Driver Diagram
Demonstrating Effective Home Visiting Grant Monitoring and Grantee Support

AIM PRIMARY DRIVERS
- Consistent monitoring processes and open communication with grantees
- Adequate and reliable documentation of grant monitoring activities
- Reliable assessment of grantee performance and risk status
- Provision of valuable technical assistance

SECONDARY DRIVERS
- Carry out and adequately document routine communication between POs and grantees and
- Perform and adequately document site visits
- Conduct ongoing assessments of grantees’ compliance and risk of noncompliance with basic program requirements
- Respond to concerns from grantees about unnecessary burden related to monitoring

SPECIFIC CHANGES FOR TESTING
- Develop SOPs for post-award monitoring processes (e.g., quarterly communications)
- Provide support/training for RPOs and CO staff (e.g., use of checklists, documentation)
- Develop guidance for grantees (e.g., site visits)
- Develop standard checklists or templates for topics to cover (e.g., in site visits)
- Develop criteria to assess grantee’s programmatic or financial risk (e.g., drawdown)
- Develop survey to gauge grantee satisfaction with grant monitoring processes

Measure, test and redesign as needed by February 1st, 2014 the system of post-award grant monitoring and grantee support developed to date for the MIECHV program in order to help grantees better understand and follow program requirements and deliver consistently high levels of service.

Respond to concerns from grantees about unnecessary burden related to monitoring.

Dr. Carlos Cano

Revised 10/1/13
AIM:

By June 30, 2014, the Pediatrics team at the Eureka Community Health & Wellness Center will increase the percentage of Well Child Visits for children aged 3-6 from XX% to XX% by improving current workflows, creating a recall system, and better engaging parents on the importance of these visits.

Specific Changes to Test

- MA, RN, Front Desk Protocols
- Well Child Flag in Epic
- MA makes appointment
- Well Child Calendar for Parents
- Postcards, Call, Text Message Reminders
- No Show Call Back
- Appt. Note during Chart Scrub
- Patient Portal – Appt. & Reminders
- Extended Hours
- Transportation Vouchers
- Educational Visits
- Same Day Well Child Visits
- Family Visits
- Language Services for Hispanic population
- English Class for Spanish-speaking families
- Parent Focus Groups
- WC Handouts: Components & Milestones
- Advertisement and PSA
- Surveys & Interviews

Trisha Cooke
Increase by 20% on average children reaching a fluent level in the development of language: oral comprehension, writing and vocabulary in the five schools UBC-RM between October 2012 and November 2013.

**Language: Oral Comprehension.**
- Increase exposure to oral texts.
- Use reading comprehension strategies.

**Language: Vocabulary.**
- Introduce new words.
- Reinforce new words during the week.

**Language: Writing.**
- Emergent writing activities with a defined purpose and audience.

**Social-emotional development.**
- Room organization and behavior management.
- Working on self control.

**AIM PRIMARY DRIVERS**
- Increase exposure to oral texts.
- Use reading comprehension strategies.

**SECONDARY DRIVERS**
- Introduce new words.
- Reinforce new words during the week.
- Emergent writing activities with a defined purpose and audience.
- Room organization and behavior management.
- Working on self control.

**TERTIARY DRIVERS**
- Reading fairytales.
- Reading of non literary texts (Informative texts).
- Predict.
- Summarize.
- Make connections.
- Reading story with precise definition and a friendly word.
- 8 steps in vocabulary using more than one interaction per word.
- Check the New Word at the end of the week.
- Involve representatives (family experience).
- Set of ideas.
- Writing in block.
- Rules and logical consequences.
- Song of standards for story.
- Mark transitions (singing, instruments, etc.)
- Specify the steps before developing activities.
- Regulate participation.
- Positive reinforcement.
- Active breaks.
- Sitting strategically.
- Give responsibilities.
- Work in pairs.
- Scaffolding.
- Poster rules.

**QUATERNARY DRIVERS**
- Use sticks inquisitive / wand.
- Reading buddies.
- Turn and talk.
- Ear - mouth.

*Carolina Valenzuela*
Aim
Frail older adults with complex needs will live with the dignity and independence they want to have, with health care needs met reliably and well, and with a sense of well-being and inclusion in personal relationships and in the community – and with the costs being sustainable for families and for the larger society.

Primary Drivers
- Identify the frail elder population
- Establish person’s current situation and likely course with various care plans
- Develop and implement the care plan (perhaps, “Personal health and well-being plan”)
- Make services appropriate for frail elders (including health care, housing, personal care, nutrition, and other supportive services)
- Manage a trustworthy, effective, responsive local service production system with a competent, thriving workforce

Secondary Drivers
- Assess risk for illness, disability, and populations
- Develop administratively feasible criteria
- Use opt-in or opt-out: Individual/family agreement to use special frailty care
- Stage of life (multi-dimensional assessment)
- Understand family and caregiver(s) capabilities and willingness
- Develop a shared understanding of what is the most desirable service plan
- Implement the plan, monitor and adapt
- Evaluate the care plan against preferences and values, not just against professional standards
- Routinely evaluate care plans and learn from the evaluation
- Provide comprehensive support at home
- Follow geriatric/palliative principles and priorities
- Enable promise-making and reliability
- Support caregivers and relationships
- Organize volunteers: family, friends and neighbors
- Provide information system to monitor supply, practices, and quality
- Enable governance of the local care system in the interest of frail elders
- Develop appropriate numbers and skills of workforce; reasonable rewards and career ladders
- Reflect appropriate priorities: Reliability, continuity, endurance, dignity
**MENTAL HEALTHCARE IN RESOURCE-POOR SETTINGS: TACKLING DEPRESSION**

### DRIVER DIAGRAM

**AIM**

- Improve clinical outcomes for patients with depression to intensive control

#### PRIMARY DRIVERS

- Access to primary mental health care
- Clinical assessment and Follow-up
- Change packages
- Supply chain

#### SECONDARY DRIVERS

- Local capability building with a task shifting approach
- Early detection/diagnosis
- Linkage of patients to the clinic
- Clinic control visits
- Support groups
- Guidelines/algorithms
- Evidence supported-treatment
- Medications available

#### SPECIFIC CHANGES TO TEST

- Train local physicians, nurses, CHW
- Active case finding/health fairs
- Free, timely primary care
- Implement an appointment system for follow-up
- Adapt validated scales for clinical outcomes assessment
- Provide group sessions
- Adapt clinical guidelines/algorithms to local context
- Adapt evidence-based pharmacologic and cognitive-behavioral therapy interventions
- Adapt push/pull systems

### Outcome measures

- By July 31st, 2013: % of patients with depression under reasonable control

### Process measures

- Total number of patients diagnosed with depression in the clinic
- Average PHQ9 score per month
- Percent of patients with depression attending follow up visits

### Balancing measures

- Level of patient satisfaction (M)

Dr. Jafet Arrieta
HBS IHI Joints Project

Outcome

Primary Drivers

Secondary Drivers

Eliminate waste and reduce variation in process steps (reduce waste in processing)

- Reduce waiting time
- Assure clinical excellence (avoid SSI, etc.)
- Assure smooth handoffs across transitions
- Develop standard work as foundation for improvement

Reduce 5% dollar costs in total hip and total knee replacement surgery (acute care)

- Clinicians work at top of license
- Reduce idle time personnel, starting with most expensive resources in process cycles
- Match personnel to demand (avoid overcapacity beyond appropriate buffer level)

Reduce personnel costs (reduce waste of personnel time)

- Reduce unit cost of materials and supplies
- Rationalize inventory and ordering
- Rationalize use of materials and supplies

Rationalize materials and supplies (reduce waste of material and supplies)

Balancing: maintain or improve (1) clinical measures (e.g., SSI); (2) Patient Reported outcomes on flexibility and pain; (3) patient experience measures of overall satisfaction
Driver Diagram: Reducing all-cause 30-Day Readmission Rates

**Aim:**
- Reduce all-cause 30-day readmission rates from 10.37% to 9.85% or less within 24 months
- 5% reduction on two pilot units within 12 months

**Outcome Measures:**
1. 30-day all cause Readmissions
2. Patient and family satisfaction with transition out of the hospital
3. Patient and family satisfaction with coordination of care in community

**Balancing Measures:**
Re-hospitalization rates
1. 30-Day All-Cause Readmission to Observation Status
2. Emergency Room Visits within 30 Days of Hospital Discharge

**Primary Drivers**
1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide effective teaching and facilitate learning
3. Provide real-time handover communications
4. Ensure post-hospital care follow-up

**Secondary Drivers**
- A. Involve the patient, family caregiver(s), and community provider(s) as full partners in completing an assessment of the patient’s home-going needs
- B. Reconcile medications upon admission
- C. Create a customized discharge plan based on the assessment

- A. Involve all learners in patient education
- B. Redesign the patient education process
- C. Redesign patient teaching print materials
- D. Use Teach Back

- A. Give patient and family members a patient-friendly post-hospital care plan that includes a clear medication list
- B. Provide customized, real-time critical information to the next clinical care provider(s).
- C. Warm handover for high-risk patients

- A. Reassess the patient’s medical and social risk for readmission
- B. Schedule timely and appropriate follow-up care
WORKSTREAM 3 (30 months to start of primary school)

Theory of what drives developmental milestones

Aim

1°

2°

Societal Issues

- Poverty
- Quality Of Home Environment
- Domestic Abuse & Violence
- Workforce Issues
- Transport, Community Capacity & Cultures
- Access To Services
- Employment

Child’s physical & mental health and emotional development

- Early Learning & Play
- Health
- Attachment
- Additional Support
- Level of education
- Misuse of alcohol & drugs
- Nutrition
- Disabilities & Mental health
- Parenting skills & knowledge

Carer’s physical & mental health and skills

- Improved teamwork, communication and collaboration
- Improved uptake of benefits
- Improved child’s dental health
- Improving child nutrition
- Improving brain development and physical play
- Improved family centred response
- Improved stability / permanence for LAC
- Improved identification
- Improved joint working
- Improved management, planning and quality of services
- Improved sharing of information
- Improved leadership, culture & planning
- Identification & reasons for current resilience

Children have all the developmental skills and abilities expected at the start of primary school

Detailed Aim:

90% of all children within each CPP have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017

Version: 06/03/2013
WORKSTREAM 2 (1 year to 30 months)

Theory of what drives developmental milestones

Aim

1°

Poverty
Quality Of Home Environment
Domestic Abuse & Violence
Workforce Issues
Transport, Community Capacity & Cultures
Access To Services
Employment
Health
Attachment
Early Learning & Play
Additional Support

2°

Level of education
Misuse of alcohol & drugs
Nutrition
Disabilities & Mental health
Parenting skills & knowledge

Societal Issues

Child’s physical & mental health and emotional development

Carer’s physical & mental health and skills

Detailed Aim:

85% of all children within each CPP have reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review by end-2016

Theory of what actions will ensure developmental milestones are reached

Improved teamwork, communication, skills and collaboration
Improved money management
Improved child’s dental health
Improved brain development and physical play
Improved family centred response
Improved stability / permanence for LAC
Improved early identification
Improved joint working
Improved sharing of information
Improved management, planning and quality of services
Improved leadership, culture and planning
Identification & reasons for current resilience

Version: 06/03/2013
WORKSTREAM 4 (Leadership)

Theory of what drives leadership support

Aim 1°

Early Years Collaborative is a strategic priority & underpins all policy planning and operational activity

Early Years Collaborative values, culture and behaviours are modelled by all leaders at all levels

Provide the Leadership System to support quality improvement across the Early Years Collaborative

Detailed Aim:
Timely delivery of all three workstream “stretch aims”

Infrastructure to support delivery of Early Years Collaborative

Theory of what actions will ensure leadership support

Aim 2°

Build commitment with partners to focus on delivery

CPPs communicate the EYC with enthusiasm and consistency

Leaders illustrate how users are included in design, improvement, and delivery of Early Years

Leaders facilitate change by cultivating innovation from intelligence, insights and wisdom of people working together

Leaders demonstrate their ability to set direction and engage and mobilise staff to constantly improve quality of service

Leaders can describe how they personally maintain early years focus within their working environment

Early years executive and operational leads are identified

Measurement plan and priorities are established and triangulation with other key data

Spread plan is in place for core and innovative work

Strategy for capturing, celebrating and spreading innovation

Establish an EYC Implementation Committee

Ensure a feedback mechanism for issues raised in Walk-rounds

Ensure the development of a measurement system used to understand and drive quality indicators

Assign a senior leader to each improvement area (Workstreams 1-3 and measurement)

Establish Programme Management and remove barriers

Meet regularly with the Implementation Committee to track progress and remove barriers

Display data that depicts progress towards aim

Ensure that the senior team participates in Walk-rounds

Place quality issues at the top of senior leader meeting agendas

Add Early Years Collaborative and outcomes to the CPP agenda

Version: 06/03/2013
Aim:
- Reduce 30 day mortality in acute kidney injury patients by 30% from 2010/13 baseline (26.1%) over a period of 10 months.
- Reduce LOS for acute kidney injury by 30% from 2010/13 baseline (18.0%) over a period of 10 months.

**Primary Drivers**

1. **Identification of AKI**
   - Effectively identifying patients at risk
   - AKI alert tool (automated clinical chemistry)
   - AKI definitions and guidance: On all in-patient U&E
   - Increase staff understanding of AKI and its evaluation
   - Communication of appropriate patients to nephrology on-call
   - Accurate coding of AKI

2. **Effective Intervention & Monitoring**
   - AKI Bundle
   - Appropriate and timely nephrology referral
   - Timely investigations: 24h UE, u/o, MEWS, dipstick, USS
   - Senior review protocol

3. **Process that ensures effective handover**
   - Medication chart alert
   - Patient empowerment leaflet
   - Presentation and tracking UE results
   - AKI care guideline > intra-note pathway
   - Feedback from incident reporting

4. **Staff and patient engagement**
   - Analysis of patient journey
   - Clinical lead and key stakeholder nominated staff
   - QIM training
   - Project ‘marketing’ and profile, campaign, patient story
   - Learning boards in A&E, AMAU, SAU
   - Mobile webpage/smart phone reference
   - Intranet guidance linked to clinical chemistry alert

**Secondary Drivers**

Victim of a 10/11.0: P. Chamberlain, V04 /11.10.2013