

ORGANIZING FOR QUALITY: THE IMPROVEMENT JOURNEYS OF LEADING HOSPITALS IN EUROPE AND THE UNITED STATES

*Looking is not seeing. Listening is not hearing.
It is possible to miss so much that is right in front of us if we lack the
categories and skills to notice. The greatest of these skills is, perhaps,
to put aside our expectations, and to stay open to the actual.
(Donald M. Berwick, from the Foreword).*

Summary

- Despite evidence of a ‘quality chasm’ in health care, little is known about the organisational causes of these deficiencies.
- While studies have shown lists of factors associated with quality improvement, little research has taken place into how to set these processes in motion, and how they interrelate.
- In *Organizing for Quality: The improvement journeys of leading hospitals in Europe and the United States*, the authors examine medical organisations that have earned reputations for sustained achievement of quality improvement with the goal of understanding the process of improving quality.
- The authors found that quality improvement processes are interconnected and symbiotic.
- While there are many different routes to sustained quality improvement, the authors conclude that all the successful organisations shared an ability to address multiple challenges simultaneously and a talent for adapting solutions to their own organisational context.
- The authors identify key lessons for quality improvement, and call for greater research into how to incorporate improvement strategies into organisational contexts.



Introduction

Ever since the landmark reports by the Institute of Medicine,^{1,2} the ‘quality chasm’ in healthcare delivery has become ever more evident and difficult to ignore in both the United States and Europe. During this time, health services research has grown increasingly adept at documenting serious deficiencies in the quality of care – including findings that patients typically receive only half of recommended care, high levels of under- and overuse, as well as misuse of medical treatments, clinically unnecessary variations in care and disparities in health outcomes, and extensive inefficiency and waste. This continuing accumulation of evidence has led to an emerging consensus in health research, policy and practice that our healthcare systems, in their current state of organisation, are plagued by dysfunction and incapable of providing the quality of care that the citizens of most developed countries expect (and pay for).

Despite the increased ability to measure the quality chasm, little is known on the organisational causes at the root of these deficiencies, and even less still on how to change and improve healthcare organisations. Studies of these issues have tended to generate lists of factors associated with successful implementation of quality improvement (QI) initiatives such as leadership, information technology and incentives. However, they have tended to offer less insight into how these ‘key success factors’ relate to each other as change unfolds, or how organisations go about setting them in motion. As a result, the process of implementing, managing, and sustaining quality improvement – that is, of *organising* for quality in healthcare – has remained something of a ‘black box’, largely impenetrable to the outside observer.

An international study conducted jointly by researchers from University College London and RAND in the USA directly addresses this critical gap in understanding. In *Organizing for Quality: The improvement journeys of leading hospitals in Europe and the United States*, authors Paul Bate, Peter Mendel and Glenn Robert examine hospitals and medical centres that have earned reputations for sustained

achievements in quality improvement and performance. Their aim was to understand the process of improving quality, both in the complex ways different organisational and human factors influence each other, and in how the different levels of the organisation can make this process effective.

The study includes:

- **in-depth case studies** of how a set of leading healthcare organisations have been able to achieve – and sustain – high levels of performance and quality. These case studies combine rich descriptions in the case participants’ own words with application of current streams of organisational theory relatively untapped by conventional research on healthcare quality.
- a **model of six core challenges** in organising for quality, derived from the experiences of the organisations studied.
- a **codebook for quality improvement** in healthcare that catalogues the diverse processes and strategies utilised by the case organisations in addressing the six core challenges. The codebook includes a glossary illustrated by examples from the case studies, as well as a diagnostic checklist tool for healthcare and improvement practitioners.
- a **novel method for mapping quality improvement processes** that graphically reveals the complexity of change and improvement processes related to the six core challenges within healthcare, the relative emphasis attached to each and the relationships among them.

The authors conclude that there are many different paths to successful, sustained quality improvement; however, the unifying features to be found across all of them are an ability to address multiple challenges simultaneously and to adapt solutions and strategies to the organisation’s own context. The findings emphasise the need for all those concerned with promoting and implementing change within healthcare organisations to attend to the

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TABLE 1. KEY THEMES

ORGANISATION (MACRO-SYSTEM)	DEPARTMENT (MACRO-SYSTEM)	KEY ORGANISATIONAL THEMES AND CONCEPTS
UNITED KINGDOM		
Royal Devon and Exeter NHS Trust	Orthopaedics centre	Organisational identity: a shared sense of ‘who we are’ and ‘what we stand for’ that conveys the distinctive character of an organisation and the groups within it.
Peterborough and Stamford Hospitals NHS Trust	Radiology department	Empowerment: both the process of granting power over decisions and resources to members at various levels of an organisation and a relationship with formal leadership that infuses staff with a sense of confidence, self-esteem and trust.
King’s College Hospital NHS Trust	Breast Cancer Clinic	Organisational citizenship: dedication to the common good, reflected in such behaviors at work as altruism, courtesy, and conscientiousness.
NETHERLANDS		
Reinier de Graff Groep, Delft	Varicose surgery	Multi-level leadership: recognising the strength of leadership for quality improvement that is ‘distributed’, ‘multi-layered’, and ‘strategically collective’ across different parts of the organisation.
UNITED STATES		
Children’s Hospital of San Diego, California	Allergy and immunology clinic	Mindfulness: a heightened state of involvement and wakefulness, characteristic among members of ‘high reliability’ organisations.
Cedars-Sinai Medical Center, California	Emergency department	Organisational learning: the ability of an organisation as a whole to search for, retain, and act on new knowledge.
Luther-Midelfort Mayo, Wisconsin	Critical care unit	Socio-technical design: an approach to the design of work systems that emphasises the joint optimisation of social and technical aspects of an organisation, with the objective of maximising both productivity and quality of working life.
Albany Medical Centre, New York	AIDS treatment centre	Mobilisation: the process of marshalling and organising various resources, including funding, physical assets and, not least, the commitment and talents of people, to achieve common goals.

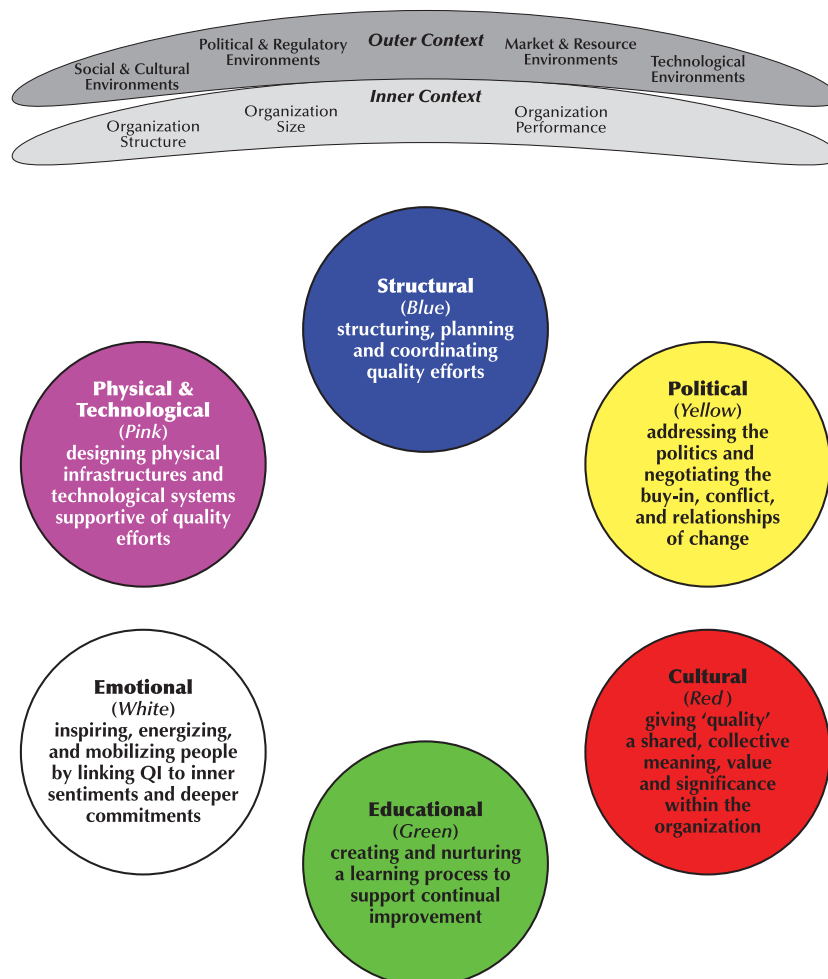
organisational and human dimensions of implementing change, and to look particularly at how these forces interact over time to sustain a trajectory of sustained improvement.

A new approach to healthcare improvement

The study is one of the first to apply contemporary streams of organisational theory to provide detailed, multi-level accounts of QI experiences across a variety of healthcare organisations. The RAND–UCL team selected for study nine hospitals and medical centres in the United States and Europe that are renowned for high performance and excellence in implementing

and sustaining quality improvement. Utilising staff interviews and narrative accounts, as well as organisational documents and direct observation of everyday organisational life, the research team conducted in-depth case studies to re-trace each organisation’s ‘quality journey’ at the level of the senior team (macro-system) and a selected high-performing, front-line clinical unit (micro-system). They were thus able to incorporate two critical perspectives on this journey that are rarely analysed together. In each case it was possible to identify a dominant theme or key organisational concept that gave each organisation’s approach to QI its uniqueness and distinctiveness, and to which other factors seemed integrally connected. (See Table 1.)

FIGURE 1. THE QUALITY FRAMEWORK



Core challenges to organising for quality

Though each quality journey was unique, it also became clear that each organisation was facing a set of common issues and challenges. The research team distinguished six core challenges faced by all of the case study institutions in organising themselves for quality improvement:

- **structural** – organising, planning and coordinating quality efforts
- **political** – addressing and dealing with the politics of change surrounding any QI effort
- **cultural** – giving ‘quality’ a shared, collective meaning, value and significance within the organisation
- **educational** – creating a learning process that supports improvement
- **emotional** – engaging and motivating people by linking QI efforts to inner sentiments and deeper commitments and beliefs
- **physical and technological** – the designing of physical systems and technological infrastructure that supports and sustains quality efforts.

TABLE 2. IMPLICATIONS OF QUALITY IMPROVEMENT FAILURES

LACK OF...	CAN LEAD TO...
Structural process (planning and coordination)	Fragmentation and a general lack of synergy between the different parts of the organisation doing QI
Political process (negotiating change and managing conflict)	Disillusionment and inertia because QI is not happening on the ground, and certain groups or individuals are blocking and resisting change
Cultural process (giving ‘quality’ a shared, collective meaning)	Evaporation because the change has not properly ‘anchored’ or become rooted in everyday thinking and behavioural routines
Educational process (learning and accumulating knowledge)	Amnesia and frustration as lessons and knowledge are forgotten or fail to accumulate, and improvement capabilities and skills fail to keep abreast of growing aspirations
Emotional process (motivating)	Loss of interest and fade-out as the change effort runs out of momentum due to a failure to engage front-line staff
Physical and technological process (design of technical and other systems)	Exhaustion as people try to make change happen informally, without a system or standardised set of routines to take the weight of necessary everyday activities

One of the main conclusions of the study is that the reason why these organisations have been able to achieve – and then sustain – high levels of care is that they have recognised and successfully addressed each of these challenges.

Their experiences also indicated the likely implications of not responding (or not responding adequately) to any of these particular challenges. Thus, different kinds of failure are associated with each of the six challenges: improvement efforts can fail or underachieve in different ways (see Table 2).

Many paths up the mountain

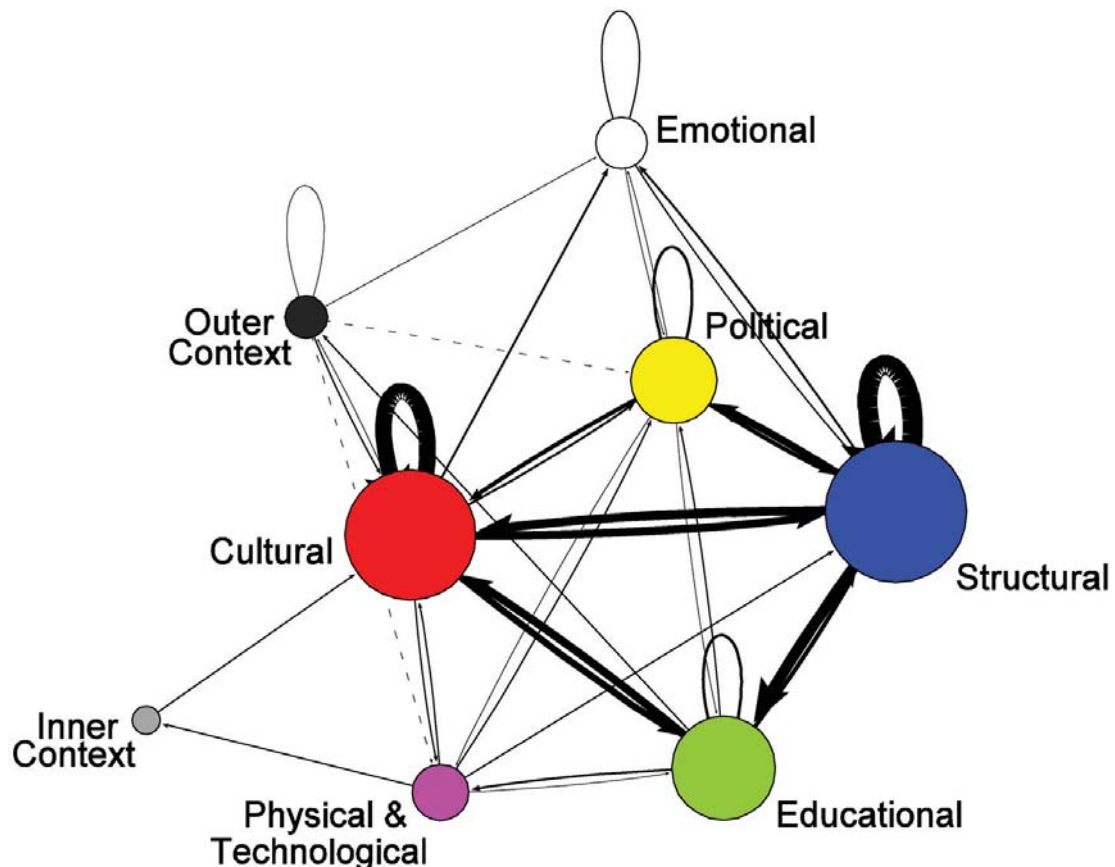
The participants in the case studies talked about the many and various solutions they had applied to these challenges at various points and stages on their quality journeys. These activities either helped them

to meet the six core challenges, or to avoid the pitfalls associated with them described in Table 2.

The study team created a ‘codebook for change’ to assist quality improvement efforts in organisational settings. For ease of use as a diagnostic tool and aid to thinking, the team translated the six common challenges into a colour-coded schema (see Figure 1). This framework is intended to help practitioners and researchers by:

- identifying the range of challenges any QI effort will face
- giving improvement participants a method for identifying gaps in their own QI activities that will need to be addressed
- allowing implicit assumptions about the theory and practice of QI to surface and be exposed to

Figure 2: Cedars-Sinai high-level process map



conscious thought and challenge, perhaps for the first time

- providing people with a common framework and language to think and talk the issues and challenges associated with organising for quality.

The colour-coded framework is also a way of mapping the findings of the case studies. Drawing on network analysis techniques, these maps show the relationships between the various organisational processes underlying the improvement journeys of each case.

For example, at Cedars-Sinai, where the case study focused on emergency department quality improvement, the analysis found that the process of change centred around efforts to solve structural, cultural, and educational challenges. The size of the circles in Figure 2 indicates the proportion of all process ties in the narrative of Cedars-Sinai's quality journey that included a solution or element related to a particular challenge. The pattern suggests that Cedars-Sinai appears relatively strong on the structural (blue) and cultural (red) aspects, and less strong on learning (green) and political (yellow). Emotional (white) and physical and technological (pink) processes appear to be less important.

Quality improvement processes are interconnected and symbiotic

Implications for practice and further research

Taken together, the case studies underscore that quality improvement processes are interconnected and symbiotic. Organisational processes can form cycles or closed loops, and these can be virtuous (upward improvement) or vicious (downward/ degrading) spirals. Both of these can be present in an organisation at the same time.

For healthcare leaders, policy-makers and other quality improvement activists, this suggests that healthcare organisations should not neglect human and organisational processes at the expense of clinical and technical ones.

The authors distill seven basic lessons for quality improvement efforts:

- focus on getting the basic structures in place (structural)
- take time to build camaraderie and strong team work (cultural)
- deal with conflicts and tensions (political)
- learn from your mistakes (educational)
- feel and share the passion for getting to the top (emotional)
- avoid being distracted too early by high-tech solutions (physical/technological)
- above all, don't look down (manage the context).

Understanding how these organisational processes interrelate has important implications for quality improvement efforts. Structural and cultural processes proved to be at the heart of organising for quality, and these go hand in hand.

For researchers, the results imply the need for new directions in studying quality of care. Analysis of quality of care has tended to be focus on isolating the factors associated with change rather than understanding how these interact and the organisational contexts in which they happen. Greater focus on organisational processes and their interactions would assist in developing more understanding of the sometimes punishing contextual terrain that has to be crossed to bring about those quality improvements that are best suited to a particular organisation. There is also a need for more longitudinal case studies, to improve our understanding of the pace and sequencing of quality improvement.

References

1. Institute of Medicine (1999) *To Err is Human: Building a safer health system*. National Academy Press.
2. Institute of Medicine (2001) *Crossing the Quality Chasm: A new health system for the 21st century*. National Academy Press.

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