QUALITY IMPROVEMENT TOOLKIT

Care Transitions Network

for People with Serious Mental Illness

The Care Transitions Network is a partnership between the National Council for Behavioral Health, Montefiore Medical Center, Northwell Health, the New York State Office of Mental Health and Netsmart Technologies.

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For more information contact CareTransitions@TheNationalCouncil.org or go to www.CareTransitionsNetwork.org.

INTRODUCTION TO QUALITY IMPROVEMENT

As health care providers across the country begin the transition from traditional fee-for-service payment models toward alternative, value-based payment models that reward high-quality, cost-effective care, it is imperative to adopt a culture of continuous quality improvement. To be sustainable in a reimbursement environment driven by population-, outcome- and cost-related metrics, providers must have the capability to gather and analyze data and adapt as necessary to achieve desirable outcome goals.

Quality improvement (QI) is a systematic approach to analyzing performance in an organization, in which designing, testing and monitoring interventions lead to measurable improvement. The overall goal of QI is to identify and adapt ineffective or inefficient systems to improve the health experiences and outcomes of patients. Quality improvement is NOT quality assurance, which is a common misconception and a barrier to overcome with staff when establishing QI within an organization.

QUALITY ASSURANCE	QUALITY IMPROVEMENT
Guarantees quality	Raises quality
Relies on inspection	Emphasizes prevention
Uses a reactive approach (e.g., adverse event review)	Uses a proactive approach
Looks at compliance with standards	Requires continuous effort
Focuses on individuals	Focuses on teamwork
Examines criteria or requirements	Examines processes or outcomes

ESTABLISHING A CULTURE OF QI

Quality improvement is a team effort. Because it is focused on system reform, QI must involve multiple systems and disciplines within an organization – which means it is crucial to have multidisciplinary staff involvement in QI efforts. Engaging team members from across the organization early and often is key to facilitating staff's adoption of QI goals, and the only way to establish sustainable change.

The following components are essential to successfully establish a culture of QI within your organization.

Think of times when significant organizational processes or procedures changed within your organization. Did development of those changes include multiple levels of staff? Were they communicated effectively? When they were not, how invested or inclined to change did you feel?

Securing Leadership Buy-in

Successful QI is about building a culture that is accepting of change — change that leads to improved outcomes for patients and more effective, efficient processes for staff. Although most organizational leadership will not be involved in the day-to-day implementation of QI activities, they play a strong role in setting the tone, communicating the vision and demonstrating through action a commitment to organizational values, goals and expectations that promote quality and performance excellence. When engaging with leadership around establishing a culture of QI, consider the following:

- How will QI initiatives align with broader organizational goals?
- How will leadership communicate the vision to the organization?
- Who will be your champion among executive leadership (executive sponsor)?
- How will the QI team and leadership engage with one another?

Establishing a Quality Improvement Team

The QI team or committee is the group of individuals within an organization responsible for carrying out improvement efforts. The QI team should meet regularly (bi-weekly or monthly) to review performance data, identify areas of needed improvement and execute and monitor improvement efforts.

The size of the team is typically between five and eight individuals, but more important is the diversity of participants. Your QI team should be comprised of individuals with different perspectives from various departments that will be impacted by the proposed improvement, as well as patient representatives, if possible. An effective team has both the influence to drive change and an understanding of day-to-day realities. It is important that the QI team includes at least one of each of the following:

- **Quality Improvement "Champion"** An individual who is experienced in and committed to continuous improvement. They will be responsible for ensuring the team functions effectively and completes all tasks.
- **Clinical Leadership** An individual who has both an understanding of clinical processes and the authority to test and implement change.

- **Subject Matter/Technical Experts (SMEs)** An individual or individuals with a deep knowledge and understanding of the process or area in question. You may also have several SMEs on your team and they may change or rotate as the QI team tackles new challenges. For example, if you are looking to improve coordination among your care teams, you may want to include staff involved in the care teams as well as health information technology staff who could help with the redesign of data sharing.

- **Executive Sponsor** An individual within executive leadership who serves as the link between the QI team and senior management. They may not participate with the team daily but will stay apprised of progress. When needed, the executive sponsor will provide support to overcome barriers or to obtain resources.

Potential members of a QI team might be:

- **Clinical:** Medical directors, physicians, clinical supervisors, therapists, nursing staff, physician assistants, etc.

- **Administrative:** Clinic directors, operations managers, finance director, billing department staff, receptionists, medical records staff, etc.

- **Support:** Patient representatives, peer mentors, community health workers, community representatives, case managers, etc.

Creating/Communicating the Vision

As stated earlier, engaging team members from across the organization early and often is key to facilitating staff engagement and adoption of QI goals, and the only way to establish sustainable change. When planning how to effectively communicate this to staff, consider the following:

- **Train staff in quality improvement.** Don't make assumptions that everyone understands what QI is and what you are trying to achieve. Take the time to orient staff to the principles of QI and why these activities are being taken on. This slide deck is a starting point that you can adapt as necessary.

- **Keep staff informed on quality improvement projects.** As you undertake "Plan, Do, Study, Act" (PDSA) cycles or other QI approaches, make sure to inform the entire staff of the project, the team and the goals you are trying to achieve. Be sure to talk about the problem you are trying to solve, not just the specific metrics. Provide regular updates to staff on progress (or setbacks) and opportunities for them to ask questions or provide feedback. Get them as invested in the results as you are.

- **Clarify staff roles and responsibilities in quality improvement projects.** Quality improvement projects require staff outside the QI team to do things differently. When developing your project, take that into account and be sure to clearly communicate to staff any changes in processes, procedures and/or roles that will be affected – as well as the reasoning. Staff want the best for their patients and their workplace; knowing the reason for and impact of change is a motivator.

- **Make contract expectations transparent** so that clinicians understand how reaching clinical quality measures or other benchmarks may impact the organization's ability to succeed under value-based payment contracts.

IMPLEMENTING CONTINUOUS QUALITY IMPROVEMENT IN YOUR ORGANIZATION

Before we dive into identifying and implementing a quality improvement project within your organization, it's important to note that this toolkit is structured around a PDSA cycle for quality improvement. The PDSA cycle enables organizations to implement quality improvement quickly by testing changes on a small scale, observing results, tweaking as necessary and testing again or scaling approaches. PDSA enables rapid testing and learning in a framework that is easy to understand for most participants. However, there are various quality improvement frameworks available, some of the most well-known being PDSA, Lean and Six Sigma. If you or someone in your organization is familiar or comfortable with other approaches, we encourage you to utilize what works best for your team.

Identifying a Quality Improvement Area of Focus

When selecting a QI initiative, involve your staff. Those doing the work daily are best suited to identify what is and is not working. To pinpoint areas for improvement, ask the following questions:

1. **Where do we need to improve patient care?**

   Use the data you already have – whether it is from your electronic health records (EHR), data registries or financials – to identify areas where patient outcomes could be improved and/or where there are gaps in care. Use national standards or literature to understand how your organization's performance compares.

2. **Where are we less efficient than we should be?**

   Engage with your staff to identify where lapses in efficiency and/or productivity are occurring. There will likely be more than you anticipated; prioritize those you have the most control over or ability to impact, while also considering where increased efficiency most directly impacts the clinic's ability to control costs. Process mapping can be used to further understand what is happening and where changes could be made.

3. **What areas cause frustration for staff or patients?**

   Ask your patients and staff what their points of frustration are. Root cause analysis can be used to understand the underlying causes of these problems and how they could be addressed.

ABC Healthcare reviewed data from their EHR and data registry and found that they had a large population of patients with psychotic disorders who were taking antipsychotics. The data showed that only 43 percent of these patients were receiving regular diabetes and LDL screenings, which is much lower than the national standard of 80 percent.

Read on for how ABC Healthcare applied a QI approach to address this.

To successfully address the gaps or barriers identified, understanding the underlying causes of these problems is paramount. Root cause analysis is a process your team can use to systematically identify the "root causes" of your problem. The purpose is to better understand what is happening and why to determine the changes that can be made to avoid similar issues in the future. These changes will become the foundation of your QI initiative.

To conduct root cause analysis, gather staff that represent areas of the organization impacted by the identified gap. Once the causes are identified, an action plan can be developed to address them. For guidance on conducting a root cause analysis, refer to Appendix pg14.

Define Your Project: Set Goals, Identify Targets and Metrics

Before planning your project, you must identify what you are trying to achieve and how you will measure success. Since the QI process is focused on addressing performance gaps, start by using data to set your goal. When doing so, it is helpful to ask the following questions:

What data sources were used to identify a performance gap within your organization?

- Example: EHR, billing records, patient survey, etc.

What was the performance gap identified?

- Example: Patients on antipsychotics at risk for comorbid conditions are not systematically being screened.

What are you aiming to improve?

- Example: Increase regular diabetes and LDL screening for patients over 18 years old with schizophrenia or bipolar disorder who are on an antipsychotic.

What is your specific target for improvement?

- Example: 80 percent of patients over 18 years old with schizophrenia or bipolar disorder who are prescribed an antipsychotic will receive an annual diabetes and LDL screening, at minimum, over the next six months.
- Note: Targets should be grounded in assessment of baseline performance and understanding of national or benchmark standards relative to your performance area.

How will you measure improvement?

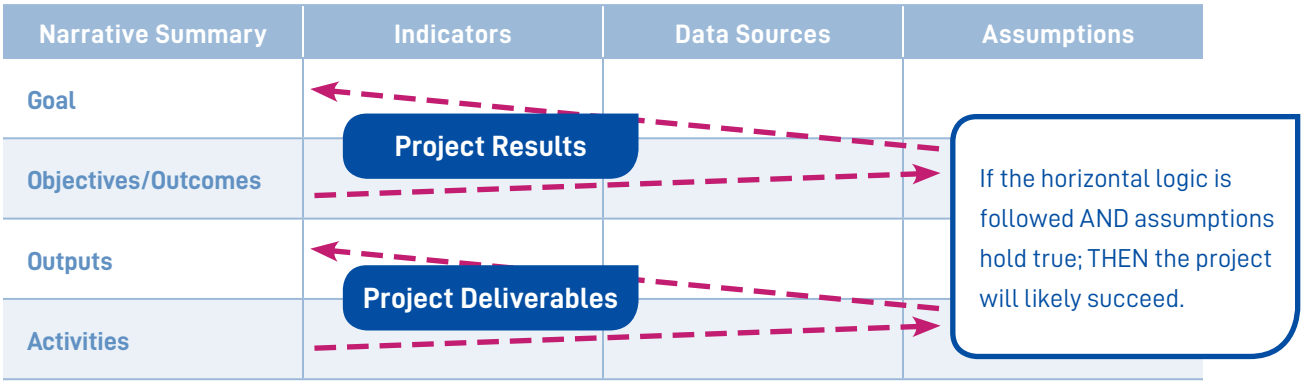
- Example: Screening and results will be tracked through our EHR and examined monthly.

ABC Healthcare set a goal to ensure that 80 percent of their patients over 18 years old with schizophrenia or bipolar disorder who were prescribed an antipsychotic would receive an annual diabetes and LDL screening, at minimum. Through baseline data collection and analysis, ABC Healthcare identified which clients were not receiving annual screenings.

PLAN: Planning Your Improvement Project

Once your performance improvement goal is defined, you will need to determine how it will be achieved. Developing a logical framework (logframe) is one way to engage your QI team in setting a strategy for your improvement project. A logframe is a tool used to prompt the team to work through the intervention logic of your improvement project – the logframe requires defining the following questions:

- What is the goal of my project?
- What activities will we implement? What are the anticipated short and long-term results of these activities (outputs and outcomes) that will lead to achieving the goal?
- What are the indicators for success at each of these levels, and where will this data come from?
- What critical assumptions do these results depend on?



The logframe worksheet and example in Appendix pg17 guides you through this process.

Refine Your Team

As stated before, SMEs on your team may change or rotate as the QI team tackles new challenges. Once your improvement project is defined, make sure you have the appropriate staff on your team – SMEs should align the performance goal. If an area of the organization will be impacted by the proposed change, an effort should be made to include representation from that staff.

ABC Healthcare has determined that its medical director in charge of physical health integration will lead the project. The mental health clinic director, operations manager, part-time nurse and IT manager will also be part of the core team. They also identified a patient who was willing to join the team and provide insight and feedback along the process.

Plan Your Project

Your QI team should work together to develop a plan. It is important to note that your plan is a test — you have identified a problem and potential solutions and are now using PDSA to test each potential solution. Proper planning helps identify the activities, resources and timelines necessary for successful implementation of your test. When formulating your plan, answer the following questions:

- What are the key changes you will be undertaking?
- Who will be responsible for them?
- When will they take place?
- What are the greatest dependencies within your project activities?
  - *Examples: Do any activities rely completely on a specific person or technology? Do certain activities have to happen before others can be completed?*
- What resources do you need (staff, technology, money)?
- Are there any financial implications of this work?
- What training or preparation is needed for staff?
- Will patients be affected? How?
- What are the anticipated barriers or constraints?
- What data will you collect? How?
- Who will collect the data?
- Who will analyze the data?
- How and when will you inform your team about progress?

Planning Your Improvement Initiative

Remember to keep the following in mind:

ACTIVITIES: The concrete steps that must be taken to reach your goal.

RESOURCES: The money, time and other necessities to complete the project. For most practices, the most important resource is staff.

TIMELINES: Realistic assessment of how much time each activity identified will take given the resources available. The steps should be ordered following a logical sequence, avoiding lapses in efficiency.

Use the planning worksheet in Appendix pg20 *to develop your project plan.*

The QI team identified several activities they believe will help accomplish their aim.

- **Revision of current clinical protocols to promote on-site screening:** ABC Healthcare provides metabolic monitoring onsite. ABC will review and revise current clinical protocols to include standards around screening and clear processes for staff to follow to ensure patients are linked for screening.
- **Promotional campaign of screening services:** ABC Healthcare will do a promotional campaign for patients on their screening services. Patients who are not currently meeting standards will be targeted specifically, but the campaign will also include posters in waiting areas and examination rooms informing patients about screening standards and prompting patients taking antipsychotics to ask their clinicians about diabetes and LDL screening.
- **Establish data collection and regular review of data:** ABC Healthcare will review current data collection processes to ensure all process and outcome metrics are being collected and tracked. Progress will be reviewed on a monthly basis during staff meetings so all staff are kept up to date on performance. Data will be used regularly to identify patients not receiving screenings and conducting outreach.

DO: Implement Your Improvement Project

Best Practices in Implementation

Strong planning sets you up for successful implementation. You have an established team and a defined plan to drive progress. However, planning is iterative – being able to set a plan and stick to it, especially in a dynamic health care setting, is highly unusual. As you progress in your improvement project, things will likely change or there will be a need to adapt. Some best practices for managing the implementation process include:

- **Use of your implementation plan as a modifiable document and management tool.** Your QI team should meet frequently (weekly or biweekly) to review progress against the workplan, available data, discuss changes or challenges and revise accordingly.
- **Communicate openly and often with leadership and staff.** Your QI team should not be the only individuals tracking the progress of improvement projects. Identify opportunities, such as a set time during weekly huddles or staff meetings, to update all staff on progress, changes that may impact them and success stories that will keep them engaged and motivated.

Ongoing Data Collection and Monitoring

The implementation process should be monitored regularly using the indicators identified in your logframe. Routine review and analysis of the data as you collect it can lead to early identification of challenges or barriers to success. Building in time and resources to regularly review your results will help your organization be nimble and respond to information as it becomes available.

Overcoming Barriers

Enacting change in a practice is not always simple. Sometimes an unexpected barrier will stop you from carrying out your plan as originally written. One strategy to overcome these barriers is to revisit your root cause analysis and logframe and ask yourself:

- What is the **data** telling us?
- Are the **assumptions** we made correct?
- Are there other **root causes** we could explore?

A systematic review of your underlying assumptions armed with the results of the ongoing monitoring process may yield a new path to achieve your desired result. Do not be afraid to change your workplan to suit a change in or a new understanding of the environment.

After three months, data indicates that ABC Healthcare has made progress – screenings have increased to 59 percent. The QI team further reviewed the data to understand where they are still having challenges. Although ABC Healthcare provided screenings onsite, hours are limited due to only having a part-time nurse on staff. Through review of data and engagement with staff, the QI team found that screening hours were not aligning well with appointment times for patients who needed screenings. The team reviewed screening hours and appointment patterns and readjusted the screening schedule to better accommodate patient needs.

STUDY: Evaluate Your Project

Review and Discuss Results

Although implementation of your project includes continuous monitoring and evaluation of progress, it is important to stop and reflect on the results of your project once it is complete. Final evaluation should include both quantitative data (review of metrics and clinical) and qualitative data (subjective experiences, feedback and discussion). It is a good idea to visualize quantitative data in a format such as a run chart (See Appendix pg 22) to track progress over time. Compare the actual results of the implementation project to the expected results and reflect on factors that may contribute to the findings. It may also be helpful to evaluate how the project impacts the clinic's finances (e.g., did the project result in improvements that help ensure the clinic qualifies for incentive payments, increased billing opportunities or increased efficiencies?).

ABC Healthcare was able to increase their screening rate from 43 percent to 73 percent over the nine months since implementation. They have had significant improvement but have not yet achieved their goal. They decide to have the operations manager and the IT manager stratify the data for the patients in the cohort to determine reasons why the remaining patients have not been screened.

Identify Areas of Improvement Based on Lessons Learned

Final data collection and analysis should also prompt further discussion around what went well, what could be improved or revised or where new information has changed your assumptions about the project. A helpful tool to use is the After-Action Review, which provides a quick, structured process for compiling discussion points into useful information for future implementation.

ACT: Scale or Communicate Your Results

If You Achieved Your Goals (or made progress toward them) Communicate Your Results!

Now is the time to celebrate your success. Think more broadly than your QI team – include staff, patients, community partners and payers. Sharing your successes with your staff helps create a positive work environment, sharing successes with patients engages them in the process and sharing with payers demonstrates your ability to drive outcomes. Some ideas for communicating results include:

- Posting displays in heavy traffic areas that highlight best practices and measurable changes resulting from improvement projects.
- Preparing a summary of the actions taken and the measurable results for inclusion in value propositions. For examples on how to communicate success externally, see Additional Resources.

Identify Opportunities to Scale or Improve

Once you have met your goal, it is time to look toward your next steps. Ask yourself the following:

- Are there opportunities to scale this practice to other parts of your organization or apply the method you have used to another population or service?
- Were there new processes put in place on a pilot basis that now need to be formalized or documented?
- Were there things the team noticed throughout the process that could be improved?
- Did improvement in this area of the practice uncover another area where change is needed?

These questions will help you identify the next change cycle your practice may want to undergo.

After a thorough review of the data, the team at ABC Healthcare has determined they have drastically improved screening among patients receiving their primary care services in the integrated clinic but have not been able to impact screening rates for patients who see independent primary care providers. The quality improvement team is now considering a process to partner and exchange data with other primary care providers in the community with whom they share patients.

If You Did Not Make Progress – Communicate Your Results!

"Failure" is a necessary part of the QI process and is nothing to hide. If your improvement project did not end with the desired results, take what you learned to inform future projects. Share your insights broadly within the organization so that others learn from them as well. Then, revisit your root cause analysis and logical framework with your team and ask yourself:

- What is the **data** telling us?
- Are the **assumptions** we made correct?
- Are there other **root causes** we could explore?

If your team believes a different approach would be more successful, you can return to the planning stage and begin a new PDSA cycle.

APPENDIX A: PDSA WORKSHEET

This worksheet can be used by your QI team to work through selection, planning and implementation of your improvement project.

Identify Your Team

Who is on your QI team?		
List members of the team	Organizational titles	Roles within QI team

How frequently will your QI team meet?

Identify an Improvement Area

With your team, answer the following questions:

1. Where do we need to improve patient care?

2. Where are we less efficient than we should be?

3. What areas cause frustration for staff or patients?

Note: Answering these questions should not be a completely subjective process – data should play a role in identifying performance gaps.

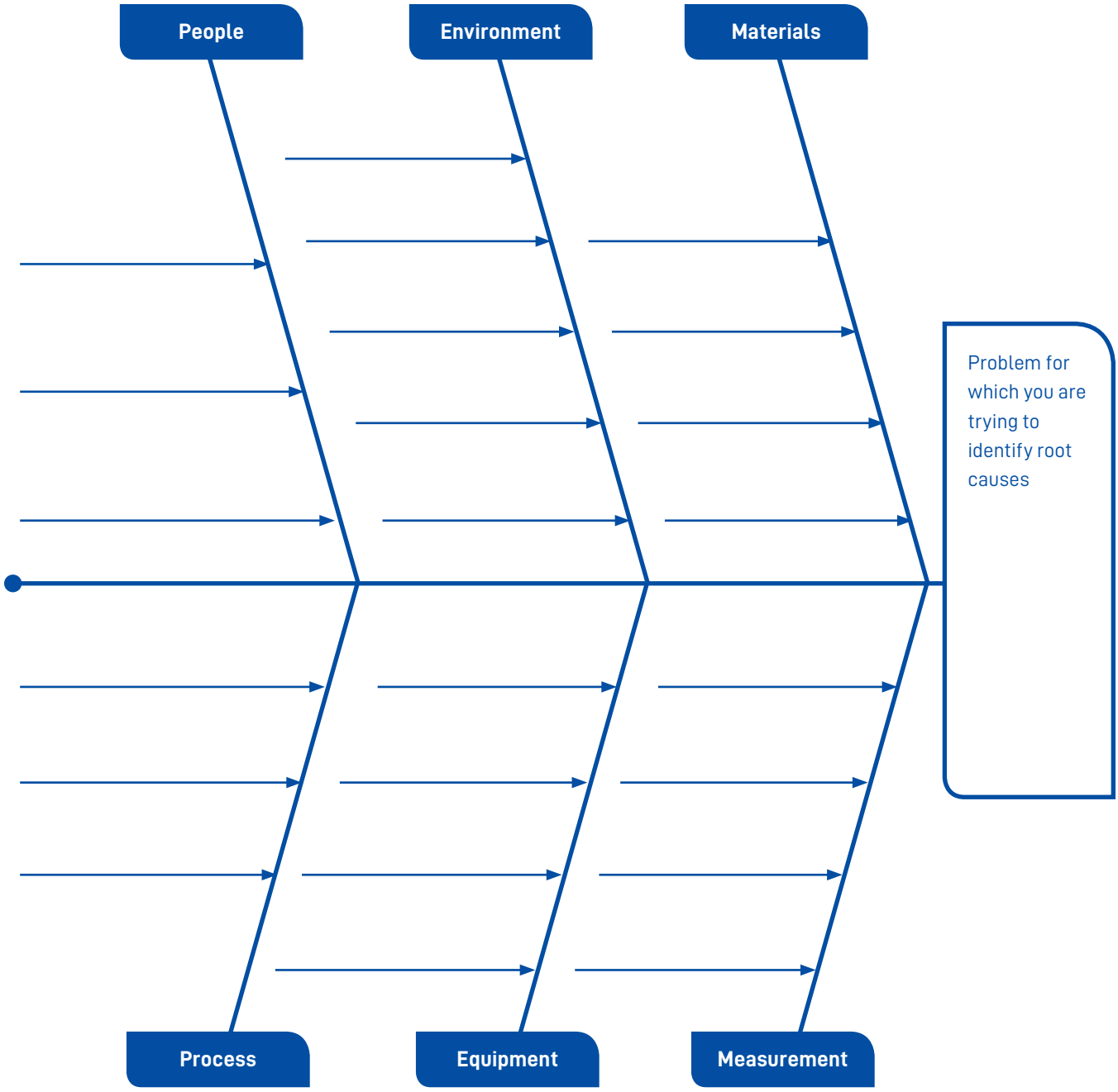
When answering these questions, which data sources were used to identify the performance gaps within your organization?

Conduct Root Cause Analysis

Select one problem from above to prioritize and conduct a root cause analysis.

For guidance on conducting a root cause analysis, see next page.

TEMPLATE



Conducting Root Cause Analysis

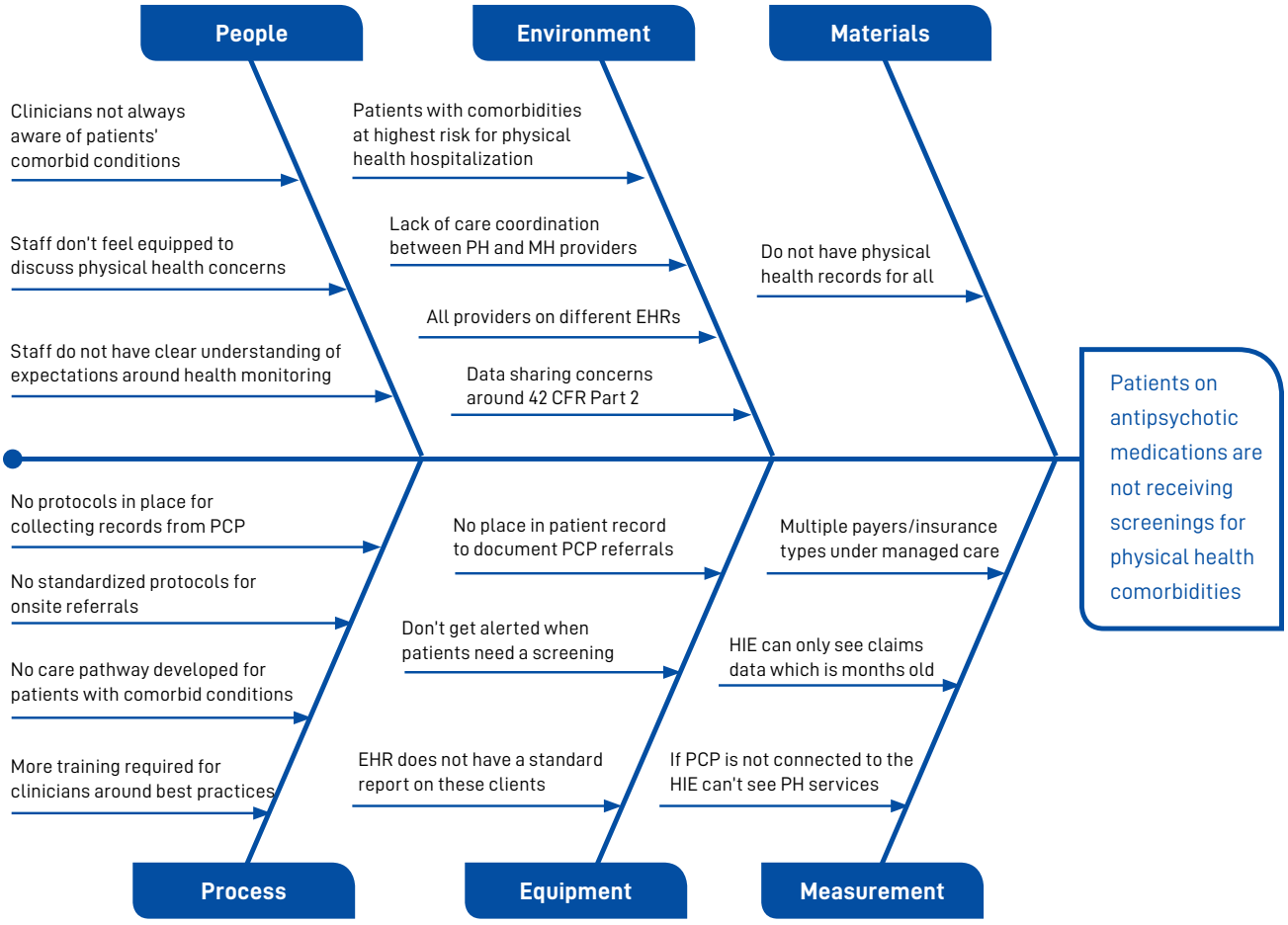
Using a fishbone diagram allows your quality improvement team to visualize the many possible cause to the problem identified in your gap analysis by sorting them into categories. The generic categories below can be used, or you can create your own better suited to your practice's needs.

Process: The 5 Whys

1. Identify the specific problem you are trying to solve for.
2. Working with a team and looking across each of the categories, ask yourselves why the problem may be happening tied to that category (identifying the potential causes).
3. For each of these potential causes, continue to ask yourselves why until you come to a potential cause that is concrete and actionable. This is your root cause – the one you can act upon!

EXAMPLE Problem – Unable to report on metrics

WHY? Data not being collected consistently.	**WHY?** Staff unclear on expectations of data collection.	**WHY?** Nobody was designated to collect the data.	**WHY?** No data collection workflow was communicated.	**WHY?** No data collection workflow was developed.



Once you have completed your root cause analysis, select **one root cause** you will address through your QI project. When selecting which cause to address, consider the following:

- Which causes do I have the most control over?
- Which areas would have the most impact?
- Are there any low-hanging fruit – causes with solutions that would be quick and easy to implement?

What problem have you selected to address?

Define Your Project

Answer the following questions about your selected problem to clarify what you are trying to achieve.

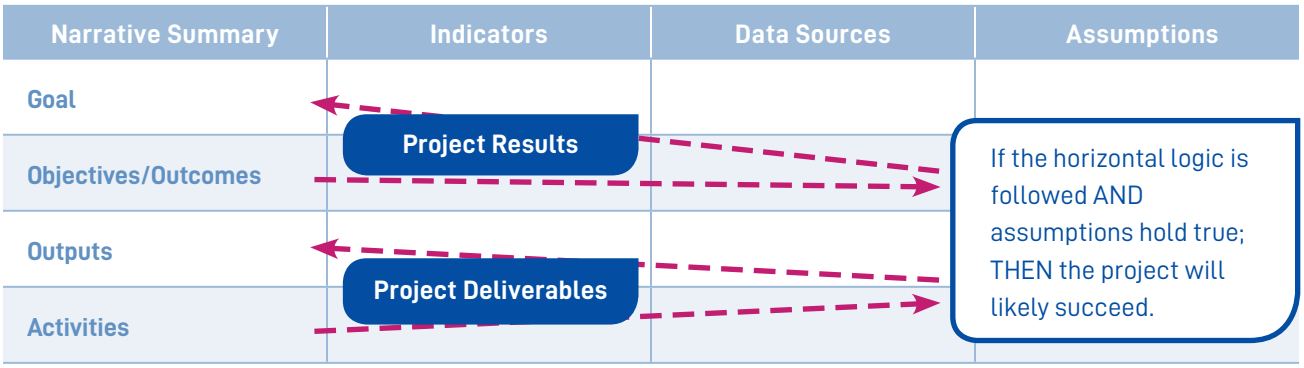
What are you aiming to improve?

What is your specific target for improvement?

How will you measure improvement?

Develop Your Logframe

A logical framework gives a concise summary of the project's intervention logic. The framework allows the team to structure strategy and narrative and to analyze whether proposed interventions will achieve expected results. **Establish the strategy for your QI project by completing the logframe template.**



GOAL	Overall aim
INDICATORS	Metrics you will use to measure the achievements
DATA SOURCES	How you'll collect the information for the indicators
ASSUMPTIONS	External conditions needed to get results
OBJECTIVES/OUTCOMES	What will be achieved, who will benefit and by when
OUTPUTS	Specific results the project activities will generate
ACTIVITIES	What tasks need to be completed

TEMPLATE

Narrative Summary	Indicators	Data Sources	Assumptions
Goal			
Objectives/Outcomes			
Outputs			
Activities			

EXAMPLE

Narrative Summary	Indicators	Data Sources	Assumptions
Goal 80% of patients 18+ with schizophrenia or bipolar disorder who are prescribed an antipsychotic will receive an annual diabetes and LDL screening, at minimum, over the next six months	Percent of patients screened	EHR; data registry with primary care physician (PCP)	
Objectives/Outcomes 80% of referrals attend screening	Percent of referrals attending screening	EHR	A majority of eligible population is being captured through referrals
Outputs 1. All clients with SMI taking anti-psychotics referred for screening 2. Protocols for screening and data sharing developed in collaboration with PCPs 3. All staff trained on revised protocols	1. Number of clients referred for screening 2. Number of PCPs with established memorandums of understanding 3. Number of staff trained in revised processes	EHR, training log	Protocols will be followed and patients will be referred
Activities 1. Promotional campaign of screening services 2. Realignment of screening hours 3. Revision of current clinical protocols 4. Establish data collection and regular review of data 5. Identify and engage with PCPs for collaboration	1. Marketing materials distributed 2. New hours established 3. Staff implementing workflows 4. Indicators selected and protocol in place 5. Population review of PCPs complete	Organization protocols, monthly staff meeting	Staff are given the tools and resources to effectively implement change

Plan Your Project

To help organize your project, complete the following worksheet keeping in mind the planning questions highlighted on page 7.

Project Overview
Project Aim:
Project Timeline:

Project Activities			
Activity	**Resources Needed**	**Responsible**	**Timeline**

Data Collection			
Metric	Data Source	Responsible	Frequency

Project Risks	
Anticipated Challenges/Barriers	Mitigation Plan
With your team, brainstorm and list out anticipated challenges	*...as well as how you plan to address them*

Project Communication Plan		
Information to be Communicated	**Audience/Forum**	**Frequency/Timeline**
Example: Project launch – purpose and implications for staff	*All staff via monthly staff meeting*	*Once – December 2018*
Example: Progress on metabolic monitoring rates	*Clinical teams via weekly huddle*	*Weekly throughout life of project*

DO: Implement Your Improvement Project

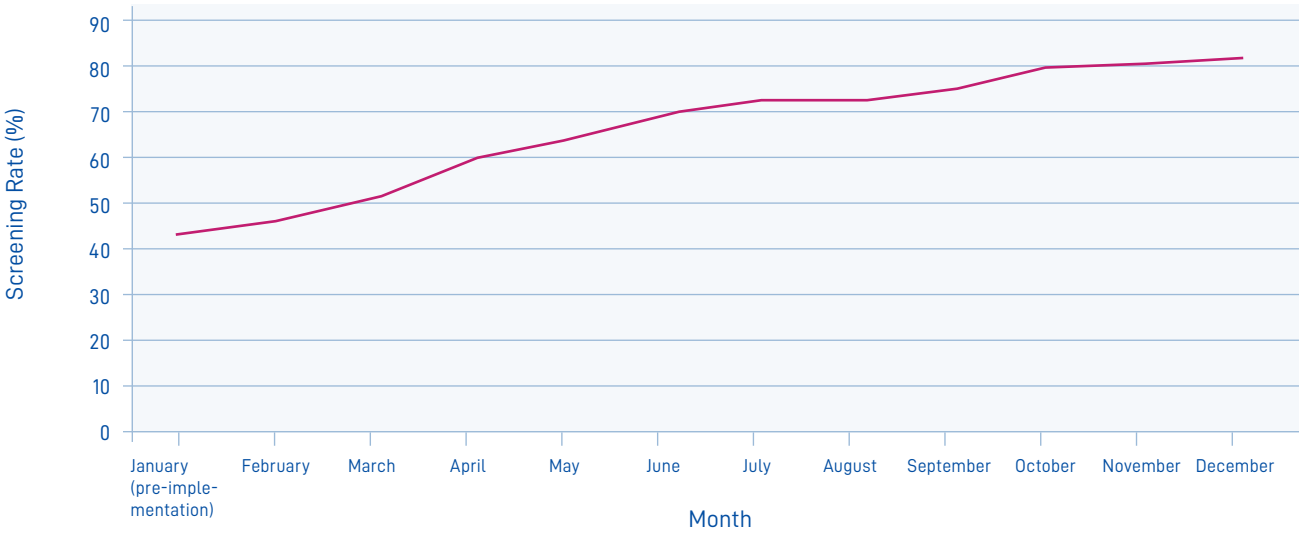
Information from the planning worksheet can be used to develop a project workplan and track progress visually. Use this project workplan template.

Study Your Results

Using the metrics your team is tracking, evaluate the results and success of your QI project. Use this run chart template to visualize changes over time.

EXAMPLE

Diabetes Screening Rates for Patients with SMI on an Antipsychotic



After-Action Review

An after-action review is a quick and simple process used by a team to capture the lessons learned from past successes and failures, with the goal of improving future performance. At the end of your QI project, take the opportunity to reflect with your team by answering the following questions:

1. What were our intended results (what was supposed to happen)?

2. What were our actual results (what really happened)?

3. What went well and why?

4. What can be improved and how?

Act: Share Your Results

Did you achieve your goals?

IF SO, GREAT

Determine how you will communicate and scale them. Complete the following table to determine how you will share your results. Keep in mind the following:

- **Audience:** Who do you want to share your results with? Think both internally (C-suite, staff in other departments) and externally (patients, payers).
- **Interests:** Think about the difference interests and motivators for each audience, as this will inform your messaging. For example, patients are interested in receiving the best care and knowing their provider is invested in their health, while your executive leadership is likely most interested in results that demonstrate improvements within clinical outcomes and ties to cost.
- **Message:** Knowing the interests of your audience, what is the message you are giving them?
- **Approach:** How will this information be delivered – via a newsletter, a report, a presentation? The appropriate approach will likely vary by audience.

Audience	Interests	Message	Approach

In addition, answer the following questions:

1. Are there opportunities to scale this practice to another part of your organization or apply the method you have used to another population or service?

2. Were there any pieces of the process that could be improved?

3. Did this process identify any additional areas where change is needed?

IF NOT, GREAT

Go back to your root cause analysis and logical framework and answer the following questions:

- What is the **data** telling us?

- Are the **assumptions** we made correct?

- Are there other **root causes** we could explore?

ADDITIONAL RESOURCES

General QI

AMERICAN MEDICAL ASSOCIATION (AMA) STEPS FORWARD MODULES

- Preparing Your Practice for Change www.stepsforward.org/modules/practice-transformation
- Selecting Sustainable Change Initiatives www.stepsforward.org/modules/implementing-change
- Quality Improvement Using PDSA www.stepsforward.org/modules/pdsa-quality-improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT

- Free Online Course app.ihi.org/lmsspa/?utm_source=ihi&utm_medium=internal&utm_campaign=qi-102-web-promo#/1431fa43-38e4-4e40-ab3b-7887d3254f72/41b3d74d-f418-4193-86a4-ac29c9565ff1
- Quality Improvement Essentials Toolkit
  www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
- Quality Improvement Project Management
  www.ihi.org/resources/Pages/Tools/QI-Project-Management.aspx

PDSA

PLAN

- AMA Process Map Toolkit
  www.stepsforward.org/Static/images/modules/31/downloadable/process-map-toolkit.ppt
- Institute for Healthcare Improvement – 5 Why's Worksheet
  www.ihi.org/resources/Pages/Tools/5-Whys-Finding-the-Root-Cause.aspx

DO

- Institute for Healthcare Improvement Project Planning Form
  www.ihi.org/resources/Pages/Tools/ProjectPlanningForm.aspx

STUDY

- Center for Evidence Based Management – Guide to the After Action Review
  www.cebma.org/wp-content/uploads/Guide-to-the-after_action_review.pdf
- Institute for Healthcare Improvement – Visual Management Board
  www.ihi.org/resources/Pages/Tools/Visual-Management-Board.aspx

ACT

- Performance Story Template
  www.thenationalcouncil.org/wp-content/uploads/2018/10/Performance-Story-Template.docx
- Institute for Healthcare Improvement – Communication Strategies for Spreading Changes
  www.ihi.org/resources/Pages/Changes/CommunicationStrategiesforSpreadingChanges.aspx