Pathway to Performance
Using Quality Improvement to Elevate Program Performance

May 1, 2018
NMDOH Pathway to Performance

➢ Welcome – Secretary Gallagher

➢ Introductions
  • Objectives for the day
  • Housekeeping
NMDOH Pathway to Performance

Workshop: Using Quality Improvement to Elevate Performance

Webinar 2: Performance Management

Webinar 1: Quality Improvement
Agenda for today

Morning Session

➢ Welcome
  • Secretary Gallagher

➢ Introductions
  • Objectives for today
  • Housekeeping
  • Encyclopedias

➢ Highlights from Webinar 1 (QI) and Webinar 2 (PM)

➢ Questions about today

➢ Form QI Teams
  • Selecting a good QI Project
  • Review: Performance Accountability Scorecard

➢ Teamwork
  • Develop an AIM statement

Afternoon Session

➢ Continue Teamwork
  • Forcefield Analysis
  • Cause and Effect Diagram
  • Solution and Effect Diagram
  • Project plan

➢ Teachback
  • 10 minutes per team

➢ Large Group Discussion
  • What did we learn
  • What can we do new/now

➢ 4:00 PM   Final remarks and adjourn
Highlights from Webinar 1
Highlights from Webinar 1: Quality Improvement

Pathway to Performance: Quality Improvement
February 23, 2018

New Mexico Department of Health
Accreditation Readiness and Performance Improvement to States Technical Assistance

Audio Information
Dial-In Number: 866.740.1260
Access Code: 5222314
What Is Quality and What Is Quality Improvement?

➢ **Quality** is “meeting or exceeding our customers’ expectations”

➢ **Quality Improvement (QI)** is “the use of a deliberate and defined process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health.”

**Quality Improvement** refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
NMDOH Practice-Based Definition

➢ QI is the strategic, deliberate implementation or management of change to achieve measurable, desirable outcomes. Outcomes may relate to efficiency, effectiveness, performance, or experience, and may apply to people, programs, processes, or services. – NMDOH QI Council Charter

Quality Improvement is a process or activity designed to lead to improved performance
The PDCA and SDCA cycles are separate but rather integrated.

Once we have made a successful change we standardize and hold the gain.

When the process is not performing correctly we go from SDCA to PDCA and once we have the process performing correctly we standardize again.

This switching back and forth between SDCA and PDCA provides us with the opportunity to keep our process customer focused.

Continuous Improvement
Building an Organizational Culture of Quality: 6 Foundational Elements

- Employee Empowerment
- Teamwork & Collaboration
- Leadership Commitment
- Customer Focus
- QI Infrastructure
- Continual Process Improvement

Quality Culture
Assessing Our Culture of Quality

Assessment performed by NMDOH Senior Leaders during 1-day Quality of Culture Workshop
August 18, 2016

Assessment performed during NMDOH Pathway to Performance Webinar 1: Quality Improvement
February 23, 2018
NACCHO Roadmap to a Culture of Quality Improvement

Phase 1: No Knowledge of QI
Phase 2: Not Involved with QI
Phase 3: Informal or Ad Hoc QI
Phase 4: Formal QI in Specific Areas
Phase 5: Formal Agency-Wide QI
Phase 6: QI Culture

➢ Agency Characteristics
➢ Transition Strategies
➢ Resources
Webinar 1 Polling Results

In what phase is the NMDOH?

- Phase 1: No Knowledge
- Phase 2: Not Involved with QI
- Phase 3: Informal or Ad Hoc QI
- Phase 4: Formal QI in Specific Areas
- Phase 5: Formal Agency-Wide QI
- Phase 6: QI Culture

0% 6% 41% 41% 12% 0%
Highlights from Webinar 2
Highlights from Webinar 2: Performance Management

Pathway to Performance: Performance Management

March 30th, 2018

New Mexico Department of Health
Accreditation Readiness and Performance Improvement to States Technical Assistance
What is Performance Management?

- Performance Management can be regarded as a proactive system of managing performance for driving the organization toward desired performance and results and accomplishment of excellence in performance.

- The term Performance Management gained its popularity in early 1980’s when Total Quality Management programs received utmost importance for achievement of superior standards and quality performance.
What is Performance Management

➢ Meeting agency goals is the ultimate purpose of performance management, but it can help with other areas of the agency’s business.

➢ It works well as a preventative tool to stop problems from occurring. Leaders and managers can look at past performance reports and see where issues arise.

➢ This helps them to set more reasonable goals that relates to the overall skills and abilities of their employees. Fewer problems help increase productivity.
Performance Management System

➢ A Performance Management System is the central nervous system of an organization since it is providing business intelligence on a regular and timely basis to help make informed decisions at all levels of the organization.

➢ This is accomplished by indicating performance to:
  • goals
  • effectiveness and efficiency of its programs and services,
  • processes performance
  • customer satisfaction levels
  • providing knowledge to help prioritize areas needing improvements.
What Is Performance Management?

Performance Management is the discipline of applying and reviewing Quality Improvement and Performance.
Performance is a measure of how well a program, process, or activity is meeting a desired result.

Performance Management is the discipline of applying and reviewing Quality Improvement and Performance.
Public Health Performance Management System

Developed in 2013, adapted from the 2003 Turning Point Performance Management System Framework
**Roadmap to a Culture of Performance**

**Stages of Agency Performance Management (PM)**

**Stage 1**
- Minimal Awareness of PM
  - No organization agreement on need for data-driven decision making
  - Data collection driven by grants
  - Fear about how data will be used

**Stage 2**
- Limited PM Deployment
  - Data drives QI
  - PM integrated into regular meetings
  - Measures align with strategic plan
  - Deployment primarily at program level (not agency-wide)

**Stage 3**
- Formal Agency-Wide PM Process
  - Functioning PM Council/Team
  - Measures collected, analyzed & reported by all programs on a defined timeframe
  - Role clarity
  - PM System (data collection process/tool) in place

**Stage 4**
- Culture of PM
  - Performance data drive decisions & budgets
  - PM training on a regular schedule for all staff
  - PM reports drive program planning
  - PM Communications Plan implemented

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<th>Stage</th>
<th>Percentage</th>
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<td>Stage 2</td>
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<td>Stage 3</td>
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<td>Stage 4</td>
<td>33.3%</td>
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<td>Stage 5</td>
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Assessment performed during NMDOH Pathway to Performance Webinar 2: Performance Management March 30, 2018
NMDOH Assessment Results

Assessment performed during
NMDOH Pathway to Performance
Webinar 2: Performance
Management March 30, 2018
Differentiate between Measures of Health and Measures of Performance on Health

- Measures of Health, which we call Indicators, provide a snapshot of New Mexico’s health status.

- Measures of Performance on Health, which we call Program Performance Measures (or just Performance Measures), provide an up-to-date assessment of program actions that contribute to improving New Mexico’s health status, as measured by the Indicators.
The Clear Impact Results Scorecard

Population Accountability

- **R**: A Result (aka outcome, or goal) is a desired condition of well-being for a population.

- **I**: An Indicator is a measure of a population’s health status.

Program Accountability

- **P**: A Program is the organizational unit accountable for action to improve a population’s health status.

- **PM**: A Performance Measure is a measure of the performance of a program on health status.
How we use the Scorecards to support Performance

- Health Status Indicators – 3 year strategic planning cycles
- Performance Measures – Annual cycles
- Milestones – Quarterly cycles

  - Programs report on performance quarterly
    - Action Plans with Milestones
    - Story Behind the Curve
<table>
<thead>
<tr>
<th>Completeness Determinants</th>
<th>Num</th>
<th>Denom</th>
<th>Performance Result</th>
<th>Weight</th>
<th>Performance Score</th>
<th>Improvement Available</th>
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<tbody>
<tr>
<td>Four or more years of baseline data (Indicator &amp; PM)</td>
<td>40</td>
<td>51</td>
<td>78.4%</td>
<td>0.25</td>
<td>19.6%</td>
<td>5.4%</td>
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<td>All Notes sections completed</td>
<td>208</td>
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<td>0.25</td>
<td>25.0%</td>
<td>0.0%</td>
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<tr>
<td>Notes up-to-date</td>
<td>190</td>
<td>208</td>
<td>91.3%</td>
<td>0.25</td>
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<td>2.2%</td>
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<td>Actual data values up-to-date</td>
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<td>51</td>
<td>90.2%</td>
<td>0.20</td>
<td>18.0%</td>
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<td>Measure forecast value</td>
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<td>51</td>
<td>0.0%</td>
<td>0.05</td>
<td>0.0%</td>
<td>5.0%</td>
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<table>
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<th>Quality Determinants</th>
<th>Num</th>
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<td>Notes updates follow guidelines</td>
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<td>208</td>
<td>48.1%</td>
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<td>21.6%</td>
<td>23.4%</td>
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<td>What works are for reaching the measure target</td>
<td>34</td>
<td>51</td>
<td>66.7%</td>
<td>0.15</td>
<td>10.0%</td>
<td>5.0%</td>
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<tr>
<td>Strategies are subset of what works</td>
<td>39</td>
<td>51</td>
<td>76.5%</td>
<td>0.20</td>
<td>15.3%</td>
<td>4.7%</td>
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<tr>
<td>Milestones are quarterly in nature</td>
<td>80</td>
<td>160</td>
<td>50.0%</td>
<td>0.20</td>
<td>10.0%</td>
<td>10.0%</td>
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<table>
<thead>
<tr>
<th>Performance Determinants</th>
<th>Num</th>
<th>Denom</th>
<th>Performance Result</th>
<th>Weight</th>
<th>Performance Score</th>
<th>Improvement Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trending Positively</td>
<td>19</td>
<td>38</td>
<td>50.0%</td>
<td>0.60</td>
<td>30.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Better Than Baseline</td>
<td>20</td>
<td>38</td>
<td>52.6%</td>
<td>0.40</td>
<td>21.1%</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

**OVERALL PERFORMANCE**

NMDOH Results Scorecard Performance Score
NMDOH Performance Accountability Score

➢ Determinants (3)
  • Completeness – How much did we do?
  • Quality – How well did we do it?
  • Performance – Is anyone better off?

➢ Factors (5-4-2)
  • Multiple factors within each determinant
  • Evaluated as a percentage of potential value realized
  • Weighted by relative importance within the determinant
  • Factor scores sum to Determinant Score

➢ Overall Score
  • Straight average of Determinant Scores

➢ Improvement Available
  • Percentage of potential value unrealized
Questions about today?
Teamwork

➢ Group into four pre-assigned teams
➢ If you need a quick break, now is a good time!
Teamwork: Selecting a QI Project
How do we select a good QI Project?

Sponsor Questions Checklist:

<table>
<thead>
<tr>
<th>Sponsor Questions</th>
<th>Yes</th>
<th>No</th>
<th>Needs Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the proposed project needing improvement align with the Organization’s strategic goals and priorities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the improvement project have a sponsor within leadership?</td>
<td></td>
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<tr>
<td>3. Does the AIM discretely describe the project purpose and define clearly “What are we trying to improve (leaving no room for misinterpretation)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are those impacted by the project in agreement that improvement is needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is there a timeline for the project to be completed by?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is the scope of the improvement effort appropriate for the time allotted?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does the team assigned have the skills and ability to achieve an effective solution during the time allotted?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Does the AIM statement describe specific quantitative improvement targets?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. There are no solutions indicated in the AIM statement? (Remember an AIM statement is a problem statement with no solution indicated.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. There are no sub AIMs indicated? If so they may need their own AIM Statements.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Does it identify the internal and external customer rationale for the improvement?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Is the AIM statement flexible? Can it be modified as new information is uncovered?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When you have all “Yes” in every column you then have a discrete, time bound, and measureable project and you are ready to proceed with problem solving.
Selecting Good Projects

If the sponsor chooses to initially approve the project, he/she should get answers to these additional questions to continue to assess the worth of the project:

- Are QI team members skilled in QI methods? If not, the sponsor needs to identify people within the organization who can assist the team.
- Are the right people on the team? One tool that can be used to assess this aspect is the Team Selection Grid (used to help pick team members – available at http://www.phf.org/search/results2.aspx?k=Team%20Selection).
- Is the AIM statement clear and complete? Sponsors can use the Twelve Essential Questions to Help Improve Your Project’s AIM Statement as a guideline to determine the quality of an AIM statement and the project as it is shown in the Example Section.
- Are there any additional needs the QI team may have in order to be successful? This is an area that the sponsor should be checking regularly during the improvement process with the team leader.
Different Approaches for Different Projects

➢ Big QI or Little QI

Cycles of Improvement: Big QI versus Small QI

Level of Performance

Time

Big QI

Small QI
Different Tools for Different Scopes

➢ VFIT
  • Feasible solution already known
  • Low complexity
  • No resistance

➢ A3
  • Rapid cycle
  • Moderate complexity
  • Little resistance

➢ PDCA
  • Disciplined, stepwise approach
  • High complexity
  • Changes with broad impact
Application to the NMDOH Performance Accountability Score

➢ Determinant 1: How much did we do?
  • Measure Forecast Value → VFIT

➢ Determinant 2: How well did we do it?
  • A3 or PDCA

➢ Determinant 3: Is anyone better off?
  • PDCA

For today’s hands-on practice, we will focus on Determinant 2
Your QI Assignment

- Team 1: Determinant 2, Factor 1
- Team 2: Determinant 2, Factor 2
- Team 3: Determinant 2, Factor 3
- Team 4: Determinant 2, Factor 4

Each team has a handout that describes their assigned Factor
Useful Strategy for Developing a QI Project Implementation Plan

➢ Develop an AIM statement
➢ Conduct a Forcefield Analysis
➢ Complete a Cause and Effect Diagram
➢ Complete a Solution and Effect Diagram
➢ Revisit AIM statement – Add SMART objective
Develop an AIM statement

➢ A succinct statement of the problem or issue on which the team will focus the improvement effort.
➢ Describes the parameters of the QI project
➢ Iteratively refined as the team advances toward the project plan

**Ultimately, the AIM statement is an explicit description of the QI team’s desired outcomes, expressed in a measurable and time-specific way.**
AIM Work Sheet

<table>
<thead>
<tr>
<th>Describe the problem or opportunity to be addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is important to work on now because</td>
</tr>
<tr>
<td>The problem/opportunity starts when</td>
</tr>
<tr>
<td>The problem/opportunity ends when</td>
</tr>
<tr>
<td>Internal benefits of addressing the problem/opportunity</td>
</tr>
<tr>
<td>External benefits of addressing the problem/opportunity</td>
</tr>
<tr>
<td>Estimated cost of the project</td>
</tr>
<tr>
<td>Current state of the problem/opportunity</td>
</tr>
<tr>
<td>Desired future state</td>
</tr>
<tr>
<td>Improvements will benefit the following customers/clients</td>
</tr>
<tr>
<td>Key Driving and Restraining Forces</td>
</tr>
<tr>
<td>What is the improvement objective (SMART)</td>
</tr>
<tr>
<td>Project outcomes will be measured by</td>
</tr>
<tr>
<td>Describe the problem or opportunity to be addressed</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
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<td>What is the improvement objective (SMART)</td>
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<tr>
<td>Project outcomes will be measured by</td>
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Lunch
Quality Improvement

Quality improvement in public health is the use of a deliberate and defined improvement process based on needs. It is also a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes.

Key Questions in QI:

- What are we trying to accomplish?
- How will we know if the change is an improvement?
- What changes can we make that will result in an improvement?

Guiding Principles of QI:

- Develop a strong customer focus
- Continuously improve all processes
- Involve employees
- Utilize both data and team knowledge to improve decision making

QI TOOLS: ASSESSMENT

- NMDOH Fishbone Diagram
  - video: https://www.youtube.com/watch?v=1IoVhj7dXk4
- NMDOH Force Field Analysis
  - video: https://www.youtube.com/watch?v=4w2OOG6hMkA
- NMDOH Lean
- EAIZEN – (Public Health Foundation)
- NMDOH Pareto Chart
  - video: https://www.youtube.com/watch?v=yjULQJ8GCzy
- NMDOH Radar Chart
- NMDOH SWOT Diagram
- NMDOH Tree Diagram
- Results-Based Accountability (RBA) – (NMDOH OPA Presentation)

QI TOOLS: PLANNING

- NMDOH Current Chart
- NMDOH SMART Objectives
- NMDOH Plan-Do-Study-Act
- NMDOH Run Chart

QI TOOLS: DECISION MAKING

- Affinity Diagram – (Minnesota Department of Health-QI Toolbox)
  - video: https://www.youtube.com/watch?v=JSWj9ULDCzo
- Aim Statement – (Minnesota Department of Health-QI Toolbox)
- Flowchart – (Minnesota Department of Health-QI Toolbox)
- Interrelationship Diagram – (Minnesota Department of Health-QI Toolbox)
- Prioritization Matrix – (Minnesota Department of Health-QI Toolbox)

NMDOH QI COUNCIL MEMBERS

<table>
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<tr>
<th>Member</th>
<th>Name</th>
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<tr>
<td>Alphon Treade</td>
<td>Twila Kunde</td>
</tr>
<tr>
<td>Danny Mancini</td>
<td>Stad Morris</td>
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<tr>
<td>Terry Gysen</td>
<td>Chris Tichen-Kauka</td>
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<tr>
<td>Jeff Larks</td>
<td>Larry Riddle</td>
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<tr>
<td>Kathleen Lavinik</td>
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<td>Melinda Gonzales</td>
<td>Pam Argo</td>
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<tr>
<td>Thelma Theby</td>
<td>Bill Chalsty</td>
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<td>Dawn Hunter</td>
<td>Gabrielle Sanchez-Sandoval</td>
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NMDOH QI CATALYSTS

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<td>Danal Daniel</td>
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<td>John Davis</td>
<td>Mary Rodgers</td>
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<td>Jason Levy</td>
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<td>Danny Mancini</td>
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<td>Moni Blanda</td>
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When Improvement Initiatives Don’t Go as Planned: Learning from Quality Improvement (QI) Projects at BPHC

Obagie Ebeokozie; Ann Henry; Catherine Fine; Patricia Bai; Douglas Lau

PROJECT OVERVIEW

WHAT 50-70% of all improvement initiatives don’t go as planned.

WHO 50% of BPHC’s quality improvement projects in the past three years have not gone as planned.

AIM Highlight lessons learned from BPHC’s QI journey and share an After Action Report checklist you can adapt to maximize success of a QI project.

TOP REASONS WHY QI PROJECTS DON’T GO AS PLANNED*

Scope
size of project is not manageable or aligned with organizational priorities

QI Culture/Motivation to Change
low levels of staff buy-in

Resources
insufficient access to human/financial/technical resources

Leadership
insufficient guidance or support from senior management or QI team leaders; lack of attention from QI team leaders

Measurement
lack of existing data; inability to collect data on key measures


BPHC’S QI JOURNEY

2003-2013
Prior department-specific QI projects

May 2015
Convened Accreditation & Quality Improvement Committee

August 2015
Developed BPHC QI plan

November 2015
BPHC QI Culture Assessment

2016

March 2016
1. Project to improve the percent value of administrative staff meetings by 67% in 4 months.
2. Project to improve staff training and registration.

May 2016
Worked with a home visit case management program on three projects:
1. Decrease days from initial contact to assignment by 25%
2. Increase referrals assigned in 3 days by 20%
3. Increase referrals from new partners and low referral sites

August 2016
Revised BPHC QI Plan

September 2017
Received Kongi grant to support expansion of QI Program

LESSONS LEARNED

A An effective QI team needs to comprise individuals from diverse parts of the process and be motivated to participate in change ideas.

B Projects were more likely to be inconclusive if measures were unrelated to improvement aim: The team needs to determine what is within control to brainstorm improvement ideas.

C Projects may get stuck if they don’t accurately document observations that differ from planned implementation.

D Successful monitoring of improvements requires an already existing data source.

E Lack of sharing lessons and QI process discourages sustainability and cultural shift.

Since 2015, 3 out of 19 completed QI projects did not go as planned at BPHC. Through the use of the After Action Report (AAR), the Office of Accreditation and QI learned:

Presented at the National Network of Public Health Institutes Open Forum for Quality Improvement, March 2018
# After Action Report for QI Projects

**Aim of Project:**

**Team Members:**

**Date:**

## A. Overview

### A1. Leadership & Teamwork
- Was there sufficient leadership buy-in?  
- Were resources to support the change appropriately identified?  
- Was the right team selected?  
- Was the QI team motivated?

### A2. Project Timing
- Was the timing of the project appropriate for the QI team?  
- Was the timing of the project appropriate for BPHC?

## B. Plan

### B1. Determine the aim, process and customer
- Was the aim SMART (Specific, Measurable, Achievable, Relevant, Time-bound)?  
- Was the aim aligned with key organizational priorities?

### B2. Map the current process, identify appropriate measure(s)
- Did the improvement team fully understand the process under investigation?  
- Did the team identify measures that were easy to use and collect?  
- Were the process and/or outcome measures identified able to demonstrate whether a change was an improvement?

### B3. Identify root causes of the problem
- Was there group involvement in determining root causes & contributing factors of the problem?  
- Were contributing factors related to resources identified?

### B4. Brainstorm possible improvements
- Was the brainstorming process inclusive of perspectives from individuals responsible for different parts of the current process?

### B5. Prioritize interventions and make predictions
- Have all possible improvements been thoroughly attempted?  
- Were the possible improvements prioritized based on:  
  - (1) factors connected to the stated aim;  
  - (2) issues within our control; and  
  - (3) issues for your primary customer?

## C. Do

### C1. Test out one small change at a time
- Was the team able to test improvements as planned?

## D. Study

### D1. Measure and monitor the change
- Was the team able to collect data relevant to the stated aim?  
- Were observations in line with what was predicted?

## E. Act

### F1. Adapt or expand or abandon
- Were QI changes successfully expanded or sustained?

### F2. Share lessons
- Were lessons learned shared beyond the QI team?
Forcefield Analysis

➢ Tool used to identify the Driving (positive) and Restraining (negative) forces helping or hindering an organization from reaching its goals.

➢ Measures the relative strength of the forces identified

➢ Allows ready comparison of pros and cons of a problem/opportunity

➢ Helps in the selection and definition of a QI project goal
Forcefield Diagram

Positive Forces

Negative Forces
Cause and Effect Analysis

➢ A tool that displays multiple potential causes of a problem.
➢ Often used to organize brainstorming results (see: Affinity Diagram)
➢ Includes main causes and subcauses
➢ Often used in conjunction with the 5 Whys
➢ Also known as an Ishikawa or Fishbone Diagram
Cause and Effect Diagram
Solution and Effect Analysis

➢ A tool that helps identify a potential solution to a problem.
➢ Includes main causes and subcauses
➢ A positive restatement of causes and subcauses identified during a cause and effect analysis
➢ Often used to explore a priority root cause
➢ Often used in conjunction with the 5 Hows
Solution and Effect Diagram

MAIN SOLUTION

Sub solution

MAIN SOLUTION

Sub solution

MAIN SOLUTION

Sub solution

MAIN SOLUTION

Sub solution

EFFECT
Revisit AIM statement

➢ Does the Team’s AIM statement still make sense?
➢ Add a SMART objective

S – Simple
M – Measurable
A – Achievable
R – Relevant
T - Timebound
Project Implementation Plan

➢ Various methods, all of which represent the project in a structured (usually sequential) format

➢ Basic plan includes the project tasks, responsibility for each task, and associated target dates. Many plans include task dependencies.

➢ Gantt Charts and RASIC Charts are examples
<table>
<thead>
<tr>
<th>Main Action 1</th>
<th>Assigned to</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Action 1.1</td>
<td>Assigned to</td>
<td>Timeline</td>
</tr>
<tr>
<td>Sub Action 1.2</td>
<td>Assigned to</td>
<td>Timeline</td>
</tr>
<tr>
<td>Sub Action 1.3</td>
<td>Assigned to</td>
<td>Timeline</td>
</tr>
<tr>
<td>Main Action 2</td>
<td>Assigned to</td>
<td>Timeline</td>
</tr>
<tr>
<td>Sub Action 2.1</td>
<td>Assigned to</td>
<td>Timeline</td>
</tr>
<tr>
<td>Sub Action 2.2</td>
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</tr>
</tbody>
</table>
Discussion

➢ What did we learn
➢ What can we do new/now
➢ Looking ahead
  • QI Catalyst Retreat
  • Repeat Pathway to Performance Learning Series
Thank you!