Quality Data Training

November 11-14, 2025

Iloilo City, Iloilo, Philippines

Mabuhay!

Community Agreement

- Be Present
- Actively Participate
- Ask Questions (Be Courageous)
- Step Up & Step Back
- Maintain a Growth Mindset
- Manage Your Technology (cellular phones, tablets, laptops)

Community Garden

Learning Objectives

1. Understanding of the NQPS and how it is implemented throughout the levels of the public health system in the Philippines
2. Knowledge for application of tools and methods to analyze data, identify gaps in performance, and establish priorities for improving care
3. Understanding of the distinction between data for reporting or accountability and for improvement
4. Understanding and application of basic skills of improvement science including systems thinking, testing changes in practice, and evaluating results
5. Knowledge of communication strategies to engage stakeholders at all levels of the province (policymakers, providers and patients) to establish priorities for improvement and sharing results of subnational and national data systems
6. Skills for leadership of data review as part of quality management and improvement processes
7. Understanding and skills for problem-solving and working in teams

Low Performance on Key Indicator

Investigate to Understand and Address Issue

- Data Quality & Analysis
- Data Collection & Reporting
- Health Care Systems
- Patients & Populations
- QI Team & Activities
- Stakeholder Communication

Improvement Action Plans

Teams will develop an action plans to better use data to make improvements and improve communicate with stakeholders.

The plans might involve better understanding and addressing any of the following:

- Data quality and analysis challenges
- Data collection and reporting challenges
- Health care systems barriers
- Patient & population barriers
- QI Teams and activities
- Communications with stakeholders

Data Quality & Analysis

Data Collection & Reporting

Health Care Systems

Patients & Populations

QI Team & Activities

Stakeholder Communication

Quality Management Program Elements

Lecture

Low Performance on Key Indicator

Investigate to Understand and Address Issue

- Data Quality & Analysis
- Data Collection & Reporting
- **Health Care Systems**
- Patients & Populations
- QI Team & Activities
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DATA FOR IMPROVEMENT VS. ACCOUNTABILITY IN HEALTHCARE

ASPECT	IMPROVEMENT	M&E (Accountability)
Aim:	Improvement of care in system where it is delivered	Comparison, public health, reassurance, spur for change, funding, choice
Test observability	Test observable	No test, evaluate current performance
Bias	Accept consistent bias	Measure and adjust to reduce bias
Sample size	"Just enough" data, small sequential samples	100% of available relevant data
Flexibility of hypothesis	Hypothesis flexible, changes as learning takes place	No hypothesis
Testing strategy	Sequential tests	No tests

DATA FOR IMPROVEMENT VS. ACCOUNTABILITY IN HEALTHCARE (2)

ASPECT	IMPROVEMENT	M&E (Accountability)
Aim:	Improvement of care in system where it is delivered	Comparison, public health, reassurance, spur for change, funding, choice
Participants	Teams of staff involved in processes being improved	Often through external auditor or supervisory visit; training on technical content
Community Involvement	Ideal	Unusual
Information Systems	Whatever works: getting started is key Ultimately integration into clinical IS should occur	Reporting system designed to send data out
Ownership of Data	Clinic teams Aggregated data to government	Donors, evaluators, government

HEALTHQUAL Model

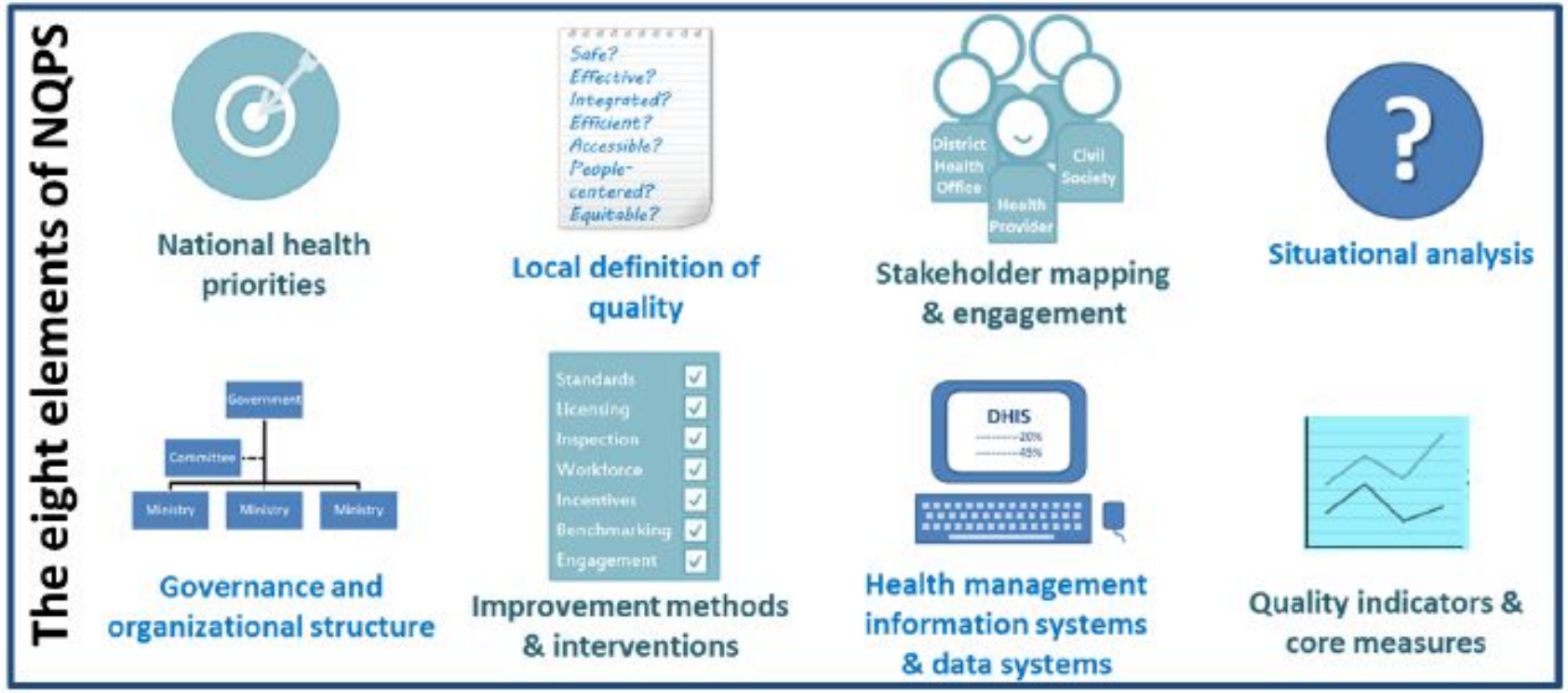
Quality management (QM) is a structural umbrella over all processes and activities related to QA and QI. QM is responsible for the coordination and facilitation of these activities in an organization. Specifically, QM is involved in the selection of health care quality personnel, the allocation of other resources, the monitoring and evaluation of plans, and the launching of improvement teams.

—World Health Organization (EMRO). 2004. *Quality improvement in primary health care: a practical guide.*

Quality Management – Key Program Elements

Embedding QI activities at all levels of the health system

National Quality Policy & Strategy - The Eight Elements



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Operational planning

Integration of technical programmes

Tools & resources

Quality Management Program: Elements of governance for quality

- Leadership & Quality Management Plan
- Workforce Engagement
- Measurement Analysis and the Use of Data
- Quality Improvement Initiatives
- Patient Involvement
- Knowledge Management - Communications
- Quality Program Evaluation
- Achievement of Outcomes

Quality Infrastructure

- Quality management plans
- Organizational Leadership - how will your leadership be involved in and support QI efforts?
- Quality Management Committee/Teams - who will serve on these, who will coordinate activities, how will these be structured, what are member responsibilities?
- Capacity Building and Resources - what is the plan for staff, time, training?

Why Quality Management Plans?

- Define a quality program's strategic direction-guide for quality planning
- A document that outlines how QI efforts will be implemented
- Includes clear definition of roles and responsibilities
- Contains program quality improvement goals and activities
- Have an annual work plan with timeframes
- Provides for ongoing assessment and evaluation of the quality program ("organizational assessment"}

Quality Management Plan Components

- Quality Statement
- Quality Management Program Description
- Quality Infrastructure
  - Leadership
  - Quality Management Committee/QI Project Team
  - Resources/Capacity Building
- Determining Quality Improvement Goals
- Performance Measurement System
- Stakeholder and Patient Involvement
- Knowledge management and communication
- Evaluation

Leadership and Quality

"Your organization will only make meaningful and sustainable quality improvements when people at every level feel a shared desire to make processes and outcomes better every day, in bold and even imperceptible ways.”

Robert Lloyd, Executive Director of Performance Improvement at the Institute for Healthcare Improvement, offers some tips for improving quality within your organization.

Leadership Support for Quality

- Make staff time available for meetings
- Provide space and supplies for meetings
- Arrange for technical assistance if needed
- Provide information and DATA necessary for QI

The Role of High-Level Leaders

Roles for Leader Champions

- Champion quality improvement
- Help build capacity for quality management at the regional and facility level
- Promote standards for quality at jurisdictional, facility and individual levels
- Review performance data to stimulate improvement
- Showcase successes in the region
- Encourage consumers involvement in facility QI programs

The Role of High-Level Leaders

Techniques & Strategies for Involvement in Quality Improvement

- Relationship building
- Identifying facility champions
- Setting Expectations
- Observation
- Quality Improvement Document Review
- Encouragement
- Goal setting
- Combining theory and knowledge, practical application and peer learning
- Establishing ongoing dialogue with senior leadership to promote culture of quality

Further reading: Reinertsen, Pugh, Nolan. Executive Review of Improvement Projects: A Primer for CEOs and other Senior Leaders
https://www.ihi.org/sites/default/files/2023-11/Executive-Review-of-Projects_IHI-Tool.pdf

Quality Committee Role

- Drives implementation of the Quality Plan
- Provides high level oversight of the Quality Management Program
- Chaired by High-Level Leader (Hospital Manager/Chair)
- Reviews performance data
- Sets priorities, goals and objectives
- Assigns and supports Quality Teams a/k/a Work Improvement Teams
- Membership is representative of departments and disciplines
- Communicates activities to broader staff consumers and key stakeholders

Workforce and Staff Engagement

- Development and promotion of staff knowledge and practice of QI methodology
- Clearly defined roles and responsibilities, e.g., job duties
- Routine engagement in QI activities
  - *Quality Improvement Committee*
  - *Quality Improvement Team*
  - *Department Meetings*
- Training and Retraining
- Regular communication to all staff re improvement progress
- Staff identification of Improvement opportunities

Measurement, Analysis & Use of Data For Improvement

- **Routine use of data to prioritize and drive improvement activities**
- Development of performance measures/indicators
  - External measures (MOH, etc.)
  - Internal – based on local priorities (regional, facility)
- Development of data validation process
- Use by staff in all relevant departments
- Development of data systems to assure routine access to results
- Use of benchmarking reports to compare performance with other facilities or units/programs (Coaches can help bridge this to regional / national level)

Quality Improvement Initiatives

- Identify and conduct QI initiatives based on data (quality committee function)
- Promote teamwork: interdepartmental and intradepartmental
- Use of standard QI methodology as guiding framework
  - Clear Aim/goal
  - Root cause analysis
  - Testing changes
  - Monitor progress over time
- Documentation - Journals, Action plan worksheets: learning system!
- Development of policies and procedures based on successful interventions: activities to promote sustainability of QI evidence-informed practices

Questions

Variation and Standardization

Lecture

Low Performance on Key Indicator

Investigate to Understand and Address Issue

- Data Quality & Analysis
- Data Collection & Reporting
- Health Care Systems
- Patients & Populations
- QI Team & Activities
- Stakeholder Communication

“Not everything that can be counted counts, and not everything that counts can be counted.”

— *William Bruce Cameron*

Quality improvement principles

Fundamental concept of improvement:

"Every system is perfectly designed to achieve exactly the results it achieves."

Principles of improvement:

1. Understanding work in terms of processes and systems
2. Controlling variation
3. Developing solutions by teams of providers and clients based on root cause analysis/process investigation
4. Focusing on client needs
5. Testing and measuring effects of change
6. Peer learning

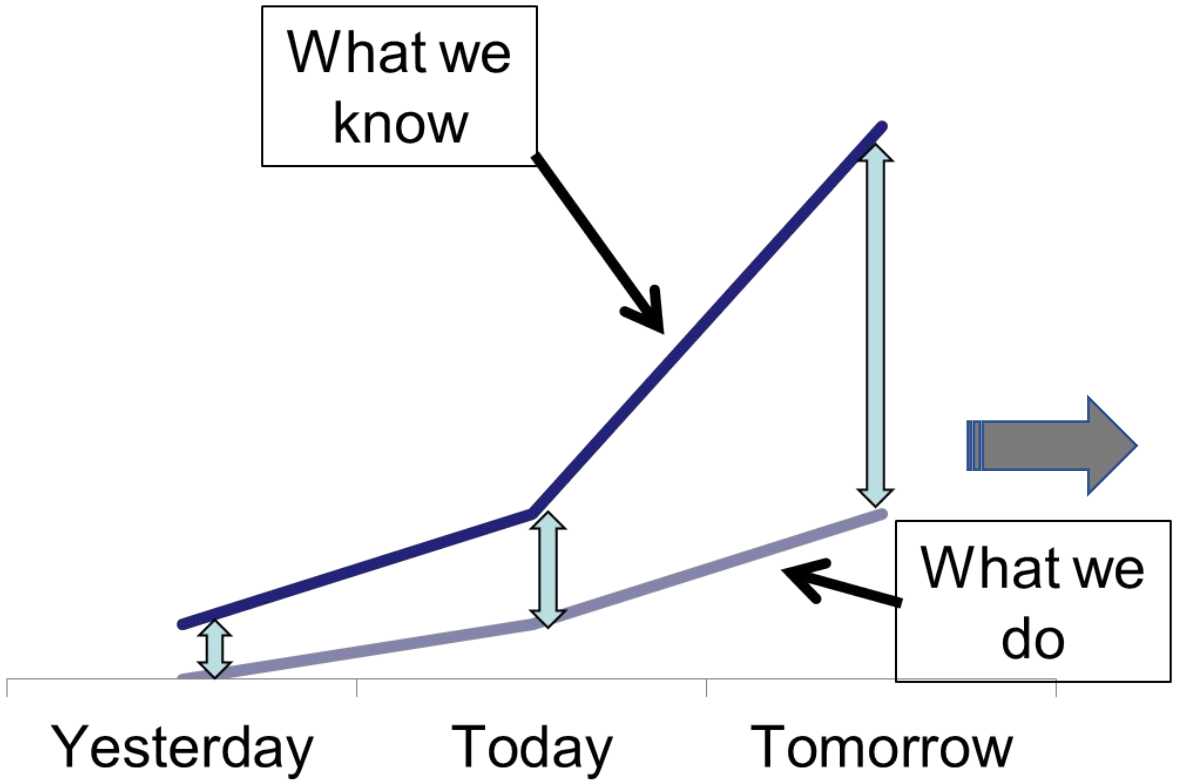
What is the problem?

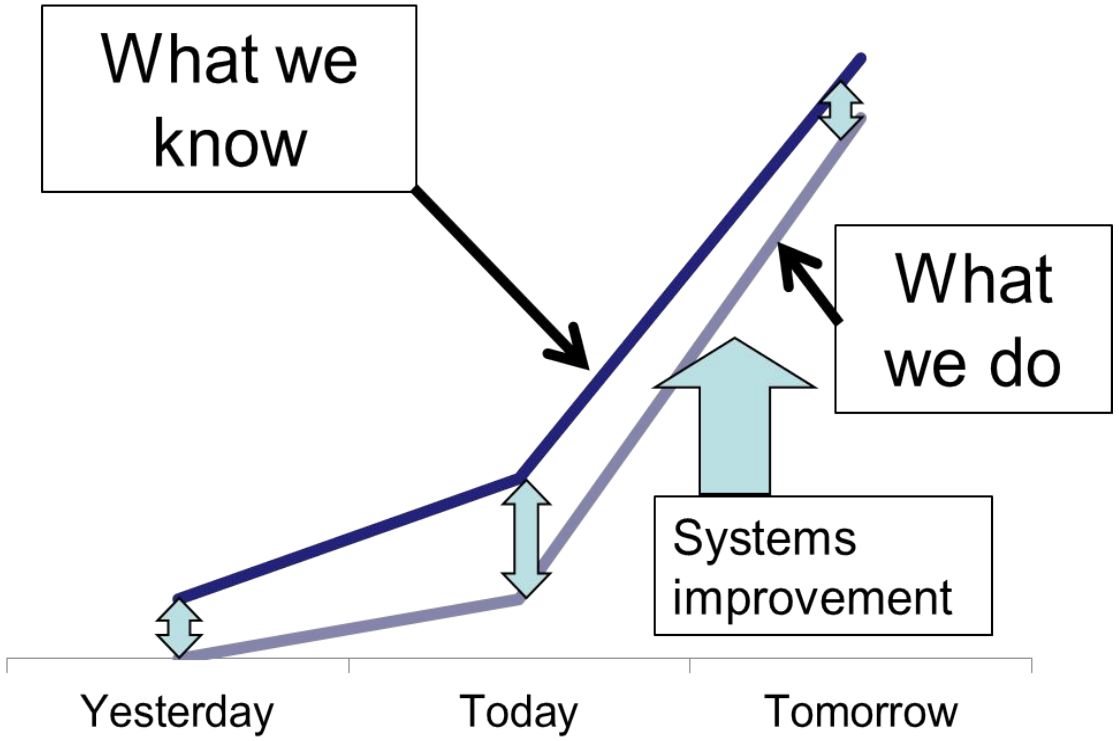
“Health care interventions that are known to work and save lives are not being implemented for every patient every time. **We must address this gap between knowing and doing.”**

The know-do gap – how what we *know* differs from what we *do*

What we know - - - - - - - - - - **What we do**

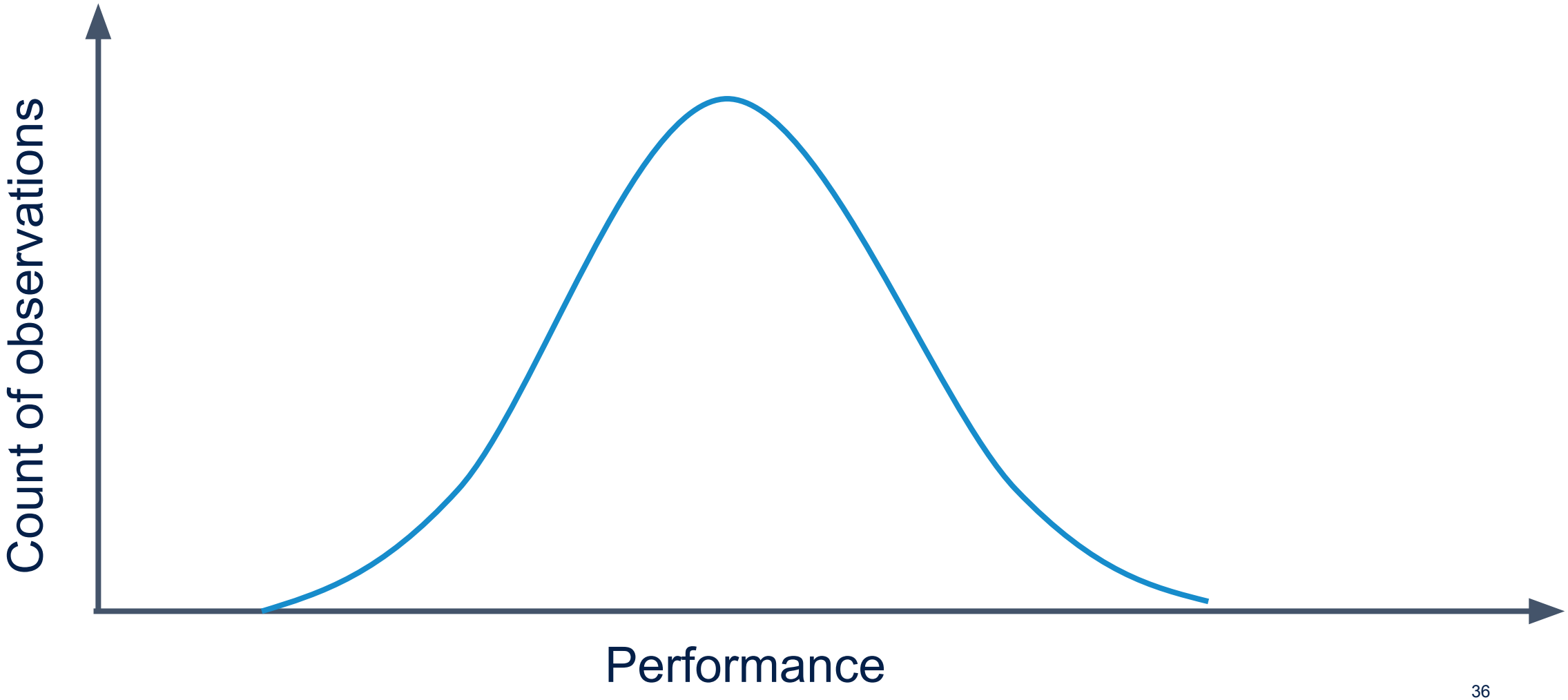
Closing the “know-do” gap



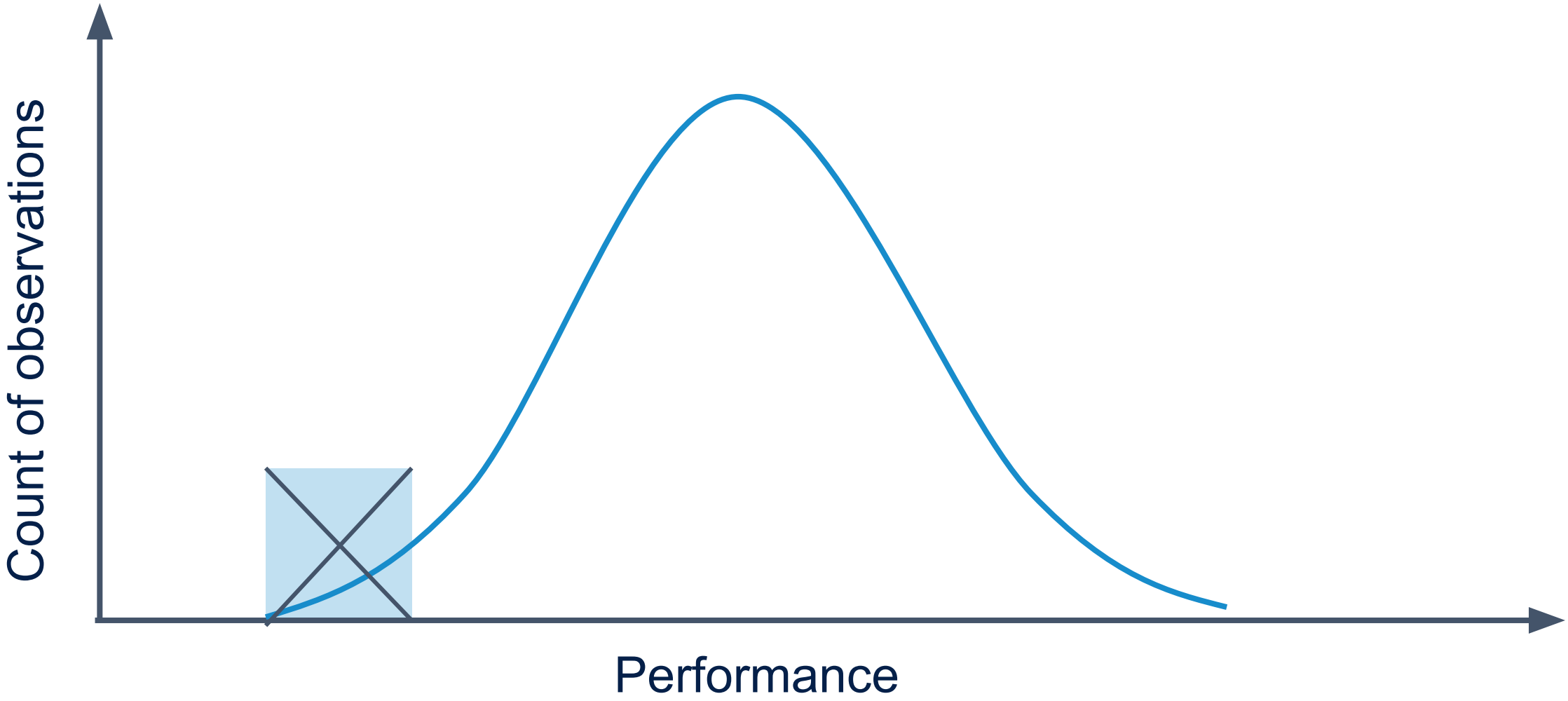


Source: Project Fives Alive!

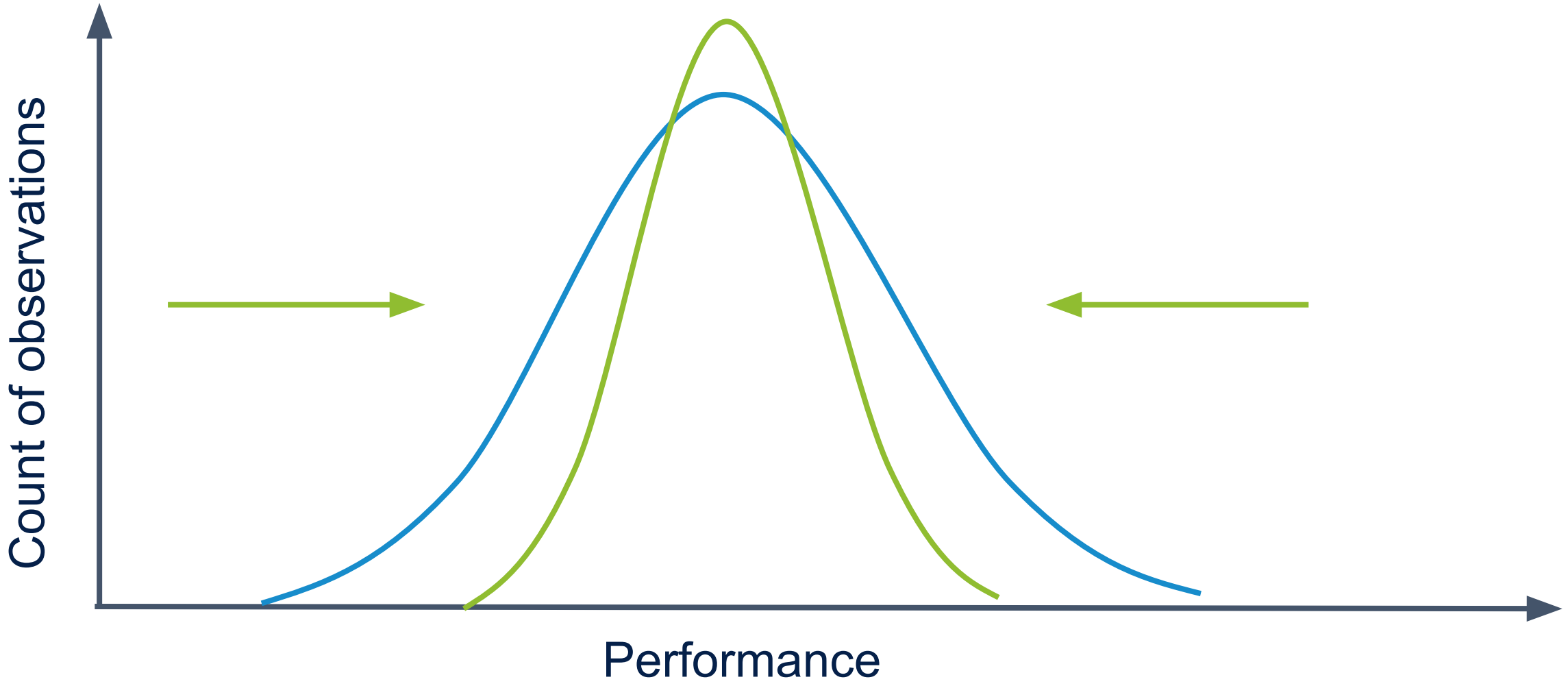
Quality assurance vs. quality improvement



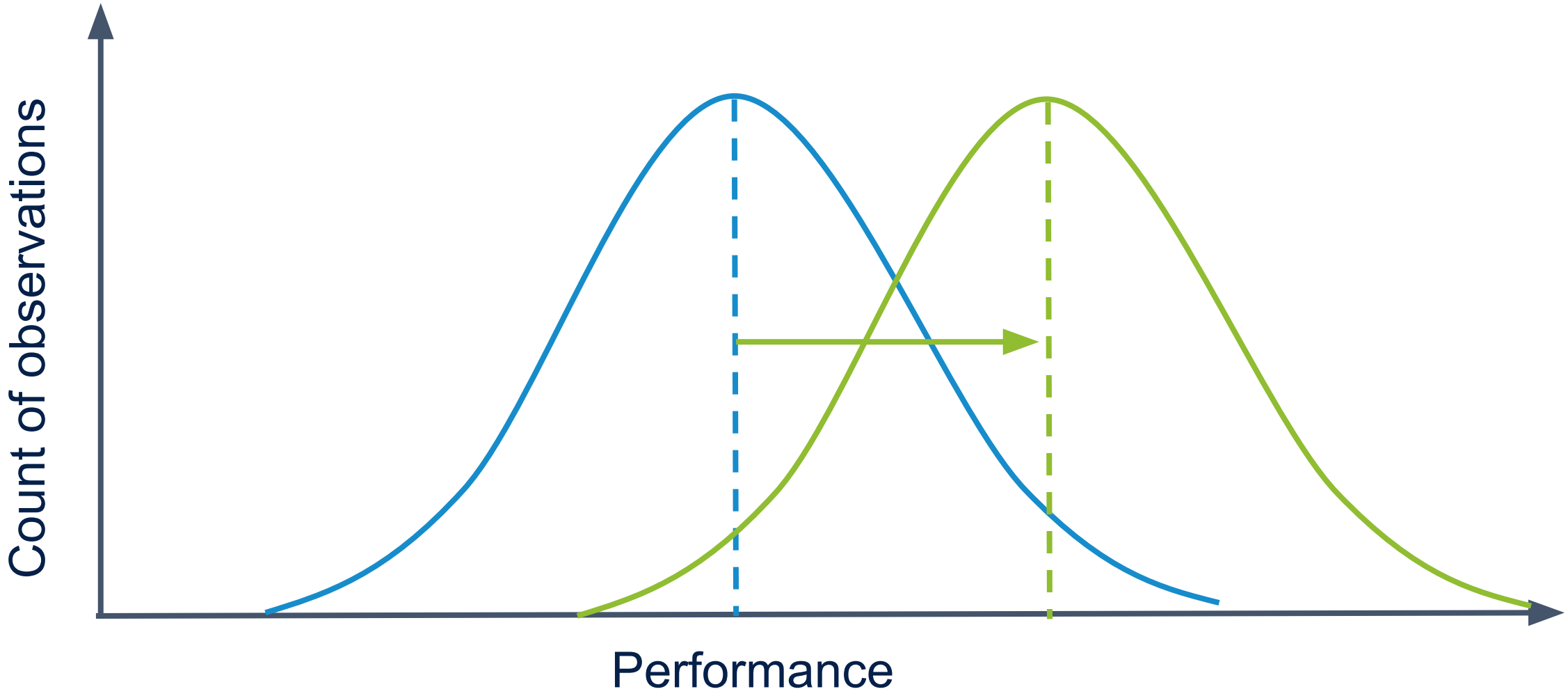
Quality assurance—pruning the “bad apples”



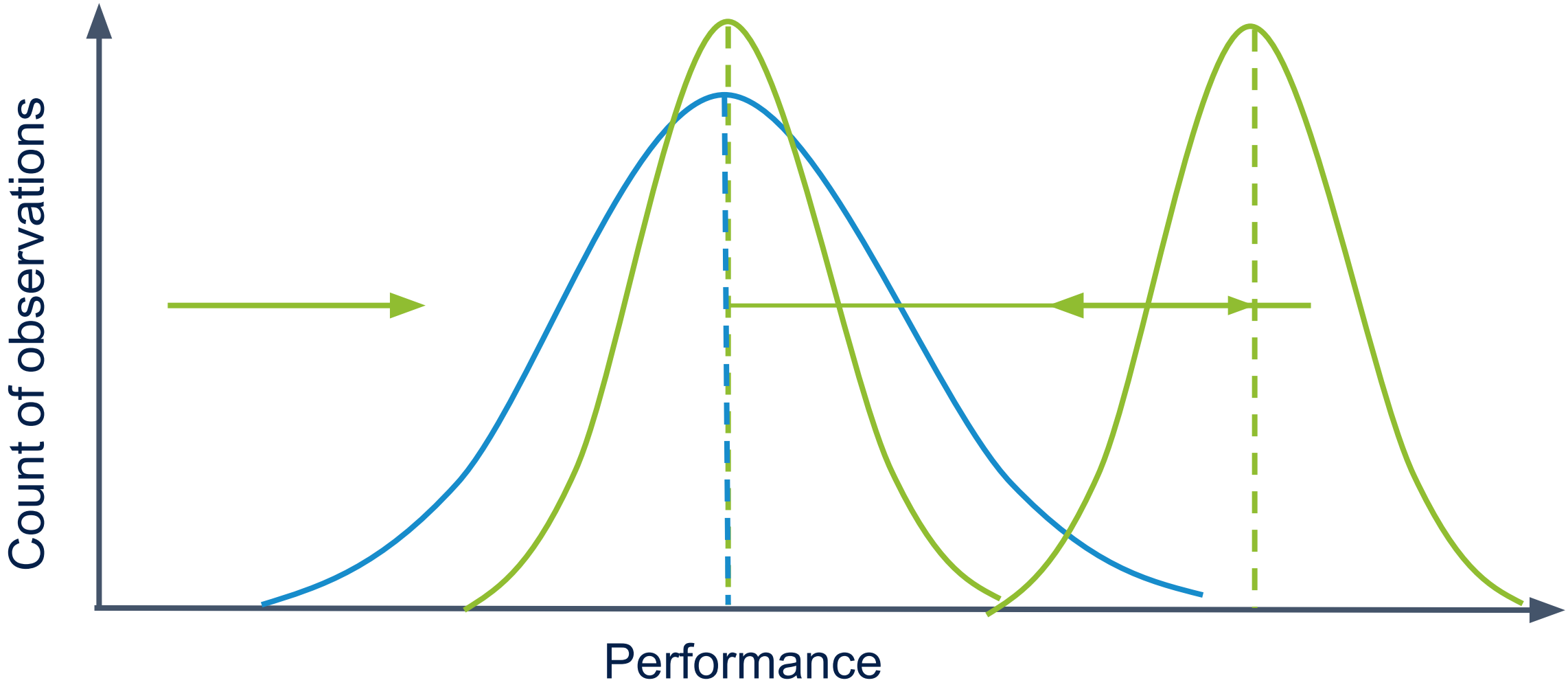
Quality improvement—reducing variation



Quality improvement—moving the curve



Quality improvement—putting it all together



How can we **accelerate** change and **standardize** improvements in programs?

QUESTION: In which discipline did QI start?

A. Laboratory science
B. Automobile manufacturing
C. Health care
D. Statistics
E. Communication

Walter Shewhart

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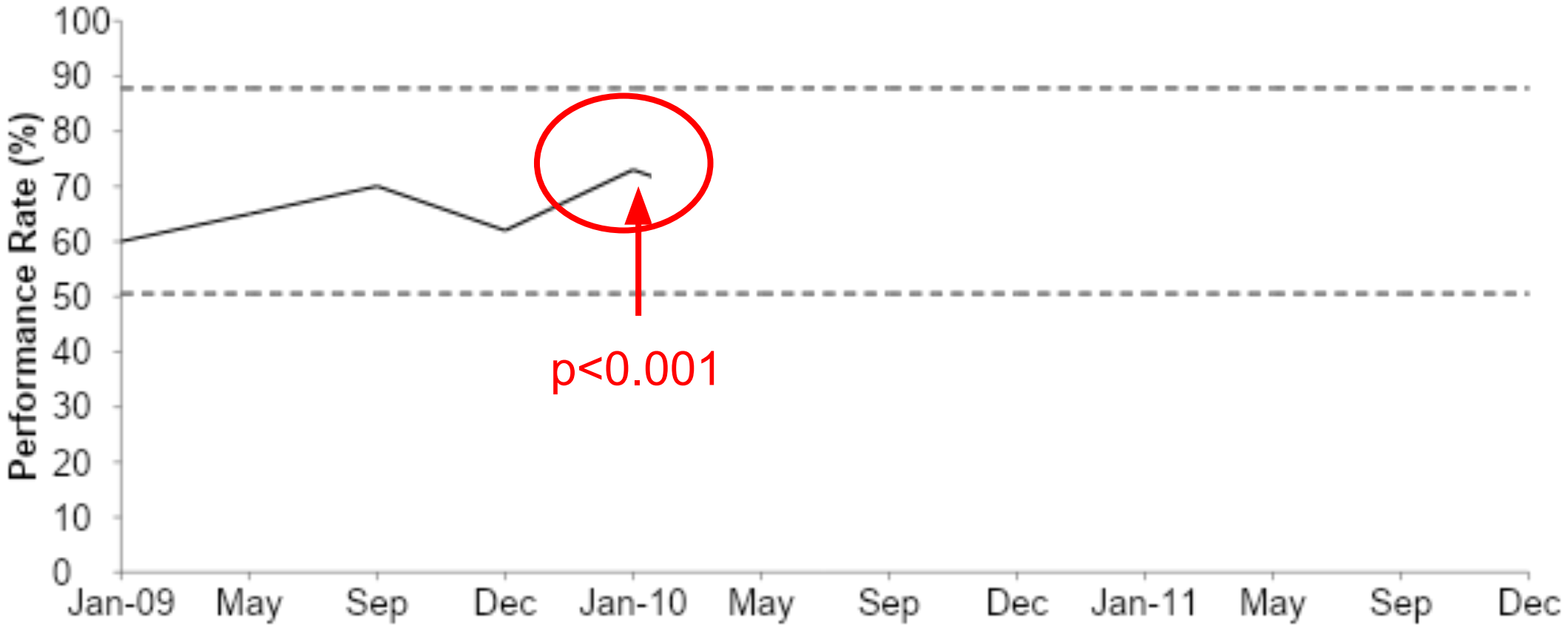
Walter Shewhart

Understanding Variation

Results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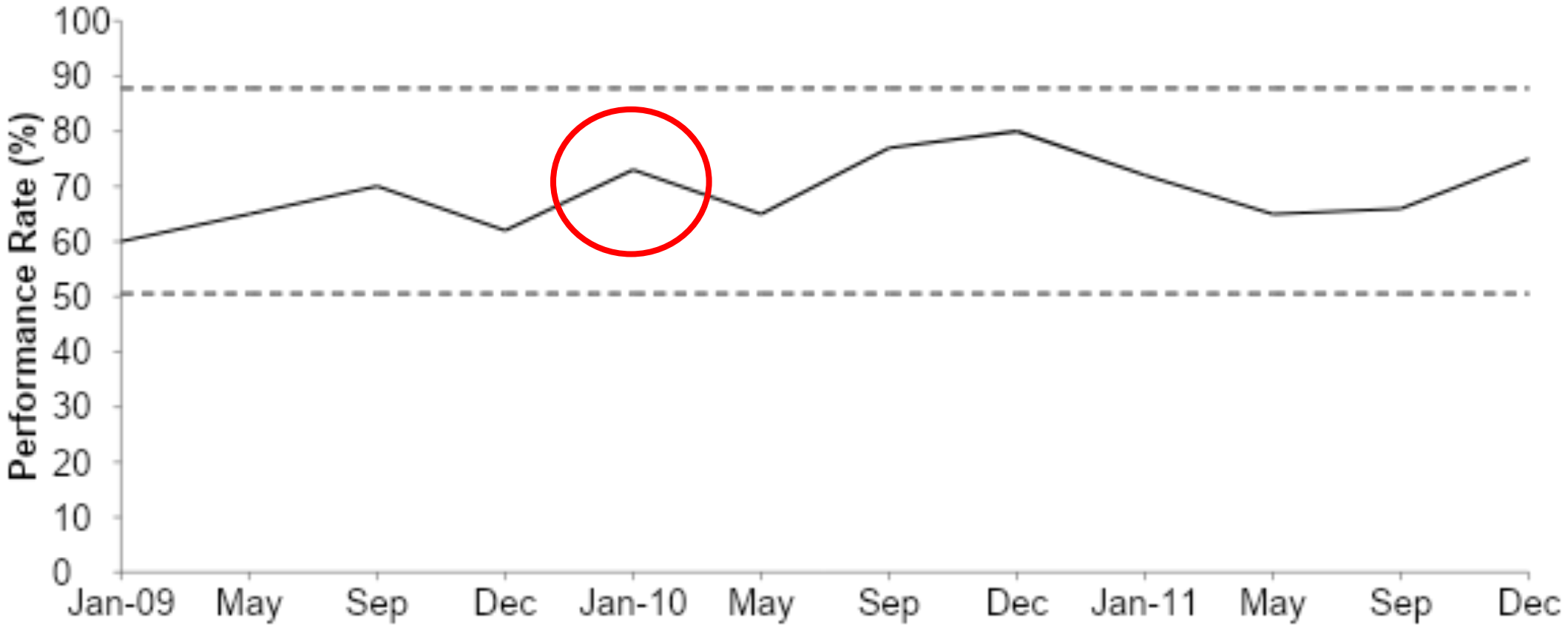
QUESTION: Should/can we publish our results?

A. Yes

B. No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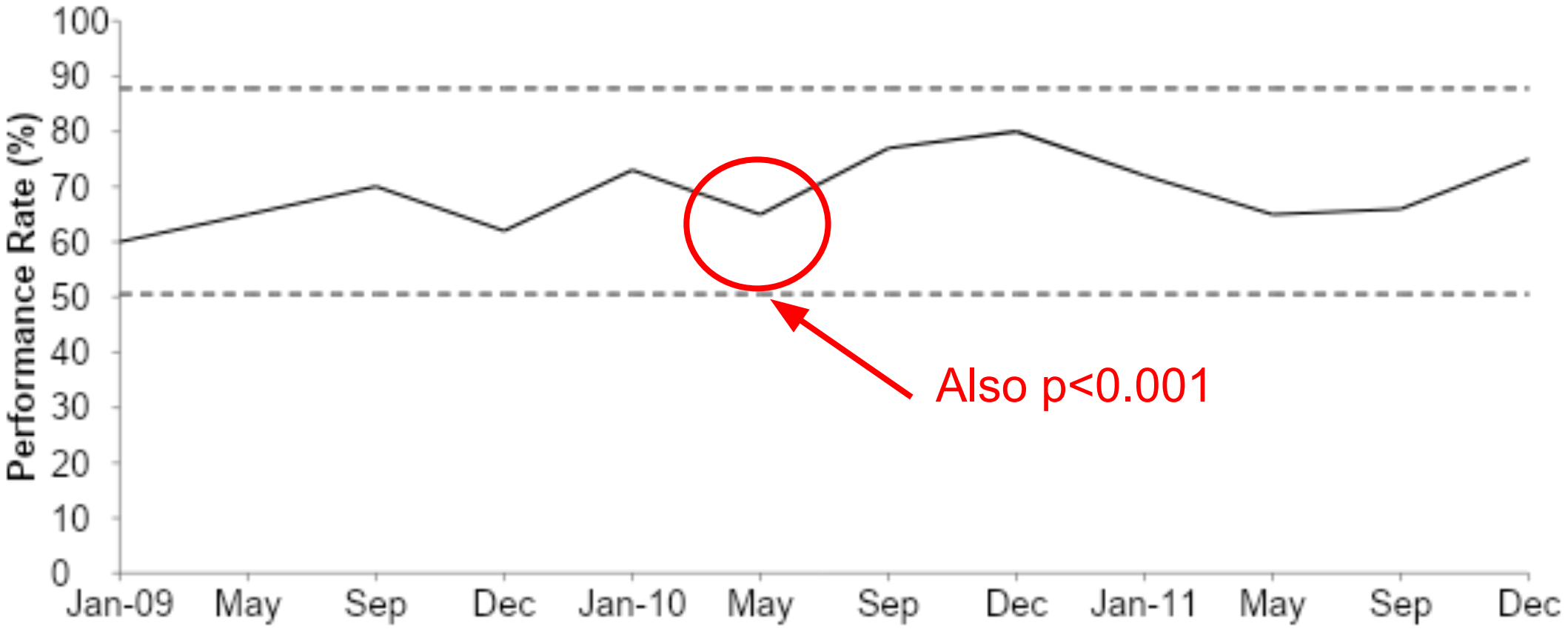
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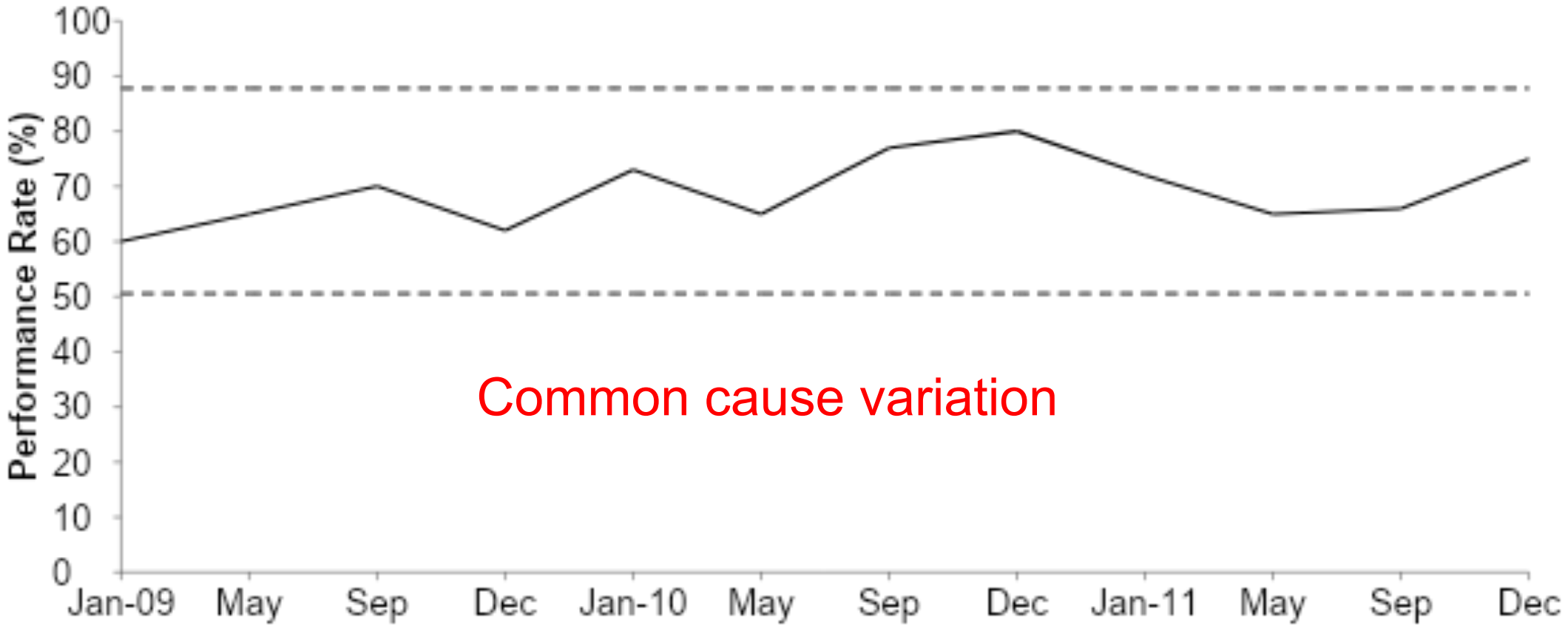
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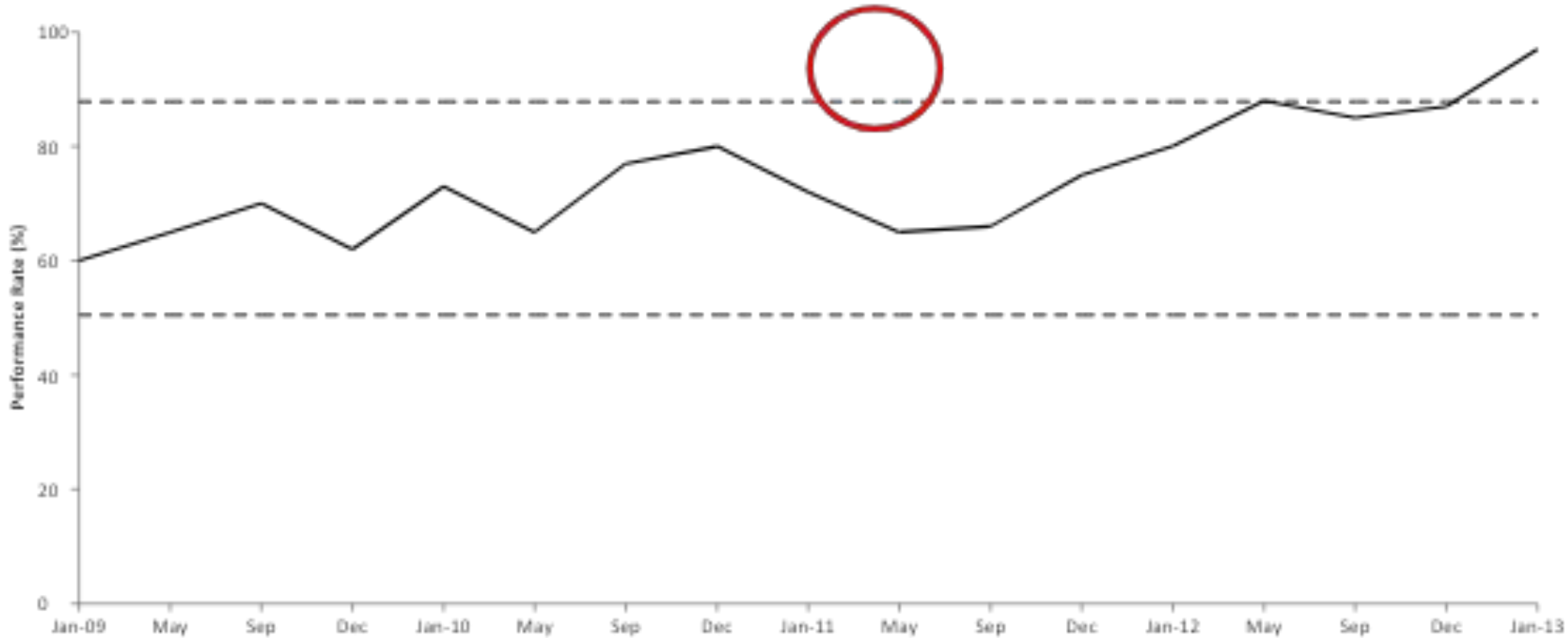
Common cause variation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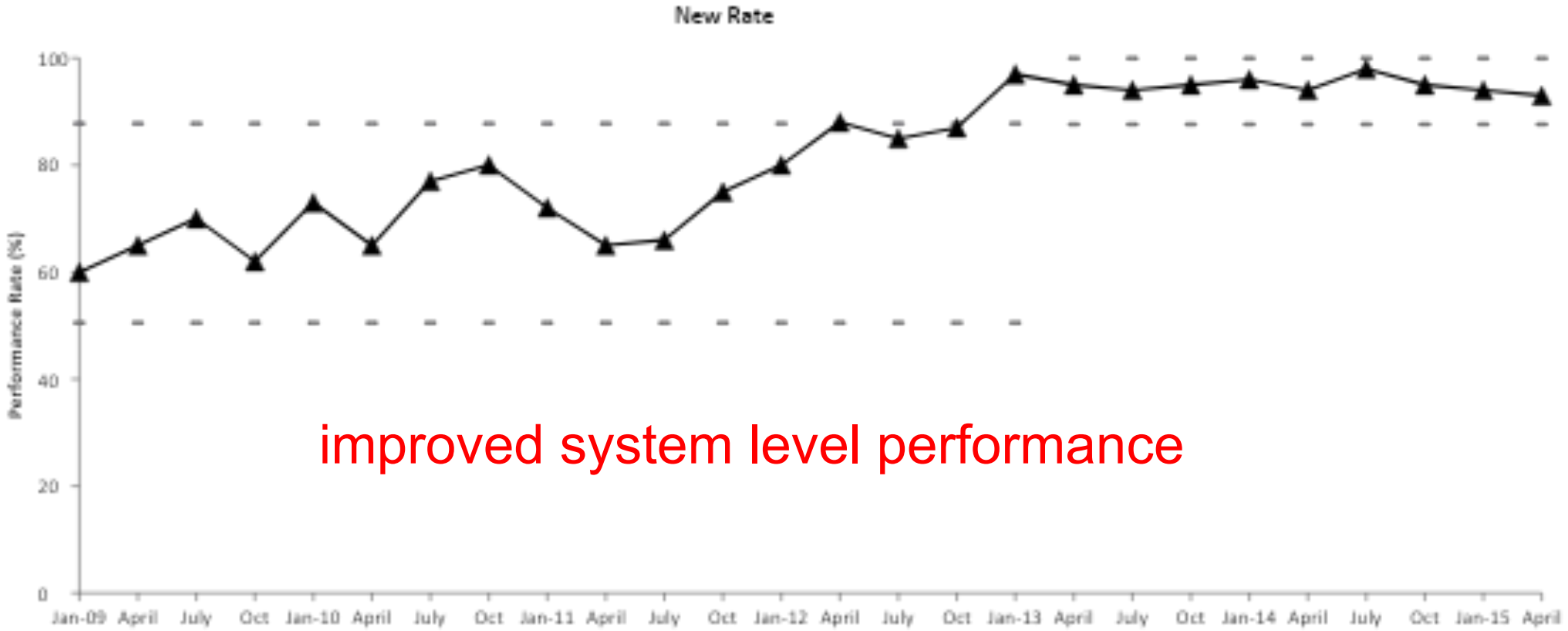
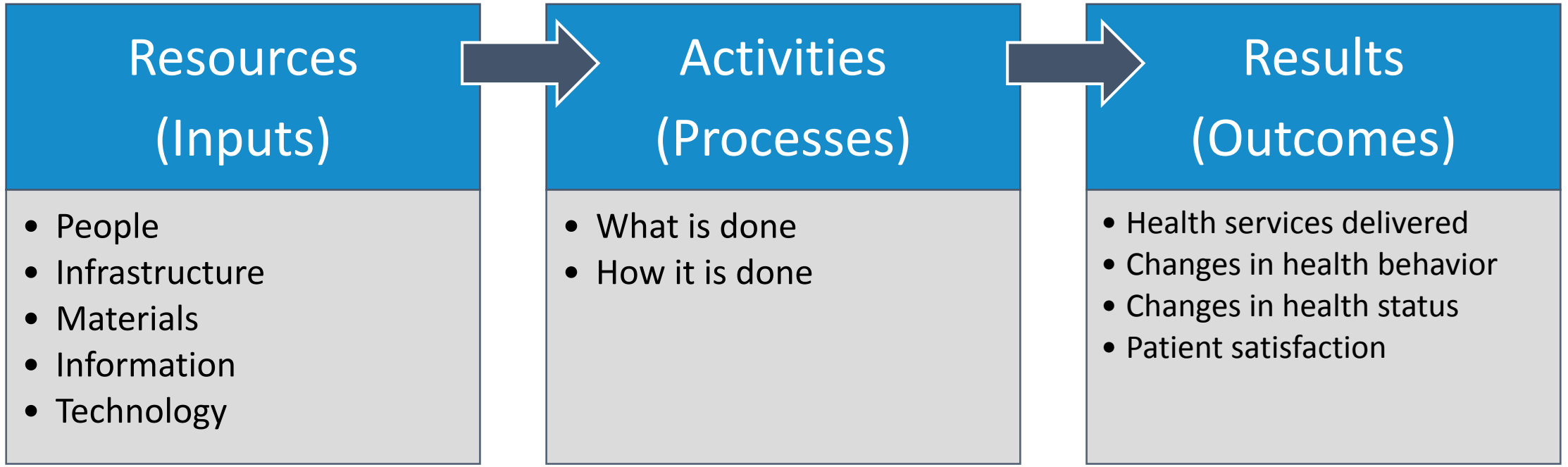


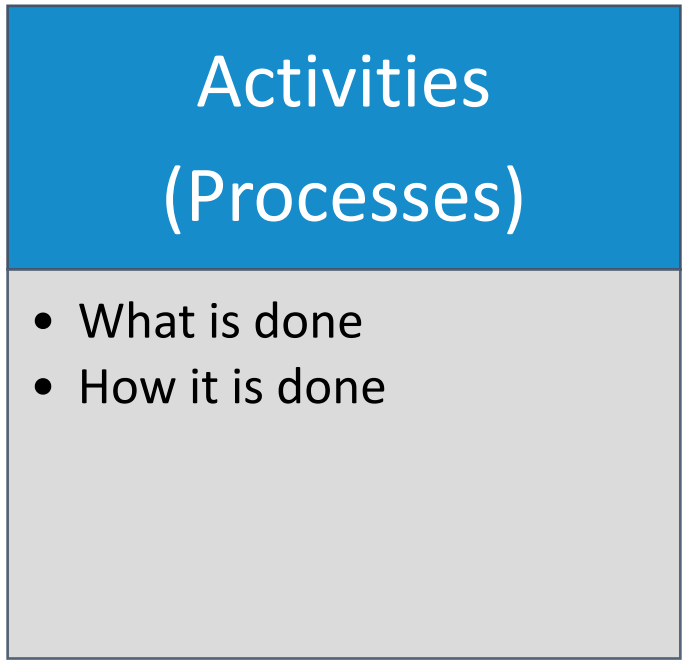
improved system level performance

Systems thinking



Source: Donabedian, A. *Explorations in Quality Assessment and Monitoring Vol. 1. The Definition of Quality and Approaches to Its Assessment*. Ann Arbor, MI: Health Administration Press, 1980.

Systems thinking



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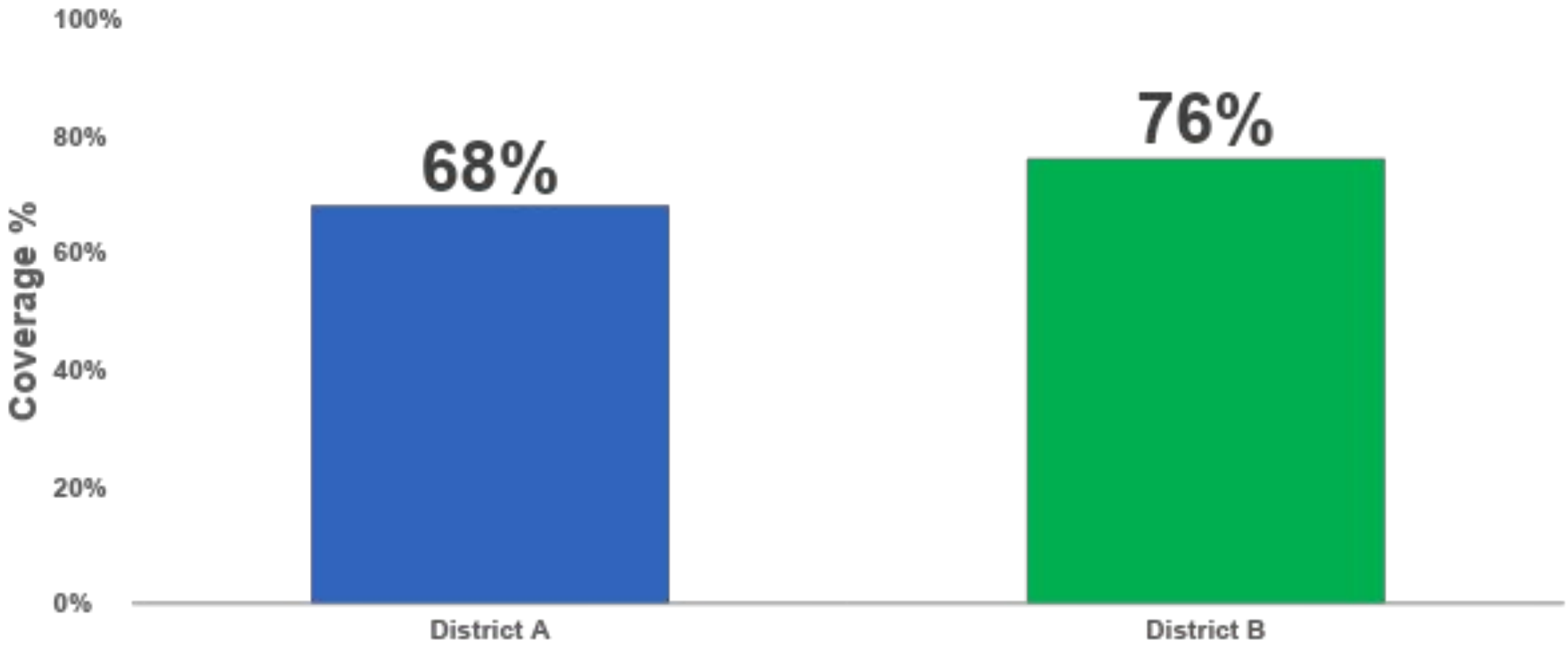
Immunization Rates Over Time



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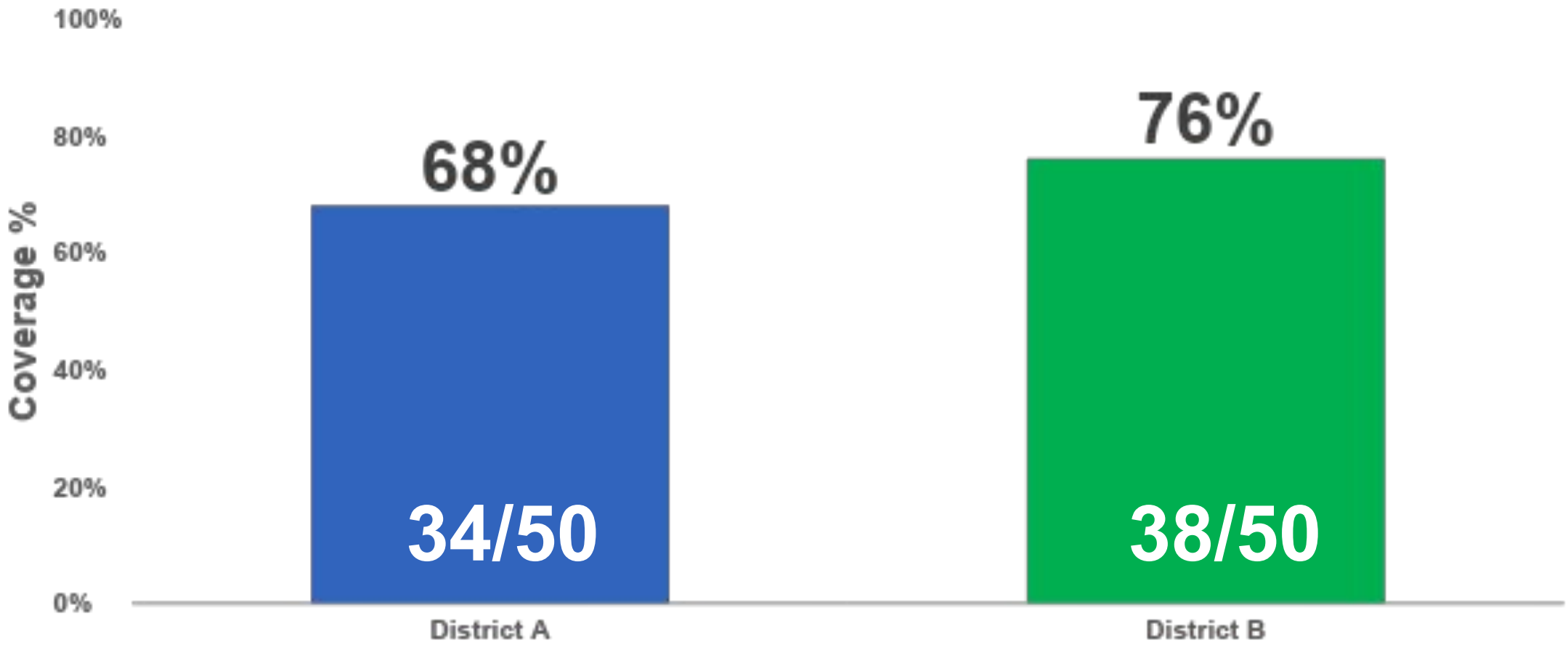
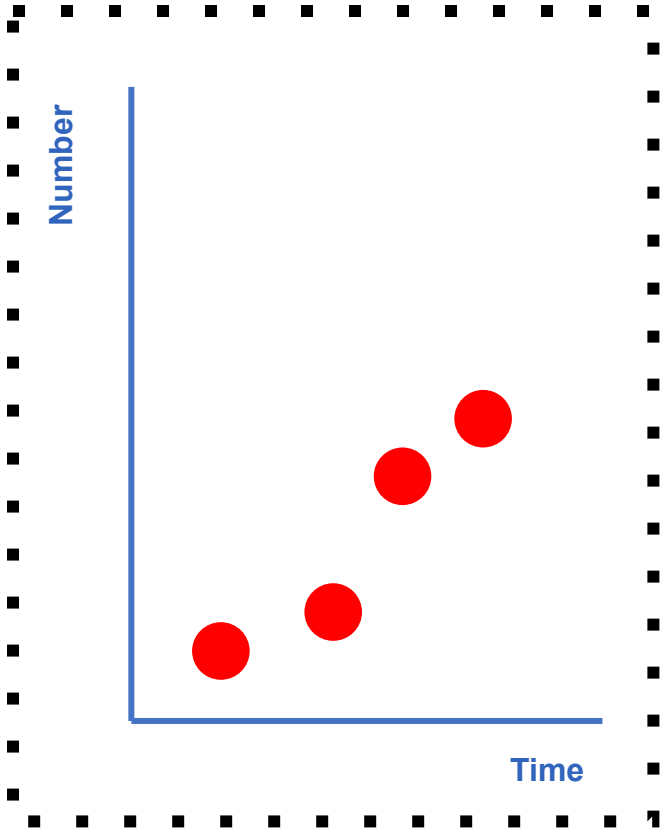
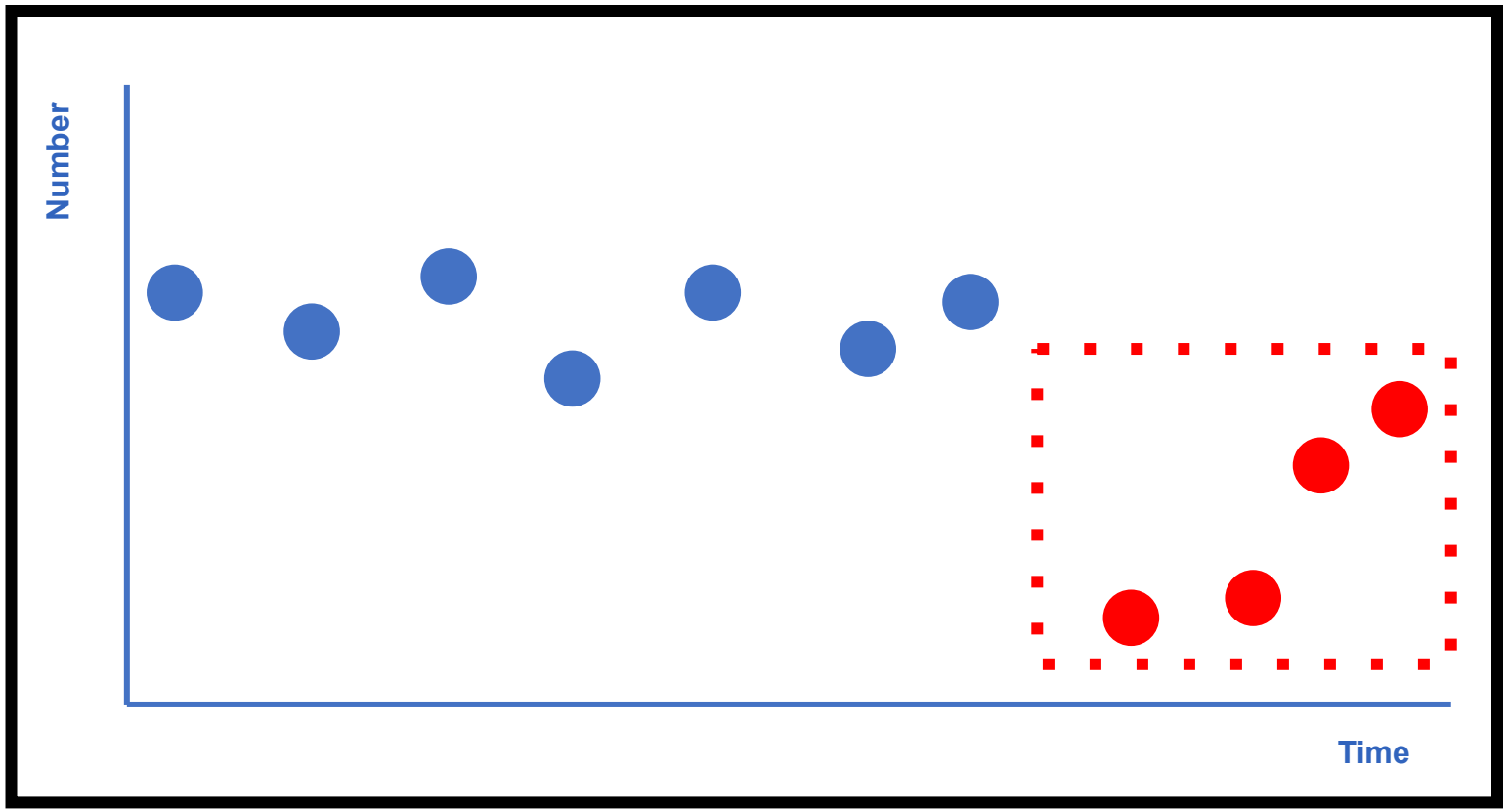


Choosing the Right Time Period

Why has this gone up?

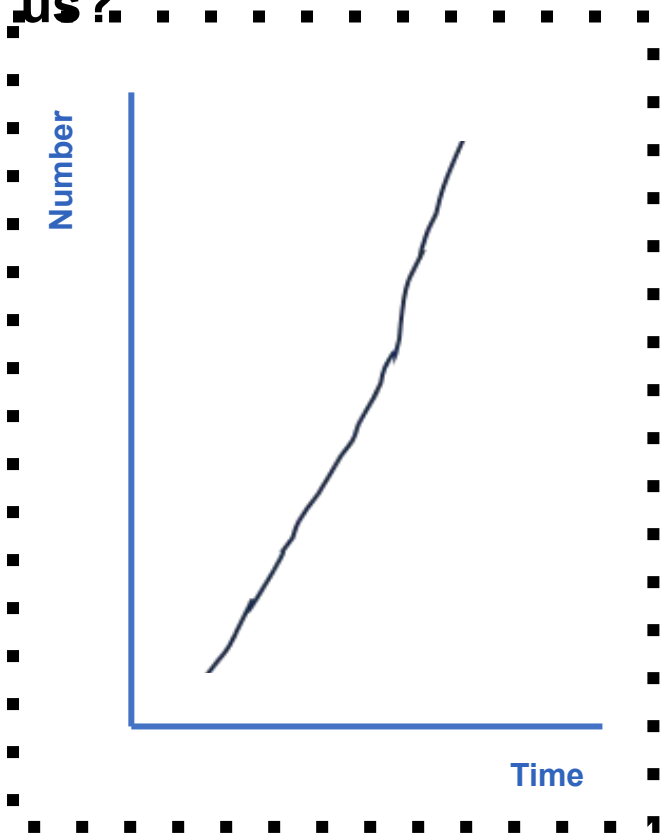


But when you zoom out …



Choosing the Right Time Period

What is this pattern telling us?



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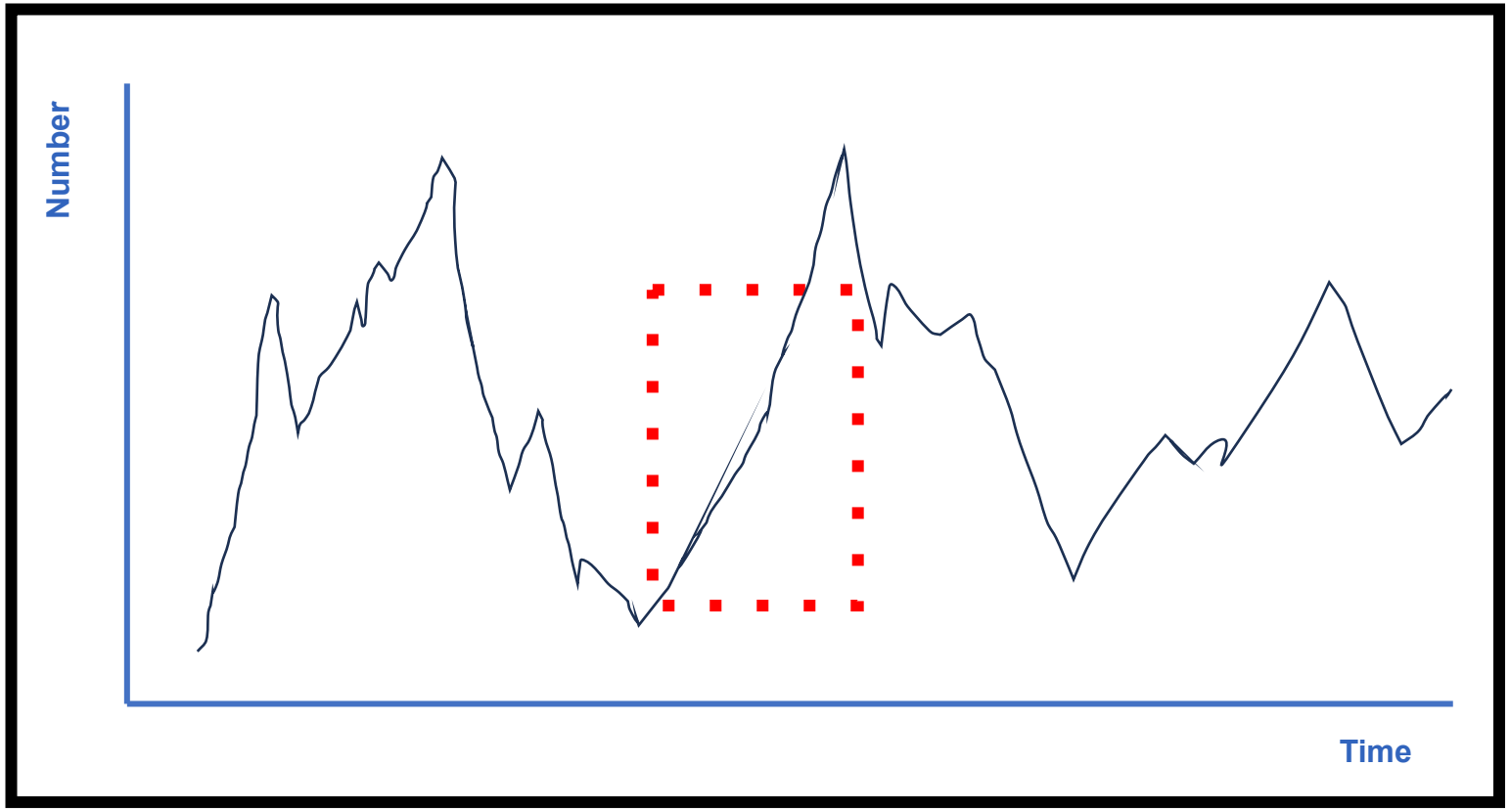


SPC Chart (Statistical process control)

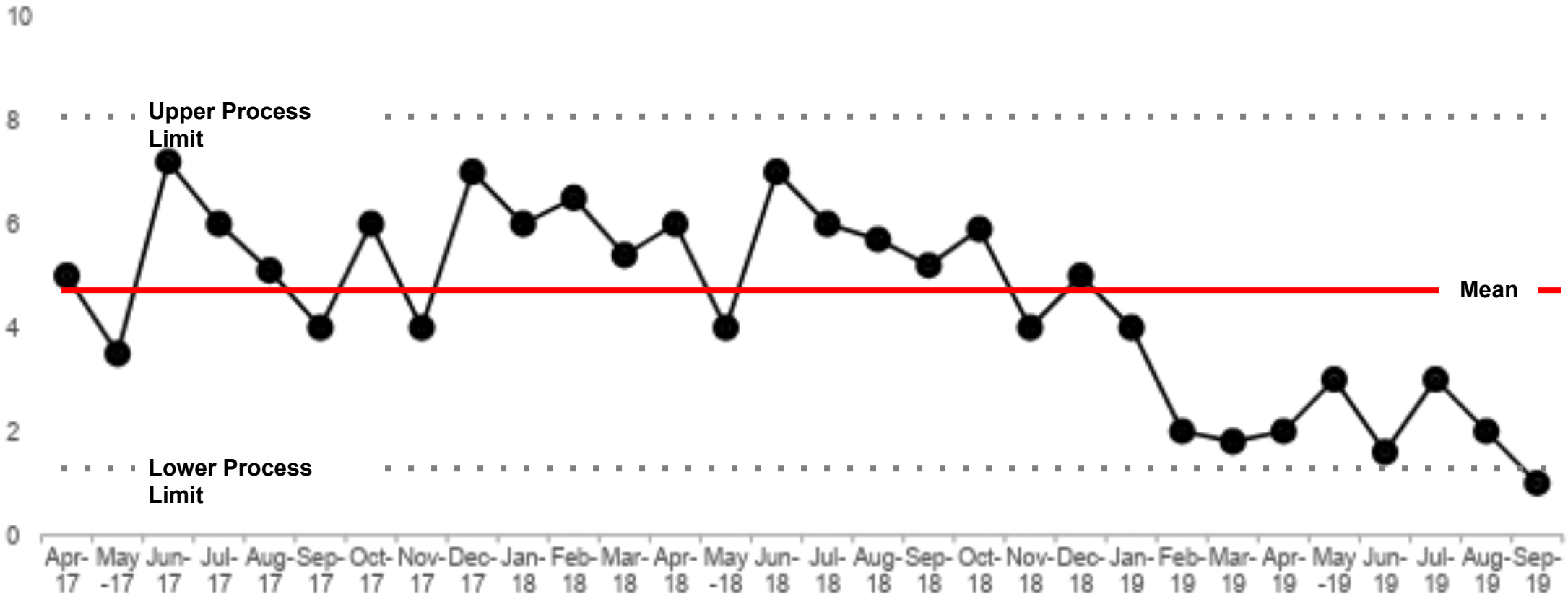
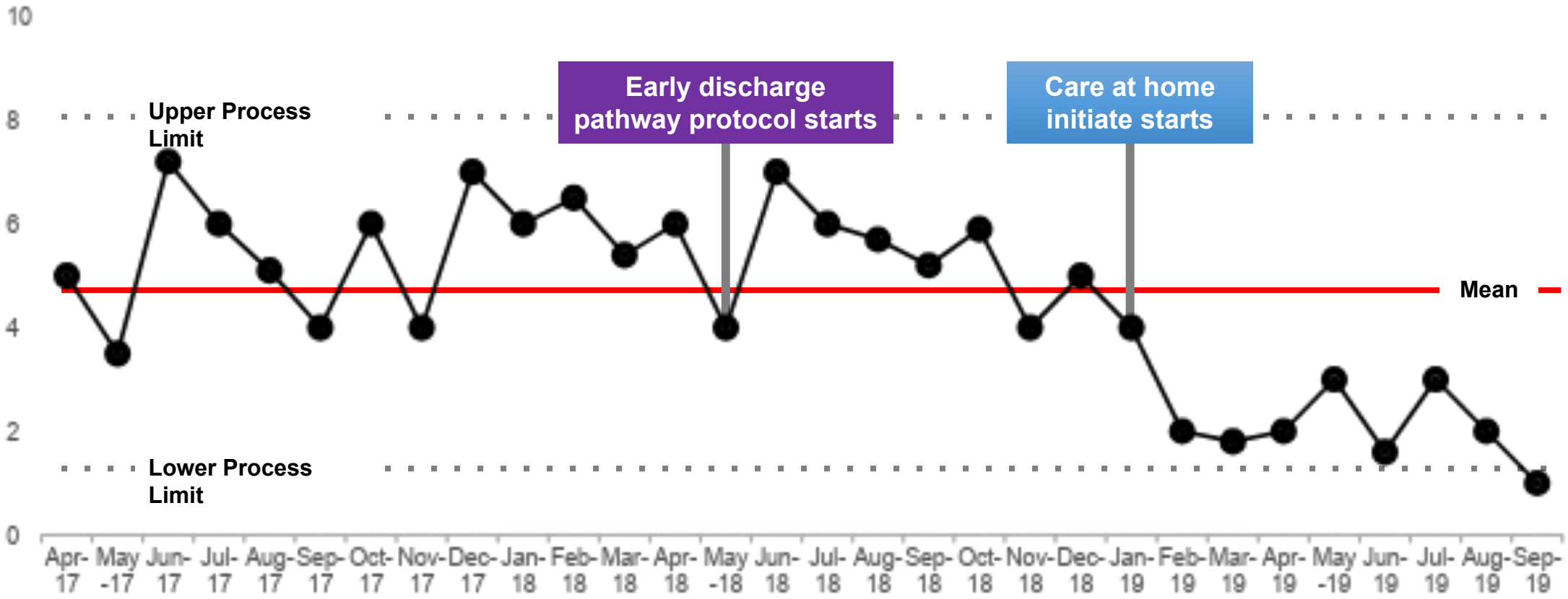
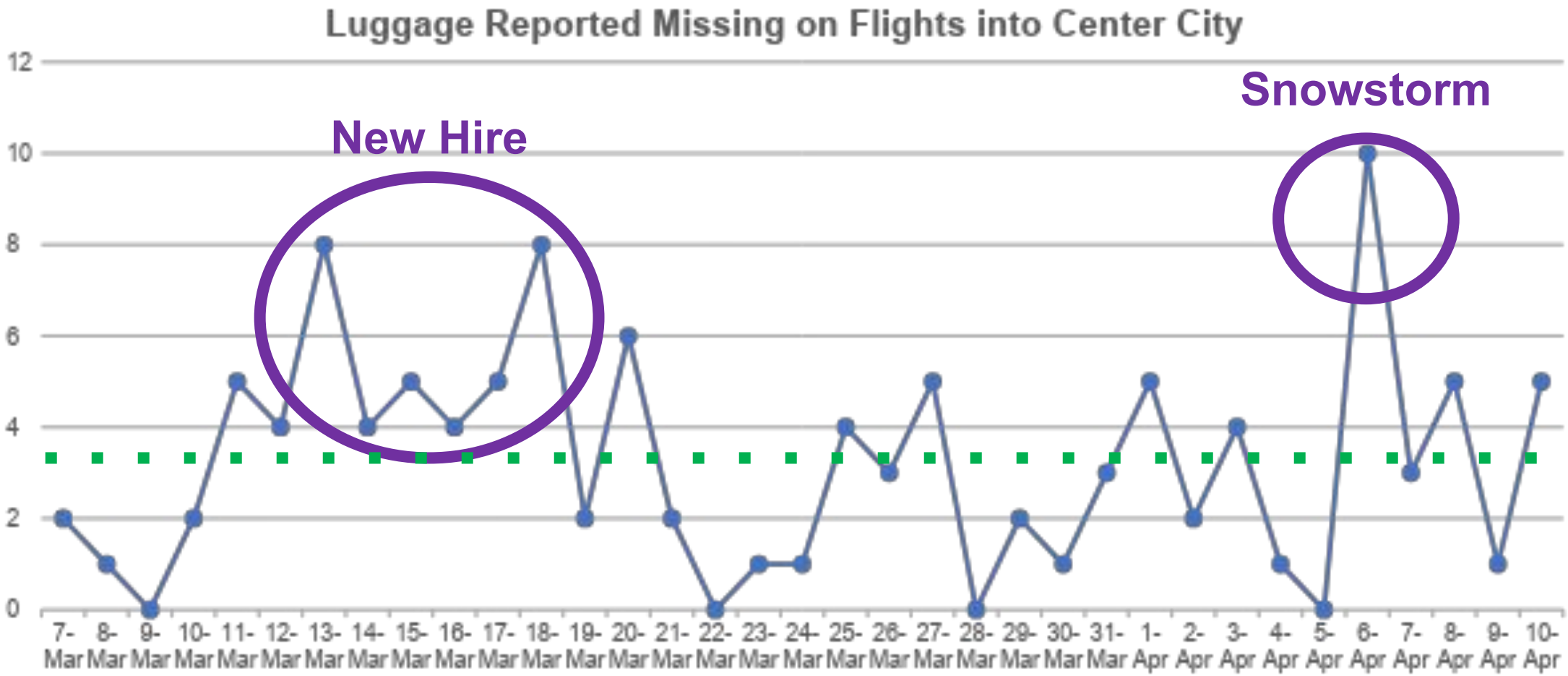


Chart with annotations to indicate changes



Special cause variation



Key Results: AMTSL Coverage and Post-partum Hemorrhage Rates in 41 Targeted Facilities, Mali, October 2009-September 2011

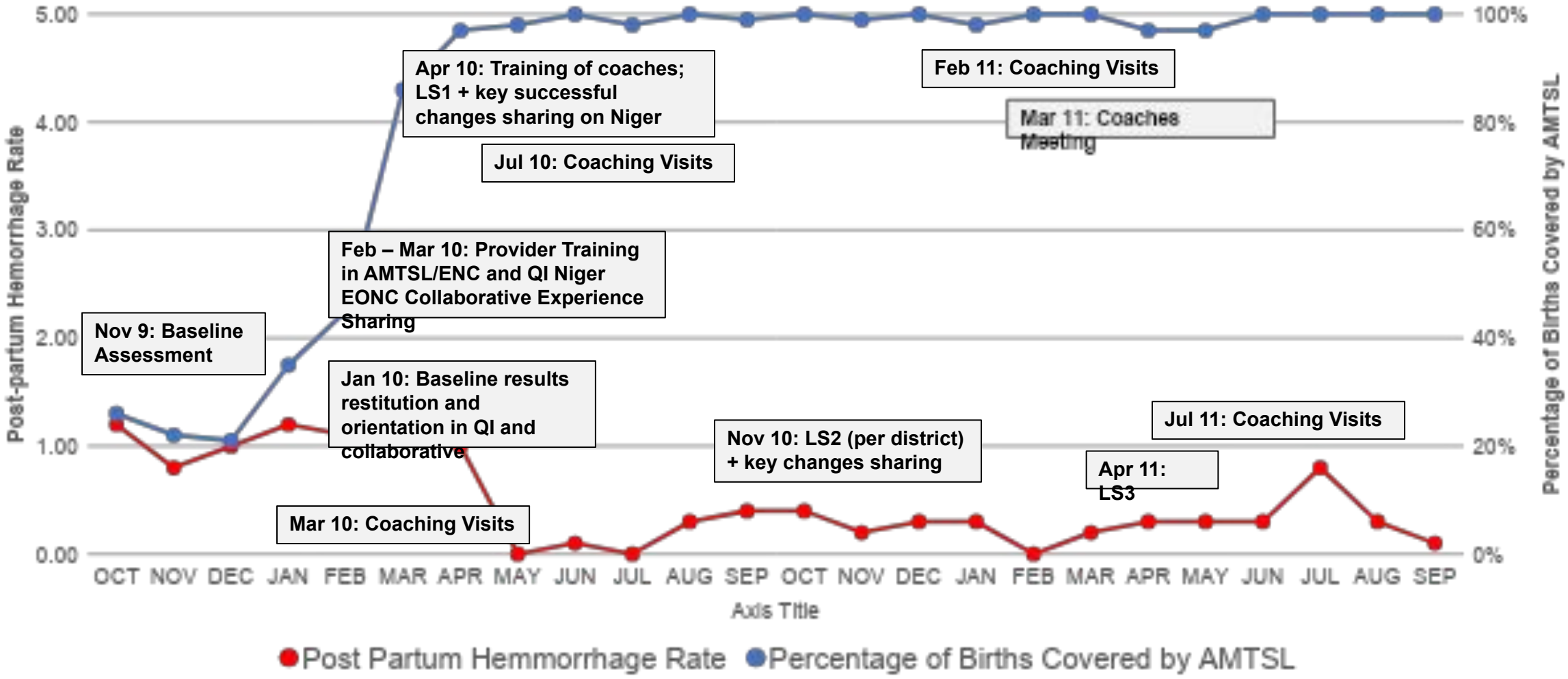
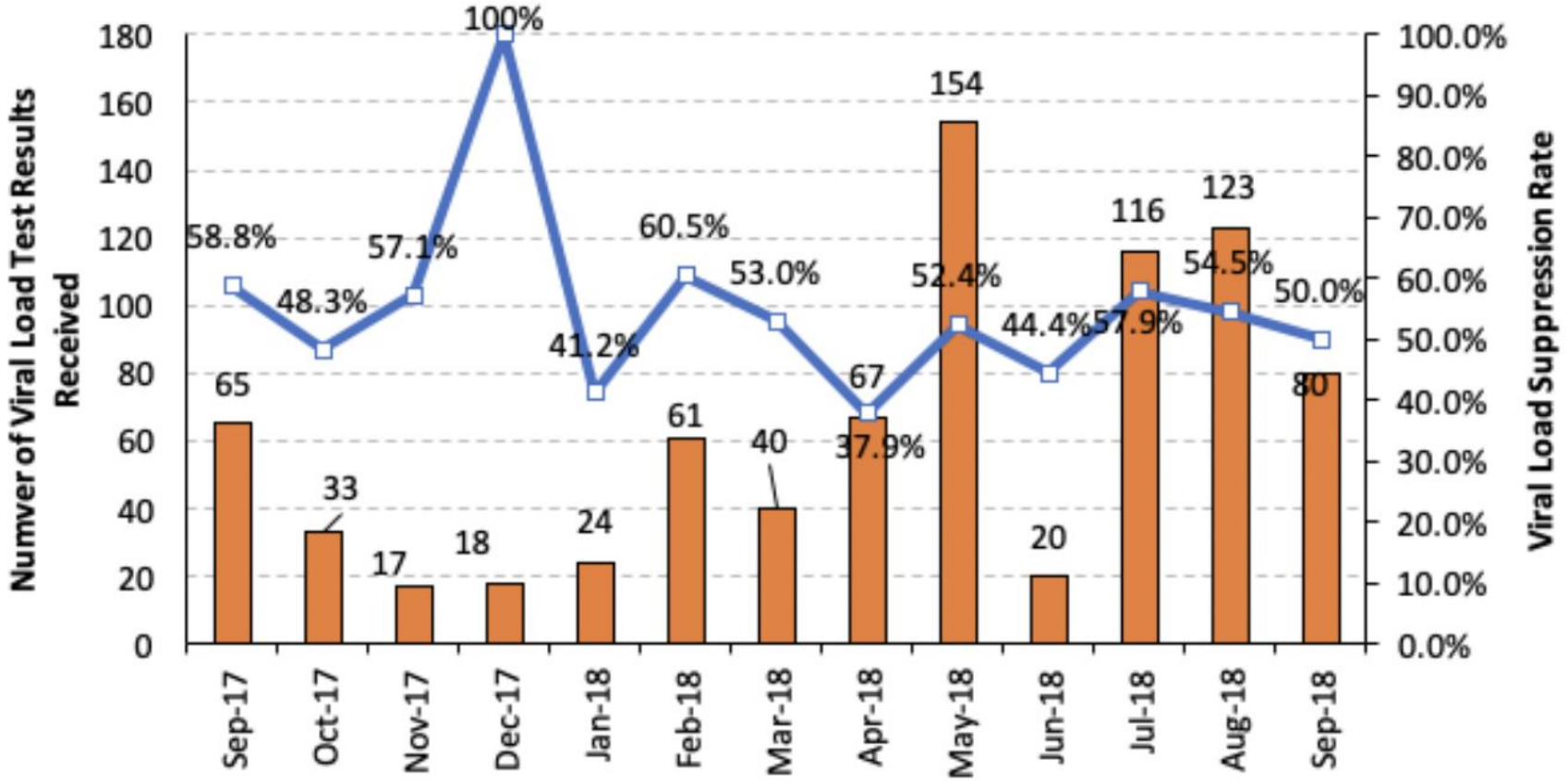
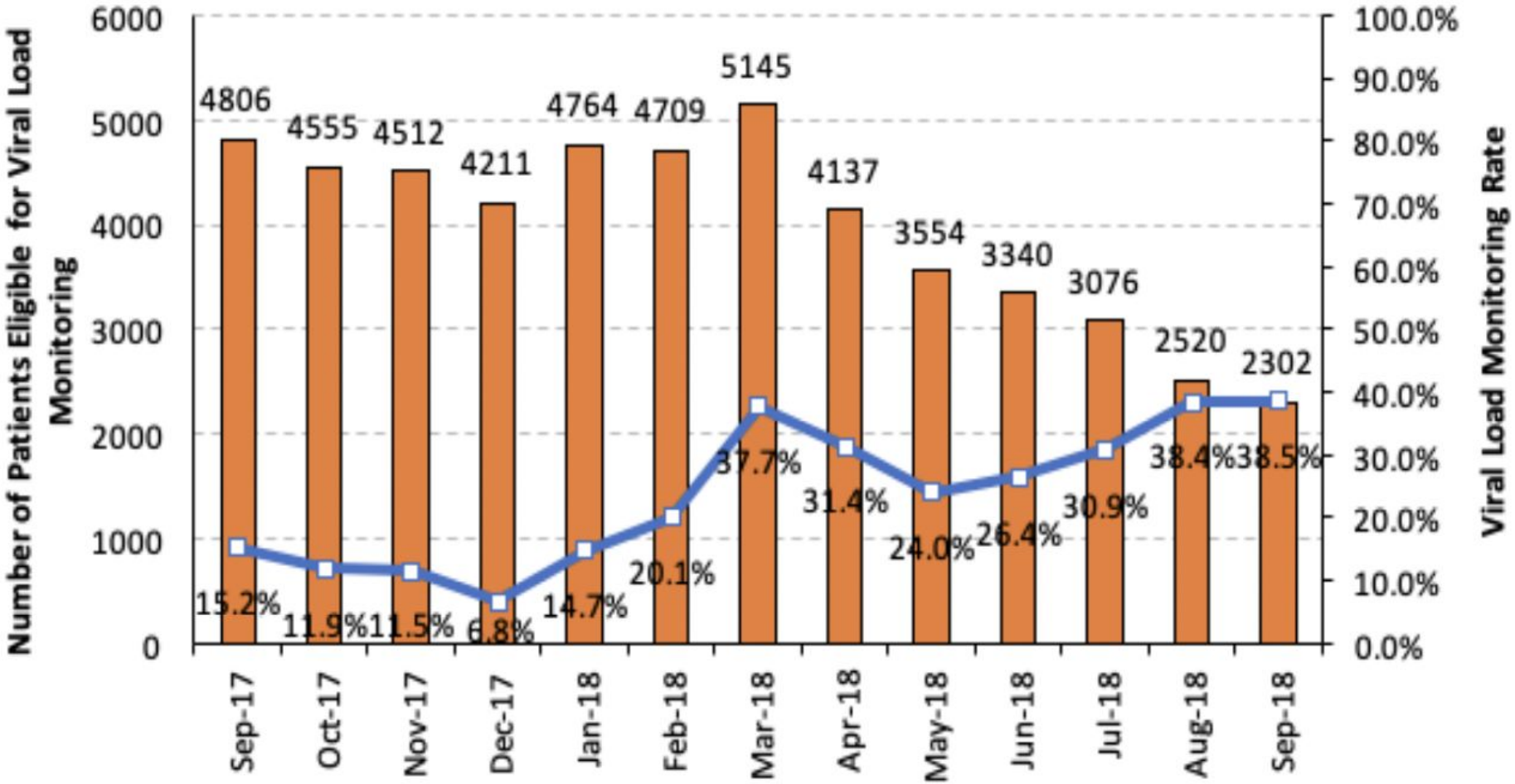


Figure A35. Number of Viral Load Test Results Received and Viral Load Suppression Rate—Rivers State, September 2017 – September 2018



UCSF HEALTLHQUAL: ALL KIDS COUNT | HRSA| PEPFAR; https://healthqual.ucsf.edu/sites/g/files/tkssra10806/files/All%20Kids%20Count%20Final%20Report.pdf

Figure 13. Number of Patients Eligible for Viral Load Monitoring and Viral Load Monitoring Rate—All States, September 2017 – September 2018



UCSF HEALTLHQUAL: ALL KIDS COUNT | HRSA| PEPFAR; https://healthqual.ucsf.edu/sites/g/files/tkssra10806/files/All%20Kids%20Count%20Final%20Report.pdf

Example 2: Presentation Norms using Count Indicator and Multiple Sites

Y-Axis with scale and label for "count indicator

Legend indicating labels for each line on the graph

Shows only values of numerator (because no denominator)

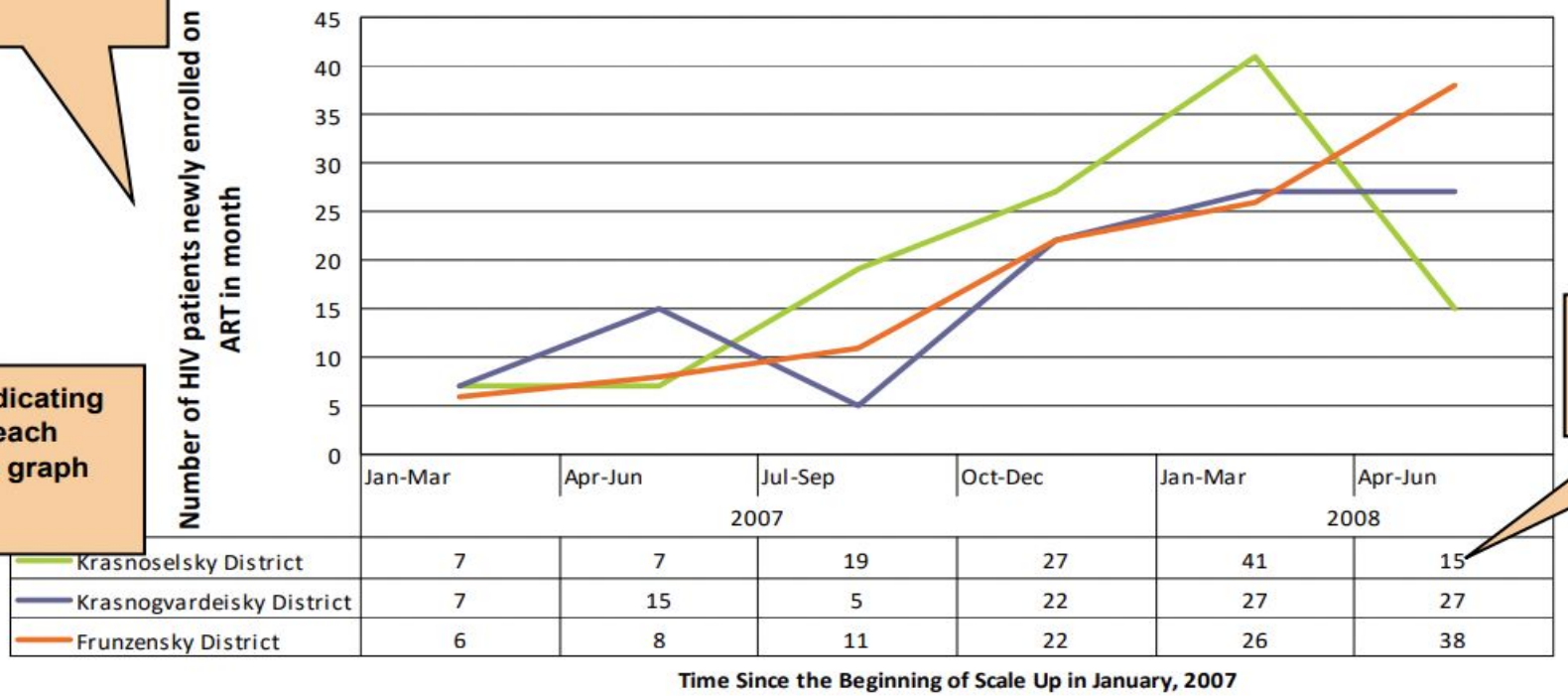
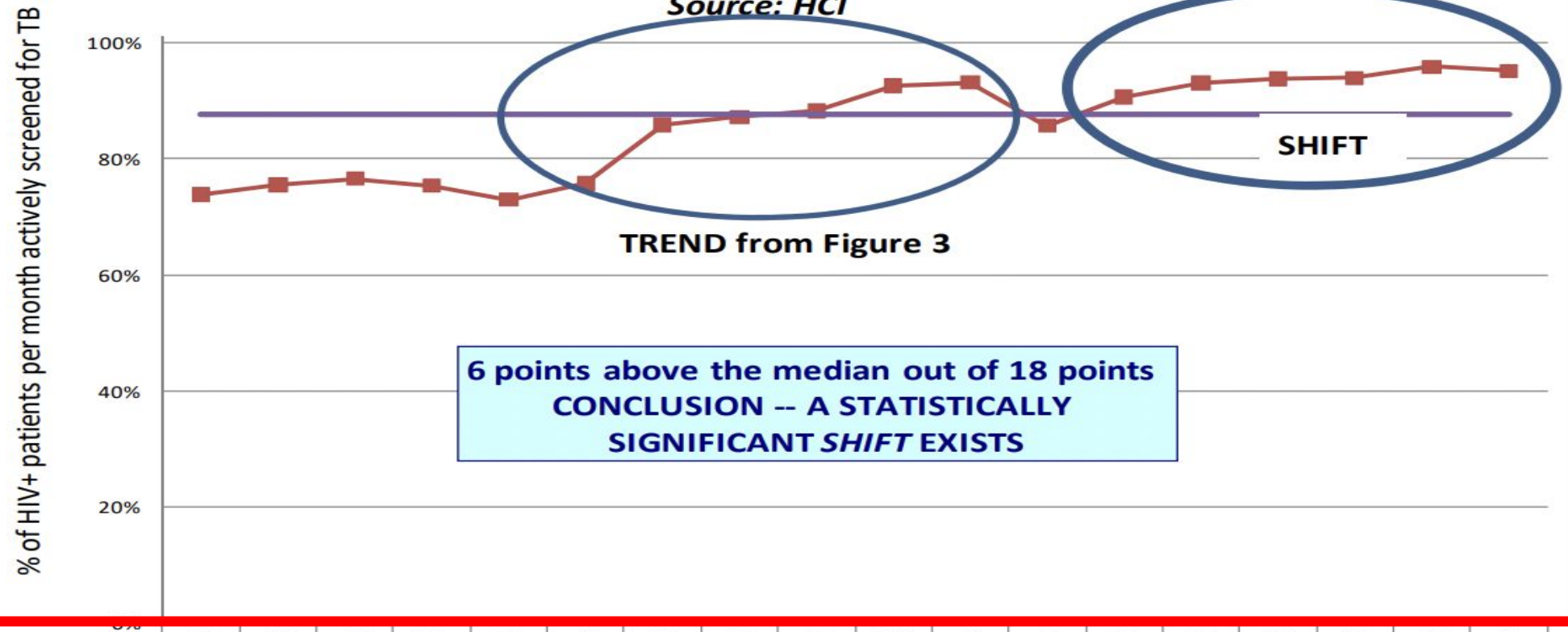


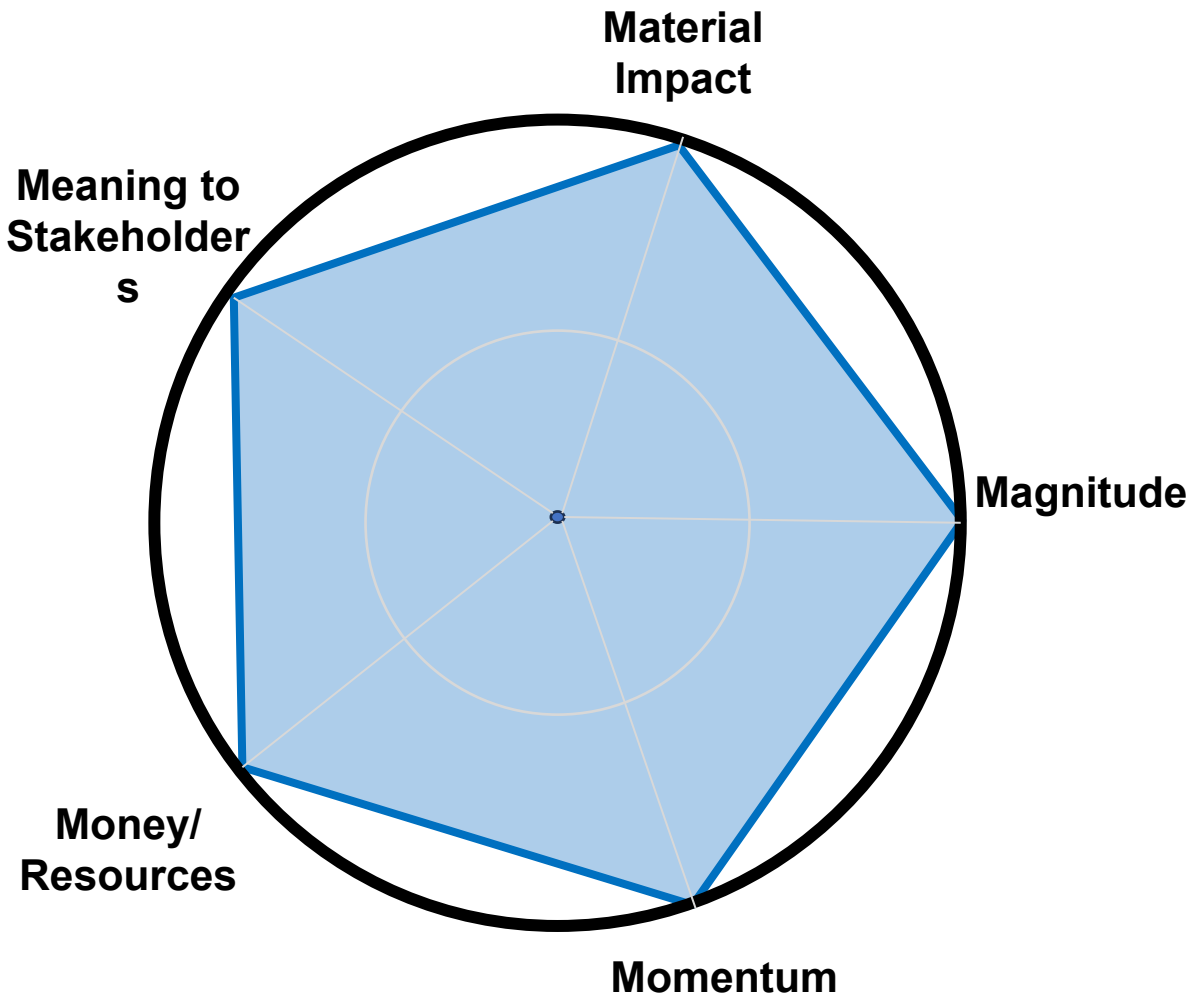
Figure 5: Uganda - Percent of HIV-positive patients assessed for active TB, August 2005-January 2007

Source: HCI



	AG	SE	OC	NO	DE	JA	FE	MR	AP	MY	JN	JL	AG	SE	OC	NO	DE	JA
PERCENT	74%	75%	77%	75%	73%	76%	86%	87%	88%	92%	93%	86%	91%	93%	94%	94%	96%	95%
denominator	9755	10578	10653	11878	11339	13259	13707	15505	16021	17198	17755	17854	22795	19274	21103	22146	21639	21023
median	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
n sites	23	23	24	24	24	25	24	31	31	32	33	34	34	38	41	42	42	41

Synthesis: The 5-M Meaningfulness Framework



Use the 5-M wheel to decide if a result is truly meaningful:

- **Magnitude** – size of change
- **Material impact** – outcomes that matter
- **Meaning to stakeholders** (patients/staff/community)
- **Money/resources** – feasible and worth it
- **Momentum** – durable and repeatable

HYPOTHETICAL EXAMPLES OF MEANINGFULNESS

Magnitude: examples

- DTP3 immunization coverage:
  - Coverage rose from 72 % → 93 % in one year after outreach micro-planning and defaulter tracing — a 21-point gain, clearly beyond random variation!
  - *But: a*fter switching denominator to “registered infants” (migrants excluded); no increase in doses, no decline in incidence of vaccine-preventable diseases; jump driven by data artifact.
- TB case detection:
  - Introduction of GeneXpert increased bacteriologically confirmed TB by 40 % within 9 months — a substantial epidemiologic impact.
  - *But:* Notifications were up **40%** only because of duplicate entries and intensified screening **without** confirmatory testing or treatment enrollment; no actual change in incidence or outcomes.
- Maternal health:
  - Institutional delivery increased from 65 % → 88 % after transport vouchers and maternity waiting homes initiated.
  - *But:* improvement was observed during a short “facility-delivery campaign”; post-campaign reverts to 66%; no change in emergency obstetric and neonatal care readiness or maternal/neonatal outcomes.

Material impact (outcomes): examples

- HIV viral load suppression:
  - VS rises **70%** → **88%** with same-day ART + differentiated service delivery; community viral load drops; new infections decline.
  - *But:* VS "improves" after excluding lost-to-follow-up and those with no test performed from the denominator; actual number suppressed unchanged; transmission proxies unchanged
- Under five mortality:
  - After community-based management of childhood illness (iCCM) and referral networks were expanded, the under-five mortality rate fell from 45 → 30 per 1,000 over 3 years. Improvement verified by multiple data sources and tied to real changes in care and survival.
  - *But:* Further data review showed mortality estimates came from a small household KAP survey covering only one season. The apparent decline driven by small-sample survey bias and short-term measurement artifact, not population-level improvement.

Meaning to stakeholders: examples
Does the change resonate with those affected?

- Community trust:
  - After respectful-care training, 95 % of postpartum women reported feeling treated with dignity, up from 68 %.
  - *But:* One-time satisfaction survey spikes after gift distribution; complaints unchanged; qualitative feedback still cites disrespect.
- Health-worker morale:
  - Environmental-health officers report renewed pride as community open-defecation-free status is verified — morale and retention improve.
  - *But:* Open-defecation-free success is celebrated but slippage common; workloads rise without support; absenteeism and turnover worsen.
- Adolescent health:
  - Youth satisfaction with SRH services improved sharply after peer-navigator programs — a result communities cite as restoring confidence in public clinics. Repeat visits and contraceptive continuation improve; STIs decline in sentinel sites.
  - *But:* funding for peer navigators and test kits was cut resulting in diminished testing rates, limiting accuracy of results; additional data obtained from exit interviews showed adolescents still perceived the clinic as judgmental and unwelcoming.

Money/resources: examples
Is it affordable, efficient, and sustainable relative to benefit?

- Malaria control:
  - Re-treatment of bed nets locally saved US $3 per household compared with annual replacement, yet maintained 90 % protection.
  - *But:* Purchase of premium nets at 2× cost without coverage/usage gain; no incidence change; allocation harms rapid diagnostic test/ACT stock (unintended consequence).
- Immunization:
  - Shifting outreach to quarterly integrated campaigns reduced per-child delivery cost by 35 % without loss of coverage.
  - *But:* Cost/child “drops” by excluding transport and per diem from accounting; true program cost unchanged; outreach frequency falls and dropouts rise.
- NCD screening:
  - Integrating hypertension screening into HIV clinics used existing staff/equipment and detected 15 % new hypertensive adults with negligible extra cost.
  - *But:* Mass BP screening tents identify many elevated readings but no confirmatory follow-up, no meds, no control; high volunteer costs, zero outcome gain.

Momentum: examples
Can the improvement be sustained and spread?

- Surveillance:
  - Routine weekly IDSR (Integrated Disease and Surveillance Response) reporting completeness remained above 90 % for 3 years across provinces after digital dashboards were adopted.
  - *But:* Completeness hits 95% during donor audit, then drops to 60%; no SOPs or feedback loops; alerts still delayed.
- Quality circles:
  - The same maternal-death-review process was replicated in five districts, each maintaining monthly review meetings two years later.
  - *But:* MDRs conducted for accreditation week only; action plans not implemented; no reduction in preventable factors.
- Community health systems:
  - Village health-volunteer home-visit model that improved antenatal coverage in one region was scaled nationally with similar gains.
  - *But:* Pilot succeeds with heavy coaching; when scaled, supervision and incentives vanish; coverage gains evaporate within 6 months.

Concluding thoughts

“Data do not speak for themselves; they need context, curiosity, and conversation.”

“In measurement, as in medicine, the diagnosis is only as good as the questions we ask.”

Questions

Questions

Performance Measurement and Reporting

Lecture

Low Performance on Key Indicator

Investigate to Understand and Address Issue

- Data Quality & Analysis
- Data Collection & Reporting
- Health Care Systems
- Patients & Populations
- QI Team & Activities
- Stakeholder Communication

Performance Measurement

Performance Measurement refers to systematically evaluating *processes, practices, and outcomes* within an organization using key performance indicators.

In healthcare, performance measurement traditionally focuses on standalone indicators, such as mortality rates or operational efficiency metrics.

While performance measurement provides snapshot evaluations, **performance measurement systems deliver integrated perspectives**, making them essential for managing complex services.

de Melo Santos, C.J., Barbosa, A.S. & Sant'Anna, Â.M.O. Performance measurement systems in primary health care: a systematic literature review. BMC Health Serv Res 25, 353 (2025). https://doi.org/10.1186/s12913-025-12412-6

Performance Measure or Quality Indicator?

Performance Measures

- Performance Measures & Quality Measures
- Based on the highest level of evidence or guidelines
- Ready for public reporting

Quality Indicators

- Do not meet the above criteria
- Still useful for some quality im provement programs

Donabedian Model for Quality Care

Structure	Process	Outcome
Physical and organizational characteristics where healthcare occurs.	Focus on the care delivered to patients (e.g., services, diagnostics, treatments)	Effect of healthcare on the status of patients and populations

Structural Measures

Structural measures give a sense of a health care provider's **capacity, systems, and processes to provide high-quality care**.

For example:

- Whether the health care organization uses electronic medical records or medication order entry systems.
- The number or proportion of board-certified physicians.
- The ratio of providers to patients.

Process Measures

Process measures indicate what a **provider does to maintain or improve health**, either for healthy people or for those diagnosed with a health care condition.

For example:

- The percentage of people receiving preventive services (such as mammograms or immunizations).
- The percentage of people with diabetes who had their blood sugar tested and controlled.

Outcome Measures

Outcome measures reflect the **impact of the health care service or intervention on the health status of patients**. For example:

- The percentage of patients who died as a result of surgery (surgical mortality rates).
- The rate of surgical complications or hospital-acquired infections.

Measurement Tree

Outcome Measure	**Maternal Mortality**			
Process Measures	Monitoring of Labor using a Partograph	Timely Assessment on Arrival	Skilled Attendant Present at Delivery	Adherence to Infection Control Guidelines
Structural Measures	Staffing	Equipment & Supplies	Transportation	Medications

Structure – Process – Outcome + Balance

Balancing Measures

Balancing Measures

Balancing Measures reflect **unintended and/or wider consequences of the change that can be positive or negative**. It is about recognizing these and attempting to measure them and/or reduce their impact if necessary.

An example of a balancing measure would be monitoring emergency re-admission rates following initiatives to reduce length of stay.

Measurement Tree

Patient Experience

Provider Experience

Outcome Measure		Maternal Mortality		
Process Measures	Monitoring of Labor using a Partograph	Timely Assessment on Arrival	Skilled Attendant Present at Delivery	Adherence to Infection Control Guidelines
Structural Measures	Staffing	Equipment & Supplies	Transportation	Medications

Do I use this measure?

Is it objectively a good measure?

Is it appropriate for my purposes?

Is the measure good for reporting?

Standardization

Comparability

Availability

Timeliness

Relevance

Validity

Experience

Stability

Evaluability

Distinguishable

Is the measure good for reporting?

Standardization: The measures are standardized at the national level, which means that all health care providers will be reporting the same kind of data in the same way.

Comparability: If appropriate, the results are adjusted for external factors that could make a health care organization's performance appear better or worse than it really is; such factors include age, education, gender, income, and health status.

Availability: Data will be available for the majority of health care organizations that you are profiling.

Is the measure good for reporting?

Timeliness: The results will be available in time for you to produce and distribute a report when it is most needed by consumers.

Relevance: The measures address the concerns of your audience.

Validity: The measures have been adequately tested to ensure that they consistently and accurately reflect the performance of health care organizations.

Experience: Health care organizations have experience with these measures, so that you can be confident that the measure reflects actual performance and not shortcomings in information systems.

Is the measure good for reporting?

Stability: The measures are not scheduled to be "retired," e.g., removed from a measurement data set to make room for better measures.

Evaluability: The results can be evaluated as either better or worse than other results, in contrast to descriptive information that shows how health care organizations may be different from each other.

Distinguishable: The measures reveal significant differences among health care organizations.

Credibility: The measures are either audited or do not require an audit.

Is the measure appropriate?

Once you've determined that the measures you are considering are objectively good measures, you next must decide whether they are **appropriate** for your purposes. You can start by answering the following three questions.

1. **Does the measure support your goal?**
2. **Do consumers view the measure as important?**
3. **Is the measure relevant to your intended audience?**

Does the measure support your goal?

Determining whether the measures are right for your project depends in large part on your **project's goal**.

Improved decision-making: If your goal is to change the behavior of consumers, it is important to select measures that are relevant to consumers.

Do consumers view it as important?

To be useful for consumers, measures of health care quality must capture aspects of health care they view as important or can easily be shown are important.

When consumers do not understand or care about the quality measures used in a report, they are very unlikely to look at the report or use the information in it.

Is it relevant to your intended audience?

A related issue is whether the measure is **important to your intended audience**. Be sure to match the measures you choose to report to the needs and interests of the intended audience.

For instance, parents of young children will be interested in quality of prenatal care, obstetric outcomes, and childhood immunization rates.

Sometimes it's not easy to find measures that address a specific target audience. For example, there are more measures addressing women's health issues (e.g., breast cancer, cervical cancer, osteoporosis, and pregnancy) than those of men.

Is the measure appropriate?

Does the measure support your goal?

Do consumers view the measure as important?

Is the measure relevant to your intended audience?

Questions

Red Bead Game

Activity

Questions

BREAK

20 Minutes

The Model for Improvement

Lecture

Low Performance on Key Indicator

Investigate to Understand and Address Issue

- Data Quality & Analysis
- Data Collection & Reporting
- Health Care Systems
- Patients & Populations
- QI Team & Activities
- Stakeholder Communication

The Model for Improvement (MFI)

The **Model for Improvement** (MFI), developed by Associates in Process Improvement, is a simple yet **powerful tool** for accelerating improvement in projects.

This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement.

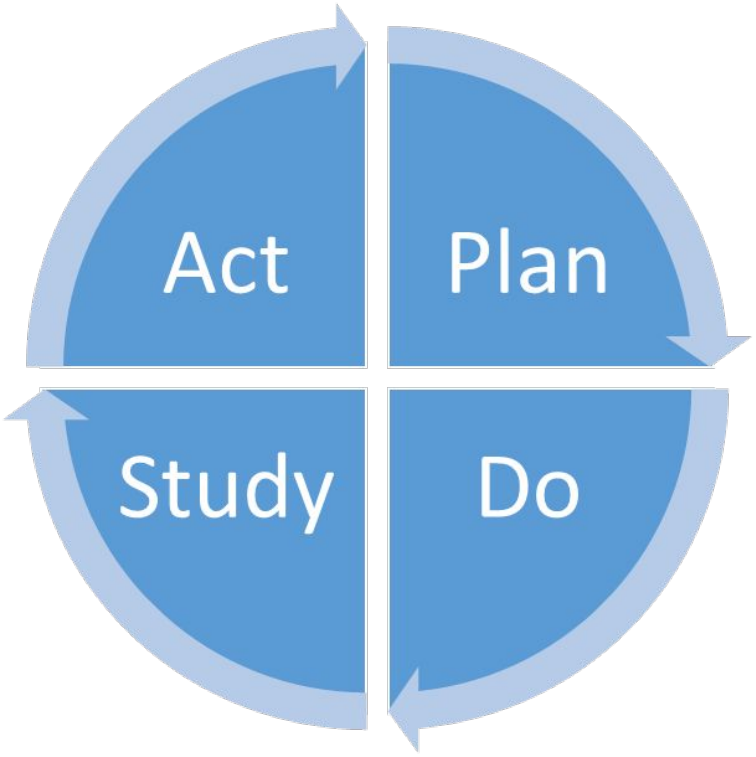
The MFI consists of answering three questions followed by plan-do-study-act (PDSA) cycles to rapidly implement small changes to improve processes.

The Model for Improvement

Three Questions

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

Plan-Do-Study-Act Cycles



The Model for Improvement

What are we trying to accomplish?

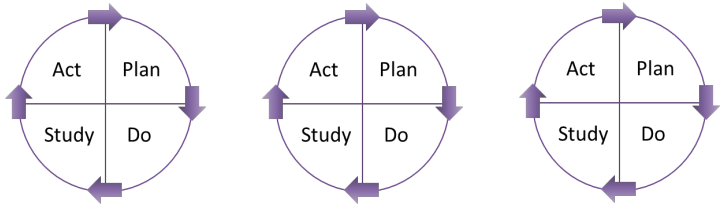
How will we know that a change is an improvement?

What change can we make that we result in improvement?

thinking part

1. Set the Aim
2. Select Measures
3. Select Intervention

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

The Thinking Part

What are we trying to accomplish?

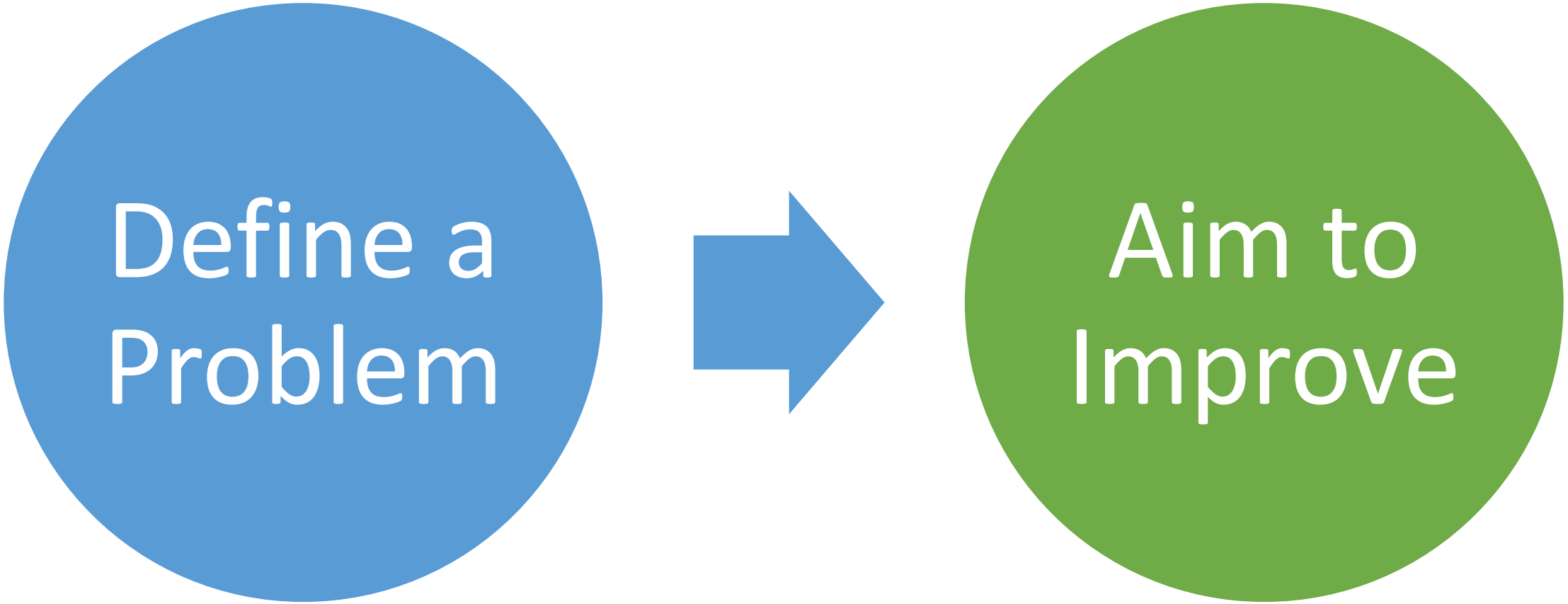
How will we know that a change is an improvement?

What change can we make that will result in an improvement?

thinking part

1. ***Set the Aim***
2. Select Measures
3. Select Intervention

Problem & Aim



Usefulness of Problem Statements

Problem statements help to form the foundation of the quality improvement project and are **used to develop aim statements**.

Problem statements are **NOT meant to solve the problem or identify a root cause**; problem statements simply **describe the problem and its current measurable impact**.

Developing a Problem Statement

A **Problem Statement** is a one or two-sentence, concise, description of the problem that the team would like to address through quality improvement.

The statement includes the **where**, **when**, **what**, and **who is harmed**, but not **who is causing the problem** or **why that problem is occurring**.

A problem statement **should not assign fault, assume a root cause, or presume a solution**.

Kamal, A. H., Nicolla, J. M., & Power, S. (2017). Quality Improvement Pearls for the Palliative Care and Hospice Professional. Journal of pain and symptom management, 54(5), 758–765. https://doi.org/10.1016/j.jpainsymman.2017.07.040
US Fire Administration. https://www.usfa.fema.gov/blog/cb-070617.html

Problem Statement

What?

What is the problem?

Why?

Why is it a problem?

Where?

Where is the problem observed?

Who?

Who is impacted by the problem?

When?

When was the problem first observed?

How?

How do we know it's a problem?

How Much?

How often is the problem occurring?

Problem Statement Example

Problem Statement #1

- We frequently miss our response time interval because of the inadequate on-scene times provided by dispatch.
- Additional training is necessary for dispatchers, and in-vehicle computer-aided dispatch data terminals are necessary for all response vehicles.

Problem Statement #2

- We failed to meet our 7:59 response time interval in 34.5 percent of emergency responses during the last six months.
- Failure to meet this response time may negatively affect our patients, decrease patient satisfaction, and may lead to a dilution of public confidence in our organization.

Which do you prefer and why?

Aim Statements

Provide a **vision** of what success will look like

Create the **urgency** to accomplish the goal

Capture the **voice of those who will be served**

Provide **alignment** of involved stakeholders

Keep the team **focused** on the tasks at hand

Institute for Healthcare Improvement. *QI Toolkit*. 2018, page 2, ihi.org

Aim Statements

An aim statement acts as a compass to guide and focus your team's efforts.

The art of writing an effective aim statement is **finding a focus that motivates, provokes action and sets expectations**.

- Focus the aim on an area that causes concern, as well as benefits, to consumers/patients & staff.
- Involve stakeholders in aim statement development
- Assure leadership support and priority alignment

An aim statement is a "living" document – as a team understands the problem or system it is working to improve the aim may be refined.

Aim Statement Key Questions

What?

State the focus of your improvement effort

How good?

Set a numerical goal for outcomes that is ambitious but achievable

By when?

Specify the timeframe

For whom?

Name the customers or population of focus. Primary persons to receive benefit?

Where?

Define the process or system you want to improve

Aim Statement Example

The [organization] will improve [measure] for [who] from [baseline]% to [goal]% by [when].

The ABC Clinic will improve the viral suppression rate amongst patients with HIV from 75% to 85% by December 31, 2025.

The Thinking Part

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 an improvement?

thinking part

1. Set the Aim
2. ***Select Measures***
3. Select Intervention

Measurement Tree

Patient Experience

Provider Experience

Outcome Measure		Maternal Mortality		
Process Measures	Monitoring of Labor using a Partograph	Timely Assessment on Arrival	Skilled Attendant Present at Delivery	Adherence to Infection Control Guidelines
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The Thinking Part

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 an improvement?

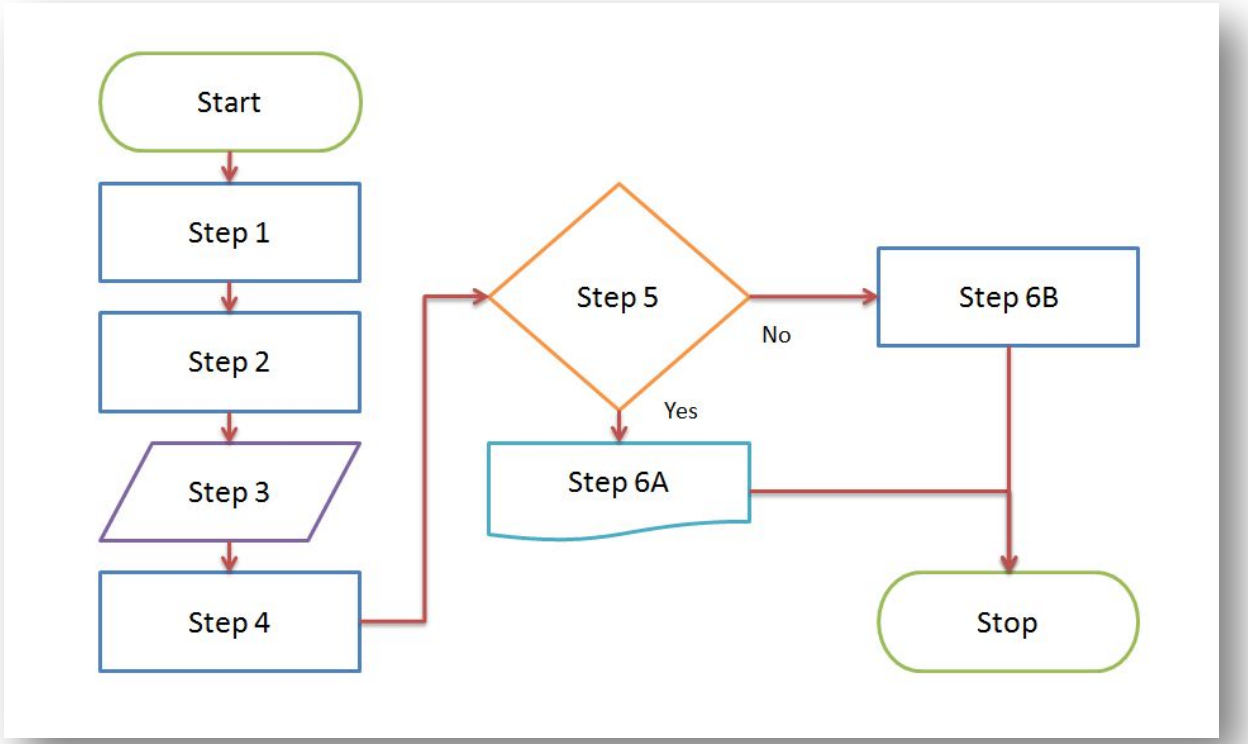
thinking part

1. Set the Aim
2. Select Measures
3. ***Select Intervention***

Identify Changes: Process Maps

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?

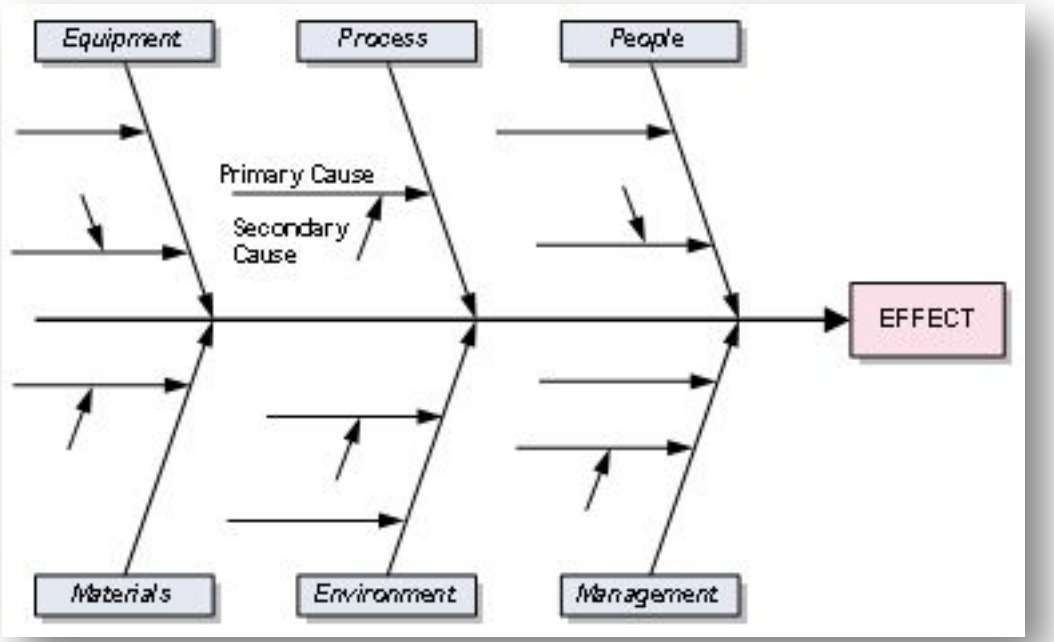


Process Map

Identify Changes: Fishbone Diagrams

Teams can use **fishbone diagrams** to identify change ideas by isolating the key causes and asking stakeholders to brainstorm changes that could address the key cause.

Often teams will pair the **5 Whys** with the fishbone to further enhance the brainstorming by ensuring the team is focusing first on the root causes rather than all causes of a problem.



Fishbone Diagram

The Model for Improvement

What are we trying to accomplish?

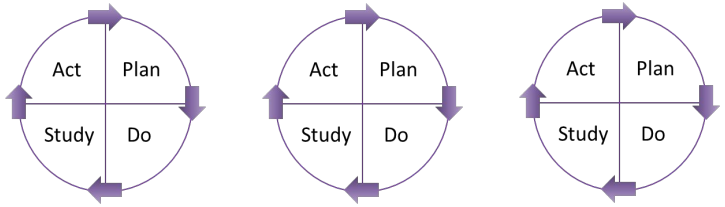
How will we know that a change is an improvement?

What change can we make that we result in improvement?

thinking part

1. Set the Aim
2. Select Measures
3. Select Intervention

PDSA Cycles



More on Day 3

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

Questions

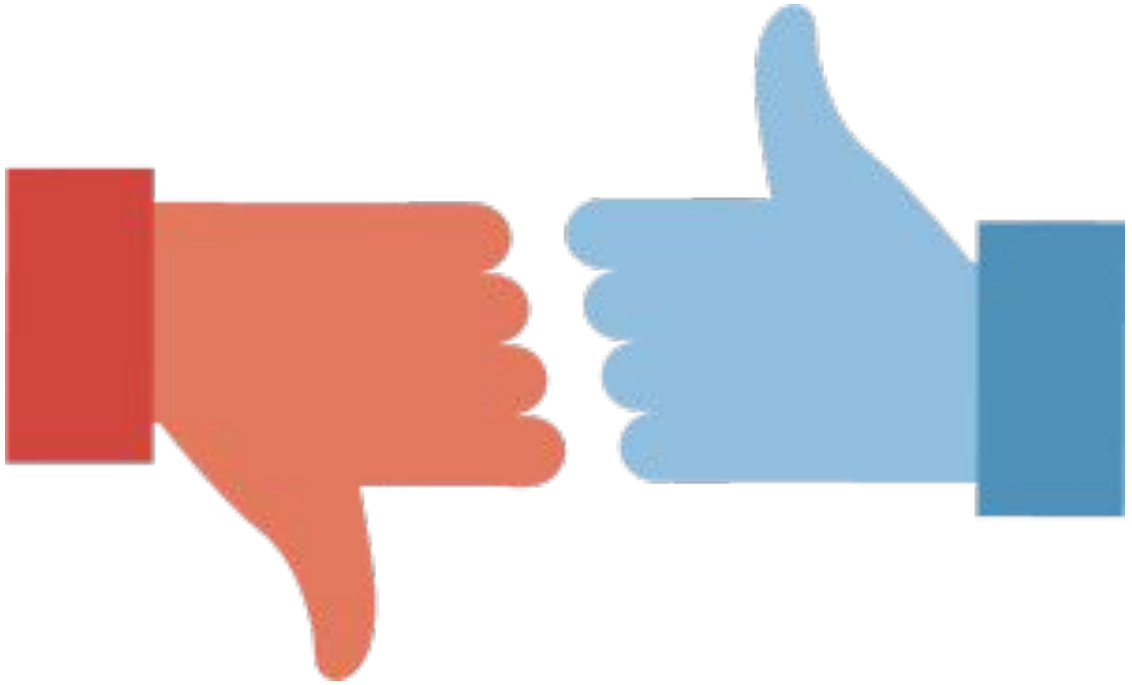
Closing and Evaluation

Reflection

Keep or Change

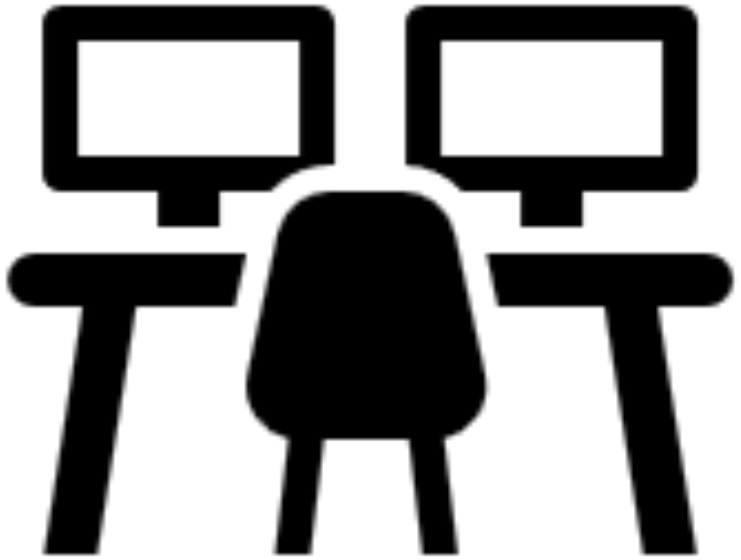
Thinking about today's training, is there anything you would recommend we **keep** doing for tomorrow?

Is there anything you would recommend that we **change** for tomorrow?



What I will apply …

What is 1 thing you learned today that you will apply in your work when you return from the training?



Questions

Salamat!