Enabling continuous learning and quality improvement in health care

The role of learning models for performance management

Robert William Smith
Nuffield Department of Population Health, University of Oxford, Oxford, UK, and
Elaina Orlando and Whitney Berta
University of Toronto, Toronto, Canada

Abstract

Purpose – The purpose of this paper is to examine how the design and implementation of learning models for performance management can foster continuous learning and quality improvement within a publicly funded, multi-site community hospital organization.

Design/methodology/approach – Niagara Health’s patient flow performance management system, a learning model, was studied over a 20-month period. A descriptive case study design guided the analysis of qualitative observational data and its synthesis with organizational learning theory literature. Emerging from this analysis were four propositions to inform the implementation of learning models and future research.

Findings – This performance management system was observed to enable: ongoing performance-related knowledge exchange by creating opportunities for routine social interaction; collective recognition and understanding of practice and performance patterns; relationship building, learning for improvement, and “higher order” learning through dialogue facilitated using humble inquiry; and, alignment of quality improvement efforts to organizational strategic objectives through a multi-level feedback/feed-forward communication structure.

Research limitations/implications – The single organization and descriptive study design may limit the generalizability of the findings and introduce confirmation bias. Future research should more comprehensively evaluate the impact of learning models on organizational learning processes and performance outcomes.

Practical implications – This study offers novel insight which may inform the design and implementation of learning models for performance management within and beyond the study site.

Originality/value – Few studies have examined the mechanics of performance management systems in relation to organizational learning theory and research. Broader adoption of learning models may be key to the development of continuously learning and improving health systems.

Keywords Performance measurement, Performance management, Organizational learning, Quality improvement, Continuous quality improvement

Paper type Case study

Introduction

Over a decade has passed since seminal reports including To Err is Human, Crossing the Quality Chasm, and the Canadian Adverse Events Study revealed significant areas for improvement in the quality of health care services delivered by health systems in the USA and Canada (Institute of Medicine, 1999, 2001; Baker et al., 2004). Substantial human and monetary capital has been invested to improve quality and while examples of success can be found in both countries, widespread improvement has yet to materialize (Baker et al., 2008; Institute of Medicine, 2013; Baker, 2015).

In order to facilitate widespread and sustained health care quality improvement, the Institute of Medicine (2013) stresses the need to establish continuously learning health care systems. Essential to learning health care systems are organizational cultures of continuous learning (Institute of Medicine, 2013). It is suggested that continuous learning cultures are ideally instilled by both formal and informal leaders, and supported by organizational
competencies and structures that enable constant information development, process/systems analysis, and feedback loops for learning and quality improvement (Institute of Medicine, 2013). These characteristics of learning health care systems are fundamental elements of management philosophies such as total quality management (Bloor, 1999; Mosadeghrad, 2015; Peljhan and Marc, 2016).

Work processes on the “frontlines” of health care, or within what some refer to as “clinical microsystems of care,” have garnered considerable focus for health system quality improvement (Baker et al., 2008). Quality improvement approaches typically involve: methods by which system and process performance can be evaluated; methods for collecting information from key stakeholders like patients and employees in order to understand the root causes of suboptimal performance; methods for integrating this information within the change design process and; methods in which changes can be tested, implemented, and reevaluated in an iterative manner (Juran, 1998; Grol et al., 2007; Baker et al., 2008). Improving performance at the microsystem level depends on teams having methods and access to supports for analyzing performance then subsequently undertaking improvement efforts (Baker et al., 2008). An infrastructure is thus necessary for exchanging information, mobilizing organizational resources, and aligning improvement efforts with strategic objectives across organizational levels (Juran, 1998; Ferlie and Shortell, 2001; Berwick et al., 2003). Herein lies an important role for performance management systems.

Performance management is described as a process that involves developing and delineating organizational strategic objectives and performance targets which are actively measured, monitored, and acted upon across organizational levels (Martinez, 2001). Traditionally, performance management was viewed as a closed process between supervisors and individual employees, most commonly recognized as the annual performance appraisal (Martinez, 2001). Since the 1990s, these more traditional—or as Lemieux-Charles and Greengarten (2014) describe them, “industrial”—models for performance management have evolved (Martinez, 2001). More contemporary performance management systems are instead designed to serve as “learning models” (Lemieux-Charles and Greengarten, 2014).

Learning models for performance management in the health care sector are performance management processes that are designed to: link individual- and team-level performance to organizational objectives; facilitate routine performance measurement; and enable collaborative learning from performance data and change efforts. The design of learning models are intended to facilitate open dialogue and bi-directional, iterative feedback and learning between employees and their supervisors (Martinez, 2001; Lemieux-Charles and Greengarten, 2014). The processes of developing objectives and targets, measuring and monitoring performance, and ultimately identifying and responding to areas for improvement are intended to be facilitated in collaboration (Martinez, 2001; Lemieux-Charles and Greengarten, 2014). While these systems have been applied within other industries, learning models for performance management have yet to be widely observed in health care organizations, particularly in publicly funded hospitals in Canada (Lemieux-Charles and Greengarten, 2014). Learning models for performance management may represent valuable tools for organizations implementing total quality management agendas and striving toward continuous learning and improvement.

The purpose of this study was to examine the following research question:

**RQ1.** How can learning models for performance management be designed and implemented within health care organizations to help foster and sustain continuous learning and quality improvement across organizational levels?

**Methods**

A descriptive case study design was used to study a learning model for performance management (the Niagara Health (NH) patient flow performance management system)
implemented in a publicly funded, not-for-profit, multi-site hospital organization. Direct observation of this learning model was carried out by the authors (RS, EO) over a 20-month period between May 2014 and December 2015. The learning process facilitated through weekly “Rhythm Rounds” and daily “Unit Huddles” was the unit of analysis. Qualitative observational data were analyzed with reference to extant research on organizational learning. Based on this analysis, propositions are presented regarding the performance management system’s potential to foster continuous learning and quality improvement across organizational levels. This study was approved by the NH Research Ethics Board (Project No. 2016-02-003).

Context

**NH and the patient flow performance management system.** While many speak highly of the care they have received from one of the NH’s six hospital sites, many also highlight significant opportunities for improvement (Smith, 2012). Suboptimal patient flow was an influential factor in the Ontario Ministry of Health and Long Term Care’s (MOHLTC) decision to dissolve NH’s Board of Directors and senior leadership team in 2010, and institute MOHLTC supervision of the organization (Smith, 2012). Following this period of supervised restructuring, the organization has since transitioned from an interim senior leadership team to board governance and permanent senior leadership.

In April 2014, improving patient flow became the organization’s top priority and the NH Corporate Patient Flow Strategy was a response to this imperative. The strategy is multifaceted and aimed at improving patient flow through performance management and strategic alignment of quality improvement work across organizational levels. NH’s three larger hospital sites delivering emergency, inpatient and surgical services were the focus as the strategy was initiated. At the core of the Patient Flow Strategy is a performance management system designed around a vision for improving the patient experience by reducing emergency department length of stay for admitted patients from 50 to 28 hours at the 90th percentile.

**Rhythm rounds.** Weekly, interdisciplinary Rhythm Rounds are central to this performance management system. Rhythm Rounds are designed to be efficient, 15-minute stand-up meetings aimed at accomplishing six primary tasks presented in the list below. These meetings take place at site and organization-wide levels. The microsystem-level component of Rhythm Rounds occurs through daily “Unit Huddles.” The various stakeholders attending Rhythm Rounds and Unit Huddles are listed in Table I.

Primary tasks involved in Rhythm Rounds are as follows:

1. present and extract learning from a positive or negative “patient story” which highlights examples of exemplary performance or areas for improvement;

<table>
<thead>
<tr>
<th>Organization-level</th>
<th>Site-level</th>
<th>Microsystem-level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance: 12–18 people</td>
<td>Attendance: 10–15 people</td>
<td>Attendance: 5–10 people</td>
</tr>
<tr>
<td>Performance coach&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Site director&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Clinical manager&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Senior leadership</td>
<td>Patient flow coordinator</td>
<td>Charge nurse&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Program directors (clinical and quality)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Clinical managers</td>
<td>Nurses</td>
</tr>
<tr>
<td>Physician leadership</td>
<td>Charge nurses</td>
<td>Allied health professionals</td>
</tr>
<tr>
<td>Quality advisors</td>
<td>Case managers</td>
<td>Case managers</td>
</tr>
<tr>
<td>Patient flow coordinators</td>
<td>Quality advisors</td>
<td>Community care coordinators&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Physicians&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Physicians&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other staff (e.g. pharmacy, environmental services, clerical)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**Notes:**<sup>a</sup>Stakeholders with facilitation responsibilities;<sup>b</sup>occasional participants
(2) review and collectively interpret performance results in relation to strategic targets;

(3) initiate inquiry into and synthesize learning from the root causes of optimal and suboptimal performance;

(4) collaboratively identify and initiate actions for improvement with designated stakeholders responsible for following-up by a specific date;

(5) recognize individuals and teams for optimal and exceptional performance; and

(6) regularly follow-up on assigned actions and extend offers of support to overcome identified barriers.

Rhythm Rounds and Unit Huddles are facilitated around Rhythm and Huddle Boards which are whiteboard-like tools used to display run charts for specific patient flow performance indicators and corresponding improvement actions requiring follow-up (Plate 1 and Figure 1). Performance indicators are collaboratively identified and targets are set by an interdisciplinary guiding coalition. The coalition's work is led by the executive vice president of clinical services/chief nursing executive (CNE), the executive vice president medical/chief of staff (CS), and a performance improvement coach. Rhythm Boards with site-specific data are located at each of the three main hospital sites, and a NH-wide board is located within the corporate administration office. Secondary NH-wide boards are in public areas of the three hospitals to communicate organizational objectives, performance results, patient stories, and quality improvement initiatives with the public.

The current Rhythm Round process is routinized yet remains amenable to continuous refinement. Stakeholders involved at organizational and/or site levels are provided with patient flow performance data via e-mail on Tuesday morning. The Rhythm Board run charts are updated, and site Rhythm Rounds are held in the afternoon. During Rhythm Rounds, the
facilitator first welcomes attendees then invites a patient story to ground the meeting’s dialogue. Those responsible for actions for improvement with approaching deadlines provide updates on their progress. The previous week’s performance results are then reviewed.

A standard work document for Rhythm Rounds is available in supplementary material.

The facilitator invites stakeholders to comment on the results and asks questions to better understand the enablers of and barriers to achieving patient flow performance targets for the prior week. This dialogue influences the creation of new improvement actions which are recorded with delineated accountability. Before adjournment, the group reviews the areas of focus and actions for improvement emerging from the dialogue. Facilitators also welcome nominations for employee recognition. Following the meeting the CNE, CS, or directors (as appropriate) follow up with identified employees with in-person, written, or online recognition.

During site-level Rhythm Rounds, hospital directors summarize their group’s interpretation of performance results and action plans. This information is then presented at organization-level Rhythm Rounds which take place the following morning. Any information, advice, or actions arising during organization-level Rhythm Rounds are brought back by directors and communicated with the appropriate site-level and then unit-level teams. While actions arising from Rhythm Rounds are often brought back to the microsystem level for action, the reverse process can also occur. If an opportunity for improvement is identified at the microsystem level, it is then brought forth for discussion and results sharing at Rhythm Rounds. The information exchange process is presented in Figure 2.

Unit huddles. Forums for dialogue at the microsystem level are daily Unit Huddles focused on clinical unit performance. After being piloted, Unit Huddles were implemented across all three hospital sites in September 2015. On a daily basis, teams review performance on specific indicators that are most relevant to their unit and that contribute to the achievement of broader
organizational goals. Like Rhythm Rounds, actions are generated and individuals are assigned accountability for executing the actions by a given deadline. For leaders at all organizational levels, the huddles are a means of communicating and translating organizational goals with teams at the microsystem level. Unit Huddles enable teams to take ownership over their contribution to the overall performance of the organization. Learning from the Unit Huddles and enacted improvement efforts may feed into site-level Rhythm Rounds.

For concision, Unit Huddles, site-level and organization-level Rhythm Rounds will collectively be referred to as Rhythm Rounds within the proceeding discussion. The design, implementation, and operation of Rhythm Rounds will be analyzed in relation to organizational learning theory, primarily focusing on Crossan et al.’s (1999) 4I Organizational Learning Framework.

Results and discussion
Organizational learning is a process involving the creation, exchange, and storage of knowledge within an organization (Argote, 2013). This knowledge can have a factual basis (e.g. performance data, empirical evidence) or a procedural basis (i.e. related to employees’ experiences, skills, and routines) (Argote, 2013). Interaction between an organization’s “members, tools, and tasks” represents the primary mechanism by which organizational learning takes place (Argote, 2013). Through these means new knowledge can be created, old knowledge combined with new, and these then retained and transferred (Argote, 2013). Rhythm Rounds afford a structured means by which these interactions, which generate knowledge and facilitate organizational learning, can occur.

Within the context of Rhythm Rounds, members are those who participate in the meetings. Generally speaking, learning is rooted in the recognition of patterns experienced during interaction with other individuals (e.g. explicit or tacit knowledge transfer), instrumental exposures to information (e.g. through tools like the Rhythm Board), and actions or experiences associated with work processes (Crossan et al., 1999; Argote, 2013). At the core of its design, Rhythm Rounds are a venue for stakeholders from across disciplines,
hospital sites, and organizational levels to congregate and interact. Member–member interaction is fundamental to learning within teams and throughout organizations (Crossan et al., 1999; Kostopoulos et al., 2013; Noe et al., 2014).

The Rhythm Board represents a tool that enables learning by depicting performance patterns and storing information. Tools (e.g. Rhythm Boards and hospital administrative databases) and members (e.g. subject matter experts or experienced employees) therefore, can serve as valuable repositories of knowledge (Argote, 2013). The facilitation process of Rhythm Rounds represents a task which involves initiating dialogue with members around their interpretation of performance results, and plans for addressing areas for improvement. Essentially, having these interactions embedded or routinized in a learning model for performance management, like Rhythm Rounds, creates an opportunity for the processes of pattern recognition, learning and action to be initiated and sustained. Hence, it is proposed that:

P1. Learning models for performance management enable ongoing dialogue (focused on performance results and improvement) and knowledge exchange by creating opportunities for routine member–member, member–tool, and member–task interaction.

To improve current work processes while investigating novel means of operating, organizations undergoing strategic renewal, like NH, must balance between leveraging the organization’s current knowledge (i.e. exploitation) and assimilating novel knowledge (i.e. exploration) (Crossan et al., 1999). The context of organizational renewal makes Crossan et al.’s (1999) 4I Framework particularly relevant for understanding how Rhythm Rounds can enable the exploitation and exploration of knowledge across organizational levels. Central to the 4I Framework is the premise that organizational learning occurs as a result of the dynamic social and psychological processes of intuiting, interpreting, integrating, and institutionalizing (Crossan et al., 1999).

The discussion thus far on learning may depict it as a solely conscious, cognitive, and social process between members, tools and tasks. However, Crossan et al. (1999) suggest that organizational learning begins at a preconscious level. Intuiting refers to an individual’s preconscious recognition of patterns (e.g. patterns related to task outcomes, or member behaviors) and/or possibilities (e.g. opportunities for process improvement) within their lived experiences (Crossan et al., 1999). Intuition can influence an individual’s actions but it is difficult to articulate without the development of language (Crossan et al., 1999). A lexicon for understanding intuition may begin as metaphors but through demonstrable action, and social interaction, individuals develop language (Crossan, et al., 1999).

Intuiting can occur during Rhythm Rounds as a result of regular feedback and analysis of performance data. Intuiting may also occur before or after Rhythm Rounds as senior leaders, managers, staff, and clinicians go about their daily responsibilities. Among the goals of the dialog facilitated during Rhythm Rounds, is uncovering this latent knowledge and generating language to understand it. This discovery process is the essence of interpretation. Hence, it is proposed that:

P2. Learning models for performance management create opportunities for previously unconsciously recognized patterns of practice and performance to be consciously recognized and interpreted (individually and collectively).

Crossan et al. (1999) present interpreting as the evolution of intuitions from non-verbal feelings to articulated language and/or demonstrable actions which aid in the communication of their understanding of a situation. From individual interpretation, knowledge can be integrated within the mental models of the broader group of members. Mental models (also referred to as cognitive maps) are mental representations of thought processes which describe how a member understands and interprets specific domains of information (e.g. the root causes of, and best approach to solving a process failure) (Crossan et al., 1999; Evans et al., 2014). Social
interaction between members and information from other sources (e.g. scientific literature) facilitates the development of shared mental models (Crossan et al., 1999; Evans et al., 2014). Shared mental models shape how groups think and act as a collective, and confer benefits for team performance by increasing capacity for coordinated action and adaptation in unstable circumstances (Evans et al., 2014).

Integrating is a process whereby a deeper, more coherent and mutual understanding of phenomena develops through dialogue and shared experience (Crossan et al., 1999). Dialogue is characterized by “collective inquiry into processes, assumptions, and certainties that compose everyday experience” (Isaacs, 1993). One method of initiating dialogue is through storytelling. Storytelling enhances the integration process by enabling the communication of complex phenomena, and the recognition of areas for improvement and approaches to problem solving (Crossan et al., 1999). The telling of a patient story and the ensuing dialogue is a simple example of how interpreting and integrating manifests during Rhythm Rounds. However, the degree to which interpreting and integration occurs seems to be heavily influenced by how the dialogue is facilitated.

Facilitation is defined as “a goal-oriented, context-dependent social process for implementing new knowledge into practice or organizational routines” (Berta et al., 2015). Fundamental to the facilitation process are effective communication and interactive problem solving (Berta et al., 2015). Through the process of dialogue, facilitators can help individuals and groups: reflect on and develop a common understanding of root causes of suboptimal or optimal performance; develop common goals, an action plan, and identify necessary resources for enacting change; and recognize and learn from the underlying thought processes influencing their perception of the root causes and the best actions for addressing them (Isaacs, 1993; Schein, 2013; Berta et al., 2015). Humble inquiry is used by the Rhythm Rounds facilitator to generate dialogue and accomplish these objectives.

Humble inquiry is a form of questioning guided by genuine interest and curiosity in another individual’s knowledge, feelings, and perspectives (Schein, 2013). The focus is on learning as opposed to assigning blame and punishment (Schein, 2013). It is hypothesized that by seeking stakeholder knowledge with humility, the facilitator demonstrates their dependence on the person, and a willingness to risk being misled or exploited (Schein, 2013). Humble inquiry is thus a means for leaders to demonstrate trust in the good intentions of others and the value of their insight (Schein, 2013). By empowering stakeholders with control over the situation, the facilitator creates an opportunity to build a trusting relationship (Schein, 2013). It is an interdependent relationship in which the facilitator exhibits their desire to learn from stakeholders, in exchange for the knowledge necessary for achieving shared goals (Schein, 2013). In essence, humble inquiry is a way to “tap” knowledge reservoirs while building relationships.

During Rhythm Rounds, facilitators were observed utilizing humble inquiry. At the beginning of Rhythm Rounds, the performance data are reviewed openly with the group in a non-punitive manner. Providing group feedback helps create a more suitable environment for learning than individual feedback as it can reduce perceived power differences (Van der Vegt et al., 2010). Next, the facilitator welcomes stakeholders’ perspectives on the results by asking “pure” questions focused on understanding the stakeholder’s story without making assumptions (Schein, 2009). For example: “Emergency department length of stay went up 5 hours last week, what are your thoughts on this?” To more deeply examine the causes of optimal/suboptimal performance, and planned actions to address them, the facilitator asks “diagnostic” questions (Schein, 2009). For example: “Just so I understand it sounds like […] [reiterate the situation]. What do you think are the main causes?” “How have issues like these been addressed in the past?” “How should we address the issue?” Pure and diagnostic questions are not only methods of drawing information about the current state, but they can also help bring awareness to underlying assumptions and tacit knowledge that govern
peoples’ mental models of a situation (Schein, 2009). In circumstances when a sense of trust has been established, the facilitator uses “confrontational” questions, where they present their own knowledge, to challenge the group’s thinking and propose new ways of thinking (Schein, 2009). For example: “Have you considered [this] as a contributor to the issue?” “Based on what you have said and what I have observed, could we try [taking this approach]?”

Facilitating dialogue using humble inquiry may help teams learn from performance first to correct suboptimal performance (i.e. single-loop learning), then to learn from the assumptions and tacit knowledge influencing how the group thinks about performance issues (i.e. double-loop learning) (Argyris and Schön, 1978; Isaacs, 1993). It has also been proposed that through dialogue, even higher orders of learning (i.e. triple-loop learning) can be achieved (Isaacs, 1993). Through triple-loop learning, organizations develop an understanding of how and under what circumstances they learn from performance (Nutley and Davies, 2001). Higher orders of learning may prevent organizations from unintentionally reproducing the same errors and perpetuating suboptimal outcomes (Isaacs, 1993). Hence, it is proposed that:

P3. In learning models for performance management, dialogue is facilitated through humble inquiry which enables relationship building, learning for improvement, and “higher order” learning.

Finally, knowledge is institutionalized when lessons learned during Rhythm Rounds are translated into assigned actions and those actions result in implemented changes in practice and/or policy. According to Crossan et al. (1999), institutionalizing represents the translation of integrated knowledge into formalized changes to processes, policies, and more latent contextual factors like culture and norms (Argote, 2013). Institutionalizing represents the goal of feed-forward learning (exploration), and the starting point for feedback learning (exploitation) (Crossan et al., 1999). Institutionalized knowledge is in a sense a source of organizational “memory” (Crossan et al., 1999).

During Rhythm Rounds, facilitators start by asking questions to understand the current state of performance. Through continued probing (e.g. “Please tell me more; why is this the current process?”) a narrative about the institutionalizing of past knowledge, and opportunities for improvement can emerge. However, depending on contextual factors including an organization’s absorptive capacity (i.e. ability to recognize valuable knowledge, then integrate and apply learning), institutionalization of new knowledge and mobilization of existing knowledge can be impeded (Crossan et al., 1999; Lewin et al., 2011). Herein lies another strategically valuable aspect of the patient flow performance management system.

The microsystem-, site-, and organization-level communication structure of this performance management system allows facilitators to affect the feed-forward and feedback learning required for exploration of novel knowledge, and exploitation of existing knowledge. Rhythm Rounds brings professionals from multiple disciplines together, and learning from shared performance indicators takes place from executive leadership to clinical microsystem levels. This structure serves as a conduit for cross-level communication and learning, and strategically aligned actions for quality improvement. Hence, it is proposed that:

P4. Multi-level feedback/feed-forward learning and communication mechanisms in learning models for performance management enable knowledge creation and exchange, while aligning improvement actions to the organization’s strategic objectives.

While presented in a linear fashion, the learning process described within the 4I Framework is suggested to be iterative and non-linear (Crossan et al., 1999). It is, therefore, the role of the Rhythm Round facilitator to manage the learning process in a manner that fosters learning and action toward common goals. As such, the facilitator’s approach, and the Rhythm Rounds’ structure may exact notable influence on NH’s absorptive capacity.
Conclusions and future directions

This case study offers a close examination of the organizational learning process facilitated by learning models for performance management. Rhythm Rounds were observed to routinize member-tool-task interactions, and create opportunities to collectively recognize and interpret patterns of practice and performance. Rhythm Rounds’ reliance on facilitation and humble inquiry fosters dialogue that enables relationship building and “higher order” learning (reflected in genuine practice change and organizations “learning how to learn”). The multi-level structure of the NH patient flow performance management system links these learning processes across organizational levels, and helps align quality improvement efforts to organizational objectives. These findings complement recent research into effective design features of huddle systems in health care (Goldenhar et al., 2013).

The design and implementation of learning models for performance management align closely with the tenets of total quality management (Bloor, 1999; Mosadeghrad, 2015; Peljhan and Marc, 2016). For example, Rhythm Rounds are inherently patient-centered as the learning and improvement efforts arising from these meetings are ultimately aimed at improving patient safety and experience. This learning model’s integrated, multi-level structure aims to engage all stakeholders in quality improvement within and across organizational levels. The learning model is a mechanism through which these stakeholders can align with the vision and purpose of their organization’s strategic priorities, and understand how quality improvement efforts at the microsystem-level performance contribute to overall organizational performance. The daily format of Unit Huddles and weekly format of Rhythm Rounds aims to routinize the review of performance data, dialogue around the root causes of quality of care issues, and evidence-based decision making. Lastly, humble inquiry represents an approach to facilitating Rhythm Rounds and subsequent quality improvement efforts while minimizing power distance and hierarchical decision making.

A limitation of this case study is that the discussion portrayed the 4I organizational learning process as one that occurs in a figurative vacuum. In reality this is not the case as many contextual factors, particularly the entrenched organizational culture, affect an organization’s capacity to continually learn and improve (Edmondson, 2002; Argote and Miron-Spektor, 2011; Noe et al., 2014). Formal and informal leaders (e.g. facilitators) play an important role ensuring that Rhythm Rounds are a psychologically safe venue for employees to discuss performance results, garner support for quality improvement efforts, and then reflect on the impact of these efforts (Edmondson, 2004; Schein, 2010). Future research should examine the Rhythm Rounds facilitators’ broader change management roles. Such roles involve coaching; building team cohesion; introducing new tools and ideas to assist individuals and teams with improvement efforts; and opening novel lines of communication between key stakeholders. These aspects are important components to a facilitators effectiveness in enabling learning and performance improvement (Goldenhar et al., 2013; Berta et al., 2015).

Due to the descriptive nature of this study, it is important to acknowledge the latent probability of confirmation bias within this study’s results. Furthermore, this study was conducted at one multi-site hospital organization within a universal health system. While our findings may only be generalizable to similar community hospital organizations in Canada, we believe the fundamental processes that make up learning models for performance management are applicable within and beyond the Canadian community hospital context. A more methodologically robust evaluation of the patient flow performance management system, and its impact on organizational learning and patient flow, would help validate or enhance the presented propositions.

Redesigning and enhancing service delivery and broader facets of NH management will be an ongoing incremental process. As is the case within many health care organizations,
achieving optimal performance takes time, commitment, and investment. Considering the potential costs and consequences of not investing in systems that enable continuous learning and improvement across health care organizations, learning models for performance management may be a viable step toward building continuously learning health care systems.

References


Argyris, C. and Schön, D.A. (1978), Organizational Learning, Addison-Wesley, Reading, MA.


Institute of Medicine (1999), To Err Is Human: Building a Safer Health System, National Academy Press, Washington, DC.

Institute of Medicine (2013), *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, National Academy Press, Washington, DC.


About the authors

Robert William Smith is DPhil Student in Population Health at the Nuffield Department of Population Health, University of Oxford. Previously, he obtained an MSc Degree in Health Services Research from the Institute of Health Policy, Management and Evaluation, University of Toronto. Robert’s research interests are broadly themed around the social determinants of health and particularly how social relationships affect health and health care delivery. Robert William Smith is the corresponding author and can be contacted at: robert.smith@ndph.ox.ac.uk

Elaina Orlando, MPH, holds a Master’s Degree in Public Health and is PhD Candidate at the Institute of Health Policy, Management and Evaluation with a specialization in Organization and Management. Her research is focused on examining the relationship between physician involvement in...
quality improvement and medical engagement. Elaina currently works as a Quality and Patient Safety Specialist at Niagara Health. Using her background in Public Health and Epidemiology, Elaina brings a unique lens to quality improvement in the acute care sector, working with leadership and frontline teams to apply the principles of quality improvement to complex challenges in the organization.

Dr Whitney Berta, PhD, is Associate Professor of Health Services Research at the Institute of Health Policy Management and Evaluation, University of Toronto. Her work focuses on three main areas: studies of factors that influence organizational learning capacity and knowledge transfer processes, studies that examine the relationship between organizational learning capacity and performance, and research activities that lead to enhanced system performance, organizational (practice) performance and leadership capacity.

For instructions on how to order reprints of this article, please visit our website: www.emeraldgrouppublishing.com/licensing/reprints.htm
Or contact us for further details: permissions@emeraldinsight.com