High-performing healthcare organisations: A brief introduction

1. Methodology

Review of literature summarising learnings across multiple organisations (i.e., books, case studies, some journal articles). Case studies of exemplary organisations identified by experts in healthcare is a well-used methodology in the study of high-performance.

Exemplary organisations included in the case studies reviewed include:

- AIDS Treatment Center, Albany, US
- Birmingham East and North Primary Care Trust and Heart of England Foundation Trust, UK
- Cedars-Sinai Medical Center, Los Angeles, US
- Kaiser Permanente, Oakland, US
- Henry Ford System, Detroit, US
- Intermountain Healthcare, Salt Lake City, US
- Jönköping County Council, Sweden
- Luther Midelfort Mayo Health System, Eau Claire, US
- Peterborough and Stamford Hospitals NHS Trust, UK
- Reinier de Graaf Groep hospital system, Netherlands
- Royal Devon and Exeter NHS Foundation Trust, UK
- San Diego Children's Hospital
- Veterans Affairs New England Healthcare System, US

You will recognise some as those organisations that are identified by experts as HPOs all-round. Others are those that have been identified for having achieved high-performance in particular areas.

2. Definition

High-performing organisations (HPOs) are those that:

- Definition from industry: "...over time continue to produce outstanding results with the highest level of human satisfaction and commitment to success." (Blanchard, 2009)
- Definition specific to healthcare: "...have created effective frameworks and systems for improving care that are applicable in different settings and sustainable over time." (Baker et al, 2008)

Both definitions include reference to **continually striving for, achieving and maintaining excellence over time**.

3. Driver: A shift from volume to value

Healthcare systems in the industrialised countries, whether publicly or privately funded, are all struggling to cope with the expanding quality chasm as healthcare systems become increasingly complex.

Commonwealth Fund analyses show that no country has succeeded in demonstrating a consistently high level of performance in improving the safety and quality of healthcare. Our healthcare systems, in their current state of organisation, are incapable of providing the quality of healthcare that most developed countries expect. Leading organisations must develop new models of care in the face of these challenges, making a shift from volume to value, defined as high quality; meeting stakeholder expectations, including patients; achieving financial solvency; and shifting from providing episodes of care to providing or orchestrating the whole package.

4. What are we aiming for? What does good look like?

There is no one single model or best way to achieve service excellence. There is no recipe to follow or boxed model to purchase/copy but, there are key ingredients. However, each organisation must find its own way to achieve those ingredients (Bate, 2008).

Nine (9) key attributes of HPOs, and their component elements, have been synthesized by MacIntosh-Murray et al (2006). They are outlined in the table on the next page. We have added some examples of putting those attributes and elements into action from case studies. The idea is to add Scottish examples over the next while as well.

5. Yet still few have achieved high performance and reliability...

If this list of key elements has been similar cross scholars across the world, then why haven't more healthcare systems achieved high levels of performance and reliability? It's because the 9 attributes are:

1) Difficult to achieve, and the path to doing so is rarely clear
   - There are broader policy and resource barriers to achieving the attributes to HPOs.
   - E.g., Technical and logistical challenges in providing relevant and timely clinical data in a format that guides improvement; Challenges in getting medical staff to "own" improvement
2) Interdependent, and therefore most, if not all, of them must be fulfilled to achieve high performance
3) Not a checklist against which current performance alone should be assessed; reality is more complex

HPOs are **systems** and therefore the attributes interact with each other to achieve high performance. Quality is a "multi-level" phenomenon that requires a simultaneous "both-and", multi-level analytical focus; the "meso" paradigm approach the synthesis of micro and macro organisational processes.

Therefore, understanding the conditions of success is key – i.e.:

- Context and environmental factors
- Strategies, structures and processes critical to success
- Leadership processes and strategic investments required over time
- Challenges and barriers encountered/overcome

The mystery of how the *process* of improving quality works must be unravelled; both in the complex ways different organisational and human factors influence each other and in how the different levels of an organisation can contribute in distinctive ways to making this process effective (or not).

6. Common 6 broad challenges experienced across the case studies (Bate, 2008)

1. Structural: Organising, planning and co-ordinating quality efforts
2. Political: Addressing and dealing with the politics of change surrounding any QI effort
3. Cultural: Giving "quality" a shared collective meaning, value and significance within the organisation
4. Educational: Creating a learning process that supports improvement
5. Emotional: Engaging and mobilizing people by linking QI efforts to inner sentiments and deeper commitments and beliefs
6. Physical and technological: The designing of physical systems and technological infrastructure that supports and sustains quality efforts

7. Key learning points

1. Quality is a system property: Quality is a system property that requires a simultaneous "both-and", multi-level analytical focus (i.e. the "meso" paradigm approach: synthesis of micro and macro organisational processes).

2. Quality as a social process: Shift from focusing on the "science" of improvement to the "sociology" of improvement.

3. Paradoxical stance towards success: An impatience, rather than satisfaction, with current performance; constantly trying to improve on the last success.

4. Benchmarking as an invaluable process: Helps to identify what 'good' looks like in health care organisations; e.g., many US case studies would complete Baldrige Award assessments annually, even if were not submitting for the award.

5. Investment in teaching and learning is essential: Particularly re: new ways of working, project management, QI.

6. Enabling structure and enabling culture as core: Performance measurement in isolation, without accompanying culture change, is not sufficient to drive improvement
   - Two general processes as the most central to sustained QI journeys: the enabling **structure** and **culture** act as an axis around which all the other processes orbited and both need each other.

7. Multi-phase, multi-year/decade journey

8. Each organisation finds its own unique path

Attributes of successful improvement and examples from the US and Canada (Sources: Baker GR et al. (2008) from MacIntosh-Murray et al. (2006))

Legend of organisations examples taken from:

BT	Birmingham East and North Primary Care Trust and Heart of England Foundation Trust, UK	IM	Intermountain Healthcare, Salt Lake City, US
CHR	Calgary Health Region, Calgary, Canada	JO	Jönköping County Council, Sweden
KP	Kaiser Permanente, Oakland, US	THC	Trillium Health Centre, Mississauga, Canada
HF	Henry Ford System, Detroit, US	VA	Veterans Affairs New England Healthcare System, US

Elements	Examples from international organisations
Attribute 1: Culture	
• Organization/leaders support and expect learning and innovation. • Organization/leaders value staff and empower all members to participate. • Organization/leaders focus on customers/patients. • Organization/leaders value collaboration and teamwork. • Organization/leaders are flexible.	• The importance of the actors involved – in particular, their leadership, insight and commitment to a culture of performance (as in Kaiser's model) (VA). • The need to be the best and to be recognized as the leader in a field is a powerful driver in cultural change → The question, therefore, is how to instill the desire to be the best ➢ Stop finding excuses: Involves an attitude change that is led by people who believe in themselves and their capabilities – people who are driven to excellence because they believe excellence is possible (VA). ➢ Appreciative inquiry approach: Not focussing on the negatives/excuses only (VA). • Compelling vision and demonstrated commitment to it through tangible investments in OD, service excellence and culture change; loop closed through clear lines of accountability (HF). • Senior leaders have an emphatic message for staff members: "We are not, and will never be, a victim of our circumstances and the conditions around us" (HF). • We don't ask, "Why should we?" anymore. We ask, "How can we?" (HF). • Leadership sets the expectation – by setting goals and putting their money where their mouth is – that we will do it. But this reputation comes at a cost; it requires the intense, sustained efforts of many staff members (HF). • Concerns about the sustainability of improvement projects and also the need for 'hurricane-proofing' of change initiatives against the next round of budget reductions and staff cuts by seeking firmer financial support to protect human and other resources (HF). • All employees have been required to go through customer service training (VA).
Attribute 2: Leadership	
• Strong administrative leadership that provides role models for organizational values. • Leadership celebrates and even participates in improvement initiatives. • Emphasis on developing, fostering and inclusion in decision-making for clinical leadership and champions. • Board support: Board sets expectations by asking for reports on improvement initiatives and results. • Board provides continuity of expectations if administrative leadership changes.	• Leadership, especially medical leadership, but also developing clinical leadership (VA). • Systematized processes, along with clear, measurable goals and rigorous feedback processes are essential tools; however, their users must also be believers → The intersection of the art and science of management (start with the art) (VA). • Importance of demonstrable commitment from the board of governors, the CEO and senior administration (HF). • Aspiration includes being courageous (THC). • The CEO promotes the concept of distributed leadership, suggesting that all staff members – with or without formal leadership titles – should develop and exercise their ability to lead (THC). • A strategy of complementary leadership skills (JO). • Linking the study of variation to leadership of improvement (IM).

Attribute 3: Strategy and policy	
• Leaders set clear priorities for improvement. • Improvement plans are integrated in the overall strategic plan as the means to achieve key strategic goals. • Leaders demonstrate both constancy of purpose and flexibility. • Operational policies and procedures, including human resources policies, provide incentives, rewards and recognition. • Incentives, rewards and recognition are aligned to support improvement work.	• Performance measurement at the national level via national standards (VA). • Realisation that money was not the only – and in most cases, not the most important -- levers for change; culture and pride in performing well became the key catalysts for change → The use of clinical care indicators and individual physician and team performance have been shown to be the most effective drivers of change (VA). • Focus on the triple aim (VA). • Winners of the Malcolm Baldrige National Quality Program Award (US) identify the Baldrige framework and criteria as a useful guide to assessing their organisations and helping to direct the leadership of improvement (VA, HF). Others have enrolled in IHI's Pursuing Perfection programme (JO). • Programmes are about excellence in service and quality and not just clinical quality but quality more broadly (HF). • Used a "starfish" model of formal change management, in which front-line staff members and providers exert as much influence on project success as does central management and leadership (CHR). • The Performance Excellence (PE) portfolio (the term used to refer to QI) was given equal status with the clinical health systems and strategic business units, signalling leadership commitment to QI (THC). • Monthly patient safety rounds provided organisation-wide (THC). • Establishing Qulturum – a centralised "quality" house (JO). • Removing disincentives for improvement (JO).
Attribute 4: Structure	
• Roles and responsibilities for improvement are clearly articulated. • Steering/oversight committees provide direction. • Teams and teamwork are part of structure.	• Developing service lines via an integrated model (VA); Governance and management structures redesigned to ensure integration and alignment at all levels, then organisational goals defined and communicated, and managers and leaders at all levels understood where the organisation was going and where they needed to focus to get there (HF). • Performance measurement and accountability via the performance contract, and the development of a standardized staffing and productivity models for physicians (VA). • Performance reporting system explicitly tied to the organisation's "seven pillars" and clear lines of accountability were established for each pillar (HF). • Flat hierarchy so directors discuss potential improvements with staff (HF). • Taking responsibility for problems: Members leave the System Quality Forum with to-do lists and a sense of ownership (HF). • Regional services and program planning managed through a matrix structure then reorganised when realised it was slowing change at the frontline to portfolios according to the population(s) served and/or services provided, and aligned around the core clinical businesses (CHR). • A systematic approach to planning, implementing and evaluating projects was introduced by project management consultants, including identifying quantitative outcome measures for all proposed projects and identifying the staff resources required to lead and implement proposed projects (THC).

Attribute 5: Resources	
• Organization provides time for staff members to learn skills and participate in improvement work. • Financial and material resources and human resources are available for improvement. • Quality improvement support/expertise: A core group of improvement experts is available to help teams and individuals. • Quality improvement department coordinates and supports initiatives.	• Ongoing training of service chiefs and senior leaders supports cultural change (VA). • The involvement of organisations in the IHI Breakthrough Series provides the structure and processes to bring about positive change (VA). • Preserve the space to work on improvement (i.e., support, attention and time) is critical → You can be mandated to collect measures but what will you do with them when you have them? (VA) • Successful clinical redesign projects each have a project manager (HF). • Developed a more focused approach to regional QI&PS through the consolidation of QI&PS staff to form the Quality, Safety and Health Information (QSHI) portfolio (CHR). • Clinical enhancement teams provide dedicated support to clinical departments/portfolios (CHR). • Quality councils and committees established at all levels of the organisation to help facilitate (CHR). • Integrated learning system/QI training curriculum developed and provided (CHR). • Participation in IHI-sponsored collaboratives gave permission to think differently (CHR). • Training included project management and internal project management services were developed to sustain the systematic approach to project planning and implementation (THC). • Chief Nursing Executive remarked that, in her view, releasing staff to do improvement work, rather than expecting it to be added to regular responsibilities, as the single most important success factor in their QI efforts (THC). • Participation in the Safer Healthcare Now! Campaign (THC). • Timing of investments a key success factor: started with education and engagement and unit-level improvement work, then phase two focused on system-level improvement (THC).
Attribute 6: Information	
• Needed clinical and administrative data are readily available. • Information is available to support improvement.	• Implementation over a 10-year period of a home-grown electronic medical record system has been a key ingredient in the network's success (VA). • Difference between health and non-health organisations trying to be HPOs: Difficulties with developing good enough measures; if not, can lead to perverse incentives (VA). • The importance of information systems and local data → "You can't manage what you can't measure" → Adopted the principle that measuring performance is an essential work in progress (HF). • Information system and strategy linked to performance measurement framework and developed and operationalised over time (CHR). • Safety learning reporting system developed and implemented to easily report hazards, close calls and adverse events, and to help monitor progress on recommended system improvements (CHR). • Investments in IT aimed at providing a standardised platform for clinical and administrative data collection and strengthening decision support capabilities based on electronic health records (THC). • Process improvement initiatives include "capacity liberated for staff and physicians" as an indicator (THC).

Attribute 7: Communication channels	
• Organization has vehicles to communicate with stakeholders regarding priorities, initiatives, results and learning. • Ample forms of communication, including newsletters, forums, meetings and intranet sites.	• Cascading communications are used extensively to engage staff members in discussion of service excellence and how their individual and unit activities link with corporate goals (HF).
Attribute 8: Skills training	
• Includes training in improvement methods, team and group work, project and meeting management, and epidemiology.	• Building capability requires ongoing education and skills training → 8 core competencies (VA). • Policies re: developing and maintaining important skills (e.g., doing 4 individual RCAs and aggregate reviews per year) (VA). • Integrating improvement knowledge and skills into clinical education (JO).
Attribute 9: Physician involvement	
• Physicians are involved in planning improvement initiatives and participate as team members. • Opportunities for physician and clinical leadership of improvement. • Clinicians "own" improvement.	• Importance of physician leadership (HF). • Employee physicians have quality improvement as part of performance expectations and reviews; contracted physicians are treated as 'customers' (HF). • Mechanisms and initiatives (with accompanying resources) to improve physician participation and communication (task forces, funds, financial subsidies, dedicated time, etc.) (CHR). • Restructured the QI consultant and QI physician role to work more closely with portfolio directers and assist in identifying strategic priorities ensured a shared understanding with physician leaders of key system drivers (i.e., acecess, quality and cost) and critical processes, and jointly set clinical and process targets and determined trade-offs necessary to achieve targets (CHR).