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Utilizing Performance Management to Harness the Power of Quality Improvement in Public Health

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Utilizing Performance Management to Harness the Power of Quality Improvement in Public Health

Abstract

Widespread adoption of quality improvement activities in public health trails other U.S. sectors. Launching the national public health accreditation program of the Public Health Accreditation Board (PHAB) has propelled health department momentum around quality improvement uptake. Domain 9 of the PHAB standards focuses on evaluation and improvement of performance, and is acting as a strong driver for quality improvement and performance management implementation within health departments. Several performance management models have received broad acceptance, including among government and nonprofits, and have direct public health application. Turning Point is a model designed specifically for public health users. All models in current use reinforce customer centricity; streamlined, value added processes; and strategic alignment. Importantly, all are structured to steer quality improvement efforts toward organizational priorities, ensuring that quality improvement complements performance management.

Keywords

performance management, quality improvement, health departments, accreditation

Cover Page Footnote

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INTRODUCTION

Widespread adoption of quality improvement (QI) activities in public health trails other U.S. sectors, notably business and health care. For the past decade governmental and philanthropic organizations have strategically invested in public health department quality improvement initiatives with the goal of strengthening their performance.¹ Health department momentum toward QI has accelerated widely following the launch of the national public health accreditation program under the auspices of the Public Health Accreditation Board (PHAB).² This voluntary accreditation process is based on health department demonstration of conformance with standards and measures, derived from the Ten Essential Public Health Services. Domain 9 specifically focuses on evaluation and improvement of performance.

TRANSLATING QI INTO PERFORMANCE MANAGEMENT

Quality improvement tools and methods are typically directed toward the improvement of processes. In public health this often translates into programmatic or administrative foci. With greater understanding of QI, it became evident that there was also an imperative to improve performance of the entire *enterprise*, not exclusively focusing on processes alone. Viewed through this lens, quality approaches morph into performance management (PM) and strive to advance the full organization, reflecting strategic priorities of senior leadership. Currently, there are several PM models that have widespread use in multiple industries and sectors. Utilizing these “generic” frameworks, an organization may apply specific QI tools and techniques based on priorities and long-term strategic planning goals. Two of the best known examples are Baldrige and Balanced Scorecard (BSC). Baldrige consists of seven related domains that must be aligned to achieve organizational performance (Figure 1). BSC was created because traditional financial measures commonly used to assess organizational performance were narrowly focused, and did not consider other important perspectives (e.g., needs of the customer). Instead, BSC fostered the balanced examination of performance indicators within four areas. It also encouraged the examination of performance within the broader context of an organization’s strategy and vision.

Figure 1



Baldrige and BSC provide well-structured approaches to assess the status of an organization. Once areas for improvement are identified, QI tools and techniques can be applied, allowing the PM system to complement the use of QI tools within the organization. One key role that senior management plays within PM is the allocation of scarce organizational QI resources where they will have the greatest impact given the desired strategic direction.

A public health PM model, Turning Point, was developed in 2002. It originally consisted of four components: (1) performance standards; (2) performance measures to assess whether standards have been achieved; (3) reporting of progress; and (4) a systemic QI process. Today PHAB standards are generally recognized as the accepted national performance standards. Current performance measures for health departments might be a blend of PHAB measures and those developed locally, at the state health department level, or by a grantor. Robust measurement systems include metrics that inform leadership/management via capacity measures, process measures, and the impact or outcome resulting from the activity/intervention. Reporting of progress refers to a systematic and periodic dissemination of data. Presently query-able websites often provide such key health data in real time. Finally, the QI component, as with Baldrige and BSC, was intended to direct limited health department resources toward priority health problems where current performance warranted higher achievement.

PERFORMANCE MANAGEMENT ADOPTION WITHIN PUBLIC HEALTH

With the launch of PHAB accreditation, health department emphasis on QI and PM have increased substantially.³ Specifically PHAB Domain 9 contains standards and measures that call for both QI and PM systems to be in place, operational, and integrated.

In 2013, the Turning Point model was refreshed. Based on practitioner feedback the elements of the original framework were validated and retained (Figure 2) while a fifth component, recognizing the vital role of leadership and organizational culture in PM, was incorporated.⁴ Leadership is expected to ensure organizational customer focus (a lesson learned from Baldrige, BSC, and QI generally), and emphasize alignment of strategies (priorities) with activities, measures, and thoughtful resource stewardship.

Figure 2
PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



Developed in 2013, adapted from the 2003 Turning Point Performance Management System Framework.

Regardless of the PM framework utilized, all reinforce several central tenets such as customer focus; streamlined, value added processes; and strategic alignment. All steer QI efforts toward organizational priorities, ensuring that QI complements PM rather than competes with it. Because the PM system provides the superstructure for overall health department management and ultimate alignment of efforts, it is inherently logical to address the intent of PHAB Domain 9 by developing the PM approach first—then instituting QI to harmonize with the model. The additional benefit of Turning Point is premised on its development for and by public health practitioners along with the availability of guidance and support materials specific to public health agencies.

Knowledge and uptake of QI tools and processes are enormously significant foundations in the transformation of health departments into quality organizations operating within a culture of quality.⁵ QI functions at three levels within the organization: macro or organizational level; public health program or administrative process level; and the individual level. Additionally, external to the health department, but potentially involving public health system partners, QI may encompass an entire sector—the so-called meso QI.⁶ When scanning across the organization, using data to make decisions about managing health department priorities, QI becomes PM. Many industries and organizations develop “dashboards” to facilitate rapid feedback to management about the performance of critical areas. The Association of State and Territorial Health Officials is now piloting a public health dashboard with eight focus areas designed to inform public health leaders about the “health” of the health department.

When directed at specific programs or processes, QI employs teams and tools to tackle public health problems, efficiencies, and effectiveness. Although it is ideal for all health department staff to become knowledgeable about QI tools and processes, and to serve on QI teams to strengthen understanding as adult learners, QI at this intermediate level should be marshalled only to address prioritized problems. The deployment of resources should be in accordance with an overall organizational QI plan, which sets forth a decision-making process for selecting QI projects for the agency.

Individual QI is instrumental to workforce development. It incorporates the concepts of an individual development plan, and also enables the mastery of QI tools to perform everyday work more effectively and contribute as a QI team member.

CONCLUSION

Public Health Accreditation Board accreditation has expedited the historically slow adoption of QI and PM by public health. Trailing other industries may actually foster opportunities to use the lessons they have learned for improved models within governmental public health. Among the most important lesson from others is to foster regular progress reporting so that resources can be appropriately allocated to the most crucial areas in need of QI.

Public health’s own recent experiences with QI/ PM have resulted in experiential learning and the development of new models, which continue to inform the uptake of QI tools, methods, and PM frameworks. PHAB Domain 9 provides a blueprint for implementing a PM system well aligned with QI. Without such alignment, there is an inherent tension between resources devoted to QI and PM, especially in resource-constrained organizations like health departments. This interaction places a greater emphasis on health department performance and marshals resources where they can best be utilized to improve key processes, efficiencies, and overall effectiveness.

When QI and PM are implemented fully, they operate at multiple levels within the health department and even externally to strengthen the public health system.

SUMMARY BOX

What is already known about this topic? Widespread adoption of quality improvement activities in public health trails other U.S. sectors. Launching the national public health accreditation program of the Public Health Accreditation Board (PHAB), has propelled health department momentum around quality improvement uptake.

What is added by this report? Domain 9 of the PHAB standards is acting as a strong driver for quality improvement and performance management implementation within health departments. Several performance management models have received broad acceptance, and have direct public health application. All models in current use reinforce customer centricity; streamlined, value added processes; strategic alignment; and are structured to steer quality improvement efforts toward organizational priorities, ensuring that quality improvement complements performance management.

What are the implications for public health practice, policy, and research? High performing health departments harness the synergy of QI and PM, providing powerful tools to achieve public health strategic imperatives. Research is necessary to determine the impact QI and PM have on public health performance, and ultimately on the Holy Grail of health outcomes.

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