may waste precious time, money, and resources responding to a false market shift. Either outcome may lead the organization to quickly finding itself irrelevant and unable to pivot in time. This dilemma leaves leaders asking: When and how should we respond when a potential market disruption surfaces? Framed another way, how can the organization balance agility to respond to valid market shifts and stability to remain focused on current strategy and avoid superficial or false market trends?

COVID provides a strong example for leaders to study and reflect on this quandary, especially across health care. COVID forced the health care industry to implement actions never imagined, such as shutting down all elective procedures in hospitals (Kerlin et al., 2021). Daily operations created dramatic shifts in workflow processes, safety standards, and resource management, which required new skills and a reservoir of endurance, often leaving staff feeling unprepared, unqualified, and understaffed (Galoustian, 2021; Gray et al., 2021; Kerlin et al., 2021). These sudden and unexpected changes quickly created a sense of crisis across health care organizations.

This article grew from a series of conversations over the past two years with leaders in health care, public health, and community roles facing significant market volatility while trying to

balance organizational agility and stability. This article focuses on two primary objectives. First, it will apply two conceptual models that can help organizations understand and assess both the organizational and environmental context during docile and volatile market conditions. This article is not intended to serve as an empirical research article about COVID or other specific market disruptions. Second, this article will highlight various case studies and creative responses that enabled organizations to remain relevant in a volatile market (i.e., during COVID) while contributing to their larger community objectives and/or maintaining a focus on their long-term strategic efforts.

Conceptual Models

Early in the pandemic, organizations had to recognize and assess if COVID was a temporary hiccup in their strategic plan or if it required a long-term, catastrophic pivot. Organizations faced challenges that forced services to slow or completely stop, margins to fall, consumer demands to change, and safety standards to rise. Crisis or volatility generates a strong desire for stability by the organization's workforce and its customer base. At the same time, crisis demands innovation and agility.

Implementation of pre-COVID strategies seemed largely irrelevant as organizations managed their immediate crisis response. Yet over two years later we see some systems still in crisis mode and others, while dealing with ongoing capacity and resource issues, remaining aligned with their strategy and mission. What then defines and differentiates successful organizations from others in both times of crisis and prosperity? Many people would argue organizational time, talent, and/or resources are significant differentiators. However, these were not themes that emerged in dissecting the conversations the authors hosted in collaboration with Baldrige Foundation-sponsored events including *Innovation Learning Labs*,[1] executive interviews, and targeted focus groups over the past two years. Instead, the authors consistently recognized the recurring theme that leaders struggled to balance organizational agility and stability. Therefore, this paper focuses on two key conceptual models: the Baldrige Excellence Framework (BEF) and the Integrated Performance Model (IPM).

Regardless of market conditions, organizations should consistently strive to optimize overall performance and increase market share, ultimately contributing to long-term viability and

1. The Innovation Learning Labs were co-hosted by the two authors of this article as part of an intentional strategy suppported by the Baldrige Foundation to bring together hospital, public health, and civic leaders to hihglight and discuss best practices and address current realities responding to the COVID crisis. These were invitation-only events targeting C-Suite leaders and involved interviews prior to, an in some cases subsequent to, the event itself. The goal of the Baldrige Foundation was to identify and highlight effective practices, create opportunities to network and share, and understand the organizational patterns in which systems manage agile, rapid responses while balancing organizational stability related to implementation and monitoring of strategies important to long-term mission and organizational viability.

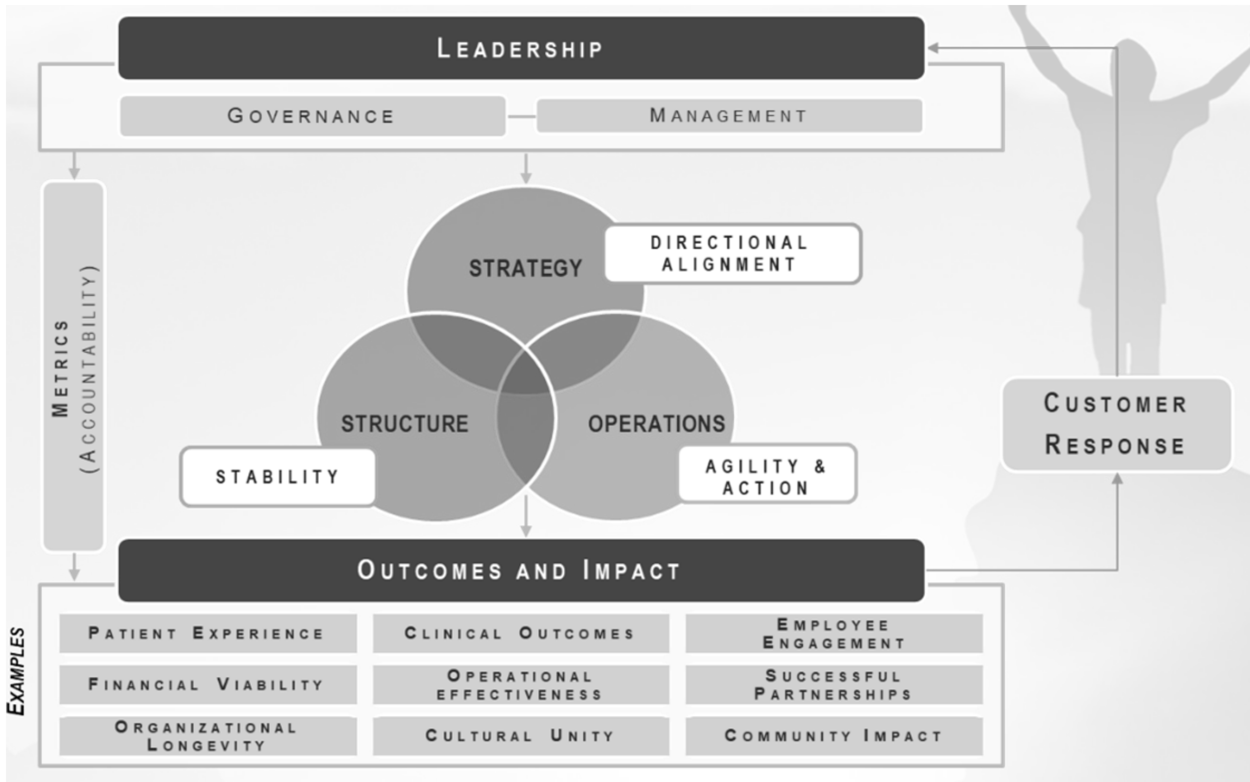
resilience. Organizational strategy does not dissipate in a crisis but should be activated and readilyanalyzed within the framework of operational excellence. Numerous methodologies exist to enhance performance and drive continuous improvement (e.g., Lean and/or Six Sigma (LSS), High Reliability Organizations (HRO), Total Quality Management (TQM), and many others). The BEF is nonprescriptive in terms of an operational excellence framework (including LSS, HRO, TQM, etc.), yet it has provided a gold standard approach for over thirty years leveraging operational excellence to address complex problems while being adaptable to local context and mission. The BEF provides a comprehensive framework across seven categories (see Figure 1) that has promoted systematic performance excellence to ensure organizations can compete in a global market (NIST, 2010). The seven categories of the BEF are: (1) Leadership; (2) Strategy; (3) Customers; (4) Measurement, Analysis, and Knowledge Management (or MAKM); (5) Workforce; (6) Operations; and (7) Results.

Figure 1: Baldrige Excellence Framework

Source: Baldrige Performance Excellence Program, 2021. 2021-2022 Baldrige Excellence Framework: Proven Leadership and Management Practices for High Performance (Health Care). Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technolody. https://ww.nist.gov/baldrige.

Similar to the BEF, the IPM does not require a specific operational excellence approach, rather the IPM emphasizes five underlying domains that interact and drive either positive or negative outcomes regardless of approach used: (1) Leadership, (2) Strategy, (3) Operations, (4) Structure, and (5) Metrics (Strahan, 2017). The choreographed interaction of these five domains enables urgent, short-term actions to inform and align with long-term strategy that drives viability and success over time (Strahan, 2017). The IPM is illustrated in Figure 2 (Strahan, 2017).

Figure 2: Integrated Performance Model



Connecting the Baldrige Excellence Framework and Integrated Performance Model

The BEF provides significant detail outlining questions within each of its seven categories that organizations should consider in developing or refining their internal processes and approaches. While the BEF outlines what the essential criteria are for organizational excellence, the IPM supplements the BEF by describing how these criteria interact. To better understand this relationship, this section briefly breaks down each category and their respective relationships between the IPM and BEF. The intention of this paper, however, is not to create a detailed crosswalk between the IPM and BEF criteria; rather it is to understand how the two models can complement one another in assessing organizational and environmental contexts.

The first category in each model is Leadership, indicating the significance of this domain. For example regarding Category 1 Leadership of the BEF, the model seeks to understand how senior

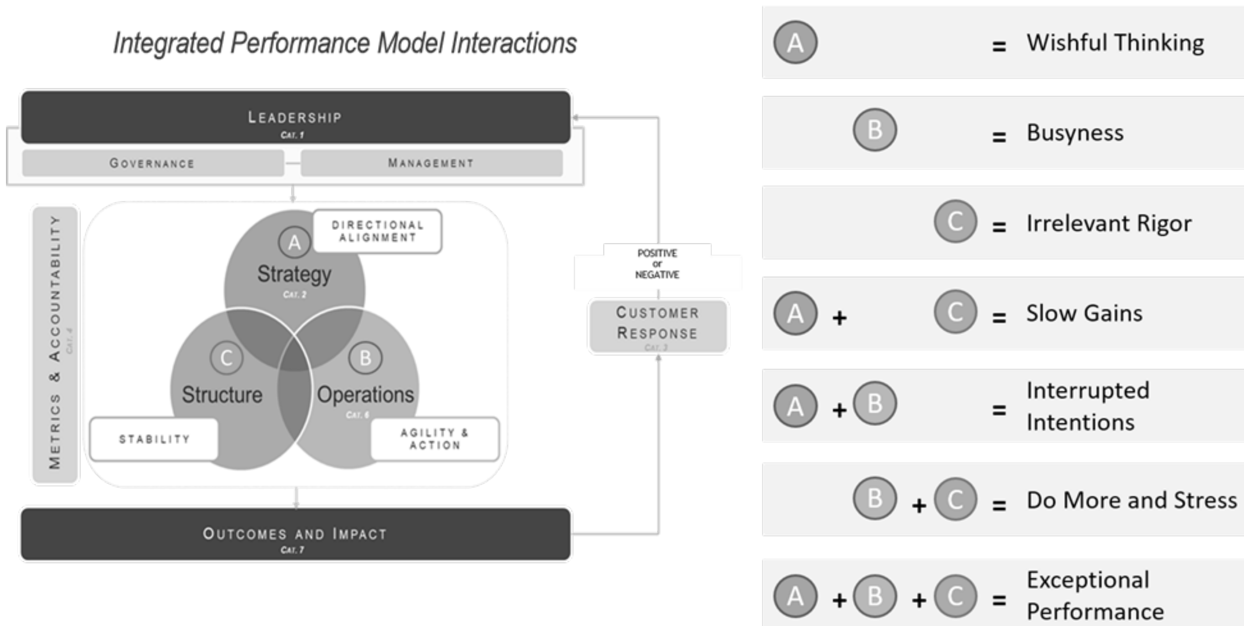
leaders lead the organization by setting the vision and values, promoting ethical behaviors, engaging stakeholders in communication, and creating an environment of success and focused action (NIST, 2021). Furthermore, it questions how organizations are governed and contribute to broader society (NIST, 2021). Building on this, the IPM describes leadership as a moderating variable because it can negate or promote the development, impact, and viability of its other domains on a daily basis through the strength and direction of organizational attention, action, resources, and sustainability (JOsleyCo, 2021; Strahan, 2017). In other words, leadership sets the tone and importance for every organizational effort by allocating resources, directing organizational communications, protecting time for operational action, managing accountability, and creating the cultural environment. For example, when leadership is repeatedly communicating strategic priorities, safeguarding time for team members to work on initiatives, and ensuring key performance indicators (KPIs) are being measured, team members feel secure knowing their efforts are important to the organization. The opposite is true as well, which can lead team members to question whether their efforts are truly meaningful. Times of crisis or volatility can often force leaders to reprioritize their message and priorities, potentially weakening the balance between organizational stability and agility (or at least the appearance of such).

Both models clearly articulate that while leadership is important, it is not enough to drive results on its own. The "meat" of the IPM model focuses on three tightly related domains: Strategy, Operations, and Structure. Each of these are also connected to the BEF.

Strategy creates direction, focus, and alignment across an organization. This requires the dual practices of both strategy development (i.e., planning) and strategy implementation (i.e., execution), which are assessed in the BEF criteria (Category 2). A detailed breakdown of the BEF criteria can be found in the BEF workbook published bi-annually by the National Institute of Standards and Technology (NIST). In terms of strategy, the BEF asks questions such as how organizations conduct their strategic planning process, how innovation is incorporated into strategic opportunities, how organizations prioritize their strategic objectives and deploy applicable action plans, and how workforce and metrics support the strategy (NIST, 2021). The IPM similarly evaluates the connection between strategy creation and strategy execution, yet it emphasizes the interdependent relationship between strategy, operations, and structure. For example, Figure 3 highlights how these three domains interact with one another and drive organizational relevance and/or success (Strahan, 2017, 2019).

Successful strategy implementation intimately depends on effective operations. The BEF analyzes Operations (Category 6) through the design, management, and improvement of service delivery and work processes (NIST, 2021). The IPM underscores that *operations* encourages agility and action through defined organizational processes, communication loops, and standard work that support the organization's delivery of value and innovation (JOsleyCo, 2021).

Figure 3: Integrated Performance Model Interactions



Structure provides a counterbalance to operations as an organizational *stabilizer* through elements such as the organizational model, systems, technology, physical plant, and overall environment (JOsleyCo, 2021). Structural elements cross multiple categories of the BEF. Using technology as an example, it is specifically called out in the BEF criteria for Category 4 Measurement, Analysis and Knowledge Management; Category 5 Workforce; and Category 6 Operations. Structural elements are typically not as easy to change as operational and strategic elements. For example, changing technology systems can require significant investment in time, capital finances, process adjustments, and cultural readiness. Both models understand how technology and other structural elements can enable or hinder organizational success across other categories or domains.

The final IPM domain is Metrics, which directly supports organizational accountability (in tandem with the other domains). Maintaining SMART (specific, measurable, accurate, realistic, and timely) metrics enables organizations to track and manage the efficiency and effectiveness of organizational actions across each of the other four domains (JOsleyCo, 2021). The BEF not only assesses how organizations measure, analyze, and improve performance through metrics via Category 4 Measurement, Analysis, and Knowledge Management, but it also provides direct guidance on how to evaluate the *maturity of processes* using ADLI (Approach, Deployment, Learning, and Integration) and the *maturity of results* using LeTCI (Levels, Trends, Comparisons, and Integration) (NIST, 2021). (Additional details about ADLI and LeTCI can be found in the BEF workbook.) As with the other domains of the IPM, metrics do not live in isolation; they impact each of the other IPM domains. For example, strategy without focused KPIs leads to

blind organizational driving and wishful thinking (JOsleyCo, 2021; Strahan, 2017, 2019). When data are locked behind a technology platform without access or transparency to key operational stakeholders, timely actions and decision-making suffer. Of course, the most fundamental element of metrics is the ability to capture, measure, and report metrics using reliable structures and systems (JOsleyCo, 2021; Strahan, 2017).

The remaining categories of the BEF include Category 5 Workforce, Category 3 Customers, and Category 7 Results. The IPM also captures these, but not as distinct categories. The IPM emphasizes results as an outcome of the model, or a dependent variable of the five IPM domains and how they interact. Customers play a similar role in the IPM in which the response, engagement, and loyalty of customers stems from the effectiveness and interactions of the other domains. However, customer response, engagement, and loyalty also serve as an input back into the model to drive leadership decisions and organizational direction. Finally, the elements of workforce are embedded across each of the five IPM domains and also referenced as an outcome of the model. Culture is considered a lynchpin that drives or hinders the overall IPM.

The BEF is a trusted model that has demonstrated positive operational and financial results across hospital performance when compared to hospitals not applying the BEF (Strahan et al., 2022). The IPM builds on the knowledge of the BEF to assist organizations in understanding the relationships *between* the BEF categories. Regardless of model used, the criteria or domains only produce partial results when implemented as independent practices. Instead, these domains should be viewed as an integrated system to rapidly respond to urgent situations while retaining (or redefining) systems and structures that help the organization stay focused on long-term viability and effectiveness. The IPM is specifically highlighted in this paper because of its emphasis helping organizations balance stability and agility in alignment with their strategic direction. Balancing these three domains can be a challenge, but when done effectively, the model suggests this balance can generate organizational viability and strengthen market competitiveness even during times of crisis or volatility.

Growing through Crisis as a Community Ecosystem: Applying Conceptual Models to Real World Cases

Organizations have had to adapt through the various phases of COVID. Pre-COVID, innovation was pursued but more often considered a superficial buzz word in relatively docile health care markets of hospitals. Over the past two years, the Baldrige Foundation and the authors have collaborated with organizations to understand how COVID has changed the way work is done and to support system capacity-building. Organizations that adapted most rapidly during COVID had an existing system in place that balanced strategic direction, agile operations, and a stable structure via a strong strategy implementation and performance excellence framework. For this

reason, mature Baldrige organizations showed promising signs early on due to their investment in leadership, operational excellence, and strategic adaptability.

Real World Case No. 1

A health system in the Midwest was featured in an Innovation Learning Lab in late summer 2020 because its response to COVID was far advanced compared to other systems in the level of cooperative relationships, resource allocation, and coordinated messaging. The system's leadership created confidence in the community about the quality of information and actions being taken in relation to COVID with coordinated, proactive, and transparent messaging across the region, even with the rise in uncertainty across the nation.

In our investigation to understand the conditions that supported their effectiveness and relatively calm, measured response, leadership shared they were mid-way through their Baldrige journey. They explained that they were able to create very detailed, coordinated, community-wide plans for COVID because they had already laid a foundation in their previous efforts to develop a strategy that integrated expertise and community systems throughout the region. The Baldrige criteria specifically call out how organizations strengthen, build, and measure community and societal engagement, relationships, and coordination in Category 1 Leadership. The organization had intentionally been working on its strategy for increasing coherence and alignment of their system with community resources to reduce hospital readmissions and minimize use of their Emergency Department for issues that could better be addressed or prevented through other community services or resources. This supported the short-term need to prevent overcrowding of the Emergency Department while capitalizing on critical community services and relationships to support their long-term strategy for patient health outside of the hospital's walls.

In summary, the system's existing strategy in alignment with Baldrige principles created a set of relationships and practices that served as a foundation for the COVID challenge, that while novel and unremitting in its demands, drew upon relationships and practices that had already been identified and nurtured.

Immediate reactions during times of crisis may throw processes and protocols to the side, which is not sustainable long-term. For many, the initial pandemic response was hyper-local and fragmented, and leaders were hungry for collaborative learnings from peers and outside industry leaders. Key problem areas identified by hospital leaders and community administrators during the Innovation Learning Labs within the earliest months of the pandemic reflected problems in which strategy is typically designed to address, such as issues of demand and system impact. Yet the following challenges strained system capacity beyond expected operational limits:

- (1) Workforce staffing, burnout, and productivity;
- (2) Capacity and resource management of personal protective equipment (PPE), hospital beds, testing sites, inventory, and supplies;
- (3) Patient flow management with barriers for transfers and transports within and between hospital systems; and
- (4) Updated and transparent communication channels within organizations and across communities.

Aligned with the words of Winston Churchill to "never let a good crisis go to waste," organizations embraced opportunities for innovation. Internally, teams implemented real-time PDSA (Plan-Do-Study-Act) practices to pilot and evaluate solutions to unexpected problems and strained workflows. Many health systems were losing tens of millions of dollars monthly due to halting elective procedures, threatening jobs for dependable employees in those procedural areas. Instead of layoffs, hospitals cross-trained teams as much as possible. For example, surgical nurses were placed as float staff and temporarily assigned to high-demand units until elective procedures were restarted. Externally, many organizations engaged in "co-opetition" (or cooperative collaboration from parties that may typically be competitors) and external industry partnerships. For example, during the initial COVID surge, many geographic regions hosted daily calls between competitive hospital systems to understand hospital occupancy, bed availability, resource limitations, and PPE needs to load-balance between facilities and prevent overburden on any one particular facility or system. This may have forced some facilities to lose patients (and revenue), but it allowed safer care for patients by balancing resources and support across the broader region. There were several states in the Southwest that took this a step further, developing an online database to transparently view available resources (i.e., hospital beds, ICU beds, ventilators, etc.) in real time across competitive health care systems. Contrast this to a standalone rural hospital that shared it was not uncommon for staff to spend up to ten hours to find a facility that had the capacity and appropriate resources to manage patients too acute for its rural care setting. Most health care systems have established programs or plans for coordination via patient transfers within their own facilities. More advanced states or regions also had established systems for coordinated patient transfer even to "competing" systems via automated, transparent processes and shared data systems. These systems or networks essentially created a "safety valve" to manage local spikes in hospital demand, which proved valuable with COVID. Decisive leadership balancing agility and stability enabled these organizations to rapidly recognize the market shift and respond in nontraditional ways to maintain steady operations.

Expanded collaboration was not only relevant for acute care facilities, but also for facilities along the full continuum of care, such as senior living facilities, nursing homes, and skilled nursing facilities. Hospitals that intentionally created strong relationships with post-acute care facilities

(beyond formal contracting partnerships) realized stronger integrated processes for efficiently transferring patients to and from the hospital; preventing illness, falls, and mobility issues; maximizing patient awareness and completion of advanced directives; and sharing responsibility for overall cost and quality. Some post-acute facilities were able to manage more acute patients on-site that they normally would transfer to a higher acuity facility, reducing noncritical patient transfers to overcrowded hospitals. Given the extreme challenges faced by nursing homes and similar facilities during COVID, these collaborative relationships helped allay bottlenecks while enhancing family communication and engagement. National interactions with health care and county administrators repeatedly demonstrated that underdeveloped relationships across vertical and/or horizontal integration points strained hand-offs and resources across care settings. It may be assumed that small, tight-knit communities would have been better positioned to coordinate community responses to resource needs, but that was not often the case. While larger systems with common inventory databases were more prepared to distribute resources within their systems, there was often a significant gap locating and disseminating resources across communities and regions. The rapid influx of COVID funds, intense pressure to locate necessary materials, and limited coordination between public and private organizations often led to hoarding and imbalanced resource allocation, even if unintentional. The following real world case (No. 2) shows how a large county managed its community-wide food security needs during COVID.

Real World Case No. 2

A large county in the Southeast recognized an immediate gap in food access when schools closed due to COVID. Schools provide a core portion of nutritional needs for many children, especially those in free and reduced lunch programs. Large scale school closures created a massive crisis in the food safety net. Nearly 50 food security agencies (including food banks, food pantries, soup kitchens, etc.) that regularly provided support across the county experienced significant increases in demand for services, over a 1000% increase at some locations, stretching resources and volunteers to the limit.

To manage acute needs, community leaders started hosting calls in the evening to coordinate across county facilities that normally did not interact. For example, there was an immediate need for peanut butter. While one organization was completely barren, another organization had excess it could share, which was uncovered during the nightly call. Although not feasible long-term, it addressed a pressing need to identify demand and share resources, enabling more equitable distribution to communities most in need. The county later initiated an economical software solution to communicate high demand items and needs across distribution centers.

Like most communities, the county had to overcome barriers including a culture of funders and coordinating agencies that preferred to link donations to individual agencies and resisted efforts

to create a systemic response across non-associated organizations. Communication within and across agencies required coordinating processes, relationships, and data to ensure organization of both logistics and messaging. Consequently, they are now better equipped to manage ongoing community needs and other social determinants of health, enabling a more stable environment to handle the next crisis.

Open, reliable, frequent, two-way communication is imperative during both stable and volatile times; however, it is absolutely essential during times of crisis. When communication is limited, individuals often assume negative outcomes. For this reason, multiple health systems hosted live virtual townhalls on social media in collaboration with local civic, education, business, and government leaders to speak with one voice and create transparent channels of communication for community members (Dunsmore & Strahan, 2020). This was another replicable example of external collaboration among distinct industries and leaders. Communities and systems with pre-established relationships were able to more quickly and effectively establish these communication channels.

These examples demonstrate collaborative efforts across systems and/or regions. Some communities recognized distinctive solutions specific to their regional resources. Example local and idiosyncratic solutions shared during the Innovation Learning Labs included the transformation of a lumber mill in New England into a swab factory; collaboration between a health center in Maine, a wood drying manufacturer, and local university to develop a unique PPE sterilization process when supplies were limited; and a temporary partnership between a health system in Louisiana with the petrochemical industry to identify resources such as generators, ventilators, and other core mechanical devices needed in response to immediate demands. Although these are not replicable solutions across all communities, these solutions are phenomenal examples of ingenuity and resourceful partnerships that can emerge when organizations enable agile mechanisms that support their strategic mission.

These real-world examples show the capability of how disparate entities can innovate and collaborate across a community ecosystem. Moreover, these examples did not arise from organizations that only focused on rapid market response (or organizational agility). As highlighted in Figure 3, a sole focus on operational agility and action leads to organizational busyness, but rarely success. Activity does not equal results. Effective leadership during times of crisis encourages innovative solutions while also creating tactical strategies that minimize the need for such crisis response. In other words, it is important for organizations to implement operational mechanisms to innovate and adapt (i.e., organizational agility), whether during crisis or not, but they must also ensure systems are as efficient, effective, and consistent as possible (organizational stability). Shifting an organizational model based on need, sharing resources and market share between competitors, and creating communication channels between normally disconnected entities demonstrate the applicable balance of organizational stability and agility that is demanded during volatile times.

From Symptomatic to Systematic with Baldrige

The BEF specifically defines a *systems perspective* by managing all aspects and components of an organization as a unified and interconnected ecosystem to achieve the organization's mission and goals (NIST, 2021). The overall health of a community can also be assessed as an ecosystem. Social determinants of health are factors affecting an individual's health outcomes, risks, and overall quality of life (CDC, 2021). Examples include environmental factors and the community in which one lives, employment status, food security, education, risky behaviors (such as alcohol and drug dependency), and housing stability (*Advancing Health in America: Addressing Social Determinants of Health*, 2018). The health of an individual is closely tied to the health of a community. In fact, up to 50 percent of a person's individual health can be tied back to their zip code via socioeconomic and environmental factors (*Going Beyond Clinical Walls: Solving Complex Problems*, 2014). Each of these determinants are connected. Unemployment impacts housing security. Being dismissed from school impacts food security for children. Even if each division of a community (via health care, housing, first responders, etc.) is working as hard as it can, the community cannot reach its full potential unless each entity is strategically and functionally aligned via the IPM outlined in Figure 2. The BEF can help organizations and communities break down the IPM into tangible criteria and personalized systems.

The interdependencies between social determinants became increasingly evident through the COVID pandemic, emphasizing the importance of creating ambidextrous short-term and long-term solutions. In their book *Lead and Disrupt*, O'Reilly and Tushman describe long-term successful organizations as those with the "ability to integrate, build, and reconfigure internal and external competencies to address rapidly changing environments" (2016). This enables organizations to *exploit* existing strengths to compete with mature businesses and to *explore* new opportunities and new business domains while leveraging current resources (O'Reilly & Tushman, 2016). The authors relate the dual nature of exploring and exploiting opportunities simultaneously to ambidexterity. Relate this to the organizations described above that balanced innovative opportunities (organizational agility) while capitalizing on existing relationships, strategies, and resources (organizational stability), perhaps established through their Baldrige or performance excellence journey.

Another evident side effect from the COVID pandemic was the lack of "systems thinking" with solutions. Consider the expansive spending through CARES Act funding as an example. The Coronavirus Relief Fund (signed into law via the CARES Act) provided every state a minimum of $1.25 billion with some local governments or counties receiving funds directly from the federal government (Walczak, 2020). Many of these counties received direct funds in excess of $100 billion each, providing ample opportunity to ambidextrously address communities' short-term needs and think strategically about long-term solutions around social determinants of health. Despite the best of intentions, however, few counties in our network focused on long-term or

coordinated opportunities through this first round of funding. In some cases, there was active resistance to efforts to do this. For example, one county prioritized allocating funds to as many agencies as possible with very limited resources allocated to coordinated efforts. In fact, agencies that intentionally submitted collaborative proposals were rejected and asked to apply as single entities. This increased the number of agencies served at the expense of resources or tools that could coordinate efforts and activities promoting interagency or cross-industry collaboration, as well as balanced and equitable distribution of necessary resources, services, and expertise across the community. Equal distribution to as many agencies as possible does not necessarily constitute equitable distribution based on needs across the region.

These decisions stemmed from a variety of causes, not the least of which being simply overwhelmed by the short-term needs of COVID, making it very difficult to pause during the early days of crisis to relate short-term needs to long-term strategy. Furthermore, the very nature of the federal CARES Act requiring local counties to spend their allocated funds within a short timeline encouraged quick spending instead of strategic spending. There were common patterns reflected in these decisions that indicated a general lack of strategic direction across community ecosystems *prior* to COVID[2]. Based on qualitative discussions between the authors and approximately fifty hospitals and communities across the nation, those with experience and mechanisms (such as the BEF) to navigate complex, interconnected ecosystems often sharing or competing for resources, time, and attention were best positioned to coordinate swift action throughout each phase of crisis. This was not due to chance, but rather the integral and functional relationship between direction, agility, and stability (or strategy, operations, and structure, respectively) from the IPM.

Relating Learnings to Your Organization

Through the Innovation Learning Lab sessions and interviews with health care leaders, leaders initially focused on what they saw as short-term solutions (e.g., cross-training staff; collaborating between large health care systems and smaller, regional or independent systems; implementing daily calls between civic leaders and hospital and community health providers) or idiosyncratic strategies (e.g., partnering with lumber mills to create test swabs; rethinking staffing and protocols across competitive paramedic companies to ease emergency room overcrowding; partnering with universities to increase testing capacity) (Dunsmore & Strahan, 2020). There was great enthusiasm for hearing and learning about ideas across the network. What people were looking for were innovations that helped them address the most immediate, urgent needs. Some, however, were better positioned than others to use the ideas and information to rethink their overall strategic priorities, metrics, and operational practices beyond the immediate realities of the pandemic. For example, this was quickly evident in conversations with health care systems already on a Baldrige

2. The National Association of Counties (www.naco.org) uses publicly available information to analyze the ways that federal COVID relief funds were allocated in counties.

journey, where they had pre-existing community and regional relationships as part of their overall approach to excellence. They did not need to initiate coordination and communication as a response to crises; it was already embedded in their approach to overall excellence.

During the Innovation Learning Labs, questions were posed to leaders to understand short-term actions heralded as effective and to reflect on actions considered "strategy essential" that addressed important and long-standing organizational and/or community priorities. These same questions can be applied to your organization and expanded upon using the BEF. The Innovation Learning Labs specifically focused on the problem areas previously discussed: Workforce staffing, burnout, and productivity; Capacity and resource management; Patient flow management; and Updated and transparent communication channels. For example, regarding capacity and resource management during COVID, participants were asked the following:

- How are you reviewing your supply chain and procurement processes to emphasize new and local sources while maintaining operational requirements?
- How are you rethinking your inventory process long-term to create better access and flow of resources as you increasingly collaborate with organizations outside your system?
- How and to what extent are you rethinking ad-hoc or temporary collaborative relationships with other systems to transfer patients, information, and/or products; to manage and allocate resources; and to share medical expertise and infrastructure?
- At what point did you or will you formalize collaborative relationships that could lead to the redesign of operational procedures and organizational strategy?

These types of questions were designed to elicit the extent to which leaders were operating under pressure from crisis and localized reactions versus monitoring and redesigning in alignment with the existing organizational strategy. Leaders who positioned COVID actions considering an existing strategy implementation system were able to respond to the immediate crises while maintaining clarity on the important organizational practices for the future. Rather than seeing current actions as a deviation from strategy, they were a refinement and instantiation of it.

Conclusion

Pursuing excellence is not merely a characteristic of how systems respond to urgent crises, but rather it is a reflection of the consistent patterns of behavior, internal commitments, and operational practices with which leaders attend to short- and long-term needs and outcomes in a way that balances stability, agility, and directional alignment. Crisis or volatility leads to chaotic actions and threatens the long-term viability of a system when it is not anchored to an overall framework for strategy delivery. While terms such as "unprecedented" are often used to describe the COVID

crisis, opportunities abound for redefining internal structures and operational practices in the context of clearly delineated strategy. For systems that have already begun this process, leaders can demonstrate increased clarity to choreograph urgent demands into strategies that also address, perhaps in new ways, long-term needs in population health, financial strength, coordination of services, and staffing expertise. For systems that have yet to embark on a journey of organizational excellence using the BEF and IPM, this is a prime opportunity to do so. Do not use times of volatility merely to react to the situation but use the current context to create opportunities to realize and/or redefine systems and strategy.

The learning period of COVID is not over, as we repeatedly see with the emergence of each new variant, nor is it the only example of a volatile market shift. Look at the unstable macro environment of the economy today related to high inflation, supply chain and transportation challenges, stock market volatility, and uncertain international relationships as another instance in which we can apply these concepts and learnings. Organizations cannot let their guard down managing ongoing operational challenges, targeting important strategic initiatives, and monitoring environmental changes. Mission-driven organizations, whether hospitals, school systems, municipalities, or community service organizations, have a responsibility to continue learning and improving throughout their life cycle. To reference a quote attributed to Albert Einstein, the day we stop learning is the day we start dying. This is relevant to organizations and communities as much as it is individuals. Improvement frameworks, such as the BEF, can help organizations not only acquire but also maintain the balance between direction, agility, and stability, even in the midst of crisis.

Every organization, regardless of size or industry, should use an improvement framework like the BEF or IPM to ensure accountability and effectiveness. Existing strategy within organizations served as both a stabilizing force and as a predictor of areas where COVID caused buckling of systems, forcing the organization to build agile new processes, mechanisms, and communication pathways. Strategy is not merely a luxury during times of crisis, but rather a bellwether of the system characteristics most needed to support innovation and response to change. One unique result of COVID was that it demanded innovation both inside the walls of the organization and across the community ecosystem. What systems learn during times of crisis or volatility can enhance performance excellence and system capacity when crisis is recognized as a reflection of patterns of behaviors and practices as opposed to an aberrant experience. In essence, strategy should guide actions in crisis, and at the same time, crisis should be used to reframe and refine the strategy moving forward. This continuous learning loop feeds the integrated relationships between direction, agility, and stability, and the BEF provides one such approach to evaluate and manage these relationships.

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GUIDELINES FOR AUTHORS

All submissions should be sent via email to the editor at chronicle@baldrigefoundation.org. Please state whether your paper should be considered as a *Feature Article* or as a *Leadership and Management Perspectives* piece. *Feature Articles* are intended to provide original and useful information of interest and practical significance to organizational leaders, and which are grounded in experience, innovative thought, and appropriate literature research. Executive summaries of feature articles are provided as brief overviews of these articles to assist readers. *Leadership and Management Perspectives* provide specific points of view designed to support understanding or to provide insights about current issues, emerging issues, Baldrige challenges, implementation strategies, best practices, and similar topics. These are typically shorter than feature articles.

All submissions should draw upon the concepts and philosophy of the Baldrige Excellence Framework and must provide useful information of interest to organizational leaders.

Highly technical papers of limited scope or academic-type papers are not appropriate. Manuscripts submitted to the *Chronicle of Leadership and Management* must be original works not previously published or under review by another publication.

Types of articles suitable for publication in the *Chronicle of Leadership and Management* include, but are not limited to, the following:

1. *Case studies* that highlight role model practices or implementation strategies for performance excellence, drawing upon Baldrige principles.
2. *Innovative and insightful discussions* about Baldrige categories, items, areas to address, or key (and difficult to understand) criteria questions that provide practical value.
3. *Articles that translate cutting-edge research literature into practical language* that would be applicable and useful to practitioners and may contribute to leading-edge validated practices in the future.
4. *Thorough and comprehensive review articles* that provide clear and unique perspectives on a significant topic.

Submission Requirements

Papers should be of the style of journals such as the *Quality Management Journal*, *Harvard Business Review*, or *Sloan Management Review*, and should include appropriate references. They should not be as informal as those published in magazines such as *Quality Progress*. There are no minimum or maximum length restrictions. Say what is necessary to get your message across fully; however, we may ask you to shorten the paper if necessary. *Feature articles* must be accompanied by an Executive Summary of about 250 words and a bullet list of 4-6 takeaways that summarize key points. This does not apply to *Leadership and Management Perspectives* submissions.

References

References should be listed in alphabetical order using *The Chicago Manual of Style*, 16th Edition. Examples:

Book

Grazer, Brian, and Charles Fishman. 2015. *A Curious Mind: The Secret to a Bigger Life*. New York: Simon & Schuster.

Smith, Zadie. 2016. *Swing Time*. New York: Penguin Press.

In-text citations: (Grazer and Fishman 2015, 12), (Smith 2016, 315–16)

Journal article

In the reference list, include the page range for the whole article. In the text, cite specific page numbers. For articles consulted online, include a URL or the name of the database in the reference list entry. Many journal articles list a DOI (Digital Object Identifier). A DOI forms a permanent URL that begins https://doi.org/. This URL is preferable to the URL that appears in your browser's address bar.

Keng, Shao-Hsun, Chun-Hung Lin, and Peter F. Orazem. 2017. "Expanding College Access in Taiwan, 1978–2014: Effects on Graduate Quality and Income Inequality." *Journal of Human Capital* 11, no. 1 (Spring): 1–34. https://doi.org/10.1086/690235.

LaSalle, Peter. 2017. "Conundrum: A Story about Reading." *New England Review* 38 (1): 95–109. Project MUSE.

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2. *Significance to practitioners*. Are the concepts discussed of practical significance and meaningful to organizational leaders and managers?
3. *Readability and clarity*. Is the article well organized and presented in a clear and readable fashion that will be understood by a wide audience?
4. *Figures and tables*. Are figures and/or tables used appropriately to enhance the ability of the article to summarize and/or communicate information and conclusions?
5. *Organization and style.* Is the content of the article logically organized? Are the title and Executive Summary, if applicable, representative of the article's content?

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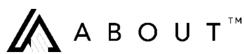

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