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Marni Mason discusses the importance of data and teamwork for a successful approach to quality improvement efforts in healthcare environments.

Tell me a little about your background and why/how you are able to help public health departments.

I've been working in quality improvement, performance management, and accreditation, both in general private healthcare and in public healthcare, for more than 30 years. I was trained back in 1990 by the Juran Institute for Total Quality Management the quality improvement methods and tools, and began applying them as a quality consultant at numerous organizations. I had an opportunity to help develop the Public Health Accreditation Board (PHAB) standards in 2009 and 2010. I was privileged to have the opportunity to facilitate many quality improvement projects; upward of 200 - 250, all related to public health performance management, performance measurement and accreditation.

Can you explain the "Principles of Quality Improvement" that you teach when working with organizations?

The principles of quality improvement are the foundation of successful improvement regardless of the methods that are used. By methods I'm talking about the Rapid Cycle Improvement method, Lean Six Sigma, Kaizen events and all different types of quality improvement methods; all of which use the Plan-Do-Study-Act (PDSA) cycle that Deming used extensively.

All of these methods are founded on basic principles that include ensuring the use of proven QI tools including the Voice of the Customer, Root Cause analysis and many others. Another important principle is to use data and data analysis in the QI effort. Quality improvement is done on existing programs and activities in a health department since you need to know the results of work process, outputs and outcomes in order to be able to understand whether you need to improve that specific work process or not.

Work processes are what quality improvement focuses on. It's improving the way in which the work is done by understanding the voice of the customer and how the work is value-added to our customers as well as ensuring that work processes are really effective as well as efficient. So one of the basic principles is to use quality improvement to improve efficiencies of our work and to reduce waste. That buys us a lot of additional staff time because they're not spending time doing tasks or steps in a work process that do not add value to the results of the work or to our customers or clients.

The final principle I would like to talk about is teamwork. When it's formal quality improvement using specific methods and tools that I just described, it's always done with a team. A QI team can include managers or supervisors of that particular work process as

well as staff that are involved in that work, and then, of course, the customers of that work process. So the most successful quality improvement is done through a team applying the QI methods and tools to a specific work process.

Where in Public Health can we apply Quality Improvement?

Prioritized QI efforts can and should be used in any aspect of the public health departments work; so administrative activities and processes, such as human resources, purchasing, finance – all of those types of processes lend themselves beautifully to improved outcomes when quality improvement is applied in an intentional and selected manner as well, obviously, as environmental health and all of our maternal and child, communicable disease, or chronic disease programs. It is a wonderful tool that can be applied to any aspect of public health department work and improve both the lives of the public health staff and leaders, as well as the clients and the constituents of a public health department.

How important is data for quality improvement?

You always need to be comparing your results to a target or goal. We have lots of output data within public health where we're counting the numbers of things that we achieve, and the results from programs and public health activities. What we need to be doing is taking that output and comparing it to some type of target or goal, whether it is our previous performance within that same program or that health department in prior years, quarters or months, or a sister health department that has some comparability, or a state average or a national benchmark that the health department can use for that particular work process. Always comparing results to targets or goals is the only way to understand whether quality improvement is even needed or not.

How can EHRs help in quality improvement? Can you provide examples where quality improvement is done based on data collected from EHR?

Quality improvement requires some form of baseline data so you can evaluate where you are and if you need improvement or not. Having family planning or immunization records for example available electronically to everyone in the program and even everyone in the agency is helpful. Data are required in order to do quality improvement.

What are 2-3 specific examples on how quality improvement made a difference to either a public health department or to a client of a health department?

I don't know that I can pick just 2 or 3. I have personally facilitated quality improvement projects in public health departments that are related to improving immunization rates. They have seen the immunization rates go up from the mid-60% of 2-year olds immunized all the way up to 90-95% of the children being immunized. That's one example.

What I would like to emphasize in this interview is that we're now, across the United States, getting many more compilations of good quality improvement projects that show the results of quality improvement for many different health issues, as well as administrative work processes. One fantastic example is called PHQIX (Public Health Quality Improvement Exchange) through the Robert Wood Johnson Foundation, available at PHQIX.org. Probably at this point, PHQIX has approximately 200-300 stories with full descriptions of the problem, how the QI teams went about the improvement project, what methods and tools were used, the results they achieved and the lessons they learned.

Over the span of your 20+ years of helping clients integrate quality planning and improvement into organizational culture, what are the top 3 most common pitfalls health departments have and is there one key thing they could do that would have the biggest impact toward improvement?

Quality Improvement is resource-intensive of time, staff and energy and it needs to be applied selectively through a prioritization process. One of the primary pitfalls that I often see is trying to use "quality improvement" for everything that is going wrong within a health department or that is frustrating to staff. We need to use our QI resources to ensure that we select high-priority opportunities for improvement, that we are intentional about decreasing the gaps between the results we achieve and the results we need to achieve through our QI efforts.

There are many pitfalls in conducting successful quality improvement, but another big one that I'd like to mention here is not assigning sufficient resources to the QI effort. Not having a leader/champion for the effort can make the quality improvement project

and initiative less successful and effective. Not having data analysts to translate data into information and display data for analysis is critical to developing good solutions to the problems QI teams seek to improve.. We don't always have as much analysis of the data as is needed to do good quality improvement.

The final thing, again related to resources, is having a good quality improvement facilitator. Assigned resourc-

es and expertise do not need to come from within the agency. They can be from a community college, another health department, or another major stakeholder that would offer analysis and quality improvement facilitation but every team needs to have someone who knows where they are in the QI process and what would be the best tool to use. By avoiding these pitfalls we can encourage successful quality improvement.

About Marni Mason, BSN, MBA

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Mason manages a consulting practice specializing in assessment and improvement of public health practice, development of performance standards for public health, preparation for Public Health Accreditation Board (PHAB) and NCQA accreditation, and operational and clinical improvement in general healthcare, public health, and behavioral health organizations. She also has expertise in assessment and compliance with performance standards such as the National Committee for Quality Assurance (NCQA), the National Public Health Performance Standards (NPHPSP), and the Baldrige Criteria for Performance. She served as consultant to the PHAB in the development of the national Standards for Public Health for voluntary accreditation and in training the PHAB Beta Test site reviewers. Ms. Mason has more than 20 years of experience in teaching the application of quality improvement methods and tools and helping clients integrate quality planning and improvement into organizational culture. Recently, Ms. Mason has been consulting with the Multistate Learning Collaboratives, facilitating quality improvement (QI) teams and teaching QI methods and tools to public health leaders in numerous states, including workshops in Illinois, Kansas, Montana, Ohio, Oklahoma, Washington and for national conferences for ASTHO, NACCHO, NIHB and NNPHI. She serves as consultant for the Washington State Quality Improvement Initiative (2006, 2007, 2008-2010) and the Illinois PHI Collaborative (2009-2010) to improve public health performance. Marni has co-authored articles regarding performance management in public health and contributed to the Public Health Quality Improvement Handbook and Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook.



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