5 Tools and Tips to Make Process Improvement More Do-Able
In basic terms, process improvement is a systematic approach to continuously try to do things better within an organization. Pretty simple concept, right? And yet process improvement can become very complicated very quickly given all the specialized terminology and systems that have become associated with it. These tools, terms and step-by-step processes all serve an important function. They create more structure and standardization in order to make this type of ongoing process improvement work the norm for a team. However, teams can easily get off track in their efforts to get better if they become preoccupied with doing process improvement “right” versus just doing it.

In the spirit of not letting perfection get in the way of progress, the tips and tools in this guide are designed to simplify process improvement for your team.

5 Tools and Tips to Simplify Process Improvement

1. Get Everyone On the Same Page
2. Ask the Right Questions
3. Prioritize Efforts to Maximize Impact, Optimize Resources
4. Go Small Before Going Big
5. Establish Failure Triggers
1. Get everyone on the same page.

An important accelerator of your improvement work will be clear communication from the start about:

1. The desired outcome
2. The scope of the effort
3. The roles within the improvement team
4. The timeline

Documenting all of these in a fairly simple improvement team charter like the one pictured here gets the effort started off on the right foot. This charter positions the team for high quality dialogue around the desired outcome and what it will take to achieve it within the specified timeframe, as well as how the team will know it is progressing in the right direction.

Get the Tool: Sample Improvement Team Charter
2. Ask the right questions.

Effective process improvement starts with constructive dialogue focused on 1.) truly understanding why a current practice or process has failed to generate the desired results; 2.) what specifically you are aiming to achieve; and 3.) the risks and benefits to changing business as usual. These discussions should be framed around processes or systems versus around individual failings. Examples of questions to kick-start high quality dialogue around improvement include:

1. What in the process is broken?
2. Which steps in the process create roadblocks?
3. Which step requires the most time to complete?
4. Which step causes the most delays?
5. Are there any steps that cause costs/resources to go up?
6. Are there any steps that cause quality to go down?

*But the two most important questions to ask are WHY and WHAT IF.*

- **Ask Why...and then WHY...and then WHY again.** As your team begins to explore the factors that have contributed to the problem you are aiming to solve, quick fixes can become very alluring. Quick fixes are often fairly apparent, convenient and not overly burdensome to implement. But there is reason to approach quick fixes with caution. They often fail to address the underlying cause of an issue. As a result, quick fixes can become distractions that end up delaying the team from making meaningful improvement toward the desired results.

The **5 Whys** is a common process improvement technique designed to guard against quick fixes. The exercise is simple. Essentially, the team leader asks the following question, “Why is this happening?” to more closely examine the causes and effects of the problem to be solved. The team responds, focusing on process or system factors that have contributed to the issue. The team lead follows-up by asking why that system/process issues exist. Each time the question is answered, the team will have peeled back another layer of the problem, positioning itself to come up with solutions that address the root causes of the problem. (A good rule of thumb is to ask the question five times).
A common temptation – and misstep – in this kind of work is to jump too quickly into resolving a symptom of the underlying program rather than the actual problem at the root of those symptoms. Each time the group responds to the question “Why?” team members should challenge each other to determine whether they have, in fact, hit upon the root cause or if they are still dealing with symptoms.

For example, a group examining the causes behind a medication error could, after asking themselves why numerous times could arrive at a number of symptom, including pharmacy issues, labeling concerns and other high-level causes. But only when continuing to dig – and resisting the urge to jump right into solving these other causes – does the group uncover that the root cause of the issues was interruptions during medication pass. Without continuing to probe, this underlying cause would have remained a persistent source of disruption to the process.

Ask What if? Depending on the problem to be solved, sometimes incremental improvement is sufficient. But other times, more disruptive change is in order. In these cases, an aversion to change and a desire to maintain the status quo work against progress. Asking What If? can be a powerful conversation generation that supports teams in moving beyond their comfort zone and increasing their receptivity to an appropriate amount of risk.

Get the Tool: What If Worksheet

Key to posing all of these questions is to actively invite the perspectives of the patient/family advisors on your team. They bring a unique perspective to this dialogue which can be invaluable for breaking us out of entrenched patterns for how we talk about what is and is not possible and/or important, as well as why things can or cannot occur in healthcare.
3. Prioritize Efforts to Maximize Impact, Optimize Resources

The high quality dialogue that results from asking the right questions will likely yield a long list of change ideas. That’s exactly what you want! But now comes the important step of choosing where to focus your energy, time and resources – at least for now.

Below is a visual technique teams can use to organize the results of brainstorming to narrow in on the most high priority, high leverage changes, based on impact and ease of implementation.

The team assigns each of the change ideas to one of the four quadrants in the matrix below, with placement based on two factors: 1.) the impact making the change will have on the desired results and 2.) the degree of effort it will take to implement the change. Once the change ideas are plotted onto this matrix, the team will have a visual depiction of where to focus their immediate attention.
4. Go Small Before Going Big

One of the greatest threats to nurturing an organizational culture of continuous learning and continuous improvement is planning paralysis. Meetings abound where team members discuss all the possible things that could go wrong and get mired in trying to preemptively solve hypothetical scenarios. This is the state where the amount of talk about a change far exceeds to the action taken to create the change.

The antidote to planning paralysis is a commitment to learning by doing – and doing so while limiting the potential harmful consequences should you learn that what you *thought* would work, actually doesn’t. These risks can be minimized by initially testing changes on a very small scale. Rather than revamp an entire system that will affect all patients and staff, the team starts by testing it with a small group before gradually scaling up those elements of the change that are having a positive impact. This ensures that any unintended consequences of a change are identified early and can be addressed before the effort is launched in full. This small scale testing can also be done in a simplified fashion before more costly investments are made. For instance, rather than working with an EHR vendor to modify templates and fields in order to better collect information related to a patient’s health literacy level and preferred learning method, the team can test out questions and assessment methods in a low-cost paper format to learn what works best.

This approach of learning by doing on a small scale accelerates the process of identifying solutions that will work in the real world because these findings are based on experience, not assumptions.

Implement PDSA Cycles

One common approach for testing changes on a small scale is the use of PDSA cycles. PDSA stands for Plan, Do, Study, Act. This is an iterative process where each subsequent cycle or test is adjusted based on the learnings from the one before. To support this progressive approach, each test is framed about three key questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will yield an improvement?

Get the Tool: PDSA Worksheet

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5. Establish Failure Triggers

As part of the development of the improvement team’s charter, it is important to ask yourself what could cause this project to fail? Or, alternatively, what unintended consequences would render this effort a failure? For instance, if an improvement effort reduces length of stay, but an unintended consequence of the effort is an increase in the readmission rate, the effort can certainly not be considered a success.

Having these discussions early on builds awareness for when a course-correction plan may be necessary. Identify specific events that will signal to the team that the project may be going off track, and could be venturing into failure territory. These are your failure triggers. As the effort progresses, evaluate your progress not only against the measurement targets you have established, but also against these failure triggers.
Person-Centered Care Improvement Project Charter

1. Project Name:

2. Process to be Improved:

3. Project Goal: *What outcome(s) do you hope to achieve with this improvement effort?*

4. Process Owner: *Organizational champion for the effort. Provides resources, guidance, and commitment.*

5. Data needed: *What information do you need to collect to understand current state and to measure improvement after changes have been implemented?*

6a. Improvement Team Members

6b. Patient/Family Partners

   *How are you harnessing the voices of patients/families to ensure ultimate solutions are indeed, person-centered?*

7. Challenges / Problems with current process: *Brief description of some of the challenges facing customers and/or stakeholders.*

8. Expected measures of success: *When you look back on the effort, what are signs that it was successful?*

9. Failure Triggers: *How will you know if the effort is getting off-track and that the plan needs to be re-evaluated?*

10. Proposed Schedule (high level)

<table>
<thead>
<tr>
<th>Task</th>
<th>Start Date</th>
<th>End Date</th>
<th>Responsible Party</th>
</tr>
</thead>
</table>
This worksheet was developed by Planetree as an exercise for healthcare professionals and volunteer patient and family advisors to complete collaboratively. It is designed to encourage councils to break out of their comfort zones and to take on new, potentially intimidating, but high impact improvement initiatives.

1. Define your “What If” endeavor (an opportunity ahead of you that, as a group, you have been reluctant or unwilling to undertake)

   *Could be structural, e.g.: Inviting patients to serve on the quality and safety committee, involving residents in hiring new LTC caregivers, etc.*

   *Could be programmatic, e.g. co-developing a plan for re-engineering the care partner program so that it is more effective for patients, family members and staff.*

2. Assess level of risk.

   Will moving forward with this initiative compromise quality of care? □ YES □ No

   Will moving forward with this initiative put us out of business? □ YES □ No

   Will moving forward with this initiative damage our brand? □ YES □ No

If you answered NO to all of the above, go to #3

If you answered YES to any of the above, identify an alternate “What if” endeavor.
<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
<th>Potential Gains:</th>
<th>Hold-Ups:</th>
<th>Strategies for Overcoming Barriers:</th>
</tr>
</thead>
</table>
| 3.   | Assess Reward. | - Identify and document what the organization could potentially gain by moving forward with the endeavor. | 1. | a.  
|      |           | 2. | b.  
|      |           | 3. | c.  
|      |           | 4. | |
| 4.   | Assess Why Not. | - Candidly discuss what is holding you back from moving forward with this endeavor, i.e. why is this a “What if?” versus a “Done that.” | 1. | a.  
|      |            | 2. | b.  
|      |            | 3. | c.  
|      |            | 4. | |
| 5.   | Co-Develop a Plan. | - For each hold-up identified, come up with 1-3 strategies for overcoming that particular barrier. | 1. | a.  
|      |               | 2. | b.  
|      |               | 3. | c.  
|      |               | 4. | a.  
|      |               |    | b.  
|      |               |    | c.  |
Plan-Do-Study-Act
A Process Improvement Guide for Committees

Definitions:

Plan Phase: A change or need for change is identified. In this phase, committees, teams or individuals are assessing the need for improvement and creating a plan of specific change ideas or interventions to address the issue. For this guide, we will use the opportunity of improving quiet at night for our patients. This phase should also include goal setting and metric identification. Each goal should be established as an aim that is clearly defined and measurable. Each performance improvement event should have two types of measures:

  **Lead Measure:** a predictive measure of how well the change or improvement project is performing. This measure could be as simple as we will assist patients with a bedtime routine that includes the offering of blankets, eye masks, ear plugs and other sleep menu options. We will also ensure that care is clustered to limit interruptions to the patient's sleep. Our lead measures will be: Number of patients offered the sleep menu and clustered evening care and number of patients that slept greater than 5 hours uninterrupted.

  **Lag Measure:** a longer term, bigger goal that is evaluated by post-experience data as opposed to real time data in the lead measure. The Lag Measure for our example is Quiet at Night Score improvement on the HCAHPS survey. Overall we desire an improvement in the Lag Measure, however, if we only measure that we will be in a constant state of addressing concerns and challenges reflectively instead of proactively. The Lead Measure gives us real-time data that can help us predict if the Lag Measure will improve. Instead of waiting for the Lag metrics, we will know from Lead data that the interventions are successful and can then predict that the Lag measure will improve.

Do Phase: This is the phase of action, the phase where we implement the plan and track the lead measure. It is important that this phase lasts long enough to determine initial outcomes. As it pertains to our example, this phase is where we would implement the sleep menu and clustered care routinely.

Study Phase: This is the observation portion of the cycle. The implementation has begun, the collection of Lag Measure data is in progress, and early results or challenges are being discovered. It is important that this phase lasts long enough to determine if the intervention is successful or needs to be refined. In early phases of change, there is resistance and anxiety related to process improvement. The Study Phase must last long enough to evaluate whether the implementation needs refinement or the responses are due to change anxiety. This also underscores the need for lag measures, as the data will provide the team with an understanding of what is occurring during implementation.

Act Phase: This phase is where the data, both quantitative from lag measures and qualitative from feedback from staff and patients, is evaluated and acted upon. The decision for the team is to continue with implementation in the current state or to respond to the data and refine and adjust the implementation; starting another cycle with the planning phase.
### PDSA Team Worksheet

**Identified Project/Process:**

<table>
<thead>
<tr>
<th>PLAN PHASE</th>
<th>Identified Lead Measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Data Collection Tool:</td>
</tr>
<tr>
<td></td>
<td>• Data Owner:</td>
</tr>
</tbody>
</table>

**Identified Lag Measure:**

|            | • Data Source: |
|            | • Data Owner: |

<table>
<thead>
<tr>
<th>DO PHASE</th>
<th>Initial Observations:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>STUDY PHASE</th>
<th>Quantitative Metrics from Lead Measure:</th>
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</table>

<table>
<thead>
<tr>
<th>Qualitative Data from Lead Measure:</th>
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<table>
<thead>
<tr>
<th>Early Lag Measure Results (if any):</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>ACT PHASE</th>
<th>Evaluation and Results:</th>
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