Steps to Success with the Oro™ 2.0 High Reliability Organizational Assessment
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Director, High Reliability Initiatives
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What does it take?

- Buy in from CEO
- Determine senior leader participants
- Self-Assessment
  1. Pre-meeting: participants take the assessment (20 minutes)
  2. Consensus meeting, ideally with a facilitator: senior leaders meet and take assessment as a group (2 hours)
  3. Post-meeting: time commitment varies. Review of results, strategic action planning
BUILD THE TEAM:
Ideal group to take the Assessment

- CEO participation is essential
- Clinical leaders (e.g. CMO, CNO, VP Medical Affairs)
- Administrative leaders (COO, CFO)
- Board chair/Board Quality Committee Chair
- Quality and Patient Safety leaders (e.g. VP PI, Patient Safety Office, Risk Management)

Ideal participant group size is no more than 15 to allow in-depth conversation and high level perspective
Oro™ 2.0
For more information:

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High Reliability in Health Care

Excellence in patient care for every patient, every time
FROM LOW TO HIGH RELIABILITY

Leadership
Commitment to zero patient harm

Safety Culture
Empowering staff to speak up

Robust Process Improvement®
Systematic, data-driven approach to complex problem solving

High Reliability Model

Leadership Commitment
- Board
- CEO/Management
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of IT

Adoption of Safety Culture
- Trust
- Accountability
- Identifying Unsafe Conditions
- Strengthening Systems
- Assessment

Robust Process Improvement®
- Methods
- Training
- Spread

Stages of Maturity: Beginning ➔ Developing ➔ Advancing ➔ Approaching
## High Reliability: Stages of Organizational Maturity

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Beginning</th>
<th>Developing</th>
<th>Advancing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board</strong></td>
<td>Board quality focus is nearly exclusively on regulatory compliance</td>
<td>Full Board’s involvement in quality limited to hearing reports from its quality committee</td>
<td>Full board engaged in development of quality goals and approval of quality plan; regularly reviews adverse events and progress on quality goals</td>
<td>Board commits to goal of high reliability for all clinical services</td>
</tr>
<tr>
<td><strong>CEO/management</strong></td>
<td>CEO/management quality focus is nearly exclusively on regulatory compliance</td>
<td>CEO acknowledges need for plan to improve quality; delegates development and implementation of plan to subordinate</td>
<td>CEO leads development and implementation of proactive quality agenda</td>
<td>Management aims for zero failure rates for all vital clinical processes; some demonstrate zero or near-zero failure rates</td>
</tr>
<tr>
<td><strong>Physicians</strong></td>
<td>Physicians rarely lead quality improvement activities; overall physician participation in these activities is low</td>
<td>Physicians champion some quality improvement activities; physician participation in these activities occurs in some areas but is not widespread</td>
<td>Physicians often lead quality improvement activities; physician participation in these activities occurs in most areas, but we still have some important gaps</td>
<td>Physicians routinely lead clinical quality improvement activities and accept leadership of other appropriate clinicians; physician participation in these activities is uniform throughout the organization</td>
</tr>
<tr>
<td><strong>Quality strategy</strong></td>
<td>Quality is not identified as central strategic imperative</td>
<td>Quality is one of many competing strategic priorities</td>
<td>Quality is one of our organization’s top 3 or 4 strategic priorities</td>
<td>Quality is the highest priority strategic goal of the organization</td>
</tr>
<tr>
<td><strong>Quality measures</strong></td>
<td>Quality measures not prominently displayed or reported internally or publicly; only measures used are those required by outside entities; not part of reward systems</td>
<td>Few quality measures reported internally; few or none reported publicly; not part of reward systems</td>
<td>Routine internal reporting of quality measures begins; first measures reported publicly; first quality metrics introduced into staff reward systems</td>
<td>Key quality measures are routinely displayed internally and reported publicly; reward systems for staff prominently reflect accomplishment of quality goals</td>
</tr>
<tr>
<td><strong>Information technology</strong></td>
<td>Provides little or no support for quality improvement</td>
<td>Supports some improvement activities, but principles of safe adoption not often adhered to</td>
<td>IT solutions support many quality initiatives; organization commits to principles and practice of safe adoption</td>
<td>Safely adopted IT solutions are integral to sustaining improved quality</td>
</tr>
</tbody>
</table>
# High Reliability: Stages of Organizational Maturity

<table>
<thead>
<tr>
<th>Safety Culture</th>
<th>Beginning</th>
<th>Developing</th>
<th>Advancing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>No assessment of trust or intimidating behavior</td>
<td>First codes of behavior adopted in some clinical departments</td>
<td>CEO and clinical leaders establish a trusting environment among all staff by modeling appropriate behaviors and championing efforts to eradicate intimidating behaviors</td>
<td>High levels of (measured) trust exist in all clinical areas; self-policing of codes of behavior in place</td>
</tr>
<tr>
<td>Accountability</td>
<td>Emphasis on blame; discipline not applied equitably or with transparent standards; no process for distinguishing “blameless” from “blameworthy” acts</td>
<td>Beginning recognition of importance of equitable disciplinary procedures; some clinical departments adopt these procedures</td>
<td>Managers at all levels accord high priority to establishing all elements of safety culture; adoption of uniform equitable and transparent disciplinary procedures begins organization-wide</td>
<td>All staff recognize and act on their personal accountability for maintaining a culture of safety; full adoption of equitable and transparent disciplinary procedures</td>
</tr>
<tr>
<td>Identifying unsafe conditions</td>
<td>Root cause analysis limited to adverse events; close calls (“early warnings”) not recognized or evaluated</td>
<td>Pilot “close call” reporting programs begin in few areas; some examples of early intervention to prevent harm</td>
<td>Staff in many areas begin to recognize and report unsafe conditions and practices before they harm patients</td>
<td>Close calls and unsafe conditions routinely reported, leading to early problem resolution, before patients are harmed; results routinely communicated</td>
</tr>
<tr>
<td>Strengthening systems</td>
<td>Limited or no effort to assess system defenses against quality failures and remedy weaknesses</td>
<td>RCAs begin to identify same weaknesses in system defenses in many clinical areas; systematic efforts to strengthen them are lacking</td>
<td>System weaknesses catalogued and prioritized for improvement</td>
<td>System defenses proactively assessed; weaknesses proactively repaired</td>
</tr>
<tr>
<td>Assessment</td>
<td>No measures of safety culture</td>
<td>Some measures of safety culture undertaken but are not widespread; little if any attempt to strengthen safety culture</td>
<td>Measures of safety culture adopted and deployed organization-wide; beginning efforts to improve</td>
<td>Safety culture measures part of strategic metrics reported to Board; systematic improvement initiatives underway to achieve fully functioning safety culture</td>
</tr>
</tbody>
</table>
## High Reliability: Stages of Organizational Maturity

<table>
<thead>
<tr>
<th>Performance Improvement</th>
<th>Beginning</th>
<th>Developing</th>
<th>Advancing</th>
<th>Approaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>No formal approach to quality management adopted by organization</td>
<td>Exploration of modern process improvement tools beginning</td>
<td>Organizational commitment to adopt full suite of Robust Process Improvement (RPI) tools</td>
<td>Adoption of RPI tools accepted fully throughout organization</td>
</tr>
<tr>
<td>Training</td>
<td>Limited to compliance personnel or to quality department</td>
<td>Recognition that training in PI tools outside quality department is critical to success</td>
<td>Training of selected staff in RPI underway; plan in place to broaden training</td>
<td>Training in RPI is mandatory for all staff, as appropriate for their jobs</td>
</tr>
<tr>
<td>Spread</td>
<td>No commitment to widespread adoption of improvement methods</td>
<td>Pilot projects using some new tools conducted in a few areas</td>
<td>RPI used in many areas to improve business processes as well as clinical quality and safety; positive ROI achieved</td>
<td>RPI tools used throughout organization for all improvement work; patients engaged in redesigning care processes; RPI proficiency required for career advancement</td>
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**PERFORMANCE IMPROVEMENT**

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Today

Leadership Commitment
- Board
- CEO/Management
- Physicians
- Quality Strategy
- Quality Measures
- Safe Adoption of IT

Adoption of Safety Culture
- Trust
- Accountability
- Identifying Unsafe Conditions
- Strengthening Systems
- Assessment

Robust Process Improvement®
- Methods
- Training
- Spread

Stages of Maturity: Beginning ➔ Developing ➔ Advancing ➔ Approaching
Board’s Role

- High reliability starts with the Board
- Fiduciary responsibility includes quality of care delivered

- Board: Vision
- Board: Mission
- Board/Management: Strategy
- Management: Operational Tactics
Leadership Commitment

- Commitment to high reliability
  - AIM:
    - Outcome: Zero harm
    - Processes: Zero defects

- Commitment to quality & safety

Is the aim explicit at your organization?
ZERO
Leadership Commitment

Board Agenda

Quality & Safety on Board agenda:

– Placement: first
– Frequency: every time
– Proportion of time dedicated
– Quality Committee
– Education of the Board
Journey to Zero

- Transformational Change
  - Leadership, focus, execution
- Not incremental
- Major Change

Eight Stage Process of Creating Major Change

1. **Establish a sense of urgency**
2. Create the guiding coalition
3. Develop a vision and strategy
4. Communicate the change vision
5. Empower broad-based action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture

Current State of Value (Quality/Cost)

Cost
- 17.5% of GDP in 2014
- Shrinking margins

Routine safety processes fail routinely
- Hand hygiene
- Transitions of care-communication

Uncommon, preventable adverse events
- Wrong surgery, retained foreign objects
- Fires in ORs
Physicians

- Direct most of health care spending
  - 80% is often quoted
- No training in systems, management, teamwork, communication

ASSESS:
- Are physicians leading your PI initiatives?
  - Training, skills, time, resources

PLAN:
- Increase investment in physician leadership, QI skills
Leadership Commitment

Maintain urgency

1. Set a consistent direction through organization structures and processes
2. Demonstrate authentic passion for and commitment to quality

Personal involvement by CEO in QI efforts

Leadership Commitment

- Top Performers: Shared sense of purpose
  - Patient care: first mission
  - Campaigns
  - Explicit values
  - Greater level of focus on Q/PS in regular leadership mtgs, reports
  - Leadership walk rounds, Town mtgs: address Q/PS

- Strong sense of dissatisfaction with current state of Q/PS in their institutions: dwelt on gaps

Leadership Commitment: CEO

- Hands-on leadership style
- Accountability systems for Quality & Safety
- Focus on results
- Culture of collaboration

Quality and safety are inextricably linked. **Quality** in health care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety.

What does it mean at your organization? Have you defined quality & safety?
Quality & Safety

Patient safety emerges as a central aim of quality.

Patient safety: the prevention of errors and adverse effects to patients that are associated with health care.

-World Health Organization

While patient safety events may not be completely eliminated, harm to patients can be reduced, and the goal is always zero harm.
Quality Management System

Should include the following:

- Ensure reliable processes
- Decrease variation and defects (waste)
- Focus on achieving better outcomes
- Use evidence to ensure that a service is satisfactory
## Scorecard

### Sugar Land Hospital HAI Scorecard

<table>
<thead>
<tr>
<th>ICU CLABSI</th>
<th>Floor CLABSI</th>
<th>ICU CAUTI</th>
<th>Floor CAUTI</th>
<th>Total SSI</th>
<th>Perf Std SSI</th>
<th>NHSN SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hip</th>
<th>Knee</th>
<th>ORIF</th>
<th>MRSA</th>
<th>Clostridium difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
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</table>

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PLAN
"A goal without a plan is just a wish"
Antoine de Saint-Exupery

PLANNING TO MAKE A PLAN IS NOT A PLAN

If you fail to plan, then you plan to fail.
KEEP CALM AND MAKE A PLAN
Board: Planning

- Strategic Plan
- Performance Improvement Plan

- Do these plans exist?
- Are they up to date?
- Do they align?
Quality Strategy

Define the overall focus and goal, e.g. “zero preventable deaths in five years”

1. Patient outcomes
2. Patient & family expectations
3. Financial outcomes
4. Learning, growth, innovation: staff

An organization’s strategy is how it intends to create value for its shareholders, customers and citizens

-Kaplan and Norton 2004
Quality Measures

- Strategic
  - Patient outcomes, patient/family expectations, finance, learning/growth
  - Drivers: Priority Focus Areas

- Versus Operational Measures
  - Comparisons, regulatory standards, benchmarks
TRUST
Culture of Safety: Imperatives

Quality Measures: Communication

Communicate the Change Vision

- Aim of zero harm
- Key patient outcomes you are striving for (e.g. zero CLABSI)

Dissemination

- Staff
- Public

Display

- Consistent
- Easy to understand
Transparency: Sentinel Events

- Staff, Patient & family, Public
- Start with
  - Education on classification events
- Reported to the Board?
  - Level of detail provided (e.g. outcome, providers involved, comprehensive analysis and plan)
- Who vs. **What, Why**
ZERO

PLAN

TRUST
Oro™ 2.0 Tools & Resources

ACTION PLANNING
Form a High Reliability Action Team

Team Members
- CEO (leadership support is crucial)
- Clinical and Operations leaders
- Board members
- Ad Hoc members (mid-level, front line)

Define what high reliability means for your organization

Develop an elevator speech
Solicit Support and Involvement

Elevator Speech

“High reliability is about…”

“It is important because…”

“Success will look like…”

“What we need from you is…”
Sample Assessment Results:

![Assessment Results](image-url)

### Executive Summary

"Who said what?" - Select Assessment Reports to view different report options for your Individual and/or Consensus Assessment results.

The Executive Summary outlines your organization's Consensus Assessment results by maturity stage. Embedded links direct you to Resource Library materials for a specific component.

Choose an previously completed Assessment: [Consensus 2014](#)

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<tbody>
<tr>
<td>Board</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO/management</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Physicians</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Quality strategy</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Quality measures</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td></td>
<td>✓</td>
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</tr>
</tbody>
</table>

| Safety Culture   |           | ✓          |           | ✓           |
| Trust            |           |            |           |             |
| Accountability   |           |            |           |             |
| Identifying unsafe conditions | | ✓        |           |             |
| Strengthening systems | |           | ✓         |             |
| Assessment       |           |            |           |             |

| Performance improvement | |           | ✓         |             |
| Methods              |           | ✓          |           |             |
| Training             |           | ✓          |           |             |
| Spread               |           | ✓          |           |             |
Determine Area(s) of Focus

- Review Oro™ 2.0 Consensus Meeting Results
- Identify projects you have going on in each of the components
- Identify areas of focus: one or two
- Utilize Action Planning Document
Resource Library

The Oro™ 2.0 Resource Library provides references and tools that will help organizations learn more about each of the 14 components within the High Reliability Maturity Model. This additional information will assist organizations as they prioritize areas of focus for strategic planning.

Recommended reading: The following materials are recommended to provide you with an introduction to high reliability principles and high reliability in health care.

- *High Reliability Health Care: Getting There from Here* by Mark Chassin and Jerod Loeb
- *Managing the Unexpected: Sustained Performance in a Complex World, 3rd edition* by Karl Weick and Kathleen Sutcliffe

Maturity Levels from Consensus Report

Links to material in Resource Library
Resource Library Materials

Selected Component: Leadership > Board

Resources

Filter Resources by Category:

- All (26)
- Book/Report/White Paper (6)
- Case Study (1)
- Education Module (2)
- Guide (2)
- Magazine Article (2)
- Peer Review Journal Article (10)
- Podcast/Video (1)
- Special Issue (1)
- Toolkit (1)

Show Essential Resources Only

Resources per page: 10

Book/Report/White Paper

The Joint Commission Patient Safety Systems Chapter

The intent of this "Patient Safety Systems" (PS) chapter is to provide healthcare organizations with a proactive approach to designing or redesigning a patient-centered system that aims to improve quality of care and patient safety.


Last Posted Date: 9/18/2015

Enhancing the Board’s Role in Quality

This empirically-grounded report identifies three purposes for board involvement in quality: oversight, leadership, and service. Through in-depth case studies of five health systems—including interviews with 25 system-level board members and executives and 44 hospital-level board members and executives — this project aimed to develop practical knowledge about how to enhance the board’s role in quality. These case studies can serve as examples of "best practices" for other health systems.


Last Posted Date: 9/18/2015

Respectful Management of Serious Clinical Adverse Events

This white paper introduces an overall approach and tools designed to support two processes: the proactive preparation of a plan for managing serious clinical adverse events, and the reactive emergency response of an organization that has no such plan. The paper includes three tools for leaders — a Checklist, a Work Plan, and a Disclosure Culture Assessment Tool — and numerous resources to guide practice.


Last Posted Date: 9/18/2015
# Action Plan Template

**Action Plan: PI Spread Component**

*Date of Oro™ 2.0 Assessment:__________*

**Project Facilitator/Sponsor:** __________

**Current Level of Maturity:** __________

**Goal Level of Maturity:** __________

**Implementation Team Members:**

<table>
<thead>
<tr>
<th>Item #</th>
<th>Action Step Description</th>
<th>Responsible Party</th>
<th>Goal Date for Implementation</th>
<th>Completed Date</th>
<th>Metric for Completion</th>
<th>Cost</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
</tbody>
</table>

**Maturity Level Action Completed Date:**

**Project Facilitator Signature:**

---

**Beginning**

- No commitment to widespread adoption of improvement methods.

**Developing**

- Pilot projects using some new tools conducted in a few areas.

**Advancing**

- RPI used in many areas to improve business processes as well as clinical quality and safety; positive ROI achieved.

**Approaching**

- RPI tools used throughout organization for all improvement work; patients engaged in redesigning care processes; RPI proficiency required for career advancement.
Develop Initiatives & Goals

- Develop initiatives for area(s) of focus:
  - Utilize Resource Library and Maturity Descriptions
  - Determine goals
  - Identify resources and infrastructure needed to support

- Who will lead initiative?
Example Area of Focus

- Component: CEO/Management
- Already doing: Daily Operations Brief or Huddle (5 days a week)
- Actions to undertake:
  - Expand to 7 days a week
  - Start to track issues identified and trend across settings
## Align Operations and Infrastructure

**Operational Assessment--Sample**

<table>
<thead>
<tr>
<th>Element</th>
<th>Level of Impact</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing, Selection, and Succession</td>
<td>High</td>
<td>CEO or Safety Officer conducts</td>
</tr>
<tr>
<td>Organization Design and Reporting Structure</td>
<td>High</td>
<td>Report tracking/trending to Board</td>
</tr>
<tr>
<td>Training and Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals and Measures</td>
<td>High</td>
<td>Goal: Huddle occurs 7 days a week</td>
</tr>
<tr>
<td>Rewards and Recognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules and Policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>Med</td>
<td>Develop tracking system to trend issues identified during briefing</td>
</tr>
</tbody>
</table>
Conclusion

- Ensure Leadership support
- Don’t try everything at once
- Map the strategy out: be concrete and include goals
- Communicate and Celebrate
Excellence in patient care for every patient, every time
THANK YOU

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csmith@jointcommission.org

www.centerfortransforminghealthcare.org