California Quality Collaborative
PBGH

WORKBOOK:

IMPROVEMENT

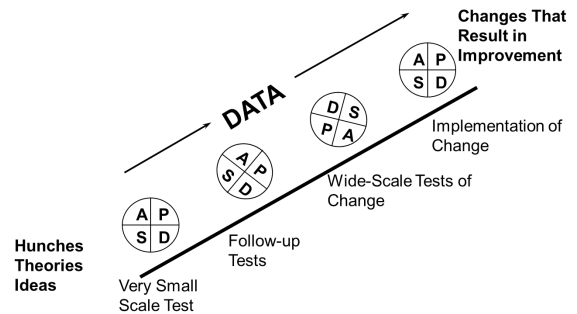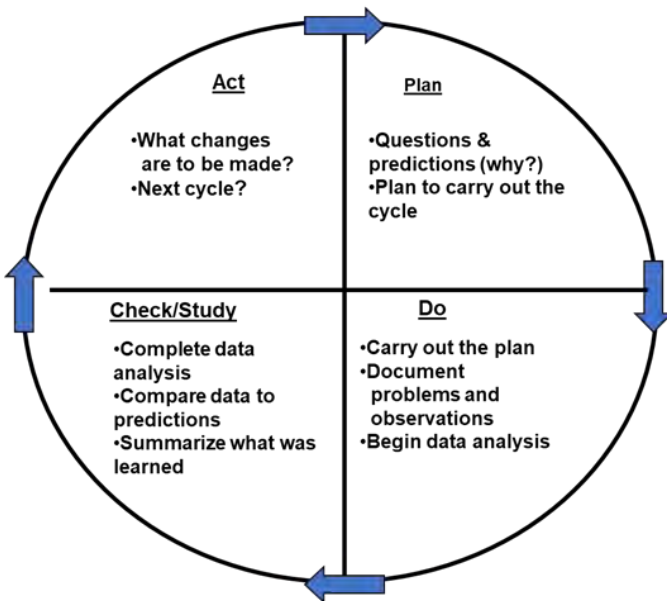# COACHING

WORKSHOP

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

IMPROVEMENT COACHING WORKSHOP WORKBOOK
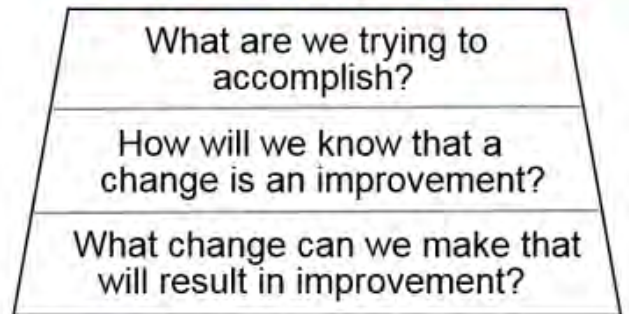
CONTENTS

MODEL FOR IMPROVEMENT OVERVIEW

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

In which populations? Experiencing what barriers?

For whom? Under what circumstances? Who might we miss?

Are there unintended consequences? Do all receive the benefits of the change equitably? Will the change worsen inequities?

Act

- What changes are to be made?
- Next cycle?

Plan

- Questions & predictions (why?)
- Plan to carry out the cycle

Check/Study

- Complete data analysis
- Compare data to predictions
- Summarize what was learned

Do

- Carry out the plan
- Document problems and observations
- Begin data analysis

DATA

Changes That Result in Improvement

Implementation of Change

Wide-Scale Tests of Change

Follow-up Tests

Hunches Theories Ideas

Very Small Scale Test

Adapted from the IHI Breakthrough Series College

SMARTIE AIMS

An effective Aim Statement contains specific characteristics, which will naturally provide a clear intention for the project.

- **S**pecific – Use explicit language which succinctly details the intended outcome of your change initiative

- **M**easurable – Quantitatively define what success will look like, using baseline data and stating the intended outcome, which will facilitate progress tracking

- ~~**A**chievable/~~**A**mbitious – Consider how good you want to be; are you meeting a threshold (just hitting a target) OR are you stretching beyond (setting a new bar)?

- **R**elevant – Should explain who or what the project will impact (e.g., population of people) and provides rationale of why this is important

- **T**ime-bound – Establishes a date by which you want to accomplish this change (remember soon is not a time!)

- **I**nclusive – Brings impacted people into processes and activities in a way that shares power

- **E**quitable – Seeks to address inequity

TEMPLATE: AIM STATEMENT

We
_____
Organization name

Will improve
_____
High level broad focus area: operational efficiency, patient experience, etc.

By
_____
Reducing/decreasing or raising/increasing project focus: diabetes management, breast cancer screening, etc.

For
_____
Patient population

From _____ **to** _____

Baseline   *Target goal*

By when
_____
Target date – specific exact date

EXERCISE: AIM STATEMENT

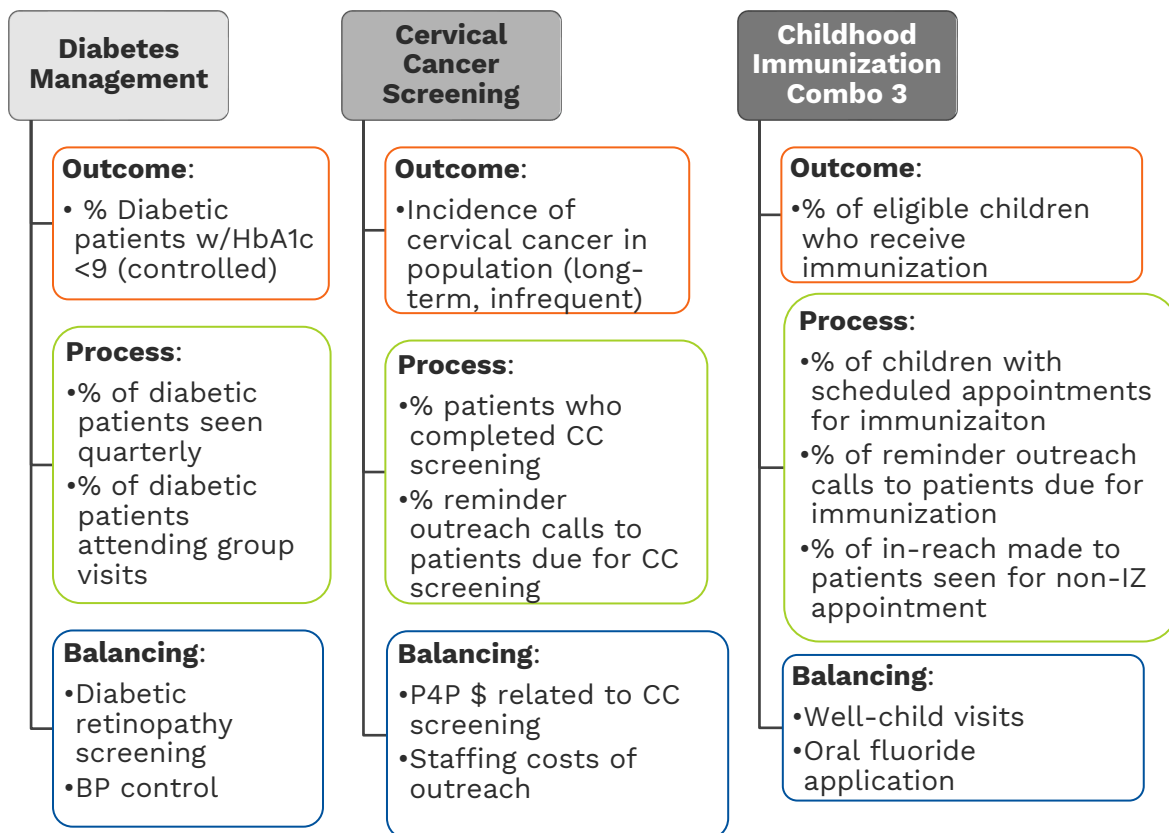| Example Aim Statements	Make it SMARTIE
1. By December 31, 2025, Seaside Clinic will decrease the gap between patients who have an up-to-date fecal occult blood test, while improving colon cancer screening rates for all.	
2. Partnership Clinic will improve the health of its members by increasing our cervical cancer screening rate for eligible women to 60% by next year.	

ACTIVITY: AIM STATEMENT

Instructions: • Determine which smart elements are missing from the assigned Aim Statement. • Rewrite the Aim Statement to meet the SMARTIE criteria.	Specific?	Measurable?	Ambitious?	Relevant?	Time-bound?	Inclusive?	Equitable?	Make it SMARTIE
1. Partnership Clinic will do a better job getting women in for their pap smears.								
2. Good Health Clinic will better manage diabetes by June 2023.								
3. Clinic ABC will reduce cycle time within 3 months.								
4. Northstar Medical Center will improve asthma management for patients.								

QI MEASURES SET

EXAMPLE: QI MEASURE SETS

Diabetes Management

Outcome:
• % Diabetic patients w/HbA1c <9 (controlled)

Process:
•% of diabetic patients seen quarterly
•% of diabetic patients attending group visits

Balancing:
•Diabetic retinopathy screening
•BP control

Cervical Cancer Screening

Outcome:
•Incidence of cervical cancer in population (long-term, infrequent)

Process:
•% patients who completed CC screening
•% reminder outreach calls to patients due for CC screening

Balancing:
•P4P $ related to CC screening
•Staffing costs of outreach

Childhood Immunization Combo 3

Outcome:
•% of eligible children who receive immunization

Process:
•% of children with scheduled appointments for immunizaiton
•% of reminder outreach calls to patients due for immunization
•% of in-reach made to patients seen for non-IZ appointment

Balancing:
•Well-child visits
•Oral fluoride application

EXERCISE: MEASUREMENT

Read the aim statement, review the list of measures, and assign each one a specific type.

AIM STATEMENT	POSSIBLE MEASURES	MEASURE TYPE O = OUTCOME P = PROCESS B = BALANCING
We will increase the percentage of Mandarin-speaking patients whose blood pressure is adequately controlled (less than 140/90 mm Hg) from 50% to 70% by September 30, 2024.	1. Blood pressure medications prescribed	
	2. Blood Pressure self-management education	
	3. BP follow-up appointment scheduled	
	4. Blood pressure	
	5. HbA1c	
	6. Health coach assigned	

ACTIVITY: MEASUREMENT

1. Partnership Clinic will increase colorectal cancer screening from 40% to 65% by June 30, 2023 .

SMART Aim:

Outcome measure:

Process measures:

Balancing measures:

2. ABC Clinic will reduce appointment cycle time from 40 minutes to 30 minutes by December 31, 2023.

SMART Aim:

Outcome measure:

Process measures:

Balancing measures:

3. Good Health Clinic will reduce the hospital all-cause 30-day readmission rate from 20% to 10% by June 30, 2023.

SMART Aim:

Outcome measure:

Process measures:

Balancing measures:

4. Hill Valley Clinic will decrease the number of preventable emergency department visits from 54% to 36% by December 31, 2023.

SMART Aim:

Outcome measure:

Process measures:

Balancing measures:

EXAMPLE: MEASUREMENT PLAN

Project Name: Increasing colorectal cancer screening

Measure	Measure Type *(Outcome, Process, Balance)*	Description/Specs *(include definition of numerator/denominator where appropriate; stratification)*	Data Source	Measure. Frequ.	Reporting Frequ.	How will data be presented	Responsible Person(s)	Baseline	Target
Percentage of patients 50-75 with colorectal cancer screening	Outcome	Numerator: Include any of the following o Fecal occult blood test during the measurement year. o Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. o Colonoscopy during the measurement year or the nine years prior to the measurement year. Denominator: Patients 51–75 years of age at end of measurement year. Exclusions: patients with a diagnosis of colorectal cancer or total colectomy.	Registry	Monthly	Monthly	Run chart at team meetings and QI committee	Data collection: MA Data presentation: PCP champion and/or QI Manager	40%	65% by 6/30/23

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TEMPLATE: MEASUREMENT PLAN

Project Name:

Measure	Measure Type (Outcome, Process, Balance)	Description/Specs (include definition of numerator/denominator where appropriate; stratification)	Data Source	Measurement Frequency	Reporting Frequency	How will data be presented?	Responsible Person(s)	Baseline	Target

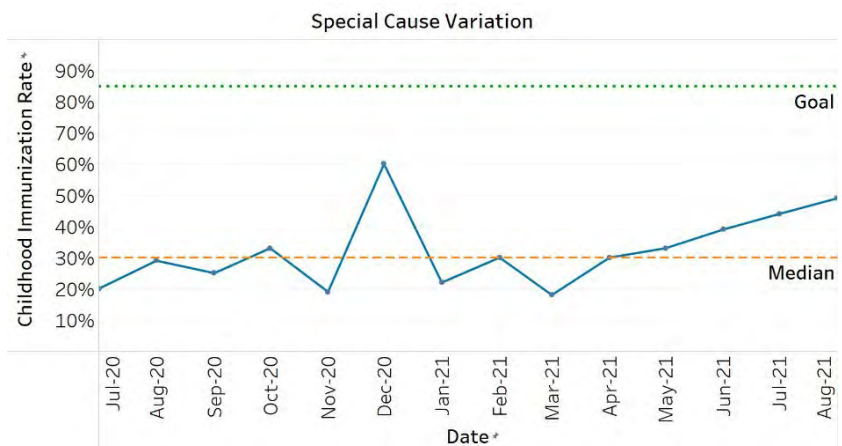California Quality Collaborative

TYPES OF VARIATION

Common Cause Variation

- Natural, inherent system patterns effecting outcomes
- Predictable within a range
- Considered "stable" (neither good nor bad)
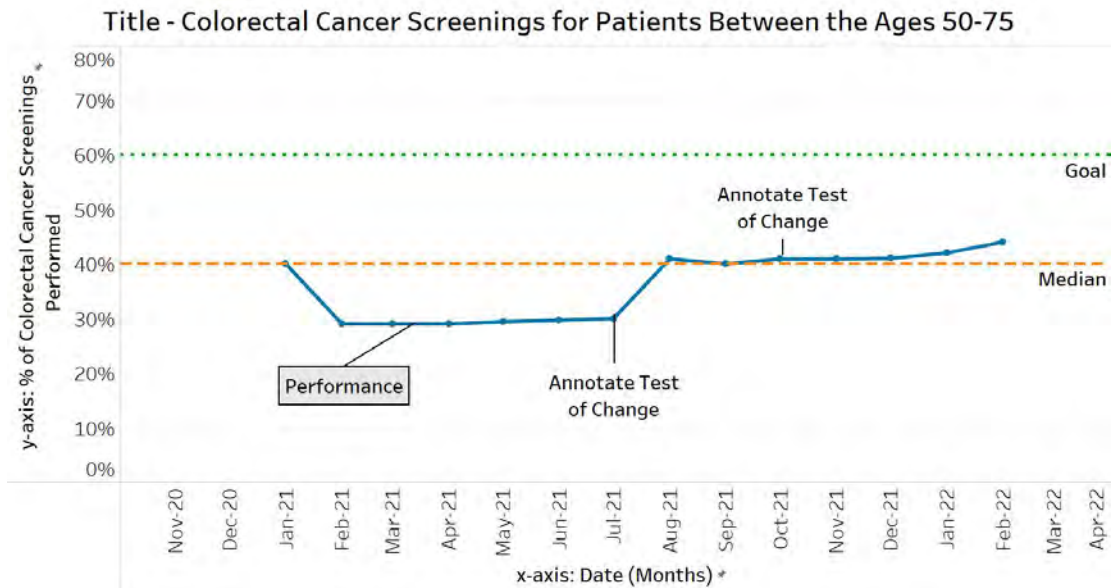
Commons Cause Variation
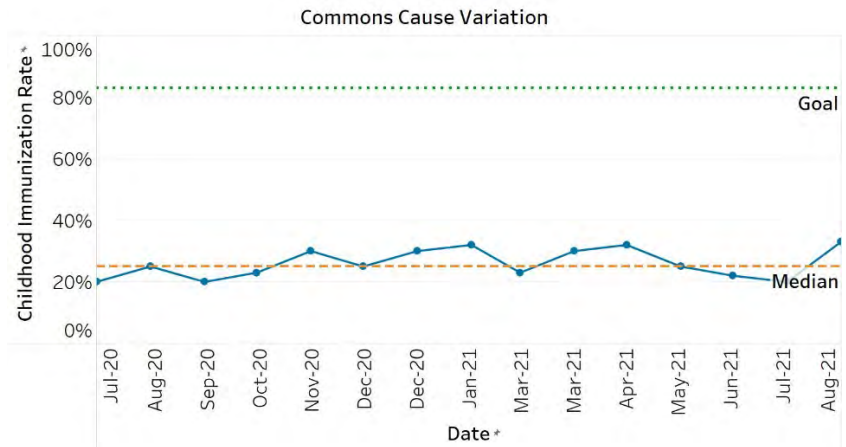
Special Cause Variation

- Due to an assignable cause/specific circumstance
- Not part of the natural system patterns
- Considered unstable or "out of control"

Special Cause Variation

ANATOMY OF A RUN CHART

Title - Colorectal Cancer Screenings for Patients Between the Ages 50-75

y-axis: % of Colorectal Cancer Screenings Performed

Goal

Annotate Test of Change

Median

Performance

Annotate Test of Change

x-axis: Date (Months)

Median: The middle value in a set of numbers arranged in ascending order (from lowest to highest).

Mean (average): The sum of values in a set of data divided by the number of data values

RUN CHART RULES

| Rule 1: Astronomical Point	Rule 2: Shift	Rule 3: Trend
An obviously different value • **Note:** Those familiar with the process would recognize as unusual	**Six (6) or more consecutive points either all above or all below the median.** • **Note:** Skip values that fall on the median and continue counting	**Five (5) or more consecutive points all going up or all going down.** • **Note:** If the value of two or more successive points is the same, ignore one of the points when counting

EXERCISE #1: RUN CHART INTERPRETATION

1) <u>By just eye-balling the run chart (don't apply the rules yet):</u>
   a. Are we observing common- cause or special-cause variation?
   b. Is their evidence of improvement?

2) <u>Apply the run chart rules:</u>
   a. Is there a shift in the data?
   b. Is there a trend?
   c. Is there an astronomical point? If yes, which point?

3) <u>Interpret the run chart now that you have applied the run chart rules:</u>
   a. Are we observing common-cause or special-cause variation?
   b. Is there evidence of improvement?

4) <u>Did your interpretation of the data change by applying the run chart rules?</u>

Run Chart 1 – Chlamydia Screening

Percentage of Patients Elegible for Chlamydia Screening Over Time
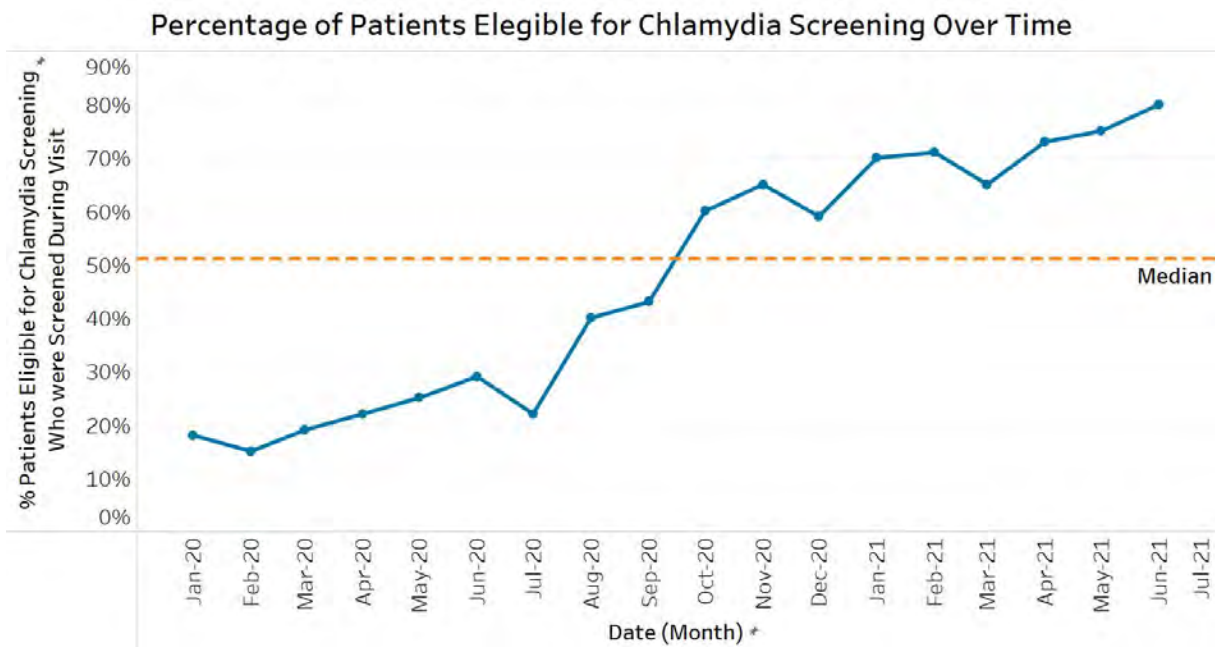
EXERCISE #2: RUN CHART INTERPRETATION

1) <u>By just eye-balling the run chart (don't apply the rules yet):</u>
   a. Are we observing common- cause or special-cause variation?
   b. Is their evidence of improvement?

2) <u>Apply the run chart rules:</u>
   a. Is there a shift in the data?
   b. Is there a trend?
   c. Is there an astronomical point? If yes, which point?

3) <u>Interpret the run chart now that you have applied the run chart rules:</u>
   a. Are we observing common-cause or special-cause variation?
   b. Is there evidence of improvement?

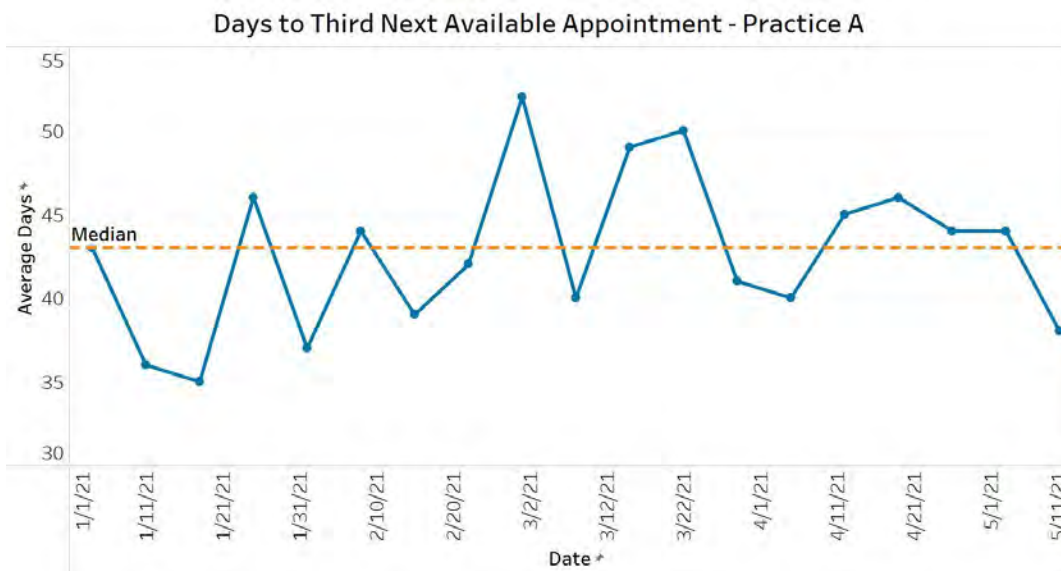4) <u>Did your interpretation of the data change by applying the run chart rules?</u>

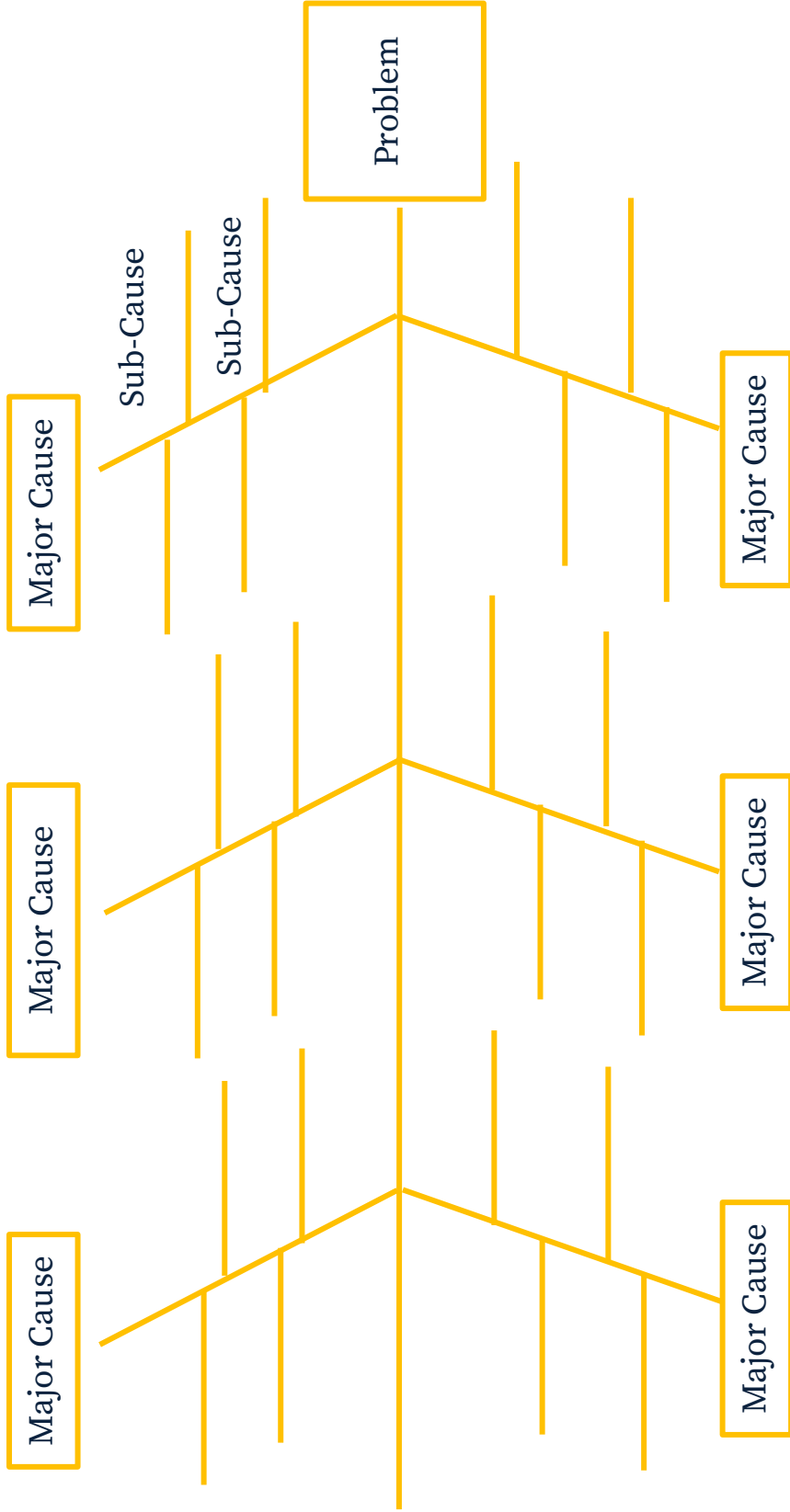**Run Chart 2 – Office Visit Cycle Time**
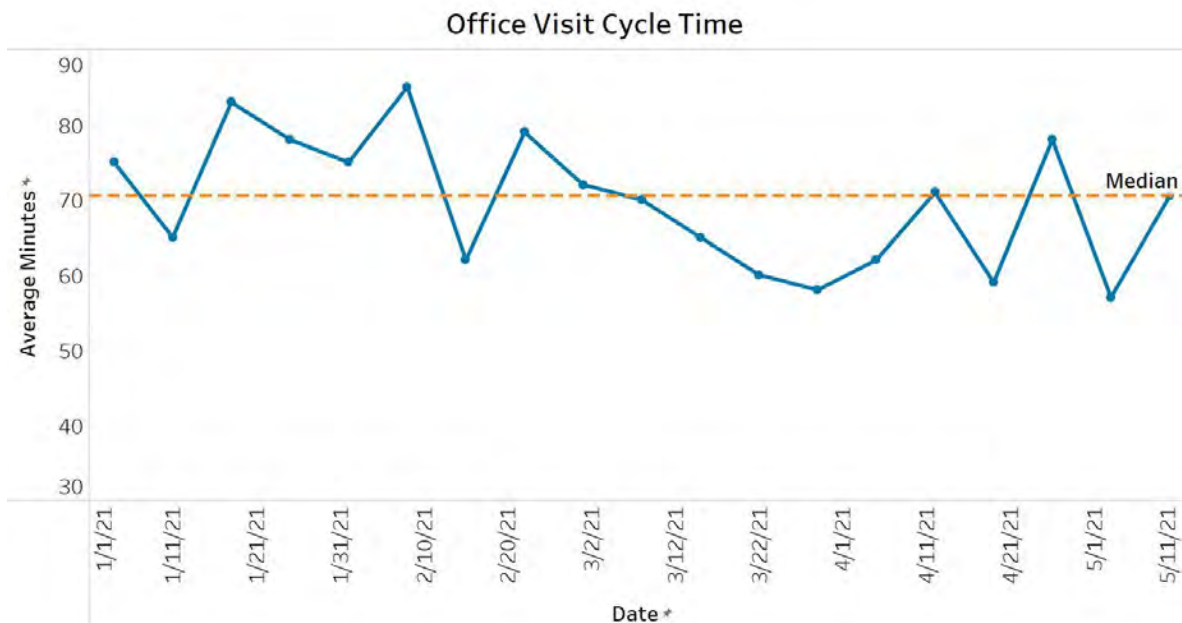
EXERCISE #3: RUN CHART INTERPRETATION

1) <u>By just eye-balling the run chart (don't apply the rules yet):</u>
    a. Are we observing common- cause or special-cause variation?
    b. Is their evidence of improvement?

2) <u>Apply the run chart rules:</u>
    a. Is there a shift in the data?
    b. Is there a trend?
    c. Is there an astronomical point? If yes, which point?

3) <u>Interpret the run chart now that you have applied the run chart rules:</u>
    a. Are we observing common-cause or special-cause variation?
    b. Is there evidence of improvement?

4) <u>Did your interpretation of the data change by applying the run chart rules?</u>
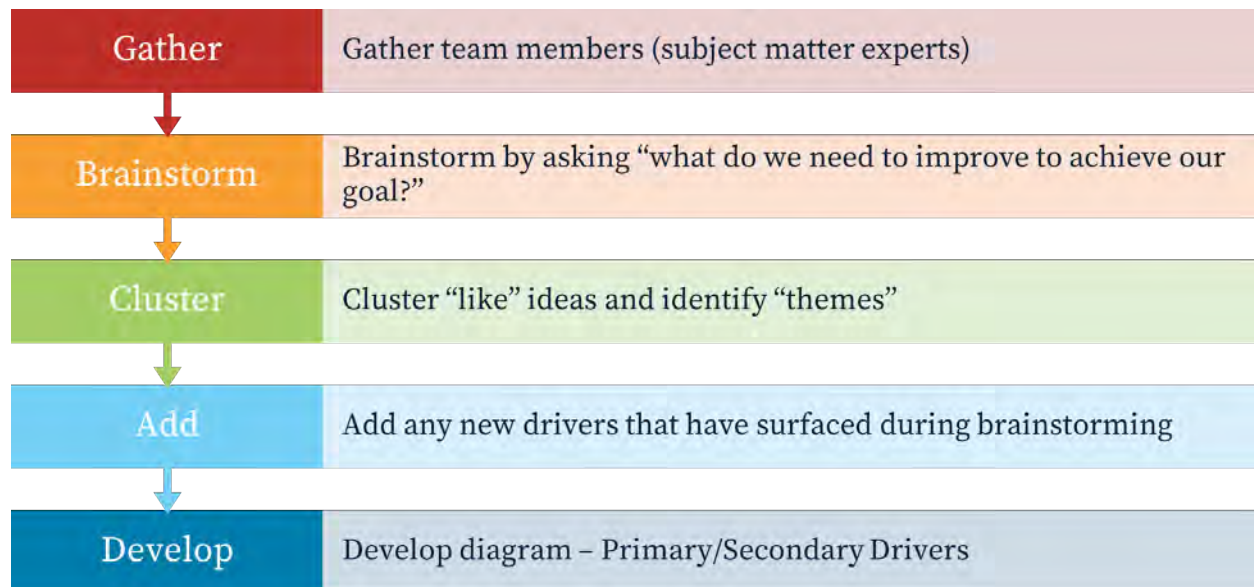
Run Chart 3 – Days to Third Next Available Appointment

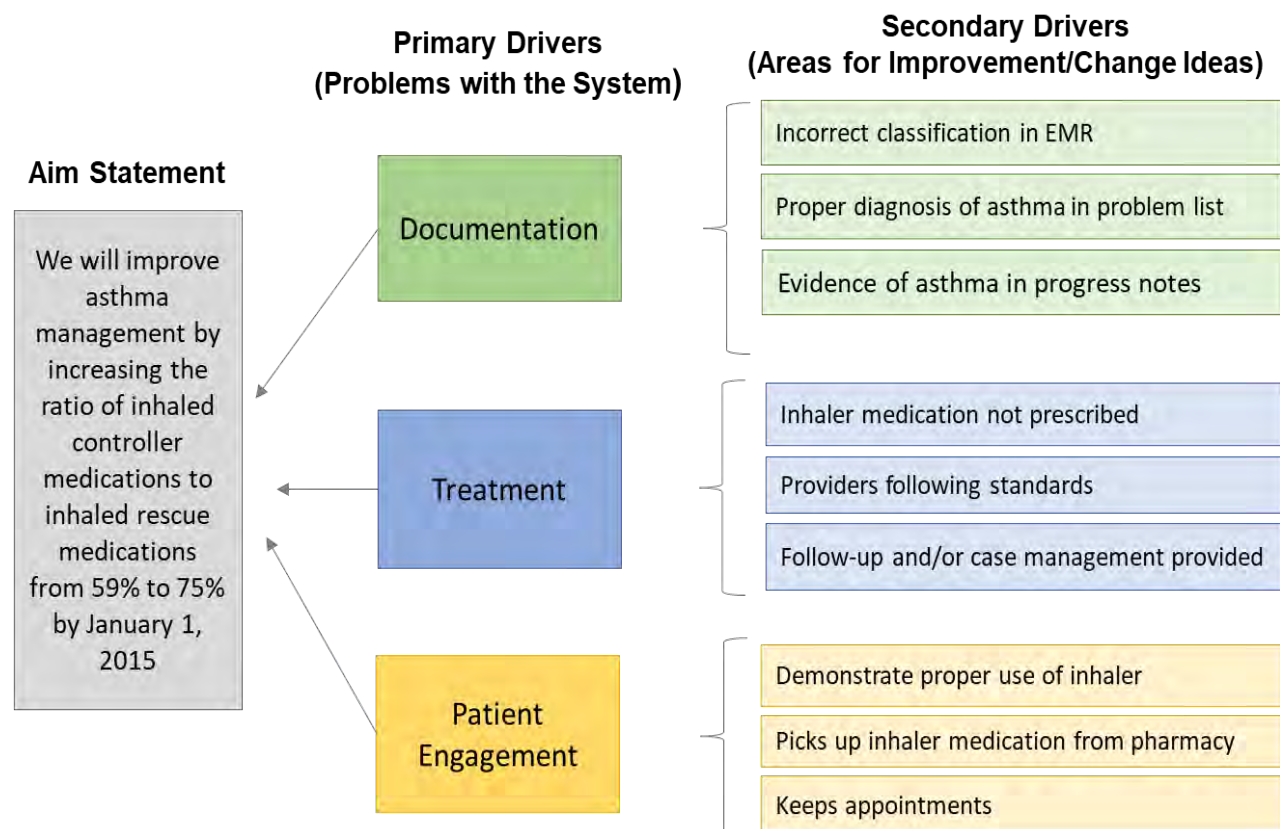## TEMPLATE: CAUSE & EFFECT (FISHBONE) DIAGRAM

DRIVER DIAGRAM STEPS

Gather	Gather team members (subject matter experts)
Brainstorm	Brainstorm by asking "what do we need to improve to achieve our goal?"
Cluster	Cluster "like" ideas and identify "themes"
Add	Add any new drivers that have surfaced during brainstorming
Develop	Develop diagram – Primary/Secondary Drivers

EXAMPLE: DRIVER DIAGRAM

Primary Drivers
(Problems with the System)

Secondary Drivers
(Areas for Improvement/Change Ideas)

Aim Statement

We will improve asthma management by increasing the ratio of inhaled controller medications to inhaled rescue medications from 59% to 75% by January 1, 2015

Documentation
- Incorrect classification in EMR
- Proper diagnosis of asthma in problem list
- Evidence of asthma in progress notes

Treatment
- Inhaler medication not prescribed
- Providers following standards
- Follow-up and/or case management provided

Patient Engagement
- Demonstrate proper use of inhaler
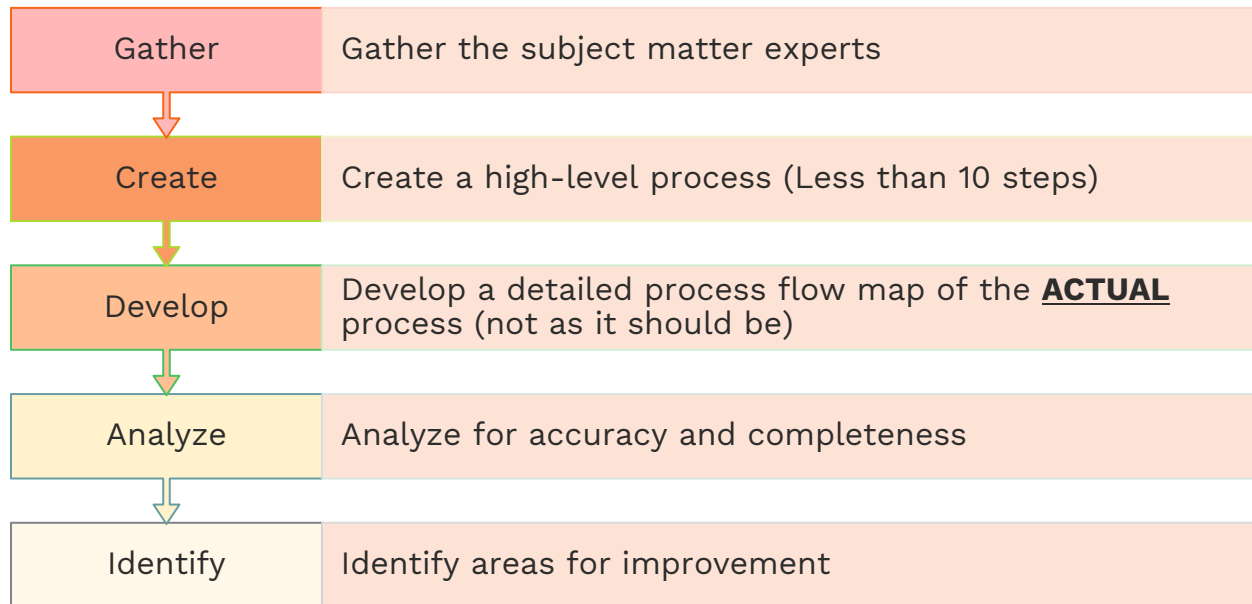- Picks up inhaler medication from pharmacy
- Keeps appointments

TEMPLATE: DRIVER DIAGRAM

Driver Diagram Template

Aim Statement

**Primary Drivers
(Systems, structures, norms)**

Secondary Drivers (Change Concepts)

PROCESS FLOW MAP STEPS

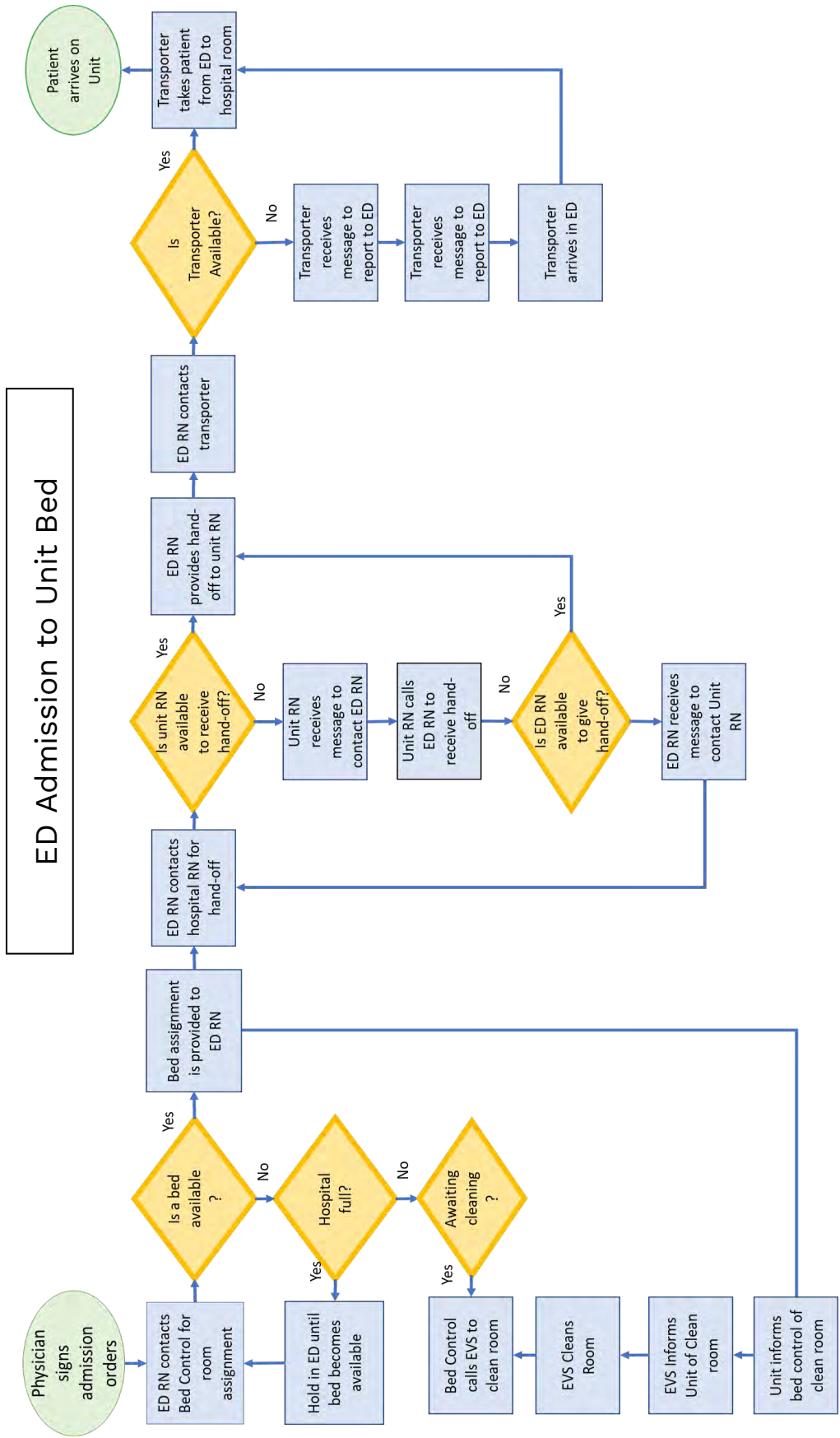| Gather	Gather the subject matter experts
Create	Create a high-level process (Less than 10 steps)
Develop	Develop a detailed process flow map of the **ACTUAL** process (not as it should be)
Analyze	Analyze for accuracy and completeness
Identify	Identify areas for improvement
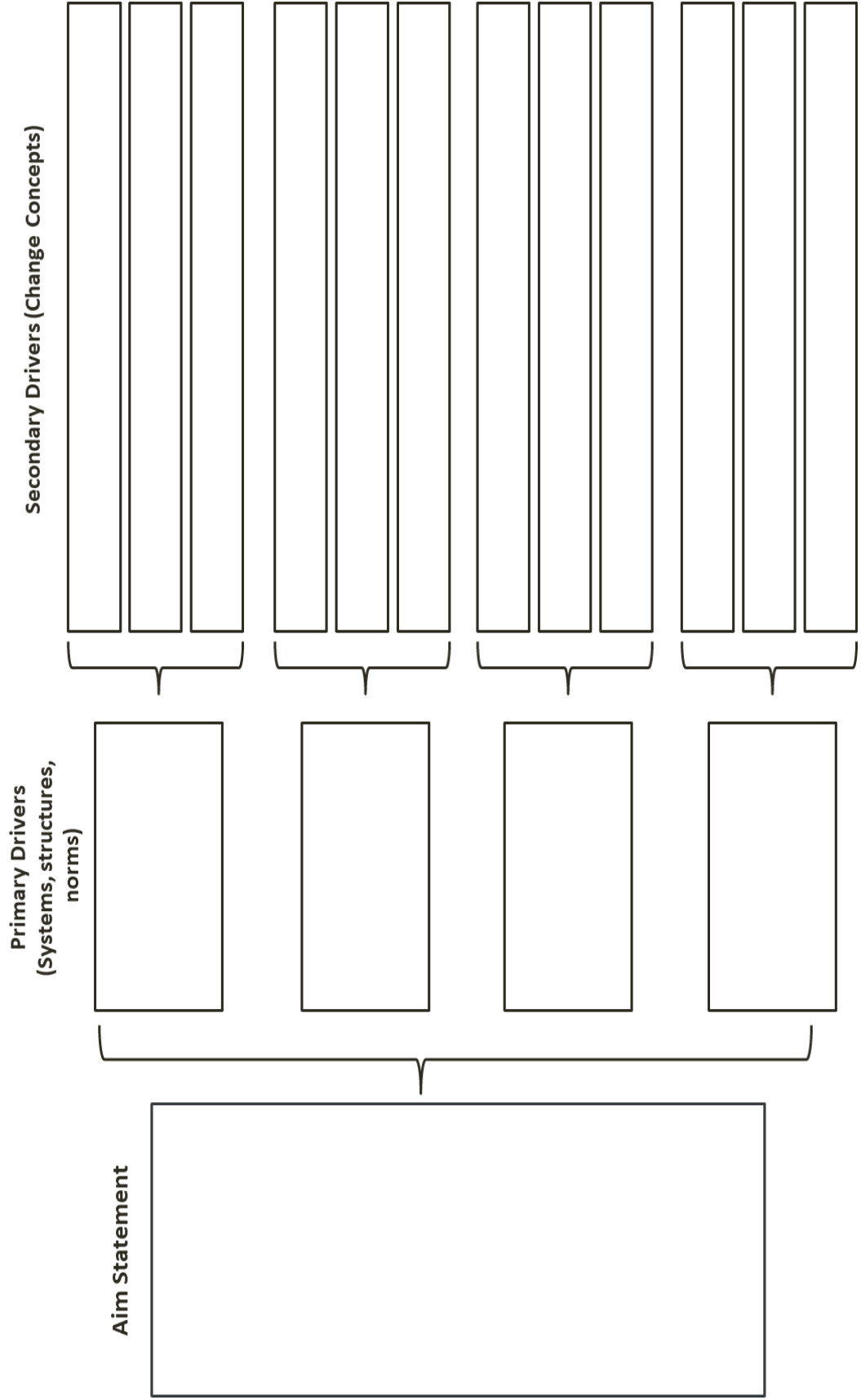
PROCESS FLOW MAP SYMBOLS

- **Start and End**: Oval used to show inputs (materials, information or action) that starts a process and outputs (the results) at the end of a process

- **Activity:** Rectangle represents one task/ activity/step in the process

- **Decision:** Diamond represents a decision point in the process

- **Break:** A circle identifies a break in the process

EXAMPLE: PROCESS FLOW MAP

ED Admission to Unit Bed

Physician signs admission orders

ED RN contacts Bed Control for room assignment

Is a bed available? — Yes → Bed assignment is provided to ED RN

Is a bed available? — No → Hospital full?

Hospital full? — Yes → Hold in ED until bed becomes available

Hospital full? — No → Awaiting cleaning?

Awaiting cleaning? — Yes → Bed Control calls EVS to clean room

EVS Cleans Room

EVS Informs Unit of Clean room

Unit Informs bed control of clean room

Bed assignment is provided to ED RN → ED RN contacts hospital RN for hand-off

ED RN contacts hospital RN for hand-off → Is unit RN available to receive hand-off?

Is unit RN available to receive hand-off? — Yes → ED RN provides hand-off to unit RN

Is unit RN available to receive hand-off? — No → Unit RN receives message to contact ED RN

Unit RN receives message to contact ED RN → Unit RN calls ED RN to receive hand-off

Unit RN calls ED RN to receive hand-off → Is ED RN available to give hand-off?

Is ED RN available to give hand-off? — Yes → ED RN provides hand-off to unit RN

Is ED RN available to give hand-off? — No → ED RN receives message to contact Unit RN

ED RN provides hand-off to unit RN → ED RN contacts transporter

ED RN contacts transporter → Is Transporter Available?

Is Transporter Available? — Yes → Transporter takes patient from ED to hospital room

Is Transporter Available? — No → Transporter receives message to report to ED

Transporter receives message to report to ED → Transporter receives message to report to ED

Transporter receives message to report to ED → Transporter arrives in ED

Transporter takes patient from ED to hospital room → Patient arrives on Unit

CHANGE CONCEPTS

From Associates in Process Improvement, The Improvement Guide

Eliminate waste
1. Eliminate things that are not used
2. Eliminate multiple entries
3. Reduce or eliminate overkill
4. Reduce controls on the system
5. Recycle or reuse
6. Use substitution
7. Reduce classifications
8. Remove intermediaries
9. Match the amount to the need
10. Use sampling
11. Change targets or set points

Improve work flow
12. Synchronize
13. Schedule into multiple processes
14. Minimize handoffs
15. Move steps in the process close together
16. Find and remove bottlenecks
17. Use automation
18. Smooth workflow
19. Do tasks in parallel
20. Consider people as in the same system
21. Use multiple processing units
22. Adjust to peak demand

Optimize inventory
23. Match inventory to predicted demand
24. Use pull systems
25. Reduce choice of features
26. Reduce multiple brands of the same item

Change the work environment
27. Give people access to information
28. Use proper measurements
29. Take care of basics
30. Reduce demotivating aspects of the pay system
31. Conduct training
32. Implement cross-training
33. Invest more resources in improvement
34. Focus on core process and purpose
35. Share risks
36. Emphasize natural and logical consequences

37. Develop alliances and cooperative relationships

Enhance the customer relationship
38. Listen to customers
39. Coach the customer to use a product/service
40. Focus on the outcome to a customer
41. Use a coordinator
42. Reach agreement on expectations
43. Outsource for "free"
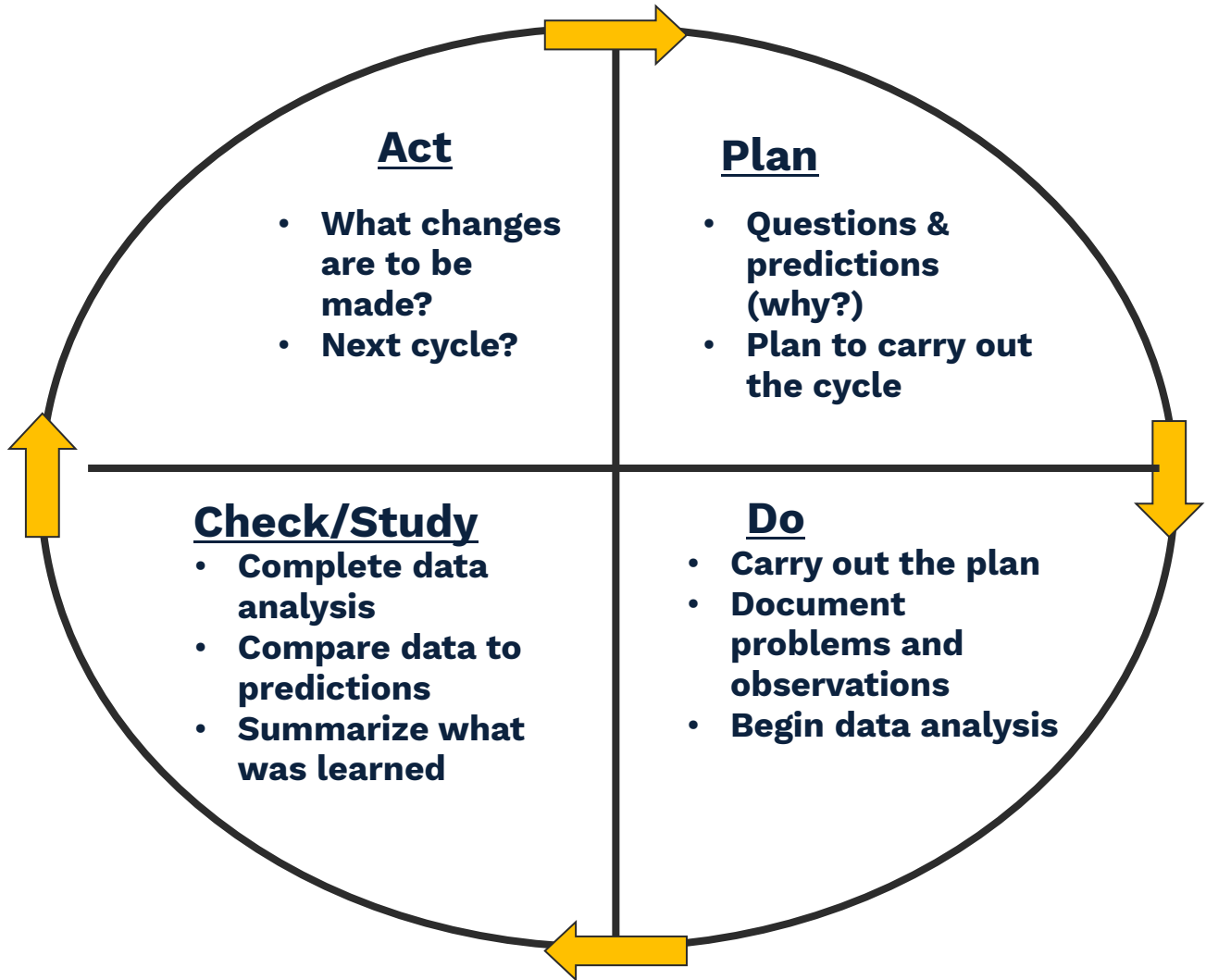44. Optimize level of inspection
45. Work with suppliers

Manage time
46. Reduce setup or startup time
47. Set up timing to use discounts
48. Optimize maintenance
49. Extend specialist's time
50. Reduce wait time

Manage variation
51. Standardization (create a formal process)
52. Stop tampering
53. Develop operational definitions
54. Improve predictions
55. Develop contingency plans
56. Sort product into grades
57. Desensitize
58. Exploit variation

Design system to avoid mistakes
59. Use reminders
60. Use differentiation
61. Use constraints
62. Use affordances

Focus on the product or service
63. Mass customize
64. Offer product/service anytime
65. Offer product/service anyplace
66. Emphasize intangibles
67. Influence or take advantage of fashion trends
68. Reduce the number of components
69. Disguise defects or problems
70. Differentiate product using quality dimensions
71. Change the order of process steps
72. Manage uncertainty — not tasks

Act

- **What changes are to be made?**
- **Next cycle?**

Plan

- **Questions & predictions (why?)**
- **Plan to carry out the cycle**

Check/Study

- **Complete data analysis**
- **Compare data to predictions**
- **Summarize what was learned**

Do

- **Carry out the plan**
- **Document problems and observations**
- **Begin data analysis**

EXAMPLE: PDSA WORKSHEET

Today's Date: September 15	Name of Test: MA conducting Diabetic Foot Exam

Objective for PDSA Cycle
 	
What question(s) do we want to answer with this PDSA cycle?
	• The objective for this PDSA cycle is to improve diabetes management and appointment efficiency by having the MA conduct the filament foot exam.
	• We want to answer the following questions:
	  ○ Will having the MA be responsible for conducing the foot exam result in:
	    ▪ An increased number of exams being completed?
	    ▪ An improved appointment cycle time for diabetic patients (appointment length)
	    ▪ Improved job satisfaction for both the MA and provider?

PLAN – WHO, WHAT, WHEN, WHERE

We plan to [steps to execute – who, what, where, when]: • Who will carry out the test? • When will they carry out the test? • What are the specific details of the test (# of patients, # of days, # of staff, # of phone calls, etc.)? • Where will the test be done?	• In preparation for this test, Dr. Jen will train MA Sally on how to properly perform foot exams using the filament for diabetic patients on Friday, September 21. • MA Sally will identify 4 diabetic patients scheduled with Dr. Jen on Monday, September 24. • MA Sally will conduct foot exam using filament for the four identified diabetic patients • MA Sally and Dr. Jen will huddle on Tuesday morning, September 25, to review what happened, analyze data, and determine next steps

Data collection tool:

What data do we need to collect? (e.g., time, date, response, observation, etc.)

Identified DM Patients Needing	Was Foot Exam Completed by MA?	Did Foot Exam Impact Length of Scheduled	Difference Between Scheduled Time and Actual Time of Appointment (+/- in Minutes)	Was Dr. Jen Satisfied? (☺ / ☹)	Was MA Satisfied? (☺ / ☹)	Comments

We predict the test will produce the following results:	• Appointments may run longer until Sally gets comfortable with filament testing process and builds it into her work day • All four of the identified patients will receive the foot exam • Dr. Jen and MA Sally will both be satisfied with the process

DO – REPORT WHAT HAPPENED (DATA); BEGIN ANALYSIS

What happened?
Did we capture the necessary data?

Identified DM Patients Needing	Was Foot Exam Completed by MA?	Did Foot Exam Impact Length of Scheduled	Difference Between Scheduled Time and Actual Time of Appointment (+/– in Minutes)	Was Dr. X Satisfied? (☺ / ☹)	Was MA Satisfied? (☺ / ☹)	Comments
1	No	Yes	+15 minutes	☹	☹	Filaments had not been stocked in exam room; Dr. Jen performed foot exam to save time
2	No	No	0	☺	☺	Patient had chest pains and was sent to the ED
3	Yes	Yes	+5 minutes	☺	☺	Patient needed extra education
4	Yes	Yes	0	☺	☺	Dr. Jen spent time interacting to meet pt. needs

STUDY – COMPLETE ANALYSIS OF DATA; COMPARE THE DATA TO YOUR PREDICTIONS AND SUMMARIZE.

What did we learn? Did we meet our measurement goal?	• MA Sally conducted 2 out of 4 of the foot exams • Both Dr. Jen & MA Sally were satisfied with the process when supplies were in the room • Seems that MA performing foot exam allows Dr. Jen more time with the patient (need to find a way to test this further)
What did we learn that we weren't previously aware of?	• Not all exam rooms have been stocked with the filaments – need to ensure that supplies are available • If patients were not familiar with the foot exam, patient education takes longer

ACT – WHAT NEXT? ADOPT, ADAPT, OR ABANDON?	
What do we conclude from this cycle?	• MA Sally has capacity and skill to perform the filament foot exam • Need to look at methods for providing patient education to diabetic patients who are receiving the foot exam for the first time
Plan for next cycle?	• Repeat the cycle with 5 additional patients on Thursday, September 27.

TEMPLATE: PDSA WORKSHEET

Today's Date:	**Name of Test:**
Objective for PDSA Cycle What question(s) do we want to answer with this PDSA cycle?	

PLAN – WHO, WHAT, WHEN, WHERE

We plan to [steps to execute – who, what, where, when]: • Who will carry out the test? • When will they carry out the test? • What are the specific details of the test (# of patients, # of days, # of staff, # of phone calls, etc.)? • Where will the test be done?	
Data collection tool:	

What data do we need to collect? (e.g., time, date, response, observation, etc.)	
We predict the test will produce the following results:	

DO – REPORT WHAT HAPPENED (DATA); BEGIN ANALYSIS

What happened? Did we capture the necessary data?	

STUDY – COMPLETE ANALYSIS OF DATA; COMPARE THE DATA TO YOUR PREDICTIONS AND SUMMARIZE.

What did we learn? Did we meet our measurement goal? What did we learn that we weren't previously aware of?	

ACT – WHAT NEXT? ADOPT, ADAPT, OR ABANDON?

What do we conclude from this cycle?	
Plan for next cycle?	

EXAMPLE: PDSA TRACKER

Aim/Project: Colorectal Cancer Screening

Test: Provide FIT Test at Time of Visit for patients with Visit Already Scheduled

PDSA Cycle No.	PLAN			DO		STUDY	ACT
	Description of test	What do you predict will happen?	How will you measure if your test made an improvement?	Date(s) of test	Notes	Results/Key Learning Key Learning	What will you do next? (abandon change, more testing, implement)
1	Jan, MA to identify 10 patients during pre-visit planning who need FIT test and provide education and order FIT at the time of the visit	Greater completion of test, as more opportunity for patient education during visit	Number of FIT tests returned	9/21 – 10/5 (2 weeks)	Dr. Y's patients only	1 test was returned; brainstormed possible reasons: • Not sure if patient really received message of education: o What was said, what tools were used, how did educator ensure patient's understanding • Would it make a difference for both provider and MA to discuss CRC screening? • What if we outreached via telephone (reminder call) to this original 10	1. Begin a second PDSA with a new set of 10 patients for Dr. Y who are scheduled for an appointment and due for CRC screening, but this time prepare flyer as a tool for MA's education with patient; then have provider to have pt. demonstrate understanding using ASK-TELL-ASK feedback technique 2. Call the remaining 9 patients who received packet at visit to test outreach phone call • Develop a script to use during f/up outreach calls • Also develop quick survey/data collection regarding reasons pt. has not yet completed

		PLAN		DO	STUDY	ACT
2	Follow-up calls to patients who received a FIT test during visit to determine status and provide further education	• 50% of patients will be reached during f/up call (actual live conversation) MA will have difficulty finding time to make telephone calls	Number of patients reached Number of FIT tests returned	10/6 – 10/13 (1 week)	MA was unable to find time to conduct f/up phone calls, due to short staffing	• Conduct same test next week
3	Follow-up calls to patients who received a FIT test during visit to determine status and provide further education	• 50% of patients will be reached during f/up call (actual live conversation) MA will still have difficulty finding time to make telephone calls • Of those reached via f/up call, 30% will complete FIT test	Number of patients reached Number of FIT tests returned	10/17 – make calls 10/26 – check for CRC screening completion	MA was able to have a live conversation with 6 patients of the 9. MA used script during the live conversations; left short message for those she did not reach Data collected regarding "why" patients had not yet completed • Apprehension regarding unpleasantness of test; fear of unfavorable result and additional testing; remiss in leaving test in bathroom Of those who were reached in-person by phone, 3 completed FIT (50%) 1 who received a recorded message also completed FIT	• F/up calls with MA delivering pt. education during appointment yielded 4 CRC screenings of the 9 calls (44%) • Try a second f/up call with remaining 5 individuals who received test at time of visit. • Develop a 2nd call script

IMPROVEMENT COACHING WORKSHOP WORKBOOK

TEMPLATE: PDSA TRACKER

Aim/Project:

Test:

PDSA Cycle No.	PLAN			DO		STUDY	ACT
	Description of test	What do you predict will happen?	How will you measure if your test made an improvement?	Date(s) of test	Notes	Results/Key Learning Key Learning	What will you do next? (abandon change, more testing, implement)
1							
2							
3							
4							
5							

California Quality Collaborative

PBGH

CONDUCT A QUALITY IMPROVEMENT PROJECT

1. **FORM THE IMPROVEMENT TEAM**
2. **REVIEW SCORING**
3. **DEVELOP A PROCESS FLOW MAP OF YOUR TEAM'S ASSEMBLY PROCESS**
4. **SET A SMART AIM**
5. **IDENTIFY PROJECT MEASURES**
6. **DETAIL THE 1st PDSA CYCLE**
7. **DOCUMENT PDSA CYCLES**
8. **DEVELOP RUN CHARTS**

8 STEP PROCESS FOR LEADING CHANGE

Implementing and sustaining for change
8. Make it stick
7. Build on the change

Engaging & enabling the organization
6. Create quick wins
5. Empower action
4. Communicate the vision

Creating the climate for change
3. Create a vision for change
2. Form a powerful coalition
1. Create urgency

Adapted from Dr. John Kotter's 8 Step Process for leading change
https://www.kotterinc.com/8-steps-process-for-leading-change/

Definitions for each step:

1. Create a sense of urgency - Help others see the need for change through a bold, aspirational opportunity statement that communicates the importance of acting immediately
2. Form a powerful coalition - effective people – born of its own ranks – to guide it, coordinate it, and communicate its activities.

IMPROVEMENT COACHING SKILLS

Ask

Promote Reflective Thinking (What, Why)

Coach (decisions, actions, focus on results, assess)

Tell

Manage Consult (SME, What Works HIT Optimization)

Teach (QI methods, using data)

Problems ← → Solutions

PRACTICE READINESS
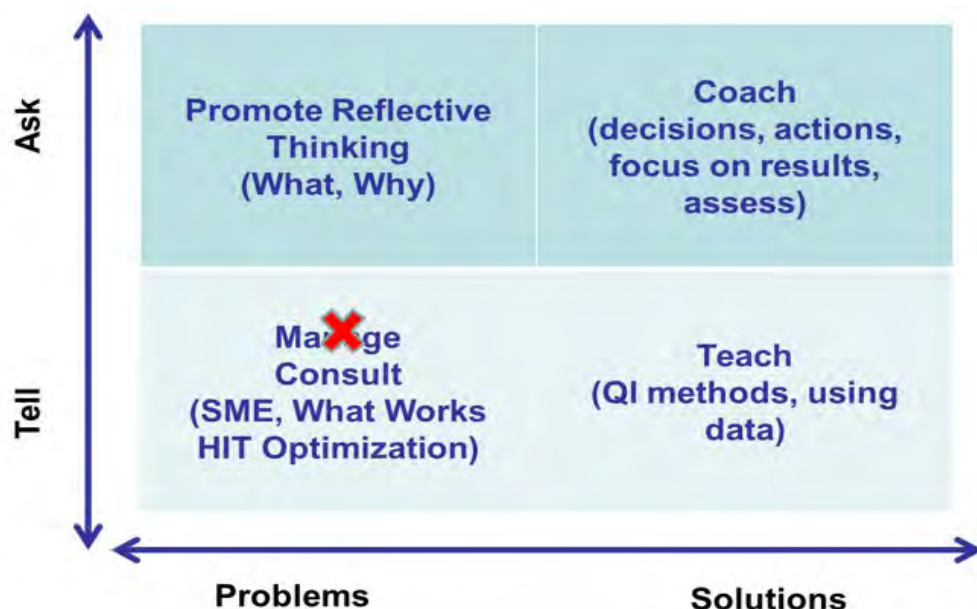
https://pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators
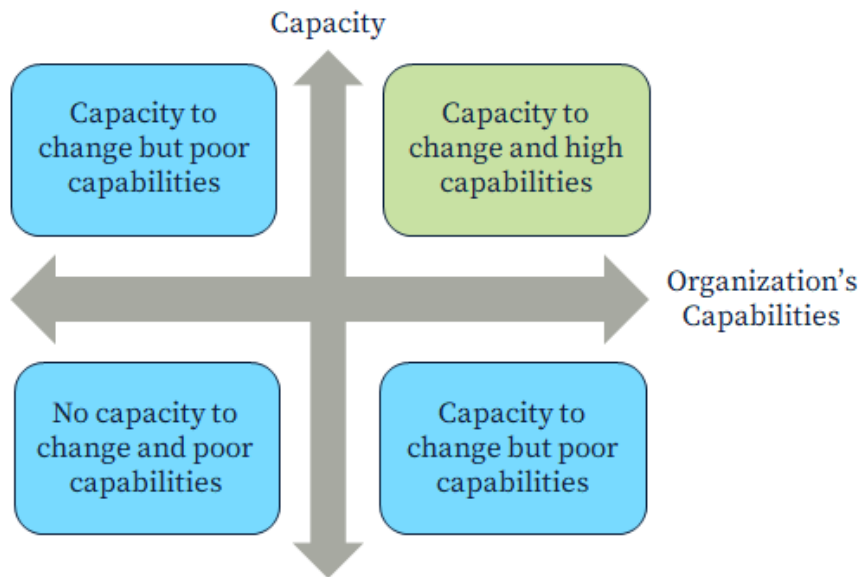
EXAMPLE: OPEN-ENDED QUESTIONS

- What is the problem you are trying to solve?

- How would you describe what's happening vs. what should be happening?

- What makes you sure you have a cause/effect link?

- What have you thought of trying?

- What impact do you expect that change to have?

- How might we make that happen?

- Can you say more about....?

ACTIVITY: ELEVATOR PITCH

Who are you?
Organizational name and vision

What do you do?
Clear description of your core benefit in one sentence

How do you do it?
Describe your methodology, model.

What do you deliver?
Solution based outputs that can be measured as success

Who do you work with?
Types of practices which need what you offer

ACTIVITY: PRACTICE ASSESSMENT WORKSHEET

Practice/Clinic:

Consider Impact Opportunity

1. What is the patient/membership volume?

2. What is the provider panel size?

3. How many providers and staff are in the practice/clinic? What do we know about them?

4. How does the practice/clinic currently perform on P4P measures? (Rate on a scale of 1 – 10; 1 = lowest and 10 = highest)
   – Estimate of potential $ being left on the table:

5. Does someone in your organization already have an established relationship with this practice/clinic?
   – If yes, make plans to request a "warm handoff/introduction" and obtain responses to the questions herein with her/him.

Assess Improvement History (Capacity/Capability)

1. What does the quality infrastructure of the practice/clinic look like? (e.g., QI director, QI committee, measures dashboard)

2. What improvement methodology is used, if any?

3. Who is responsible for quality oversight?

4. Can the current infrastructure support planned improvement efforts?

   – Will additional training be necessary to bolster capability/capacity?

5. Has this practice/clinic been engaged in previous improvement efforts? If yes:
   – What were improvement efforts focused on?
   – What were the results/successes of their efforts?
   – What were their challenges?
   – Who were the team members? Will they be on the team again? How might that help? Hinder?
   – How engaged were the providers/staff in testing changes??
     (Rate on a scale of 1 – 10, 1 = low and 10 = high)

IMPROVEMENT COACHING ROAD MAP

Build Relationships

1. Engage Champion/Team	2. Use Data to Drive Performance	3. Develop Team Charter	4. Develop Driver Diagram	5. Generate Change Ideas	6. Measurement and Tracking	7. PDSA
•Introductions; get to know the team members •Review current performance data and discuss successes and challenges (set stage for data driving improvement •Gain buy-in and commitment regarding engagement (Memorandum of Understanding) •Establish Frequency/ duration of coach check-ins (protect time) •Use assessment tool to establish baseline infrastructures that support/inform improvement •Conduct observations of processes targeted for change	•Enlist practice to prepare run chart for area of focus, with 10-12 month of baseline data •Engage practice team in data analysis, using run chart rules to discuss current system performance ("every system is perfectly designed to get the results it gets" – the current process is producing these results)	Include: •Problem statement •SMART Aim (How good do we want to be and by when?) •Plans for generating change ideas and areas of focus (driver diagrams, process flow maps, identifying change packages) •High-level measures set (1-2 outcome, 1-2 process, 1-2 balancing) •Practice improvement team members w/assigned roles and responsibilities •Team agreements (time, frequency, notetaker, calendaring, etc.)	•Use brainstorm activity to develop Driver Diagram [Change Theories] (Pose question: "Why aren't we currently meeting the target?") •Use Driver Diagram to identify area of focus and to prioritize change ideas •Use dot voting or a priority matrix to identify a change idea to start with	•Use Secondary Drivers on Driver Diagram to brainstorm ideas •Create a "current state" process flow map to allow for logical thinking about current system (conduct observations) •Benchmarking · Surveys · Internet search · Site visit · Change Packages •Use Technology •Use Creative Thinking •Use identified Change Concepts to jump start process (The Improvement Guide)	•Confirm Measures Set (one to two measures for each of the following •Outcome •Process •Balancing •Define details regarding measurement (see Measures Worksheet) •Provide details (methodology, data source, target population, etc.) •Continue to use run charts to track progress and annotate when small tests of change occur •Identify methods for sharing progress (use data to engage)	•Prepare a detailed document of your planned test (PDSA Worksheet) •Make a SPECIFIC plan – (who, what, where, when) •Document your predictions •Create data collection tool (what do you want to know? Be specific) •Test your idea – keep it SMALL (1 provider, 1 MA, 1 patient) •Analyze test learnings; determine next steps: Adopt, adapt, abandon? •Keep track of test iterations to understand which test worked (PDSA Tracker)

Next steps . . . . Implementation, Spread, Sustainability

ACTIVITY: CREATE A KICK-OFF AGENDA

Design Element	What We Know:	Still Need to Know:
WHO? People Participants and Leaders	• Improvement Coach **Improvement Team Members:** • Clinician • Office Manager (Improvement Team Lead) • Medical Assistant • Front Desk Receptionist • Patient • CEO (Executive Sponsor) • Data Analyst • QI Director	•
WHY? Situation The situation that calls for this meeting	• 40% of diabetic patients with uncontrolled A1c; disparity between Mandarin and English speaking patients; patients are at risk for heart attacks and strokes; missed opportunities for pay-for-performance monies	•

SO THAT? **Change** What will change as a result of the learning?	• The improvement team can develop an aim statement • The outcomes for analyze assessment data and identify areas that may be incorporated into change strategies, discuss future meetings, and begin forming relationships with the practice coach and each other	
WHEN? Time and Timing	• Wednesday, 40 minutes during the lunch break, before afternoon clinic starts	
WHERE? Place and Space	• Clinic staff room	

Timing	**WHAT?** The content *Skills, Knowledge and Attitudes*	**WHAT FOR?** What participants will *DO* with the content *Achievement–Based Objectives* (ABOs) **By the end of this event, participants will have:**	**HOW?** The program/plan *Learning Tasks and Materials Suggestion: Consider and note the 4As: Anchor, Add, Apply & Away*
	•	•	

COMMON RESISTANCE AND NEEDS

COMMON RESISTANCE	• **NEEDS - To be met before change can happen**
Change Averse	• Safe place and encouragement to take small risks
Independent Lone Wolf	• Be involved in setting goals
Putting out fires	• Big picture perspective - Vision or strategy
Change Fatigue	• Focus, results, impact change directly
Everything is fine	• Buy-in to the vision
No urgency	• Reason for now rather than later
Resource Constraints	• Resources – time, $$, staff, IT tools
Competing Priorities	• Alignment of initiatives or reduction in initiatives; clear communication
Tyranny of the Urgent	• Space and time to think and create
Lack of knowledge	• Learning Resources
Lack of skills	• Training and Practice

FACILITATE A KICK-OFF MEETING

1. CONFIRM YOUR ROLE
2. CONDUCT THE MEETING
3. WRITE AIM STATEMENT ON FLIPCHART AND POST ON THE WALL
4. DEBRIEF

IMPROVEMENT TEAM ROLES

- Improvement Coach
- Clinician
- Office Manager (Counterpart/Team Lead)
- Medical Assistant
- Front Desk Receptionist
- Patient
- Executive Sponsor (CEO)

TEAM OBJECTIVES

- Achieve the objectives outlined in your Kick-off meeting Agenda
- Draft Aim Statement (Measure and Goal) and write on a flip chart.

Where did you get stuck?

What were you challenged by?

Which techniques worked?

RESOURCES

- The Improvement Guide (book): Framework to guide healthcare improvement projects; "go-to" reference book for improvement; endorsed by the Institute for Healthcare Improvement (IHI)
- An Equity Agenda for the Field of Health Care Quality Improvement (paper): *NAM Perspectives,* National Academy of Medicine - conclusions about key barriers and strategies to advancing equity in health care quality
- All Quality Improvement Is Health Equity Work: Designing Improvement to Reduce Disparities (journal article): *Pediatrics* - specific steps researchers and practitioners can take to ensure that their QI work reduces, rather than increases or maintains, existing disparities

ACKNOWLEDGEMENTS