**Case Review**

# At What Price Progress? When Performance Improvement is All That Matters

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*Performance improvement activities are an important means of establishing accountability and transparency for public and nonprofit organizations. Too often, however, the organization's singular focus on performance measurement is seen by employees as the goal itself, not simply a means to an end. Improperly translated and communicated, performance goals can become the mission, derailing the original purpose of the quality improvement activities. When mission focus is replaced with an emphasis on performance standards, the organization is at higher risk for declines in employee morale, unethical behaviors to meet unrealistic goals, a decline in creativity, and, in some instances, organizational failures. Examples of mission and goal misalignment are provided through case studies to demonstrate the negative organizational effects that result when performance improvement activities or benchmarking steer an organization to meet outcomes that are subordinate to the ultimate organizational mission.*

Bryan Moreno, a six-year-old autistic child unable to speak for himself, died of cardiac arrest on July 16, 2009, following a severe beating at the hands of his mother's live-in boyfriend. Mandated reporters had three times in the preceding months contacted a local office of the Georgia Department of Family and Children Services (DFCS) to raise concerns about bruises and scratches, but each time the complaints were discounted and reports unsubstantiated (Rawlings 2010, 1-2). Moreno's death was, at least in part, the result of a practice instituted at Georgia's DFCS agency to "screenout" or "divert" cases when abuse was not substantiated and, in some cases, even when it was substantiated. After a cursory review, sometimes no more than phone call or a check with relatives, the assigned social worker was allowed, with supervisor approval, to close the case, essentially concluding that there was no danger to the child or children. Cases were classified as diverted (later renamed "family support") if the parent or other caregiver was given a referral to services – drug treatment,

counseling, or therapy, for example – but there was no obligation on the family's part to follow the recommendation and no follow-up from the agency. The case was simply closed. Even repeated cases of maltreatment did not show up as such, since most reports were not initially substantiated. In many cases, serious injury or death took place before substantiation was made.

If the goal was to reduce the number of children in child protective services (CPS), Georgia's DFCS diversion plan was highly effective. In August 2008, according to DFCS' data: 53 percent of cases received only "family support"; 14 percent were "screenouts"; and 15 percent were unsubstantiated and closed (Georgia Department of Human Resources 2008). In total, 82 percent of reports, the majority from mandated reporters, had virtually no follow-up after the initial contact. In many cases, repeated reports of abuse were diverted and no action taken. Goals were clear to DFCS employees: reduce the number of active cases and foster care placements. Active CPS cases dropped from a high of 32,449 in FY 2004 to 12,122 in FY 2008, and from 2007 until 2009, the number of children in foster care dropped by 30 percent (Department of Human Resources 2009).

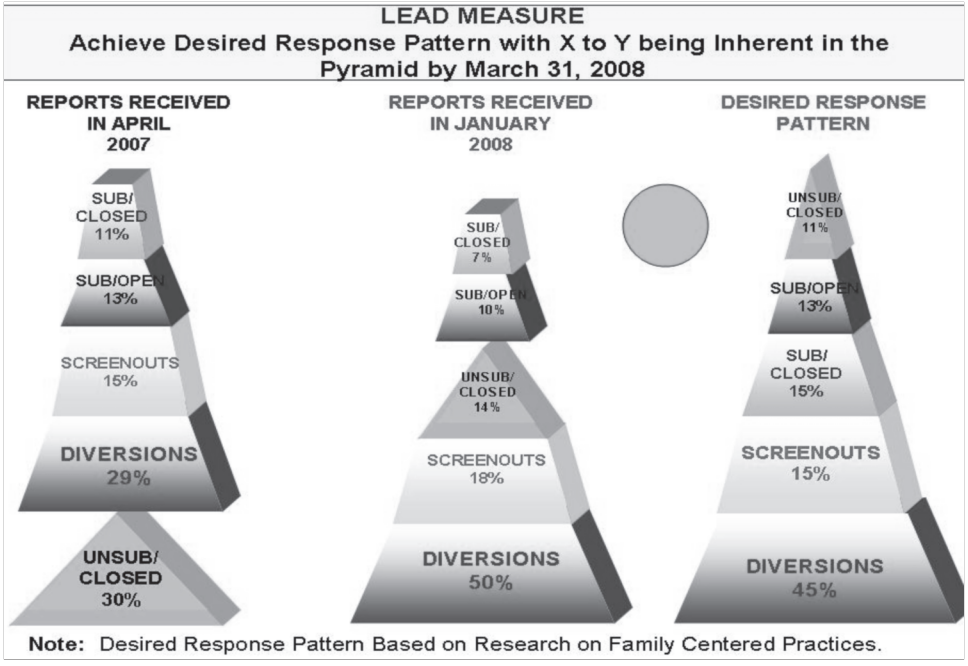
The intense focus on reducing numbers of children in foster care did not happen overnight, and its origins were, in fact, worthy. In 2004, there was widespread recognition that involvement of the state through overzealous intervention of CPS in family matters was often unnecessary and ineffective. CPS cases swelled by a third in a matter of months that year, the increases due to the actions of an agency head with a law enforcement background who took a hard line on suspected abuse in response to a series of articles on child maltreatment in *The Atlanta Journal Constitution*. At the same time, most child advocates agreed that children were better off with their own families. Interventions that allowed the child to stay at home were considered "best practice." Correcting the course and following best practices were the primary objectives of a new administration, and an intense effort began in 2005 to reduce inappropriate active CPS cases and unnecessary foster care admissions.

To assure performance improvement throughout the state, DFCS office representatives gathered quarterly in Atlanta with state agency administrators for meetings designed to motivate the workforce and to review their performance in reaching the desired pattern of agency interaction illustrated in Figure 1. The "pyramids" compared local agency performance with a "desired response pattern." The message was loud and clear: divert and screen-out reports of child maltreatment to meet the agency's new goals.

Though criticism from the Georgia Child Advocate's Office and heated public controversy over the practice of diversion led to a discontinuation of "the pyramids" by mid-2008, maltreatment and deaths of children who had been diverted from care continued throughout the administration. In the Bryan Moreno report, the Office of the Child Advocate warned that from 2008 to 2010, "[t]he number of cases of substantiated child abuse or neglect that are 'closed' without further involvement by DFCS increased by 22 percent" (Rawlings 2010, 6).

In early 2011, just days into a new state administration with new leadership at the Department of Human Services and at DFCS, four children died within three weeks, all of whom had "prior contact" with DFCS under the previous agency policy of diversion. New

**Figure 1. CPS Case Patterns vs. Desired Response Pattern**




*Georgia Department of Human Resources Power Point Presentation, 2008.*

DFCS director Rachelle Carnesale, on the job only five weeks, commented on the statistical significance of the deaths and the role of diversion in the poor outcomes. The true mission of the agency, she told the public in numerous interviews, was "child safety," and she promised a thorough investigation into the long-term practice of diversion.

The case of Bryan Moreno should serve as a cautionary tale for all public administrators, not just for those in human services organizations. While public demand for efficiency, cost-effectiveness, and transparency in government and nonprofit organizations mandates promotion and publication of performance improvement activities, concentration on performance to the exclusion of mission and core values can steer the ship on the wrong course. Improperly translated and communicated, performance goals can *become* the mission, derailing the original purpose of the quality improvement activities.

This article does not in any way diminish the need for quality assurance, compliance activities, and goal setting, nor does it condemn the concept of rewarding good performance. It is instead a reminder to public managers of the need to constantly question the reasons for such activities and to periodically question whether quality improvement activities are, in fact, achieving the desired outcomes.

The avoidable child deaths in Georgia are only one example of organizational failure when the goals for "performance improvement" are substituted for the organization's

true mission. When mission focus is replaced by a singular focus on performance standards, the organization is at higher risk for declines in employee morale, unethical behaviors to meet unrealistic goals, a decline in creativity, and, in some instances, organizational failures. Writing about the sometimes misguided goals of clinical quality management in *Military Medicine*, DeLorenzo and Phaff elaborate on the risks:

> A sophistic application of CQM [clinical quality management] risks introducing unintended consequences including negative effects on the patient, physician and other caregivers, and organization. Some effects such as lowered morale and decreased professionalism may be worse in large, bureaucratic organizations such as the military. Gaming behavior (i.e., manipulating the system) can even be introduced when a well-intended but ill-advised CQM measurement results in either superficial improvement or worse, dysfunctional behavior designed to subvert the system. 'Checking boxes' and fabricating numbers to fit headquarters' expectations are potential penalties in doctrinarian circumstances (2011, 378).

These authors point out that bureaucratic organizations, especially those with tall hierarchies, may be most negatively affected when intense focus is placed on performance measures out of mission context. The message may be garbled after multiple translations in bureaucracies where front-line workers are expected to "do" rather than think. In organizations like the DFCS agency described above, diversion was rewarded, even if the outcomes were negative, further driving confusion about the real goals of the agency. Supervisors were promoted who met goals for diversion and replaced in agencies that were not moving toward the preferred standards.

Another bureaucratic case in point is a deportation quota program operated by the federal Immigration and Customs Enforcement Agency (ICE). Section 287(g) of the Immigration and Nationality Act allows ICE to contract with local and state law enforcement agencies to carry out immigration enforcement activities. Although the established objective of Section 287(g) was to deport aliens involved in "serious criminal activity" in order to "enhance the safety and security of communities" (Government Accountability Office 2009, 7), illegal immigrants with minor offenses like open containers and speeding have more often been targeted because these cases can be more rapidly prosecuted (Hsu and Becker 2010) and local quotas more easily met. The purported objective of creating safer communities by removing criminal elements became lost as local offices sought higher ratings for meeting numerical goals and focused on the performance objective rather than the policy goals.

Shifting priorities may also result in inappropriate staffing and poor morale. Many health care entities, in particular, have witnessed registered nurses moving away from the bedside to the office to keep up with quality management paperwork. The real work of health care is left to employees without the same skill sets, thereby creating even greater performance challenges. With sufficient intense pressure to meet artificial goals, expensive turnover – with its attendant challenges – may increase, or employees may resort to under-

handed methods to comply with expectations out of fear of losing their jobs. In some organizations, particularly those under financial stress, failure to meet identified performance goals causes constant reorganization, adding confusion and fear to the workplace environment. Such organizations are less likely to reach any objectives, much less compliance with aspirational goals.

The 2009-2010 spate of school standardized testing scandals provides another example of pressure for performance and goal misalignment that have resulted in desperation tactics and unethical behaviors. The saga began after passage of the "No Child Left Behind" law put schools under the gun to demonstrate "Annual Yearly Progress (AYP)" and changed the standard for successful teachers from "highly qualified" to "effective" (Exstrom 2010). Though adequate measures of teacher performance continue to be debated, a National Education Policy Center report explains that "the Obama administration . . . define[s] 'good' teachers as those who produce gains in student achievement, measured by gains in standardized test scores" (Hinchey 2010, 1). Data from the National Conference of State Legislatures confirms widespread adoption of this new national standard for teachers: "Since late 2009, more than one-third of the states have introduced legislation, and 13 state legislatures have passed laws requiring student achievement be a significant factor in teacher evaluations" (Exstrom 2010).

Unlike the college entrance examinations, the SAT and ACT, which place students' futures at risk, student failures on elementary and middle school standardized tests now imperil teacher and administrator careers. "Teaching to the test" has replaced the goal of "educating children" in many systems, a misalignment of mission and goals that has led to ethical failures and single-minded emphasis on test outcomes. A two-year study funded by the Gates Foundation concluded that "[t]eaching to the test makes your students do worse on tests" (Dillon 2010), yet virtually all school systems now focus teaching on score improvement, and some have crossed other boundaries, including cheating.

Of particular note was Georgia's cheating scandal, where a comprehensive investigation was ordered by former Governor Sonny Perdue after local investigations were deemed insufficient. According to *The New York Times*, the inquiry conducted by the Georgia Office of Student Achievement into cheating on the CRCT in 2010 "raised red flags regarding one in five of Georgia's 1,857 public elementary and middle schools" (Dewan 2010). The Dewan article quotes University of North Carolina professor Gregory J. Cizek, an expert on cheating, on the scandal: "This is the biggest erasure problem I've ever seen. This doesn't suggest that it was just kids randomly changing their answers, it suggests a pattern of unethical behavior on the part of either kids or educators" (Dewan 2010). According to a report by National Public Radio, "as many as 250,000 answers" (Lohr 2010) were altered by teachers and administrators in the attempt to ensure that their classrooms met AYP goals, which, in turn, helped ensure their own jobs.

In July 2011, new Georgia Governor Nathan Deal announced results of the follow-up probe into one of the most egregious offenders identified in the cheating scandal: the Atlanta Public Schools (APS). Outside investigators found "178 educators, including 38 principals" complicit in cheating at "44 of 56 schools . . . examined" (Vogell 2011). Criminal charges are pending in some cases, according to Governor Deal. The artificially high

scores achieved under the leadership of former APS Superintendent Beverly Hall earned her the 2009 award for the county's top school superintendent. The improvements were, of course, false. According to the *Atlanta Journal-Constitution*, special investigators appointed by the Governor reported that: "APS became such a 'data-driven' system, with unreasonable and excessive pressure to meet targets, that Beverly Hall and her senior cabinet lost sight of conducting tests with integrity" (Vogell 2011).

Financial demands can also drive inappropriate performance standards. Bell, California, infamous for its widespread corruption in city government, raised revenue to pay exorbitant salaries to city officials through an aggressive campaign to stop motorists, especially unlicensed immigrants, to impound their vehicles. The *Los Angeles Times* reported that "Bell levied nearly $1 million in impound fees in fiscal 2008-09 alone by charging $300 for unlicensed motorists to retrieve their cars, triple what Los Angeles County and neighboring cities charge" (Vives and Gottlieb 2011). Allegations of a "ballgame" competition among police officers for the number of citations written are now under the scrutiny of the U.S. Department of Justice for possible civil rights violations (Vives and Gottlieb 2011).

Physician pay-for-performance (P4P) also raises the specter of unintended consequences. While there is widespread acknowledgement in the medical community that clinical accountability is important, many physicians have concerns that their own reputations will be damaged if they are penalized, professionally and financially, for non-compliant patients who do not achieve standardized goals. Discharge of non-compliant patients is a possibility. A 2007 article in *Health Affairs* explains other potential problems:

> If compared directly to physicians in wealthier areas, physicians in poor minority communities might be less likely to receive P4P incentive pay and more likely to be listed in public report cards as poor-quality physicians. If, as is sometimes proposed, health plans require patients to make higher copayments for seeing these "poor-quality" physicians, poor patients who live in these areas and lack the means to easily visit physicians in other areas could be harmed (Casalino, Elster, Eisenberg, Lewis, Montgomery, and Ramos 2007).

Other concerns of pay-for-performance, according to the *Health Affairs* article, are the potential for "teaching to the test," that is, the idea that physicians will focus solely on P4P measurable factors, not other important health-related concerns (Casalino et al. 2007).

Misguided goals may also reflect misunderstandings between leaders and followers. The message to "do whatever it takes to achieve our mission" may wrongly be interpreted as acceptance of unethical activity. The challenge lies in communicating to employees that goals are a means of fulfilling the mission. In order to reach such an understanding, the mission must be clearly communicated. Weiss and Piderit write:

> The mission may serve as a knowledge structure about the organization, which shapes how people who work in (or with) the agency perceive, remember, and think about the organization and its tasks. Conversation about

> a mission explicitly surfaces and questions how people think about the agency, helping people to connect their individual or unit work with the larger organizational mission, developing more widely shared schemas about the agency, and creating focus and a shared sense of priorities. Mission statements make explicit organizational goals and priorities, leading to better communication with employees about what they should be doing (1991, 196).

Once the mission is clear, goals must be directly linked to the mission to avoid goal confusion. Craig Jenkins refers to "slippage between official and operative goals" (Jenkins 1977, 570), a reminder to leaders that to ensure consistency, the operational goals must be revisited and revised episodically to avoid mission erosion and misdirection. Goal confusion can derive from over- or under-correction of trends, internal forces, external forces, time constraints, competition, misinterpretation of cause and effect, budgetary limits, mission creep, and even poor communications. Employees should be encouraged to ask why a goal is important.

At a time when government and non-profit organizations often value efficiency over effectiveness, budget over justice issues, and economy over equity, performance improvement has become the most used gizmo in the toolbox. Former Georgia Child Advocate Tom Rawlings wrote in his report on Bryan Moreno, "The old saying goes that 'you get what you measure'" (Rawlings 2010, 8). Leaders must take care not to allow performance improvement to become a counterfeit mission, unless they are sure that the goals are a means to an end of conformity with the mission.

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