

CHAPTER 13

Organizational Performance: Managing for Efficiency and Effectiveness

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LECTURE OUTLINE

A. Chapter Purpose

- The objective of this chapter is to review the major issues related to assessing organizational performance, compare and contrast the approaches of quality assurance and quality improvement, and describe the strategies to achieve an effective health care organization.

B. The Challenge of Performance

- Health care organizations operate in an environment of constrained resources, and must maximize productivity, quality, and market share while containing costs and minimizing the use of ineffective services. Managers must adapt organizations to an ever-changing environment, and innovate rather than passively react to external changes.

1. Aspects of Organizational Performance Assessment

- The first three terms relate to the potential of a health service to produce the desired benefit; they refer to the evaluation of a particular treatment or set of services. The fourth refers to organizational performance.
 - a. Productivity: The ratio of outputs to inputs.
 - b. Efficiency: The cost per unit of output.
 - c. Organizational effectiveness: The degree to which organizational goals and objectives are successfully met.
 - d. Cost-effectiveness: A composite measure that takes into account cost as well as the degree of goal attainment.
- Other terms often used to refer to organizational performance include:
 - a. Efficacy: Refers to the capability of a health service, under ideal conditions and applied to the right problem, to produce the desired effect.
 - b. Appropriateness: Focuses on whether an efficacious treatment was applied to the right patient at the right time.
 - c. Effectiveness: Involves ascertaining the quality with which a service is carried out.

2. Factors Associated with Increased Productivity and Efficiency

- a. High standards and goals
- b. Information and feedback
- c. Interdepartmental coordination and resource sharing
- d. Compensation systems oriented toward rewarding productivity or efficiency
- e. Physician involvement in decision making and governance
- f. Concentration of staff work and activity
- g. Active governing boards that deal with environmental pressures
- h. Type of ownership
 - i. Chain ownership and contract management
 - j. Degree of system integration

C. Issues in Assessing Effective Performance

1. Definitional Issues in Assessment

- a. Fundamental perspectives about organizations
 - The most important definitional issue in measuring organizational performance is related to one's view of the fundamental purpose and nature of organizations because these views affect the determination of what will be measured and why it is being evaluated. Various performance measures are available depending on the perspective being used to conceptualize performance. These measures may highlight the potentially conflicting features of performance in an organizational system.
- b. Domain of activity
 - Once a general framework or model has been selected to guide the investigation, it is necessary to determine which particular functions or activities will be evaluated. Most complex organizations serve a variety of aims and objectives. There is no simple measure of overall effectiveness of a health care organization. There is always room to continuously improve at least some aspect of performance.
- c. Different levels of analysis
 - An important insight gained from open-systems theory is that all complex systems tend to be systems within systems. Most analyses of organizational performance focus on one or more of the following three levels of systems:
 - (1) The organization itself
 - (2) A larger socially defined unit that contains the organization, such as a community, a health services region, or a system of hospitals
 - (3) Subunits contained within the organization, such as individual departments or practitioners
- d. Stakeholders
 - In any organization, both internal and external interested parties—stakeholders—have different desires and needs to be met by the organization; they have varying expectations and criteria for effectiveness. Certain views privilege the interests of shareholders, but many current observers of organizations insist that other interests—including those of managers, staff, rank-and-file employees, clients, and the wider community—have equal standing.

2. Technical Issues in Assessment

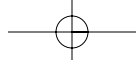
- The focus in this section is on the generic problems and concerns that arise during the process of evaluating work performance.
- a. Classes of measures
 - There are three basic classes of measures whereby evidence can be collected and evaluation performed.
 - (1) Structural measures: Based on assessments of organizational features or participants' characteristics that are presumed to have an impact on organizational performance; they do not assess work performed or effort expended but only measure an organization's capacity to permit or promote effective work.
 - (2) Process measures: Based on evidence relating to the performer's activities in carrying out work; they are valid if they lead to improved products or better outcomes.
 - (3) Outcome measures: Based on evidence gathered from the objects upon which the work is performed; focus attention on changes produced and results achieved.
 - b. Preferences for classes of performance measures
 - Associations are likely to exist between these classes of indicators and the various categories of constituents. For example, managers typically prefer structural measures since these are the measures over which they have the most control; caregivers tend to prefer process measures; and clients focus more on outcome measures or results achieved.



- c. Factors associated with effective performance
 - Studies have identified a number of factors generally associated with higher quality of care.
 - (1) Quality of professional staff
 - (2) High standards
 - (3) Experience with other cases of the same type
 - (4) More formally organized professional staffs with well-defined coordination and conflict management processes
 - (5) Participative organization cultures emphasizing team approaches
 - (6) Timely and accurate performance feedback
 - (7) Active management of environmental forces
 - (8) Type of ownership, competition, staffing continuity, and compensation
 - (9) Higher levels of differentiation and coordination of medical staff

3. Managerial Issues in Assessing Performance

- The old model in health care relegated quality to the quality assurance department, which solved problems and held individuals culpable for mistakes. The new model emphasizes quality improvement teams that cut horizontally across functions and vertically across hierarchical lines, and prevents problems by continuously improving the true source of defects—the process. This section first presents some general issues in evaluating professionals, followed by a discussion of both quality models.
- a. Evaluating professional performance—the professional model
 - Three alternative models can be used to embed professionals in an organization. These are: autonomous (in which professionals control and evaluate themselves as a group), heteronomous (in which they are subject to more line-authority control), and conjoint (in which professionals and administrators coexist in a mutually interdependent setting in which each group is roughly equal in power). Modern health care is moving toward the third model.
- b. Evaluating nonprofessional work—the bureaucratic model
 - In this model, performance appraisal is typically assigned to a supervisor. In recognition of the different skills and perspectives necessary to accomplish this task in a complex health services organization, interdisciplinary teams are increasingly being utilized.
- c. The impact of evaluation on all types of performers
 - All attempts to evaluate a performance may be expected to have effects on that performance. Ideally, the evaluations made are accurate, but if not, reactivity to the performance criteria can result in an appearance of improvement in performance, rather than motivating the worker to seek true changes in quality.
- d. Two models for changing performance:
 - (1) Quality assurance: The formal and systematic exercise of identifying problems in medical care delivery, designing activities to overcome these problems, and carrying out follow-up steps to ensure that no new problems have been introduced and that corrective actions have been effective.
 - (2) Quality improvement: A management philosophy that views work as a process in which the customer is central. The main source of quality defects is problems in the process. With a perspective that “quality is an organizational problem,” the focus is on involving every worker in improving processes and setting high standards for performance.
- e. Precautions when designing QI strategy in health care organizations
 - (1) Use physicians’ time wisely, perhaps as consultants.
 - (2) Peak physicians’ interests by capitalizing on those who are most interested in QI.
 - (3) Empower physicians’ participation—involve them early.



- (4) Respect professional values, avoiding statistics and reviews that threaten professional competency.
- (5) Diagnose and capitalize on the specific stage of adoption specific units and groups have reached.

D. The Manager's Role in Creating High-Performance Health Care Organizations

- Effective health services managers focus not only on variables that are most directly controllable, but also attempt to influence the external environment.
1. Resource Acquisition
 - The ways in which health care organizations obtain resources has changed radically in the past few years, in part because of a decline in philanthropy. More emphasis is given to the debt and equity markets for obtaining resources. Resource acquisition needs to be more carefully targeted than in the past to conform with the organization's overall strategic plan.
 2. Managing Trade-Offs
 - Health care managers must balance the perceived trade-off between efficiency and effectiveness—between containing costs and providing high-quality care.

OVERVIEW OF CHAPTER "IN PRACTICE" AND "DEBATE TIME" MATERIAL

IN PRACTICE: Health Care Organizations and Medical Errors

- 1 When assessing the performance of the UCLA Medical Center, whose responsibility is it?
 - More than anyone else, the manager is responsible for the performance of the organization, but in a professional organization this responsibility is shared with providers.
- 2 When obstacles occur, like in the UCLA example, what should health care managers do?
 - The performance of health care organizations depends on the ability of health care managers to truly lead, not just steer, through obstacles—that is, to mold and innovate within their environment rather than passively reacting.

IN PRACTICE: Frontline Bureaucracy in Health Care and Access for the Uninsured

- 1 What do frontline bureaucrats (clerical staff who have direct contact with patients) do when the goal of securing payment for the costs of care and the organizational mission of caring for patients-in-need conflict?
 - When faced with these situations, the front desk staff will talk with their supervisors about what to do. Patients are generally called aside to minimize the risk of a publicly visible conflict. Supervisors will generally know when to involve doctors. Many have noted that there can be contradictions in policies, reflecting the need to handle such issues with latitude.
- 2 How is it decided whether such patients (uninsured) will be seen or turned away?
 - Seventy-one percent staff reported that they did not independently turn patients away.
 - There were no written policies stating that patients are to be turned away.
 - Certain organizations state that you have to bring a deposit with you to your next visit.
 - Many staff advocate for uninsured patients.
 - A number of uninsured patients turn themselves away once they discover the cost of care.

**IN PRACTICE: Stakeholder Interests: Corporate Responsibility for Disclosure of Scientific Evidence in Medicine**

- 1 What is quality assurance and quality improvement?
 - Quality assurance refers to the formal and systemic exercise of identifying, monitoring, and overcoming problems in health care delivery.
 - Quality improvement is a management philosophy centered on improving the level of performance of key processes in the organization by focusing on the most important processes to improve, setting high standards for performance outcomes, and using statistical methods and tools to measure current performance, interpret it, and take corrective action when necessary.
- 2 In this situation how did the FDA apply principles of quality assurance and quality improvement?
 - In 2003 the FDA warned doctors on the use of Paxil for adolescents and children.
 - In 2004 the FDA required antidepressant makers to strengthen suicide warnings on labels.
 - According to FDA guidelines, the manufacturers of pharmaceuticals are supposed to limit their marketing to only those uses that have FDA approval.

IN PRACTICE: Applying Root Cause Analysis to Improve Health Care

- 1 Define benchmarking.
 - Benchmarking is the process of establishing operating targets based on the leading performance standards in the industry.
- 2 How would Dr. Shannon apply benchmarking to the hospital?
 - He needs to know his operation, that is, assess the organization's strengths and weaknesses.
 - Know the industry leaders and direct competitors.
 - Incorporate the best policies, practices and standards. Don't hesitate to copy or modify, but be sure to start with the best.

DEBATE TIME 13.1

- 1 For each category of missteps, develop an argument that the error was due to problems in the underlying process rather than from the individual physician's mistake.

DEBATE TIME 13.2

- 1 Figure 13.1 provides a framework for thinking about quality improvement in health services organizations. Some people believe that the greatest improvement opportunities lie with increasing clinicians' competence and skills. Others believe greater improvement results from changes in the organization and management of patient care units. Still others believe that the quality of care is largely a function of the availability of sophisticated technology or the degree of teaching activity going on. What do you think? Where would you place the most emphasis? What factors, conditions, or variables influence your decision?



DISCUSSION QUESTIONS AND SUGGESTED SOLUTIONS

1. Take the perspective of a CEO of a large group practice, which owns its own managed care health plan. Describe three major ways that you could improve the access, quality, and cost containment of health care in your organization. Critique your solutions regarding the extent to which your solution may cause other problems to surface [what kind?] and the extent to which you as the CEO should have the responsibility and power to implement these changes.

A myriad of suggestions is possible for this question. Students should consider the conflicting nature of the objectives of access, quality, and cost containment. Actions taken to accomplish attainment of one goal may adversely affect another. For example, increasing access can have a negative impact on quality if the organization does not have the necessary resources to handle increased utilization of services. It should also be noted that although quality and cost containment are often perceived to be conflicting, recent studies indicate that both objectives can be accomplished simultaneously through a quality improvement program.

2. Using a health care organization that you know well, provide three examples each of possible structural, process, and outcome measures of effectiveness. Would you expect these measures to be highly associated? Why or why not?

Students might use Table 13.1 to give them some idea of the type of performance measures they should be identifying. The measures are probably associated, but not to a high degree. They more than likely could be described as loosely coupled. The measures are interdependent (e.g., process measures are valid only if they lead to improved products or better outcomes).

3. Consider a community hospital, a major teaching hospital, and a hospital in a large for-profit system. For each, list the major constituency groups (both internal and external). Indicate what kinds of effectiveness criteria each group would be most likely to promote.

The major constituency groups should fall broadly into three categories: executives and managers, caregivers, and clients and representatives of the various external publics. Executives and managers will typically prefer structural measures of effectiveness since these activities are more

under their control. Caregivers are likely to emphasize process measures because these activities are under their control. Clients and external representatives most likely prefer outcome measures because they are focused on actual results.

4. Hospital A and Hospital B both have as their major goal for this year the implementation of a QI program. Hospital A hired a consultant firm and sent its top managers to a program to learn how to change the corporate culture and to set up quality teams to investigate problems. They formed teams to plan strategies of meaningful QI in two specific areas: billing and use of the emergency room. Hospital B, lacking funds, tried to have study groups and use self-teaching but involved everyone from the CEO to the janitor. Which hospital do you think will succeed in implementing QI? Why?

Hospital B will most likely succeed in implementing QI because they involved all employees in the training process. One of the basic tenets of QI is that all levels of employees should be involved in the improvement of processes. The employees of Hospital B will have a better understanding of the reasons for implementing the new QI program, and will be more committed to the program's success.

5. Clinic Q was a large multispecialty group practice with a major emphasis on specialist care. Because they were worried about not having enough referrals for specialist care, their major goal for the year was to set up two new branches of primary care providers. To attract primary care providers, they discovered that they had to offer salaries higher than the average salary of physicians at the clinic. Start-up costs were also high. Using concepts such as strategic planning, effectiveness, productivity, and efficiency, discuss how to evaluate whether this expansion was a "success" for the organization.

There will likely be a wide range of answers. One approach that students may take is to review the terms related to organizational performance (defined at the beginning of the chapter) and refer to these in their answers. There is not enough information provided in the question to determine effectiveness, as defined in the text (relating to assessing health services). The appropriate definition to apply to this question would be



organizational effectiveness. Students may mention that the cost of the inputs has increased by raising salaries. This will have a negative effect on productivity, efficiency, and cost-effectiveness. Although not discussed in

this chapter, students may also point out that morale problems may arise because of the lack of internal salary equity that will result from giving larger salaries to new physicians.

TEACHING TIPS AND EXERCISES

1. A “stakeholder mapping” exercise can be an effective method for discussing the “different levels of analysis.” Internal and external stakeholders have differing desires, expectations, and needs to be met by the organization, and thus have varying criteria for determining effectiveness. Choose a health service organization that most of the class is familiar with (a local hospital works well), and create a stakeholder map on either a whiteboard, flip chart, or whatever is available. Students should suggest as many possible stakeholders as they can think of. The instructor might choose to draw the map, or call on a student to do so. This stakeholder map should look like the one shown in Figure 8.1. This exercise could also be used to illustrate concepts in other chapters, particularly strategic management in Chapter 14. It also serves as a useful tool to illustrate the complexity of the manager’s role in a health services organization by discussing the wide variety of stakeholder expectations (which are sometimes conflicting),

which managers must consider when making decisions.

2. There are many possibilities for additional quality concepts that could be included in the lecture. Students have probably studied TQM or CQI in other classes, or have been exposed to quality training in their employment, but a review of basic concepts might be helpful. You might consider reviewing Deming’s (1986) “Fourteen Points,” Juran’s (1988) Quality Trilogy (quality planning, quality control, and quality improvement), or Crosby’s (1979) “Four Principles.” All of the major quality theories have common principles that apply in health service organizations. Some of these points are the customer orientation of quality improvement (both internal and external customers), a focus on incremental process improvement, and employee empowerment (making employees responsible for measuring quality and taking corrective action).

COMPLEMENTARY READINGS

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