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Quality Improvement Bootcamp

Session Three

Ryan White Part B Quality Management Program

Welcome

COMMUNITY AGREEMENT

Be **present**

Actively **participate**

Ask questions

Reflect on **your own experience**

Be **respectful** of other's experiences

Seek to maintain a **growth mindset**

Root in respect

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SESSION THREE AGENDA

Introductions and Review

The Model for Improvement – Developing Change Ideas

Process Flow Maps

Root Cause

Fishbone – Cause and Effect Diagrams

Review and Closing

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INTRODUCTIONS

Please introduce yourself with:

- Name & Pronouns
- Agency or Affiliation
- Role
- **Fun Fact**

The Earth is 4.543 billion years old.

Seahorses mate for life.

Australia is wider than the moon.

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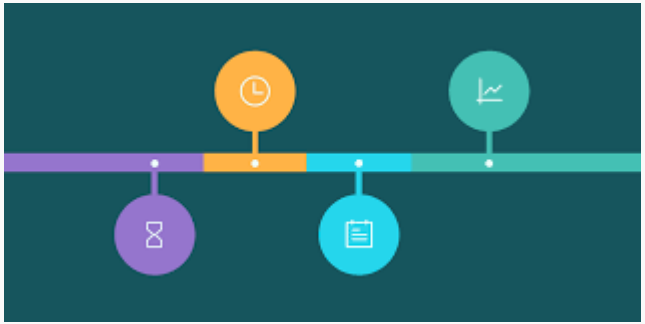
EXAMPLES FROM LAST SESSION



Quality Improvement – The Model for Improvement

THE 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 we result in improvement?

thinking part

1. **Set the Aim**
2. **Select Measures**
3. **Develop Change Ideas**

PDSA Cycles

doing part

Four steps for <u>TESTING</u> the change ideas you we develop

Plan it, try it, observe the results, and act on what is learned

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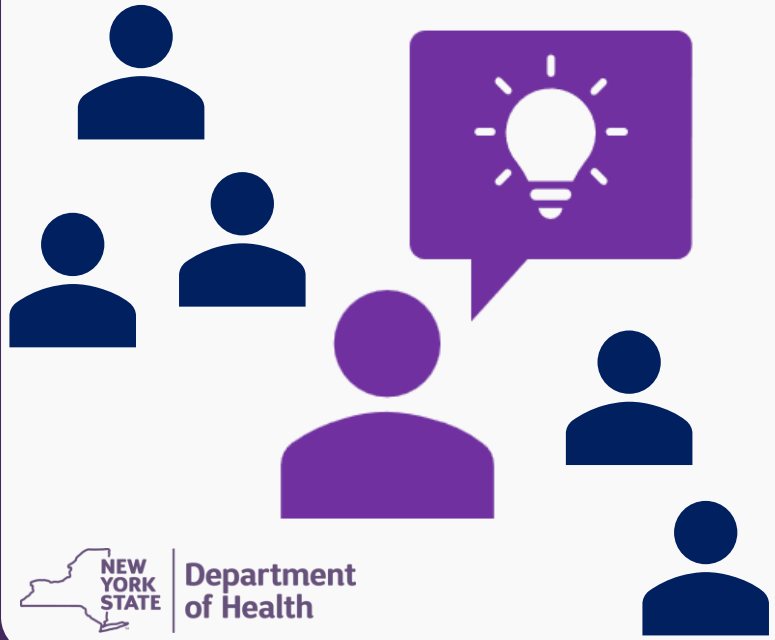
DEVELOP IDEAS FOR CHANGE



What changes can you make that will result in improvement?

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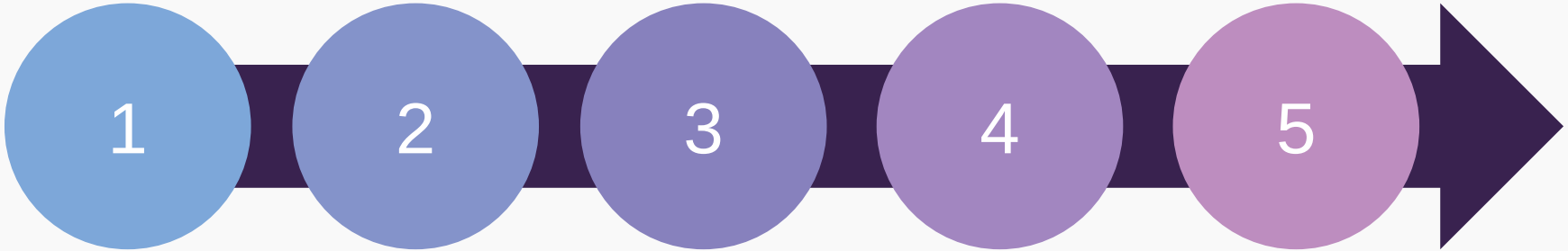
Process Mapping

PROCESS

A **Process** is a series of steps completed in order to achieve a result



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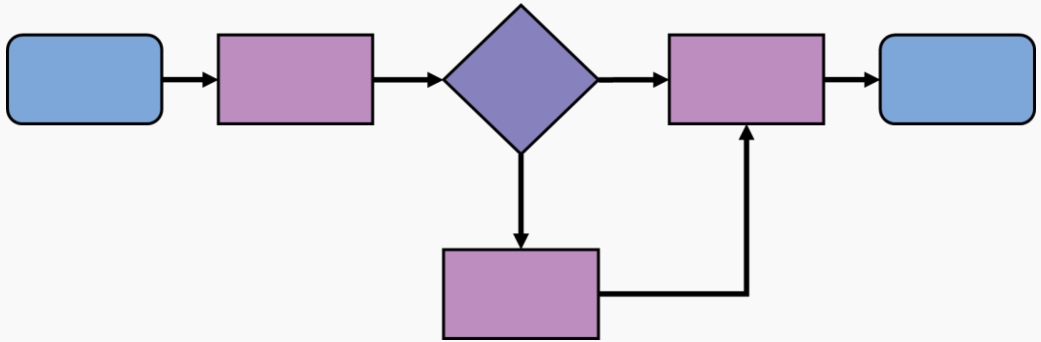
PROCESS MAPPING

Process Mapping is a systems-level intervention which results in a shared mental model of a process' implementation and is used frequently in health care improvement projects



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PROCESS MAP

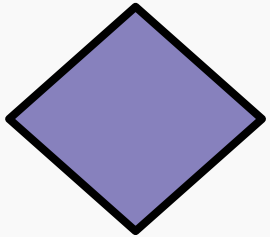
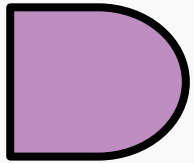
A **Process Map** is “the visual representation of the process under analysis”

A process map serves as an “**external representation of the system**” which allows for an enhanced analysis of the process under review

Process maps are widely used in process management including in health and social service settings for the purpose of quality improvement

Antonacci, G., Lennox, L., Barlow, J., Evans, L., & Reed, J. (2021). Process mapping in healthcare: a systematic review. BMC Health Services Research; BMC Health Serv Res, 21(1), 342. 10.1186/s12913-021-06254-1 7.

PROCESS MAP SYMBOLS

				
Start and Stop	**Process Step**	**Decision Point**	**Wait Time**	**Flow Line**
Used to indicate the start and stop of the process	Used to indicate a step in the process (an activity or task)	Used to indicate a decision point in the process (e.g., yes or no)	Used to indicate a delay in the process (e.g., waiting time before a visit)	Used to indicate the order of the steps on the process map

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BENEFITS OF PROCESS MAPPING IN HEALTHCARE SETTING

Addresses systems-level drivers of poor health outcomes; inefficient systems & poor communication

Generates greater **transparency** resulting in:

- Increased communication amongst diverse stakeholders
- Shared mental model of the “as-is” process
- Accessible visual depiction of complex relationships
- Enhanced ability to identify inefficiencies & gaps

Empowers a more autonomous & effective workforce

Transparency is probably the most important attribute of a culture of safety.

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Generating a Process Map

THE RIGHT SIZE PROCESS

A block diagram is a **high-level process map** which visualizes the relationship between the major components of a process

- Block diagrams use rectangles to depict steps and flow lines to depict the relationship between them
- Block diagrams usually depict **no more than 5-7 steps**

Drafting the block diagram will help to focus the stakeholder brainstorming activities

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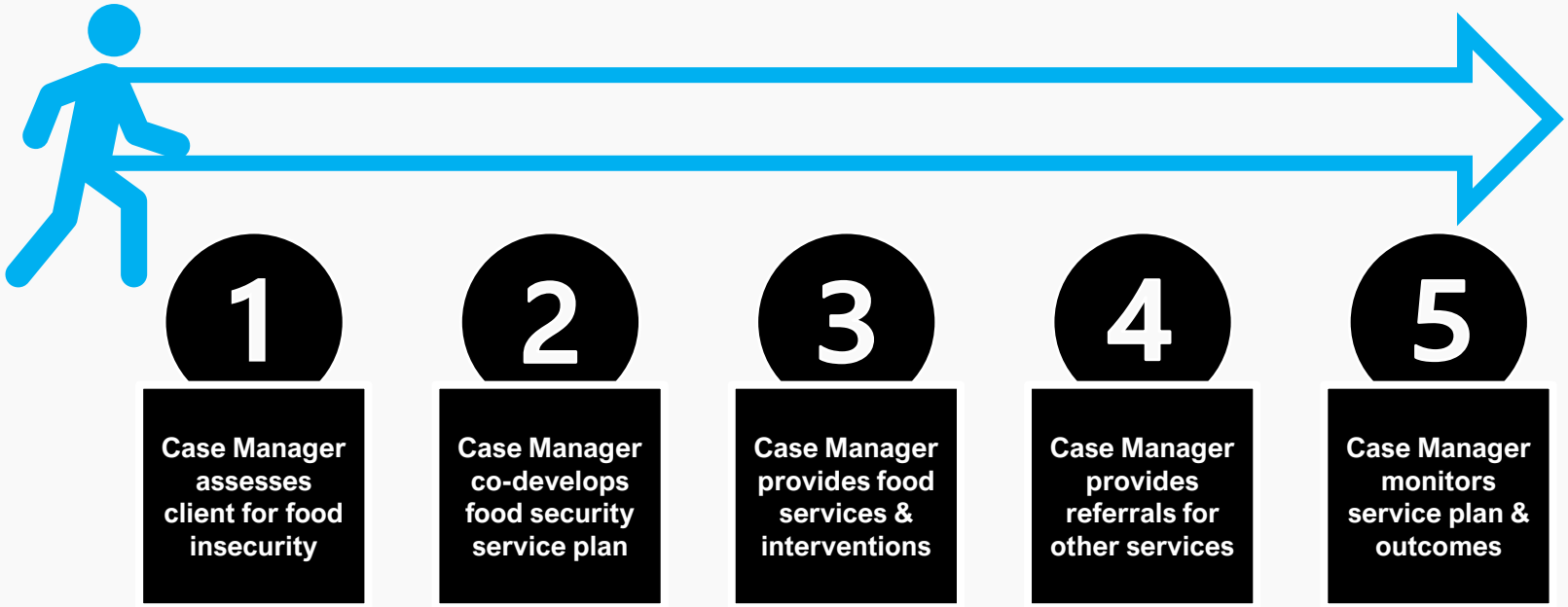
BLOCK DIAGRAM

EXAMPLE: FOOD & NUTRITION SERVICES
BLOCK DIAGRAM



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BRING IN THE STAKEHOLDERS INVOLVED IN THE PROCE

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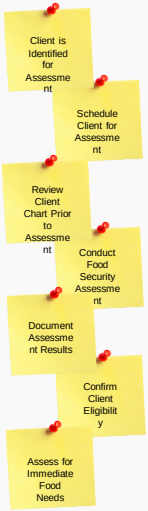
STAKEHOLDERS PLACE RELEVANT ACTIVITIES UNDER BLOCK

Case Manager assesses client for food insecurity	Case Manager co-develops food security service plan	Case Manager provides food services and interventions	Case Manager provides referrals for other services	Case Manager monitors food service plan and outcomes



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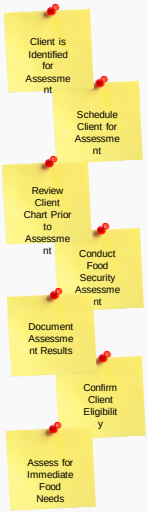
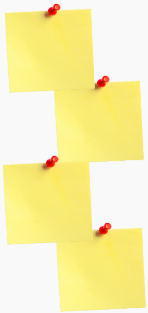
REPEAT FOR EACH OF THE BLOCKS

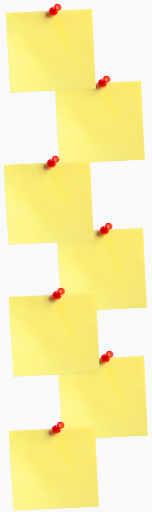
Case Manager assesses client for food insecurity



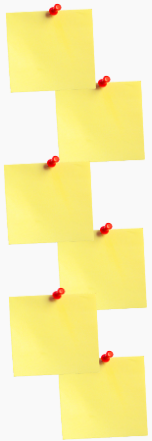
Case Manager co-develops food security service plan



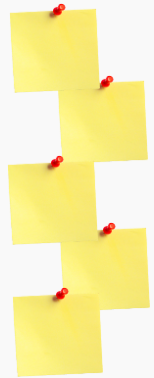
Case Manager provides food services and interventions



Case Manager provides referrals for other services



Case Manager monitors food service plan and outcomes



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QUESTIONS OR COMMENTS

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Process Mapping Activity

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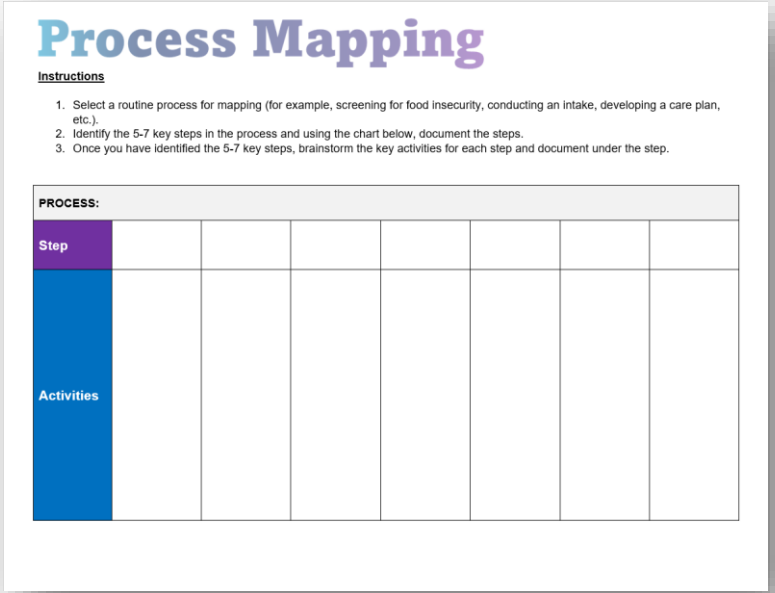
ACTIVITY INSTRUCTIONS

1. Select a Process for Mapping
2. Identify the 5-7 high-level steps in the process and document the steps using the worksheet
3. With your small group brainstorm the activities for each high-level step
4. Document the activities using the worksheet under each high-level step



Process Mapping

Instructions

1. Select a routine process for mapping (for example, screening for food insecurity, conducting an intake, developing a care plan, etc.).
2. Identify the 5-7 key steps in the process and using the chart below, document the steps.
3. Once you have identified the 5-7 key steps, brainstorm the key activities for each step and document under the step.

PROCESS:							
Step							
Activities							

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QUESTIONS OR COMMENTS

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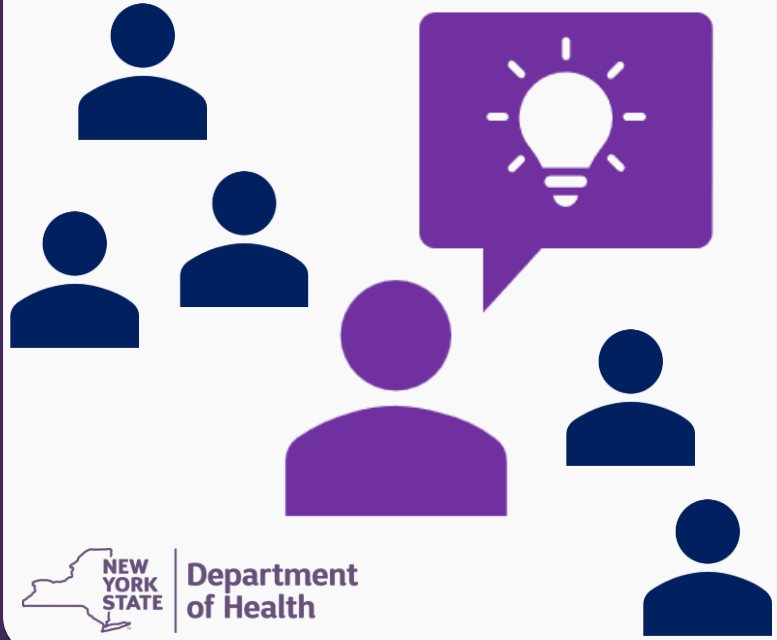
BREAKOUT DEBRIEF



Debrief

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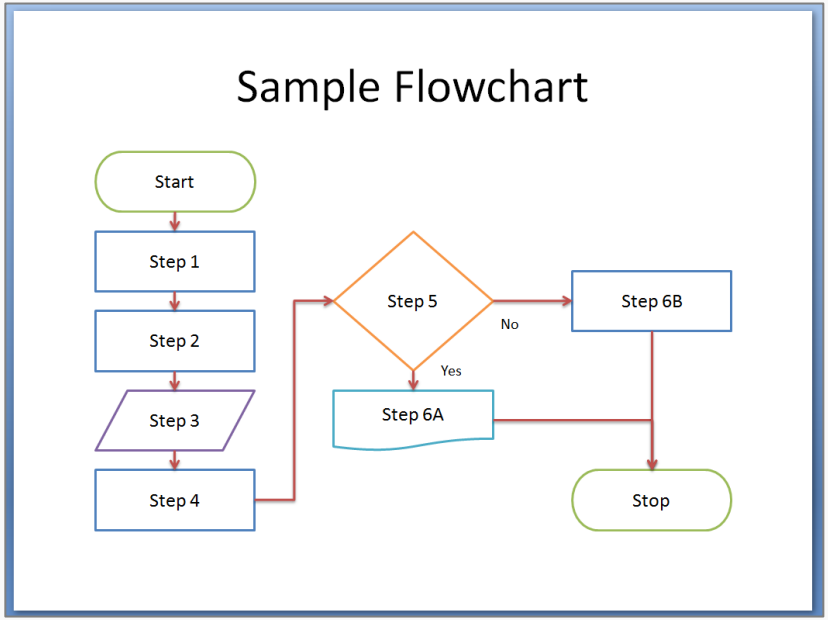
USING PROCESS MAPS TO IDENTIFY CHANGE IDEAS

Teams can use **process maps** to identify change ideas by evaluating each step in the process and asking, could this step in the process be:

1. Safer?
2. Timelier?
3. More efficient?
4. More effective?
5. More equitable?
6. More patient-centered?



Process Map

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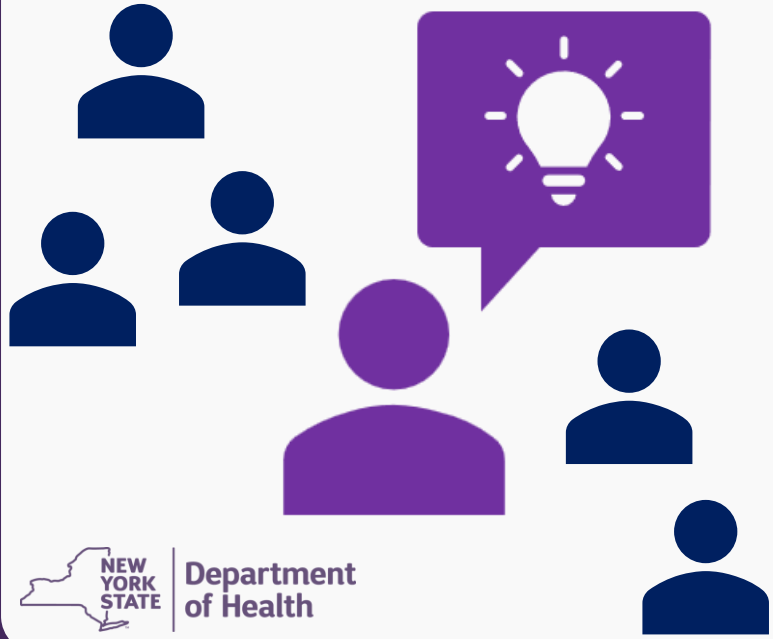
DEVELOP IDEAS FOR CHANGE



What changes can you make that will result in improvement?

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Root Cause

ROOT CAUSE

A **Root Cause** is defined as a factor that caused a problem and should be **permanently eliminated** through process improvement.

The root cause is the **core issue**—the highest-level cause—that sets in motion the entire cause-and-effect reaction that ultimately leads to the problem(s).

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The Fishbone Diagram

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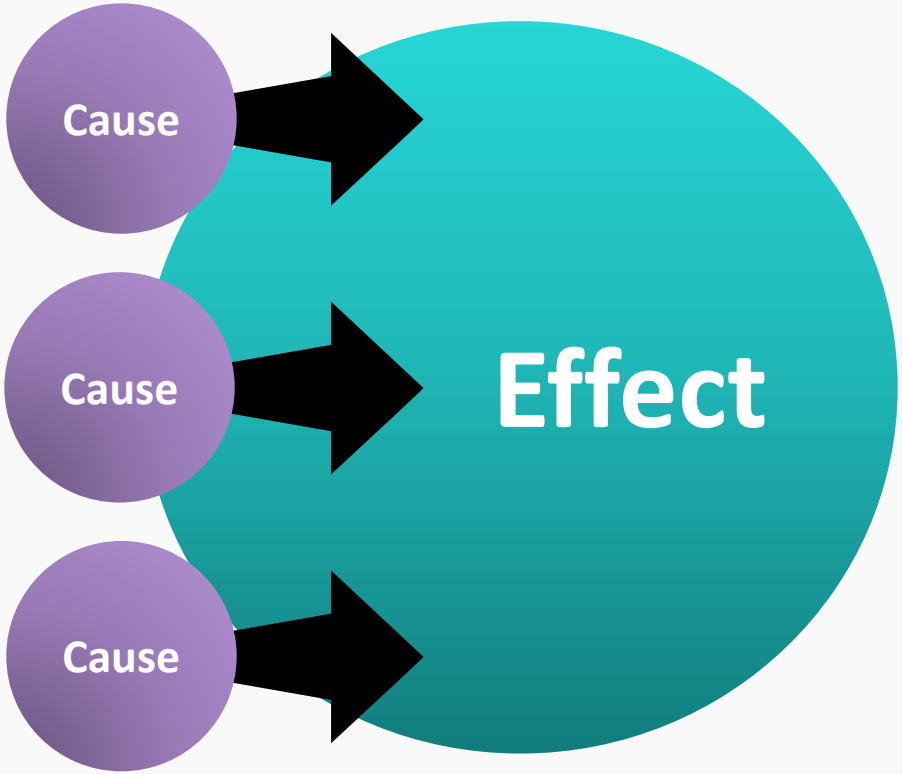
FISHBONE DIAGRAM

A fishbone diagram can help teams understand that there could be **many causes that contribute to an effect**.



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CAUSE AND EFFECT: FISHBONE DIAGRAM

A **Cause-and-Effect Diagram** has a variety of benefits:

- It **graphically displays the relationship of the causes** to the effect and to each other.
- It helps to identify areas for improvement.

It helps to identify **multiple stakeholder ideas** and allows participants to immediately sort ideas into themes for analysis coding and brainstorming.

The **Fishbone Diagram** is a cause-and-effect tool that identifies and presents **multiple potential causes for an identified problem.**

FISHBONE DIAGRAM

Why construct a fishbone diagram?

To explore and **display possible causes contributing to a problem** or an outcome and then determine key causes.

Who should participate?

A team of **multidisciplinary and community stakeholders** affected by the outcome or problem

When should you use a fishbone diagram?

After defining the problem or setting the goal

What do I learn from the fishbone diagram?

The content of the diagram is the brainstormed listing of causes, then voting to identify key causes; **key causes help teams identify areas for improvement.**

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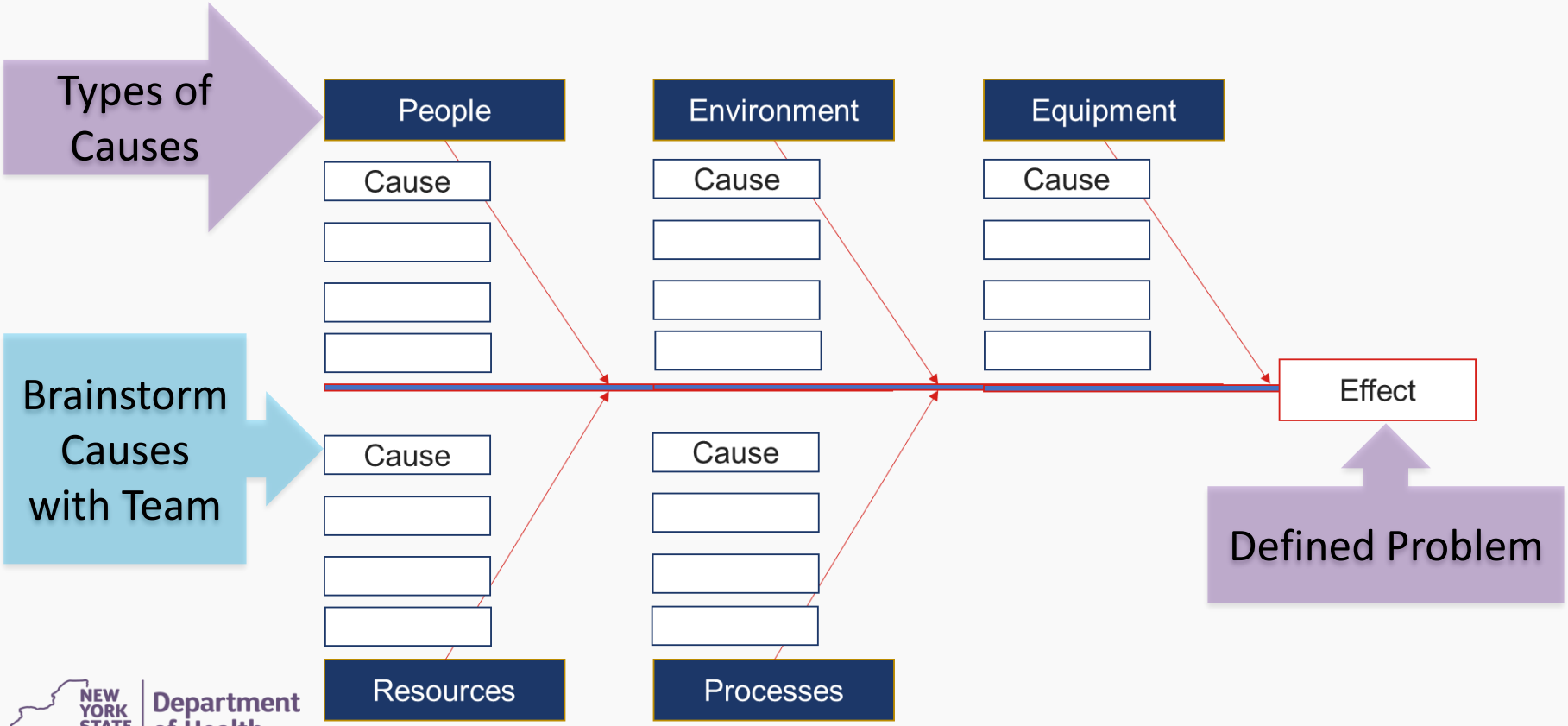
GENERIC FISHBONE DIAGRAM



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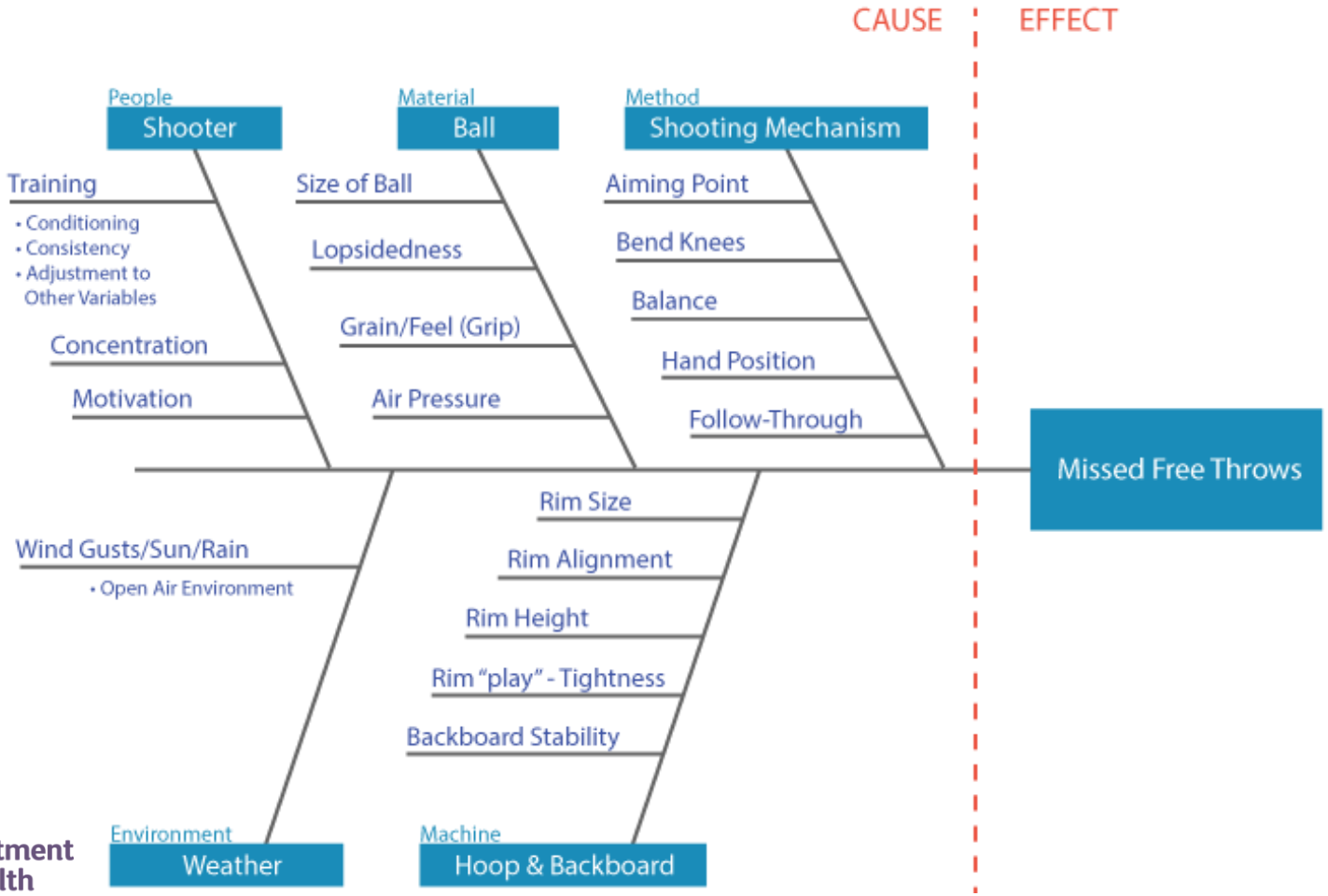

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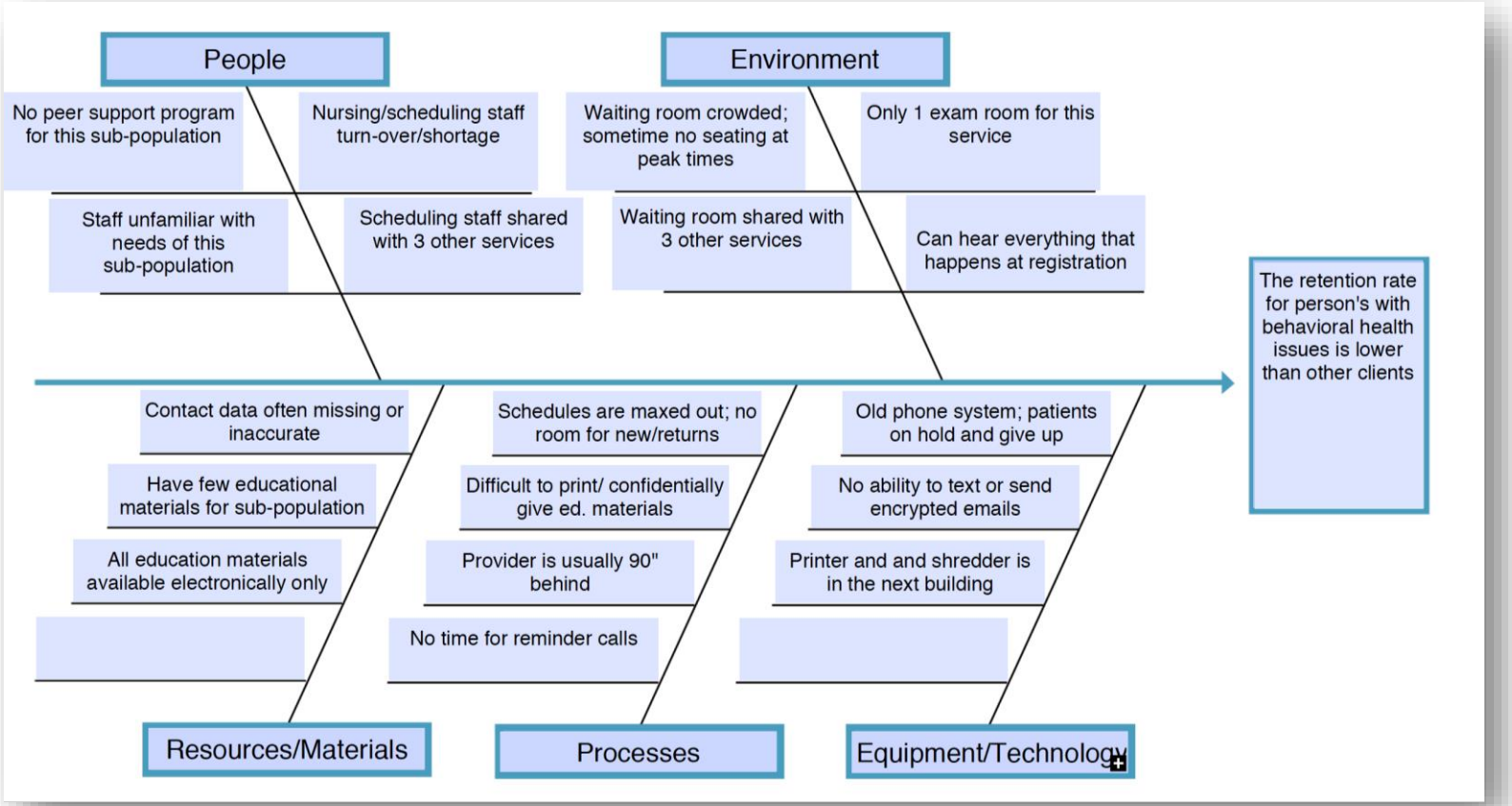

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QUESTIONS OR COMMENTS

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Cause and Effect
Fishbone Diagram Activity

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ACTIVITY INSTRUCTIONS

1. Review the problem: **I arrived at work late**

2. Reflect on the 5 categories and how each might contribute to the problem of arriving at work late (**People, Environment, Equipment, Processes, and Resources**)

3. Brainstorm **3** potential causes for **each of the 5 categories**

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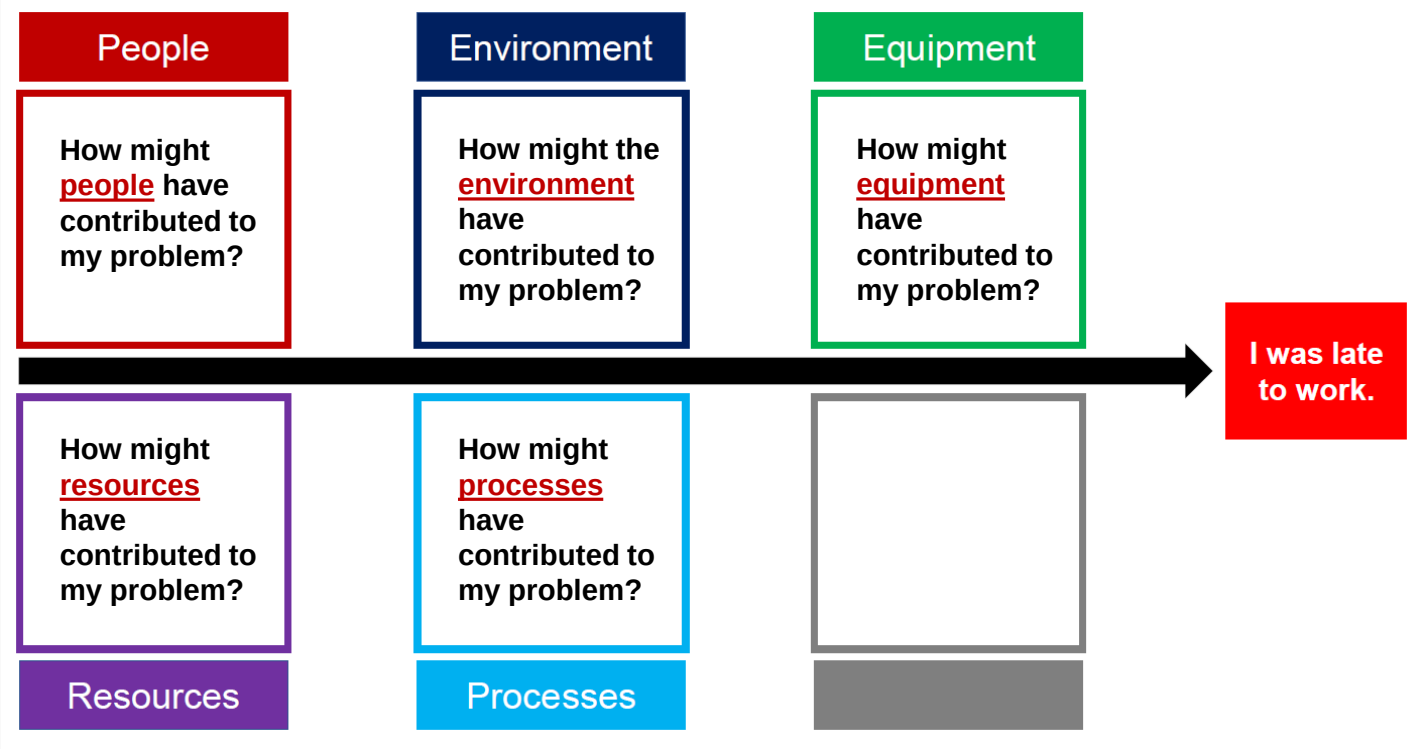
FISHBONE DIAGRAM ACTIVITY TEMPLATE



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Quality Improvement – The Model for Improvement

THE 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 we result in improvement?

thinking part

1. **Set the Aim**
2. **Select Measures**
3. **Develop Change Ideas**

PDSA Cycles

doing part

Four steps for <u>TESTING</u> the change ideas you we develop

Plan it, try it, observe the results, and act on what is learned

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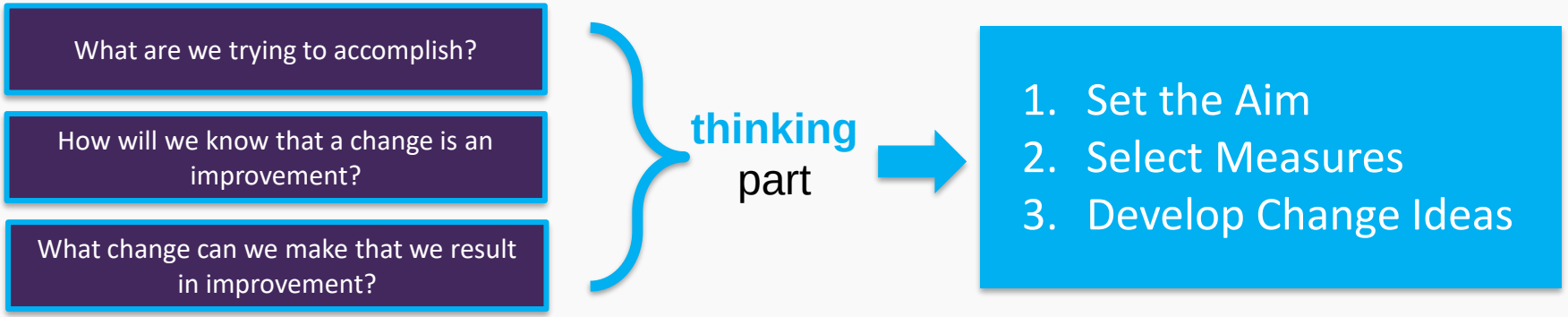
THE MODEL FOR IMPROVEMENT: THE THINKING PART



The "**thinking**" part of the Model for Improvement uses quality tools to better understand a problem or quality issue and then developing change ideas to address it.

QI tools and their outputs (i.e., process maps, cause and effect diagrams) are used by teams to brainstorm potential change ideas **to address a well-defined problem or quality issue**.

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QUESTIONS OR COMMENTS

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AHA MOMENTS

Thinking back over today's information and materials, is there anything from today that produced an "**aha**" or "**lightbulb**" **moment** where something made more sense than it did before or something new helped you to better understand?

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Thank You