Choosing Stones, Moving Mountains: Performance Excellence, Primary Prevention, and Culture Change in a State Health Department

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The man who moves a mountain begins by carrying away small stones.

Confucius (circa 500 bc)

A new health official of any size jurisdiction, anywhere, will face a mountain or two. Some will be obvious, others much less so. “The People” rightly expect us to have an approach to moving them, particularly the more obvious ones that fortunately are often also the most pressing and important ones. The scenario of being a new state health commissioner, appointed by a new governor, amid 20 years of languishing state health rankings was ours. Yet, many face similar mountains. How to move them, what stones first, why, and then how?

For me, even with years of population- and individual-level practice experience in military and civilian settings, including a decade as a multijurisdictional health department director, assessing organizational performance, embracing a broad mission, and leading public health systems change were daunting. The temptation to disassemble health indicators and attack current public health crises was attractive but lacking the broader scope of change that was required. Obvious stones, yes, and the challenge became choosing and giving deliberate attention to approaches that would result in sustainable internal performance and culture change that would create capacity to move more stones faster for a wide range of public health stakeholders.

A culture of optimal health for all is a social shift that really takes engaging a plurality of the population. To have a chance at winning over that plurality in any community, a public health practitioner must find ways to drive engagement of individuals and communities that leads to new attitudinal norms with physical and social infrastructure improvements that support optimal health for all. Conceptually, this may appear to be a one-size-fits-all approach, but operationally it is nothing of the kind. The history of our state’s long litany of sub-40 state health rankings reinforced the instinct to consider approaches that moved organizational culture change in the public health department while created meaningful population health and well-being improvements. Acknowledging the deficits, adopting a recognized performance improvement approach internally that embeds “the public” and its elected leaders as customers, and sustaining internal leadership toward this culture change generate a new creative accountability that supports innovation. The stones, therefore, were clear, and while not the boulders of changing laws against the interests of whole industries, neither were the stones light.

Two diagrams, printed on the 2 sides of a single sheet of paper, would guide the work. The first was the Malcolm Baldrige Performance Excellence framework (see Figure 1), a nationally recognized approach that focuses on both processes and results to improve organizational performance. The second diagram, “Healthy Paradigm” (see Figure 2), I created some years before as a synthesis of evidence and reflective ideas to help visualize and understand population health and strategies for meaningful improvement. Tennessee’s new governor supported this approach in his call for deep departmental reviews and “Customer Focused Government—the best service for the lowest cost.” The Tennessee Department of Health (TDH) responded using a participatory self-assessment and annual strategic plan cycle, refined and improved each year, built around the Baldrige framework.
Using the Performance Improvement Approach

The model of the Healthy Paradigm aided by the adoption of the performance excellence framework required a purposeful transformation. This included providing support to staff to creatively work the “mission”—health and prosperity, toward a clear “vision.” Simultaneously, we provided assurance to the people, as assessed by their local and state elected officials, of the department doing a good job, qualitatively and quantitatively, in delivering its large book of traditional services. Simply put, we must “mind our own store” while franchising population health all over. Concurrently, leaders must encourage continuous improvement actions that allow staff to innovate, be more time efficient, enjoy their jobs more, and encourage discretionary effort. The Baldrige framework, applied with a top-down and bottom-up approach, facilitates this present and future view.

A full review of the Baldrige framework was introduced during development of the department’s 2012 strategic plan. The commissioner and 2 deputies and 1 metropolitan health department previously had deep experience in using the framework and preparing organizational applications for external review. In introducing performance excellence, senior leaders had to avoid the “new commissioner—new flavor of the day” syndrome. It was acknowledged that the framework is not public health or even government agency specific, nor was it a process-specific tool or approach, such as Lean or Kanban. The framework instead was characterized rather amorphously, like the piece of plastic around a 6-pack ring—“the thingy that holds it all together.” The framework has 6 areas that must be attended to in order to achieve “results.” The activities are not dictated but rather ask questions about the “Approach, Deployment, Learning and Integration” for each of the organization’s self-identified “key factors” for success. This systematic and integrated view of the whole organization helps move away from a siloed segregation of units and reinforces that no one person or unit of the organization or process is more important than others. By including a customer focus, it promotes attention to community engagement—the voice of the customer. By including the results focus, the staff could view population health improvement overall, not just mere process measures, as the bailiwick of public health.

Culture change required multiple, reinforcing management strategies. A new deputy commissioner for Continuous Improvement and Training provided administrative support. Investments were made for employees to become Baldrige examiners through the state performance excellence organization (Tennessee Center for Performance Excellence [TNCPE]). The new Office of Performance Management organized these employees into a corps of examiners to assist TDH units adopt performance improvement tools and complete TNCPE applications. Since 2012, 136 TDH employees volunteered to participate as Baldrige examiners. These structural actions were critical in achieving the bottom-up success in facilitating large organizational change.

Senior leaders reinforced employee engagement in performance excellence. Leading by example was important. In 2012, senior leaders completed the TDH-wide organizational profile using the Baldrige criteria for the level 1 TNCPE Interest Award. By 2018, 74 departmental units chose to participate in Baldrige and achieved 122 TNCPE awards. These actions blended with a new participatory annual strategic plan process. Central office and field staff contributed to 29 statewide planning sessions and 1647 of 3500 TDH employees provided written feedback just in the first year.

New participatory mechanisms were begun: a Parade of Programs as idea exchanges between categorical program directors and senior leaders; logic models and strategy maps for employees from multiple
units to visualize effort, contributions and progress; bimonthly Strategic Topic sessions for extended discussion of crosscutting issues; Rising Stars Teams to channel energy and ideas of promising junior staff members; and reading groups for organizational learning to introduce ideas about innovation, case studies in culture change, and continuous improvement frameworks. In addition, we integrated performance improvement principles into 2 new major statewide initiatives, the Primary Prevention Initiative (beginning 2013) and Tennessee Tobacco Settlement Program (beginning 2014), for all counties to apply cycles of learning and demonstrate process and health outcome improvements.

Did culture change lead to population health improvements? We reviewed the National Academy of Medicine’s Vital Signs 4 to collectively identify Tennessee’s priority measures and define appropriate intermediate- and long-term evaluation metrics. To address the opioid crisis, partnerships with professional societies, health professions training programs, and practicing prescribers and dispensers led to increased checks of the state prescription drug monitoring database prior to issuing prescriptions for opioids from 7% in 2011 to 50% in 2017, resulting in a 32% reduction in morphine milligram equivalents dispensed (2012-2017).5 To address the high prevalence of physical inactivity, we offered small built environment grants to communities that attracted 106 projects in 88 counties, including walking tracks, playgrounds, exercise equipment stations, and sports facilities, many in communities where they did not previously exist. We campaigned to establish 1071 private and public sector Breastfeeding Welcome Here business partnerships, a strategy that encouraged an increase in breastfeeding initiation from 67% in 2011 to 81% in 2017. To reduce the statewide incidence of influenza in children and others, and without new funding, we encouraged annual partnerships to develop school-located influenza vaccine clinics, now currently in 600 schools in 74 counties, resulting in more than 28,000 vaccines provided. The Tennessee Tobacco Settlement Program trained 271 youth teams in 2014-2017 that become peer-to-peer health educators who then conducted 936 school and community activities, leading to a reduction of eighth-grade smoking from 11.3% (2011) to 6.9% (2016).6

Reflections

Senior leaders are challenged to create opportunities for successful external engagements that allow health departments and their leaders to be effective as chief health strategists in local communities and across larger populations. We are concurrently challenged to create conditions to ensure that daily public health work is carried out effectively, efficiently, correctly, and compassionately and always acknowledging that there are opportunities for improvement. The Baldrige performance excellence approach provided TDH with a framework for systematic improvement. Comprehensively focusing on leadership, planning, redefining customers, use of data, process improvement, and a skilled workforce enabled us to define and report organizational and population health results. Performance excellence encourages doing the right things, and doing those things right, being deliberate about engagement at all levels to foster a culture that celebrates discretionary effort and innovation, training and executing on multiple improvement, and alignment tools.

For public health, a substantial value-added aspect of the Baldrige awards program is the external review and site visit conducted by nonpublic health–trained examiners. This experience requires clear explanations of public health fundamentals, interests, and approaches. Examiners include the types of business sector leaders increasingly found in state government and legislatures. Our Baldrige journey honed our descriptions about public health principles and practice. Examiners’ feedback and our organizational responses became pivotal in making the choices of stones and mountains we chose to move in pursuing population health improvement in Tennessee.

When the best leaders’ work is done, the people will say “we did it ourselves.”

Lao-Tzu (circa 500 bc)

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