Welcome to the IHI Improvement Coach Professional Development Program Workshop 2

Please help yourself to breakfast and sit wherever you would like.

Welcome back!
Let’s get started

Improvement Coach Professional Development Program

Karen Baldoza
Session objectives

- Summarize where we are in the program and re-ground ourselves in the purpose of the program, the role of improvement coaches, and learning so far
- Review plan for the next three days
- Return to a learning place and re-introduce ourselves

Session agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>Overview</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Reflection exercise</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Agenda for the week and expectations</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Ice breaker</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Wrap up</td>
<td>2 minutes</td>
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</tbody>
</table>
Your guides

- Phyllis Virgil
- Bill Peters
- Karen Baldoza
- Val Spalding
- Caitlin Littlefield
- Mark Bradshaw
- Reshma Kodandaram

The aim of this program is to...

Further develop your improvement knowledge and skill so you can coach and facilitate improvement teams as well as support the implementation of improvement strategies throughout your organization.
Curriculum framework

THE BUILDING BLOCKS

- QI Context and History
  - Quality Chain Reaction System of Profound Knowledge
- Systems/Process Thinking
  - Systems/Process View
  - Understanding Variation and Statistical Thinking
  - Run Chart, Ishikawa Chart, Common Cause/Specific Cause
  - Measurement for Improvement
- Change Ideas
  - First and Second Order Change
- Change Ideas, Change Concepts, Change Packages
- Change Ideas

THE CORE

- QI "Consistency of Purpose" or Mission/Vision
  - Project Team (AIM) or Team (DO)
- Theory of Knowledge
  - Theory and Theory ID
  - Understanding People and Working with Teams
  - Developing Thinking and Coaching Teams
- Measurement for Improvement
  - Data Collection and Measurement
  - Data Collection and Analysis

THE ENGINE – Model for Improvement

- Define and Measure
  - Define and Measure
  - Define and Measure
  - Define and Measure
  - Define and Measure
- Improve
  - Improve Solution
  - Improve Solution
  - Improve Solution
  - Improve Solution
- Use the Basic Tools
  - Basic Tools
  - Basic Tools

Program design and key dates

- Prep Webinar: Sept 1, 12-1:30 PM ET
- Workshop 1: Sept 13-15, Boston
- Virtual Workshop 1: Sept 28, 12-3 PM ET
- Virtual Workshop 2: Oct 6, 12-3 PM ET
- Virtual Workshop 3: Oct 12, 12-3 PM ET
- Workshop 2: Oct 25-27, Boston
- Final Webinar: Nov 17, 12-1:30 PM ET

Support

- IH.org
- Email distribution list
- Faculty consults
- Coaching feedback from fellow coaches and faculty

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Coaching

The discipline of coaching focuses on how to help other people develop insights, skills, and capabilities to assess and improve their current health care experiences. Coaching is not about “telling” health care professional groups what to do, but to engage in conversations and develop relationships to support self-reflection to explore new possibilities, innovations, and actions to result in desired improvements in health care.

Expectations for improvement coaches

<table>
<thead>
<tr>
<th>Role</th>
<th>Consultant</th>
<th>Coach</th>
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<tbody>
<tr>
<td>Style</td>
<td>Tails</td>
<td>Asks</td>
</tr>
<tr>
<td>Timing</td>
<td>Looks back and forward</td>
<td>Forward looking</td>
</tr>
<tr>
<td>Action</td>
<td>Client does work</td>
<td>Action and reflection oriented</td>
</tr>
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</table>
### Coach Role

Early in the life of a team, the coach or facilitator may lead team meetings, conduct JIT training, and give the team feedback on group process issues.

As the team matures, however, the coach’s involvement with the team decreases.

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Manager</th>
<th>Content Expert</th>
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<tbody>
<tr>
<td>Facilitates</td>
<td>Directs</td>
<td>Presents information</td>
</tr>
<tr>
<td>Invested in process</td>
<td>Invested in outcome</td>
<td>Invested in providing content expertise</td>
</tr>
<tr>
<td>Asks questions</td>
<td>Provides solutions</td>
<td>Provides the right answers</td>
</tr>
<tr>
<td>Guides to solutions</td>
<td>Solves problems</td>
<td>Assists in problem solving</td>
</tr>
<tr>
<td>Challenges the team to meet groups goals</td>
<td>Sets the goals and requires the team to meet them</td>
<td>Aids the team to achieve the team goals</td>
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<tr>
<td>Helps the team “graduate” and become self-sufficient</td>
<td>Has long-term relationship with team</td>
<td>Works with team when expertise is needed</td>
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Source: Unknown
Reflections on applying the learning from Workshop 1

On separate colored sticky-notes:

- On yellow, list the ideas and/or methods covered in Workshop 1 that have helped you the most.
- On blue, list the issues that are currently posing the biggest challenges to your team’s progress.

### Workshop 2: Day 1 overview

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>7:00 AM</td>
<td>Registration and breakfast available</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>• Welcome back! Let’s get started</td>
</tr>
<tr>
<td></td>
<td>• A deeper dive: Measurement and run charts</td>
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<tr>
<td></td>
<td>• Developing change ideas: Creativity overview</td>
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<tr>
<td></td>
<td>• Developing change ideas: Six thinking hats</td>
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<td>9:45 AM</td>
<td>9:45 AM Break</td>
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<tr>
<td>11:45 PM</td>
<td>Lunch</td>
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<tr>
<td>12:45 PM</td>
<td>• Facilitation part 2: Coaching teams</td>
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<td>• Breakouts: Project presentations round 1</td>
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<td></td>
<td>• Tools spotlight: Surveys</td>
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<td></td>
<td>• Day 1 debrief and assignments</td>
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<tr>
<td>2:15 PM</td>
<td>2:15 PM Break</td>
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<td>4:10 PM</td>
<td>4:10 PM Break</td>
</tr>
<tr>
<td>5:00 PM</td>
<td>Adjourn</td>
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<td></td>
<td>Optional – Individual consultations</td>
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Institute for Healthcare Improvement
### Workshop 2: Day 2 overview

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<tr>
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<td>Breakfast available</td>
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<tr>
<td>8:00 AM</td>
<td>• Welcome back, warm up, questions from day 1</td>
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<tr>
<td></td>
<td>• Coaching to learn: One-on-one leadership coaching</td>
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<td></td>
<td>• Developing change ideas: Change packages</td>
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<tr>
<td></td>
<td>• Breakouts: Project presentations round 2</td>
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<tr>
<td>9:45 AM Break</td>
<td></td>
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<tr>
<td>12:00 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>• The art of coaching: Coaching practice round 1 breakouts</td>
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<td></td>
<td>• Visual displays of data</td>
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<tr>
<td></td>
<td>• Practical strategies for managing successful improvement projects</td>
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<td></td>
<td>• Day 2 debrief and assignments</td>
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<tr>
<td>3:00 PM Break</td>
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<tr>
<td>5:00 PM</td>
<td>Adjourn</td>
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<td>Optional – Individual consultations</td>
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### Workshop 2: Day 3 overview

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<td>Breakfast available</td>
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<tr>
<td>8:00 AM</td>
<td>• Welcome back, warm up, questions from Day 2</td>
</tr>
<tr>
<td></td>
<td>• Breakouts: Project presentations round 3</td>
</tr>
<tr>
<td></td>
<td>• Sequence of improvement: Implementation, spread, and scale up</td>
</tr>
<tr>
<td>9:45 AM Break</td>
<td></td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>• The art of coaching: Coaching practice round 2 breakouts</td>
</tr>
<tr>
<td></td>
<td>• Graduation (almost)!</td>
</tr>
<tr>
<td></td>
<td>• Day 3 debrief and next steps</td>
</tr>
<tr>
<td>3:00 PM Break</td>
<td></td>
</tr>
<tr>
<td>4:00 PM</td>
<td>Adjourn</td>
</tr>
</tbody>
</table>
Expectations for participation

- Honesty and dialogue
- Kindness and respect
- Being “present”
- Active participation in program activities
- Providing peer coaching and support in and between workshops
- Actively engage with the teams you have selected for coaching
- Make presentations on your personal progress with a team

*All teach, all learn*

Our ground rules

1. Listen
2. Keep an open mind
3. Be respectful and supportive
4. Arrive on time
5. Be engaged
6. Come prepared
7. Have fun and stay positive
8. Share your ideas and experiences
Icebreaker

- Draw a crest, shield, or coat of arms that reflects your team
- Include:
  - An animal that captures the spirit of the team
  - A fruit or vegetable that reflects the flavor of the team
  - A slogan or motto for the team
- Be creative!

Building Competency as a Coach

(W. Edwards Deming)

Learning is not compulsory... neither is survival

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"One important key to success is self-confidence. An important key to self-confidence is preparation."

Arthur Ashe, professional tennis player and civil rights activist

Let's Get Started!

A Deeper Dive: Measurement and run charts

William Peters

October 25, 2016
Day 1
Question 2 of the Model for Improvement

The most basic understanding of the 2nd question is this: MEASUREMENT

Data is not just numbers, or “quantitative data”, but “qualitative data” as well.

quantitative data + qualitative data

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How Do We Know That a Change is an Improvement?

- Improvement is about **testing and implementing change within a system, not measurement!**

The purpose of measuring is to answer critical questions and to guide intelligent action.

Measurement within the Lens of Profound Knowledge

Dr. W. Edwards Deming stressed the importance of studying four areas to become more effective in leading improvement:

- Appreciation of a system
- **Understanding variation**
  - Theory of knowledge
  - Psychology

So … measurement falls under “understanding variation” then?
Dr. W. Edwards Deming stressed the importance of studying four areas to become more effective in leading improvement:

- Appreciation of a system
- Understanding variation
- Theory of knowledge
- Psychology

Actually, measurement is intimate to all four areas of the System of Profound Knowledge.

Question 2 of the Model for Improvement

But .... In order to fully appreciate the 2nd question, the “measurement question”, we should step back for a minute...
Question 2 of the Model for Improvement

... and appreciate that **measurement** and **method** are two different yet intimately related topics...

**METHOD**

![Shewhart Chart](image)

**INSIGHT FROM THE FIELD**

The Three Faces of Measurement

<table>
<thead>
<tr>
<th>characteristic</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of ...</td>
<td>Improvement of care</td>
<td>Comparison, choice, reassurance, spur for change</td>
<td>New knowledge</td>
</tr>
<tr>
<td>Bias</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>Sample Size</td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td>Flexibility of Hypothesis</td>
<td>Hypothesis flexible, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis</td>
</tr>
<tr>
<td>Testing Strategy</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td>Determining if a Change is an Improvement</td>
<td>Run charts or Shewhart control charts</td>
<td>No change focus</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square), p-values</td>
</tr>
<tr>
<td>Confidentiality of the Data</td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
</tr>
</tbody>
</table>

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The role of data during improvement

- The Lens of Profound Knowledge: Theory of Knowledge and the use of data for improvement … how it works …

The project problem: “I’m thirsty!”

Question: “can I get a drink without missing something key?”

Knowledge: fountain right outside door, w/cool water

Theory: fountain is close, I can make it quick!

Prediction: “yes!, I can make it really fast”

Observation/life/experience/doing/living/seeing

New Data: fountain was removed

The role of data during improvement

- The Lens of Profound Knowledge: Theory of Knowledge and the use of data for improvement … how it works …

The project problem: long CT wait times

Question: “our wait times are unknown, but feared to long …”

Knowledge: we have a check-in clerk, moderate volumes…

Theory: “we are staffed adequately for our volumes”

Prediction: “no waits above 30 minutes”

Observation/life/experience/doing/living/seeing

New Data: 20% wait >30 minutes + ED chaos
The role of data during improvement

Knowledge = Data + Theory
(qualitative + (our view of quantitative)
how the world works)

Let’s learn some advanced stuff …

Let’s use a PDSA cycle we covered last session and see what we can learn about the use of data and run charts over another two PDSA cycles!
Remember the “Sterile Cockpit” test?

**PLAN:** the hardest part of running a cycle

- **Plan**
  - Objective
  - Questions & predictions
  - Plan to carry out: Who? When? How? Where?
- **Act**
  - How to implement
  - Try something else
  - Next cycle
- **Study**
  - Complete data analysis
  - Compare to predictions
  - Summarize

The Plan always, ALWAYS, contains a question and a prediction to the question!

**Q** If we create a “sterile cockpit” during med pass, will nurses find value in not being interrupted? How can we reliably identify a nurse doing a med pass?

(Prediction never Y/N, no learning in that! WHY? WHY and HOW will it work? WHAT IS YOUR THEORY?)

**P** Interruptions can lead to errors. We had an error here from being interrupted that almost cost the life of a patient! Less interruptions will reduce the room for errors. The nurse doing the med pass will find this idea very attractive. I think we can identify the nurse doing med pass by using a brightly colored hat.

... and then list ALL the gory details! ALL!

**When:** btw Monday 9/1 and Wednesday 9/3, 9:30 pass only.

**Where:** Unit 1 only, Where: Michelle Roberts all 3 days

**Data:** vocal feedback from Michelle, RNs on duty, MDs rounding and any staff who visit unit one. # of interruptions

**How:** Michelle will place hat on when entering med room.

They had to tweak the test …

**DO:** tweak the PLAN & make sure PLAN is followed

- Note any tweaks made to PLAN in order to not cancel test. Reality usually breaks a PLAN
- Are we testing the idea as laid out in the PLAN?

**DO**

9/1/2014: we had to ask Marcy and Daryl to take the duties of the unit clerk since she was out sick

9/1/2014: initial response from Michelle is very positive. “I don’t get anxious when someone walks by. Normally I would think “someone is looking for me”"

9/2/2014: Unit clerk still out sick. Marcy going to continue education people who walk onto unit about the meaning of the hat

9/2/2014: another RN noted that she gets interrupted by PTs too. She made her own script that reduces this

9/3/2014: Unit clerk back but Marcy and Daryl going to finish out last day of test

9/3/2014: test followed plan
What they learned from a small test …

The STUDY is where we compare our data to our predictions. Does the data support our predictions?

- Data can be soft (qualitative), can be the opinions and observations of SMEs
- Data can be hard (quantitative), can be hard numbers like the # of interruptions

Best practices is to use both hard & soft data in cycles!

STUDY
Michelle absolutely loved the huge reduction in interruptions. She counted 6 interruptions over the 3 days, a number she insisted was way lower than without the hat on. All the interruptions were from staff not aware of the details of the test going on. She recommends the hat be switched to a sash bc the hat isn't that comfortable and will probably fall off depending on hairstyle. Michelle forgot how often PTs interrupt med pass with simple concerns (5 times). RN Lilly noted she asks her patients a set of questions aimed at reducing simple requests while she does med pass. All 3 doctors and staff visiting unit thought the idea was great.

High degree of belief, but how many?

ACT is where decide our next steps based on the data being compared to the prediction

- Tweak is trying again a different way the next cycle
- Implement is making the change permanent
- Abandon is not pursuing the idea any more

ACT

Based on the number of interruptions, and vocal feedback from all, this idea is worth pursuing. We don’t know how many interruptions happen during a typical med pass so another cycle will be run to collect this data to use to sell the idea house wide (and maybe spread to our sister hospitals). We, especially Michelle, will speak to all of Unit 1 nurses and tell them about our findings with this small test. We will see if they will take a baseline of the number of interruptions for 3 weeks.
Let’s run another larger cycle, on Unit 1

**ACT**: Implement?, Tweak? or Abandon?

- **Plan**: A cycle is where decide our next steps based on the data being compared to the prediction
  - Tweak is trying again a different way the next cycle
  - Implement is making the change permanent
  - Abandon is not pursuing the idea any more

- **So after one cycle we:**
  - Know hat won’t work and we will use a labeled sash
  - The idea brings value as shown in hard/soft data
  - Uncovered the idea of patient med pass interruptions
  - Found out RN Lilly has her own script that reduces PT interruptions so we will test (cycle) a few nurses using it to see if it works and find the “best fit script” that reduces minor PT requests during med pass
  - Learned we don’t know how many interruptions happen so a cycle of learning will be used to find out (use this data to sell)
  - Got a lot of people involved in thinking, in improvement, we made improvement an attractive thing
  - We reduced resistance to a new change because a lot of staff were involved. Staff will hone final change. EMPOWERMENT!

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**Cycle #2, Unit 1, the baseline …**

**PLAN**: the hardest part of running a cycle

- **Objective**
- **Questions & predictions**
- **Plan to carry out**

**Q**: What is the extent of the problem of interruptions from staff, patient and family during all the med passes during one day? How many interruptions per day will we have? (Prediction never Y/N, no learning in that! WHY? WHY and HOW will it work? WHAT IS YOUR THEORY?)

**P**: Unit 1 tested for 3 days during one med pass and one nurse experienced 6 interruptions. We expect to find a lot more since we are testing across all 4 med passes, all RNs

... and then list ALL the gory details! ALL!

- **When**: btw 9/12 and 9/30, week days only (weekends are very quiet, much less staff around), all four med passes on each day
- **Where**: Unit 1
- **Who**: all nurses across all med passes
- **Data**: # of interruptions after each med pass will be given to unit clerk who will enter them into Excel file “med pass interruptions” and Michelle Vickers will create a run chart at the end of the 3 weeks
Run chart, cycle #2, entire Unit 1…

Number of Interruptions During Med Passes by Day

Baseline median 11
15 data points, 1 on median, 14 useful observations
9 Runs, at 14 points table shows btw 4 - 12

How the new data increased knowledge

- The Lens of Profound Knowledge: Theory of Knowledge and the use of data for improvement … how it works …

The project problem: unknown extent of interruptions

Question: "how many interruptions does a unit get a day during med passes?

Knowledge: a problem, one nurse had 6 over 3 days on 1 med pass time uncovered patient interruptions are a reality

Theory: "we will show lots of interruptions across all med passes"

Prediction: “1 RN had 6 interruptions over 3 days during just 3 med passes, so … we can expect around 20 a day?"

Observation/life/experience/doing/living/seeing

New Data: around 11 interruptions a day across all med passes
Cycle #3 Sterile Cockpit, entire unit …

The Plan always, ALWAYS, contains a question and a prediction to the question!

Q  We believe 11 interruptions is too many. Can we decrease the number by testing the “sterile cockpit” method here on Unit 1? Will nurses wearing “no interruptions please” sashes, and scripting to patients, during the med passes reduce the number of interruptions?

(Prediction never Y/N, no learning in that! WHY? WHY and HOW will it work? WHAT IS YOUR THEORY?)

P  We should be able to reduce the number of interruptions by at least half because the sashes will let staff, patients and family know not to interrupt during this critical time. Scripting to patients will help further reduce interruptions as well.

… and then list ALL the gory details! ALL!

When: btw 10/10 and 10/14, week days only (weekends are very quiet, much less staff around), all four med passes on each day
Where: Unit 1 Who: all nurses across all med passes
Data: # of interruptions after each med pass will be given to unit clerk who will enter them into Excel file “med pass interruptions” and Michelle Vickers will create a run chart at the end of the 3 weeks
What: Each nurse will put on a sash in the med room before going out on the med pass, patients will be asked “are there any questions I can answer before giving you your medications?” and all who enter Unit 1 will be told of meaning of the sash

Run chart from cycle #3

Number of Interruptions During Med Passes by Day

- Baseline median 11, extended over test
- 20 data points, 1 on median, 19 useful observations
- 10 Runs, at 19 points table shows btw 6 - 15
- Median calculated on data up to change
- Data are clearly well below extended median
- Begin Sterile Cockpit test

But what about the qualitative data, the opinions of the SMEs?

“the script reduced patient interruptions”
“easier without so many interruptions”
“way less interruptions” “didn’t mind the sash”
Run chart from cycle #3

Number of Interruptions During Med Passes by Day

The unit collected another week's worth of data using Sterile Cockpit test.

Time to recalculate the median!

Run chart from cycle #3

Number of Interruptions During Med Passes by Day

Now there is a new process in place, change has led to improvement!
What did we just learn, cover?

- An initial small test of a “stolen” idea can be used to sell the idea to entire unit
- Never discount the “soft data”, the qualitative data from the SMEs
- Getting a baseline is ideal, let’s us know where we are at, provides knowledge!
- Baseline can be used to “sell” the idea of trying something new (testing)
- Sometimes a chart takes no “hits” for the tests but still looks “different”
- Annotating the chart is a great idea
- Extending the median is a nice trick, will your new data “play” with old median?
- Recalculating the median is ok after a new period of functioning has been shown
- We have seen another solid example of the role of data in building knowledge!

Milestones in the Quality Measurement Journey

AIM – reduce patient falls by 37% by the end of the year

Concept – reduce patient falls

Measures – falls per 1000 patient days, number of falls

Operational Definitions - # falls/inpatient days

Data Collection Plan – monthly v. daily; no sampling; all IP units

Data Collection – unit collects the data

Analysis – run chart created in run chart template
Three Types of Measures

- **Outcome Measures**: Voice of the customer or patient. How is the system performing? What is the result?

- **Process Measures**: Voice of the workings of the system. Are the parts/steps in the system performing as planned?

- **Balancing Measures**: Looking at a system from different directions/dimensions. What happened to the system as we improved the outcome and process measures? (e.g. unanticipated consequences, other factors influencing outcome)

An Operational Definition...

... is a description, in quantifiable terms, of what to measure and the steps to follow to measure it consistently.

- It gives communicable meaning to a concept
- Is clear and unambiguous
- Specifies measurement methods and equipment
- Identifies criteria

Every measure needs an operational definition?

- Simplest answer: YES Have to be explicit.
- A simple fable on “percent mortality”
- Test driving a car, the same car …
- The more detail the better. Document all inclusions and exclusions. Being teased?
- ALWAYS include along with run or control chart
- Running PDSA cycles is an exercise in op-defs

How much data do I need to collect?

- You are essentially always “selling your case, your theory, your view of how the World works” to others, so …
- A simple rule, that annoys people, is “as much as you can and as little as you dare”
- I’ve always liked 33, at least 15, just start today!
- True random sampling v. judgement sample
Understanding variation in data

There are several tools we use in improvement to make sense of the variation that is inherent in EVERY measure.

How else would we do it? Make it up?!

But what about the stats I learned in college?

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<tr>
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<td>69.8</td>
<td>45.8</td>
<td>65.0</td>
<td>48.5</td>
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</tr>
</tbody>
</table>

Yet ... 6 different stories when plotted over time!
Understanding variation in data

Let's explore the critical concept and skill of interpreting data. Let's learn how to not react!

- Can I talk to someone here about their commute to work?
- ... and then we’ll switch it to patient experience
- How about a bolt machine?

Run Chart: the tool we use to make sense of variation

- Make process performance visible
- Determine if change is an improvement
- Determine if we are holding the gains

The Run Chart is “the hammer” of the Improver
We need data over time to show improvement

1. Improvement is the result of a change in the process
2. Result is positive, relevant, meaningful ...
3. Gains are held ...
4. Cycle time

REAL SUSTAINABLE IMPROVEMENT

Run Chart: the tool we use to make sense of variation

Benefits
- Get those closest to the process to measure it in real time, to take ownership of the data
- Can use to test changes against
- Used to prove improvement, to prove success, to strengthen theory
- We provide you with a template to use, to save time
- They can also be a quick low tech solution, paper + ruler + pencil
- If you are a clinician … then “you got this”

Steps
1. Pick measure, grab graph paper, ruler and pencil (and SME!)
2. Draw X axis
3. Draw Y axis
4. Plot data
5. Find median
6. Apply the four run chart rules to test for non-random patterns
A Run Chart

Let’s talk more about the median line and flipping coins …

And let’s also talk about the unit of time used on the x axis

The centerline (CL) on a Run Chart is the Median

The four rules to apply to a run chart

Four rules that indicate non-random pattern in a run chart

1. Shift
2. Trend
3. Too many or too few runs
4. Astronomical data point

Murray and Prevost, 3 (11-15)
Rule one: the shift

Six or more consecutive POINTS either all above or all below the median. Skip values on the median and continue counting points. Values on the median DO NOT make or break a shift.

Murray and Prevost, 3 (11-15)

Rule two: the trend

5-7 points all going up or all going down. If the value of two or more successive points is the same, ignore one of the points when counting; like values do not make or break a trend.

Murray and Prevost, 3 (11-15)
Rule three: runs

To determine the number of runs: A run is a series of points in a row on one side of the median. Are there too many, or too few, runs? Too little, or to much, variation?

Use the lookup table provided in the run chart template

<table>
<thead>
<tr>
<th>Total number of data points on the run chart that do not fall on the median</th>
<th>Lower limit for the number of runs (≤ than this number of runs is “too few”)</th>
<th>Upper limit for the number of runs (≥ than this number of runs is “too many”)</th>
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<tr>
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</tbody>
</table>

Table is based on about a 5% risk of failing the run test for random patterns of data. Adapted from Swed, F. E. and Eisenhart, C. (1943). “Tables for Testing Randomness of Grouping in a Sequence of Alternatives.” Annals of Mathematical Statistics. Vol. XIV, pp. 86 and 87, Tables II and III.

Table for Checking for Too Many or Too Few Runs on a Run Chart

Institute for Healthcare Improvement
Rule three: too many runs

20 useful observations and 19 runs

21 points, 1 on median, 20 useful observations
Data line crosses median 18 times. 18+1 = 19. 19 runs.

Use the lookup table provided in the run chart template

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</table>

Table is based on about a 5% risk of failing the run test for random patterns of data.
Rule four: “the astro”

Blatantly obvious that value is unusual. SMEs mostly agree

A random example

Percent All-Cause, 30 Day Readmissions

20 data points
8 runs 6/16
6 shift

15.9

I&P
or
I&E
&
LEARN
& TAKE
ACTION!
Institute for Healthcare Improvement

Operational Definition: Total number unplanned patient descents to a lower level resulting in harm or no harm for Acute Inpatients, SNF Patients and Observation Patients.

Subject Matter Expert Interpretation: The data shows an overall decrease in our number of falls since the beginning of 2013. The decrease is a result of several interventions that are annotated on the above graph and include the following: standardized fall assessment on every patient, standardized fall risk patient bands, specific C.N.A. education, motion sensor/video monitor, and new beds. We did have a fall in March 2015, which was a patient that was being assisted to the bathroom with two staff members. Due to the limited space in the bathroom one staff member entered with the patient and the IV pole and as the patient was backing up the staff member turned to move the IV pole while holding the patient’s gait belt and the patient lost their balance and the staff was unable to prevent the patient from falling. In April and May 2015 we had zero patient falls.
So we have a signal of non random variation...

So far, so good, so what ...

Never forget ...

- All measures have random variation
- We are forced to interpret this variation
- We use the four rules to interpret the run chart
- Over interpreting it is called tampering
- Tampering is a waste of time and hurts the willing worker
- The willing worker can use the run chart to prove improvement
- When pressed, paper/pencil work just fine

What charts with >20% data points at 0?

- Time [days] between
  - or
- Units between
  - both use the same set of run chart rules!
  - UP UP UP is good!

Industry uses them a lot!

- Most are familiar with the time between measures …
What about charts with >20% data points at 0?

Number of Falls a Week at Canton Nursing Home

Here we have 21 data points, 8 at zero, 38% data points at zero

What about charts with >20% data points at 0?

"we can expect around 30 days between falls should nothing fundamental change"

DAYS between Falls at Canton Nursing Home

But what do we want it to look like, perform like?
What about charts with >20% data points at 0?

"we keep increasing the days between falls!"

DAYS between Falls at Canton Nursing Home

date of fall days b/w median
5/21/2012   20  93.5
6/19/2012   44  93.5
9/15/2012   50  93.5
11/15/2012  64  93.5
1/21/2013   67  93.5
3/31/2013   69  93.5
6/19/2013   80  93.5
9/15/2013   88  93.5
12/23/2013  99  93.5
4/15/2014  113  93.5
8/19/2014  126  93.5
12/30/2014  133  93.5
5/24/2015  145  93.5
10/31/2015  160  93.5
4/29/2016  181  93.5
11/19/2016 204  93.5

This is a simplistic view for examples sake

An example from the field ...

Hamad General Hospital - 6 North 1 Medical Ward
GWO02 - Days between a C. difficile associated disease occurrence
388 days since last event (today 4/17/2018)

Spot the error?
Histograms: what are they good for?

Wikipedia: A histogram is a graphical representation of the distribution of numerical data. It is an estimate of the probability distribution of a continuous variable (quantitative variable) and was first introduced by Karl Pearson.

This tool allows me to see the shape, distribution and layout of the data.

Histograms: what are they good for?

Wikipedia: A histogram is a graphical representation of the distribution of numerical data. It is an estimate of the probability distribution of a continuous variable (quantitative variable) and was first introduced by Karl Pearson.
Histogram: what is our water use on this washer?

What is our water use on this new tunnel washer the past 4 months?

Histogram: the relationship with data over time...
Histogram: a real use from the field …

ER LOS of ADMITTED PATIENTS

Run Chart Working Time
Break
An Innovative Change Concept!

A Practical Need Often Drives Creativity!
Question 3 of the Model for Improvement

We attempt to use creativity techniques to come up with ideas for change, ideas to test!

Question 2 of the Model for Improvement

We attempt to use creativity techniques to come up with ideas for change, ideas to test!

What KIND of change do I look for, do I try to create?
Let’s not forget 1st Order and 2nd Order Change
First order change

MORE:

• Of the same ideas/changes already tried/implemented

OR

• More resources:
  — Time, money, staff, inspections, alerts, screens, posters, warnings, stickers, education, in-services, “talking tos,” data reviews, meetings, advice, mailings, reminders, beds, paperwork, policy and procedures, blips and bleeps, lights, signage, rooms…and my favorite “exhortations”

• Now consider your car is not running well

All improvement requires change, yet not all change leads to improvement

(what a bummer!) (property taxes are more)
Second order change

MORE: NOT MORE!
• Change that is fundamentally different
• Think of a flow chart
• Human behavior/movement is changed
• Hard to come up with because of the power of the human mind, “perceptual ruts”
• Is responsible for 90-95% of improvement
• (sometimes MORE is needed!)

And is a great thing to tease each other about!

(“I don’t know, sounds like more to me??!”)

Creativity within the Lens of Profound Knowledge

Dr. W. Edwards Deming stressed the importance of studying four areas to become more effective in leading improvement:

• Appreciation of a system
• Understanding variation
• Theory of knowledge
• Psychology
Creativity, not just for kids …

The human mind has been so incredibly successful because of “squads of simpletons” that arrange data into quickly referenced “memories”. There is no known equivalent to the human minds ability to assimilate, digest and make quick decisions on complex matters.

BUT THIS IS NOT WITHOUT ITS DRAWBACKS!

Our “rational mind” is further handicapped by …

… propensity to jump right in to “reaction mode”
Classic example of reactionary thinking in healthcare

Reactive response to a plotting of Med Errors

“last month we only had 5 and this month we had 7! What are YOU going to DO about it! We’re getting WORSE!!!”

Rational response to a plotting of Med Errors

“our processes are perfectly designed to generates around 5 med errors a month and will continue to do so until will make changes to the entire process”

Rational Thinking vs. Reactive Thinking

The “rational mind” is already far from rational … … so …

How can we avoid reactive thinking?

How can we become better at rational thinking?

Is there a way to help us see rational from reactive thinking in our WORK LIVES?
Origins of reaction …

Bottom Line: Humans are unparalleled at improving their situation BUT problems are becoming more complex

Information Age: early 1970s

Industrial: ~1760

Agricultural: ~12,000 years ago

Hunter/Gatherer: ~5.5 million years ago, 200,000 in current form

Time

Original Content: Barbara Lawton

Origins of reaction …

Bottom Line: we are perfectly adapted for a world long gone so being vigilant about whether we are responding rationally is critical for success, and in the long run, even our survival!

Information Age: early 1970s

Industrial: ~1760

Agricultural: ~12,000 years ago

Hunter/Gatherer: ~5.5 million years ago, 200,000 in current form

Time

Original Content: Barbara Lawton

Institute for Healthcare Improvement
Generating the Next Set of Changes Using Lateral Thinking of Edward de Bono

**Dr. Edward de Bono**
- M.D., Ph.D., (philosophy, medicine & psychology), Rhodes scholar
- World-renowned consultant to business, governments, schools and industry
- Author of 62 books in 35 languages
- Originator of Six Thinking Hats, Lateral Thinking and Direct Attention Thinking Tools

**Reference Material**
- Chapter 16: *Creativity Methods* from Improvement Handbook
- Serious Creativity (1992), Edward de Bono
- Personal communication with Mike Sproul, Certified de Bono instructor

At the heart of Edward de Bono

We are born without pre-conceived ideas about the world. With experience, we come to recognize patterns and categorize the things and situations we see. With experience, we become able to find a category or pigeonhole into which to put many situations. This is great because it allows us to react rapidly to these situations. The disadvantage is that our thinking becomes limited. If we do not have a pigeonhole into which to put something we are looking at, sometimes just don't see it. We carry many assumptions around in our minds, and these assumptions make us blind to new possibilities.

“If we do not have a pigeonhole into which to put something we are looking at, sometimes just don't see it.”
Conceptual view of “perceptual ruts”

The World

- your
- perceptual
- ruts
- can work against you

JUST LIKE a dried motorcycle rut in a field!

Conceptual view of “perceptual ruts”

Provocation!
- Escape
- Reversal
- Exaggeration
- Distortion
- Wishful thinking

Lateral thinking
- your
- perceptual
- ruts
- can work against you

Lateral thinking, (literally, sideways thinking) uses various acts of “provocation” to escape perceptual ruts free us from previously locked assumptions and come up with fresh NEW ideas.

Institute for Healthcare Improvement
Lateral thinking, (literally, sideways thinking) uses various acts of "provocation" to escape perceptual ruts free us from previously locked assumptions and come up with fresh NEW ideas.
Probably the most popular of his methods ...

**The Six Thinking Hats**

*A Lateral Thinking Strategy by Edward De Bono*

---

**Six Thinking Hats Exercise**

*Phyllis Virgil*

---

Institute for Healthcare Improvement

**Improve Coach Professional Development Program**

Wave 2, Workshop 2

October 25, 2016

Day 1
Session Objectives

After this session, you will be able to:
- Describe Dr. Edward de Bono's 6 thinking hat technique to generate/evaluate ideas
- Practice applying the 6 thinking hat method to evaluate an improvement idea

Session agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Six Thinking Hat Exercise</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Insights and Wrap-up</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
Six Thinking Hats of de Bono

Blue hat
- Process Control

Black hat
- Negative Aspects

White hat
- Facts & Information

Green hat
- Creative Ideas

Yellow hat
- Positive Aspects

Red hat
- Feelings & Intuitions

Simple Rules
1. Think with the **same hat at same time**
2. Keep your thinking on the hat in use
3. Use short bursts of thinking (3-5 minute rounds)
4. Extend the time if the thinking is flowing and on one color, do so explicitly and in small increments. (today we will use 3 minute rounds and not extend)
5. No in-depth discussion, use rapid round robin
6. Use a focused and simple sequence of hats (I will do this for you today)
7. View thinking as a skill – a serious game
Blue Hat Role = Process Control and Focus

- Wears blue hat only
- Manages thinking process
- Sets the focus and agenda
- Plans the sequence of hats
- Handles requests from the group
- Ensure the rules are followed
- Calls for a different hat
- Makes summaries and conclusions at end

Set-up

- I will play blue hat role (process focus and control
- Ask that you do help each other stay in the “hat” we are using for each round
- Would like table facilitator to record your work on flip chart
- Suggest recording so we can tell what was generated while using each “hat”
Participant Role

- Follows the lead of the table facilitator
- Sticks to the hat (thinking focus) in use
- Works within the short planned time limits
- Contributes honestly & fully for each of the hats

Table Facilitator Role

- Keep the conversation on track (deputy blue hat)
- Keep things going quickly (3 minute rounds)
- Record as many ideas as possible on your flip chart
- Summarize table experience and learnings

Table Facilitator will wear deputy blue hat throughout the exercise
Six Thinking Hats Exercise

We are going to use the six thinking hats on the idea of putting customers on all your improvement teams.

Pick a table facilitator to record and help you stay on track.

You will have 3 minutes to “wear” each hat.

Guidance
- Stick to the hat (type thinking) that is in use for each round
- Work within the short planned time limits (3 min/hat)
- Contribute honestly and fully under each of the hats
- Record information during each hat chat

Blue Hat Thinking

Provocation:
Place a customer on all improvement project teams in your organization

- Control of the thinking process
- Organize the thinking
- Setting the focus and agenda
- Summarize & conclude
- Ensure the rules are followed
- Used to call for a different hat

Blue Hat: Process Control and Focus
**White Hat Thinking**

**DATA AND INFORMATION**
- What information do we have?
- What information is missing?
- What information would we like?
- How are we going to get the information?

**Green Hat Thinking**

**CREATIVE ASPECTS**
- What new ideas do we have?
- Are there additional alternatives?
- Could we do this in a different way?
- Could there be another explanation?
  (no rationale needed, wild ideas ok)
Yellow Hat Thinking

POSITIVE ASPECTS
- What are the benefits?
- What are positive things?
- What is the value in the idea?

(Reasons must be given – logic, experience, data)

Yellow Hat: Logical, Positive, Benefits

Black Hat Thinking

NEGATIVE ASPECTS
- What are the risks, faults, problems?
- What are weaknesses of the idea?
- Why can we not to do that?
- What does not fit the facts or the system?
- Why will it not work?

(Reasons must be given, logic, experience, data)

Black Hat: Logical, Negative, Caution

Provocation: Place a customer on all improvement project teams in your organization

3 min

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Red Hat Thinking

EMOTIONAL ASPECTS

- How do you feel about this project?
- What is your gut telling you?
- Why are you uneasy about the way it is being done?
- What does your hunch, intuition or sense tell you?

(No reasons or justifications)

Red Hat: Feelings, Intuition, Emotions

What did you learn?

- What insights did you get from this exercise?
- What might be the benefits of using this method within your own organization?
- Where might you use it?
Appendix

- Benefits of Six Thinking Hats
- Path to Generate Idea
- Path to Develop and Evaluate Ideas
- Six Hats for Individual Thinking
- Hat Summary Sheet

Benefits of Six Hats for Improvement

What others say:
- Explores change concepts and ideas more thoroughly
- Shortens meetings and increases participation
- Critique and strengthen ideas for change
- Facilitates agreement for change
- Supports constructive and creative thinking
- Enables best use of information and team
- Harness big egos
Path to Generate Some Ideas

- **Blue hat:** Set the focus, decide where we need specific ideas
- **White hat:** What information do you have? What evidence on the subject?
- **Green hat:** Generate specific change ideas for testing on a small scale

Path for Developing & Evaluating Ideas

**Blue hat:** Set the focus; decide where we need ideas

**White hat:** What information do you have? Need?

**Green hat:** What are some possibilities or ideas?

**Yellow hat:** What are the good points of the ideas?

**Black hat:** What are some weaknesses of the ideas?

**[Optional Green hat: What are some ways of overcoming the weaknesses]**

**Red hat:** How do you feel about the idea?

**White hat:** Which of the ideas could we test based on the information and budget we have?

**Blue hat:** Select the change idea, summarize next steps
Thinking Hat Diagram for Individuals

Diagram of your thoughts divided into separate thinking "hats".

Summary
De Bono Six Thinking Hats

Blue Hat
Managing The Thinking
Setting The Focus
Making Summaries
Overviews • Conclusions
Action Plans

Black Hat
Why It May Not Work
Cautions • Dangers
Problems • Faults
Logical Reasons
Must Be Given

White Hat
Information & Data
Neutral & Objective
Checked & Believed Facts
Missing Information & Where To Source It

Yellow Hat
Why It May Work
Values & Benefits
(Both Known & Potential)
The Good In It
Logical Reasons
Must Be Given

Red Hat
Feelings & Intuition
Emotions Or Hunches
“At This Point”
No Reasons or Justification
Keep It Short

Green Hat
Creative Thinking
Possibilities • Alternatives
New Ideas • New Concepts
Overcome Black Hat
Problems & Reinforce Yellow Hat Values

Institute for Healthcare Improvement
Lunch
Session Objectives

- Review key team meeting facilitation skills
- Practice the art of knowing when and how to intervene.
- Develop strategies to successfully navigate through a variety of facilitation challenges

Session agenda

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<tr>
<td>Introduction and Review</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Fish Bowl Intervention Exercise</td>
<td>30 minutes</td>
</tr>
<tr>
<td>What If Scenarios</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>
A skilled facilitator will...

A. Recognize and embrace the team journey  
B. Know when and how to intervene  
C. Practice the art of questioning and active listening  
D. Understand and manage conflict  
E. Take stalk on a periodic basis  
F. Hone skills thru practice and experience...

Adapted from John S. Dowd, Consultant in Continual Improvement, by Phyllis M. Virgil, used with permission.

Today we will focus on honing our skills

• Team Meeting Fish Bowl (30 minutes)  
• What If Scenarios (40 minutes)
But first...

Let's do a flyby review

A. Recognize and embrace the team journey
Stages of Team Development

**Forming**
- Concerns: Inclusion
  - Why am I here?
  - Do I want in?
  - Will we be successful?
- Relationships: Guarded
  - Basic information
  - Low trust.
- Activities: Introductions, Orientations, Training, Planning.

**Storming**
- Concerns: Control
  - What role should I play?
  - Why is he/she taking charge?
- Relationships: Conflict, Emotional, Argumentative.
- Activities: Surface & Manage Conflict, Attempt to Set Rules.

**Norming**
- Concerns: Openness
  - What do you think?
  - How can I help you?
  - How can I find out more?
- Relationships: Trust
  - Ideas/feelings
  - Understanding, Support.

**Performing**
- Concerns: Success
  - Are we learning?
  - How can we be most effective?
  - What actions should we take?
- Activities: Learning, Making decisions, Supporting others, Taking actions.


Typical Team Journey

Roller Coaster of Highs and Lows

B. Know when and how to intervene

Use PDSA to Plan and Manage your Meetings

Plan – plan the meeting process
Do – run the meeting (processes)
Study – observe, provide feedback and intervene as needed
Act – incorporate improvements into next round

*Tip: Remember the Seven Step Meeting Process and Team Decision Making Tools.*
**Should I Intervene?**

- Potential harm or rework?
- Does harm outweigh learning?
- Does team self-facilitate?
- Is issue manageable for team?

**The Role of “Traffic Cop”**

**Specific words and phrases useful in directing traffic:**

- Observing
- Clarifying
- Focusing
- Stimulating
- Balancing
- Summarizing

Source: Phyllis M. Virgil, Facilitators Tool Box

Developed by the New York State Department of Health AIDS Institute National Quality Center. Facilitated through a cooperative agreement with the Health Resources and Services Administration HRSA/HRSA Review.
Institute for Healthcare Improvement
Interventions Not Detentions
A Facilitators Tool Box

Identify
Confusion

Clarify Aim

Direct to Agenda

Team Decision Making Tools
Brain Storm
Multi-vote
Rank Order
Structured Discussion
Align Topic, Tool, Time

Ground Rules
1) No interruptions.
2) Speak one at a time.
3) Cell phones on off.
4) Listen.
5) ..................
6) ................

Ask for clarification

Use Your Parking Lot

Source: Phyllis M. Virgil

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Providing Feedback Without Fallout

- Describe, specific, behaviors...
- In a timely, respectful manner, in a manageable amount

4 STEP INTERVENTION
D-E-S-Cribe
1) Describe behavior(s)
2) ID Possible Effect
   P-A-U-S-E
   &
   L-I-S-T-E-N
3) Solicit input
4) Choose what to do

Getting to Yes by Fisher and Ury

Position
What?

Rationale
Data? Interests? Why?

Beliefs, Assumptions
Where?

Position
What?

Rationale
Data? Interests? Why?

Beliefs, Assumptions
Where?

Dig Under

Source: Phylis M. Virgi, Facilitators Tool Box, 2009

Institute for Healthcare Improvement
Diffusing Conflict and Confusion

Structured Discussion

1. What is your position?

2. Why? (data, experience, rationale)

Toss it back to the team...

- Remember meetings are team sport.
- Resist being the savior.
- Summarize positions, and throw decisions back to the team.
- Ask what does the team want to do?
- Follow structured discussion with open discussion.
- Go two rounds if necessary.
Difficult Behaviors

Strategies for Handling Difficult Behaviors

Side Conversations:
- Surface: "Notice a side conversation..."
- Surface: "...carefully, not more...
- "It looks like we need to put on parking lot..."
- "Notice you have an opinion..."
- Build your confidence into group norms, rules, etc.
- Changing/Giving to engage group

Plop:
- Pick up -- acknowledge and repeat statement
- Increase validity: "Can you tell me more..."
- Specifically name people we comment

Overly Reflective Reflectors:
- Reflective statements to include round robin
- Build your confidence into group norms, rules, etc.
- Can we hear from others in the room
- Can we talk about our experience
- Can we put this on the parking lot and move on...

Empowering feedback, discussion of hearing other

Spar:
- Card someone who hears you talking...
- "Thank you for your comments, I'd like to hear from others...
- Reframe: ground rules
- Taped responses, 10 second rule

Communication Workshops

Some:
- Surface and ask for clarifications, dig under
- "Hear what you are saying, can we walk toward a solution"
- "It looks like you're saying... Can we walk toward a solution

Hidden Agenda:
- Unstructured discussion (What/Why, see Fig 1)
- Surface: "...carefully, not more...
- "It looks like we need to put on parking lot..."
- "Notice you have an opinion..."

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- "Notice you have an opinion..."
C. Practice the Art of Questioning and Active Listening

Questioning, Listening and Inquiry

- Ask open-ended questions -- how, what, why
- For a greater response -- tell, explain or describe
- Engage in the art of active listening (be present)
- Redirect content questions back to the group or individual
- Summarize positions and ask for feedback and clarification (helps to bring closure)
- Avoid closed-ended (yes/no) questions
Tips for Asking Nonthreatening Questions

- Initially ask the question of the entire team.
- Pause and allow the team members time to consider the question (be comfortable with silence).
- If a team member responds, acknowledge the remark, confirm meaning and explore the response further if possible or necessary.
- If no one responds to a question, consider rewording or reframing the question or asking if the question needs clarification.
- If no one responds in a reasonable amount of time (again, be comfortable with silence), look for nonverbal signals from a team member who is wanting to be involved—i.e., eye contact, a forward lean, etc. Then, go to that person by name.

HOW TO PRACTICE THE ART OF LISTENING

In Dialog, Discussion, Or Any Time

1. Stop talking: To others and to yourself.
2. Imagine the other person’s viewpoint.
3. Look, act, and be interested.
4. Observe nonverbal behaviors.
6. Listen between the lines.
7. Speak only affirmatively.
8. Ensure understanding.
9. Stop talking: Take a vow of silence once in a while.
D. Understand and manage conflict

Remember people see things differently...

Uncover, understand and accept differences in perspectives.

Source: John Dowd, Consultant in Continuous Improvement
Skills for Conflict Management

- Prevention before intervention, remember good meeting design
- Actively listen and question to learn
- Focus on the facts, issues not on people or personalities
- Work to understand experience, data, rationale
- Look for similarities and areas of agreement
- Demonstrate respect
- Keep conflict within the walls, don’t take outside
- If necessary call a time out (defuse, regroup, reframe)

Source: Phyllis M. Virgil Team Training, 2012
When Conflict Gets too High – Consider a Mediator

**Step I:**
Set the Stage
✓ Acknowledge Conflict
✓ Discuss the impact
✓ Agree to Dialogue
✓ Uncover the Issues

**Step II:**
Achieve Understanding
✓ Disclose Positions
✓ Reveal Rationale
✓ Clarify for Understanding
✓ Identify Similarities

**Step III:**
Generate Solutions
✓ Seek areas of agreement
✓ Bridge Differences
✓ Identify Win-Win Solutions

**Step IV:**
Develop Agreements
✓ Craft Agreements
✓ Make Commits
✓ Celebrate Success

Source: Phyllis M. Virgil, Turning Conflict into Collaboration

E. Take stock on a periodic basis
All too often team leaders and members THINK they are functioning at a high level.

A primary role for an Improvement Coach, therefore, is to continuously assess if the team is in fact functioning efficiently and effectively or if it is drifting into the land of incompetency.

This assessment tool provides a quick and easy way for an Improvement Coach to evaluate a team’s ability to achieve its desired outcomes.

Conduct this assessment at least three times during the life of the team.

Date of assessment: _________________

Evaluating your Team’s Effectiveness!

F. Hone skills thru practice and experience

Source: Executive Learning Inc. Team Training Materials.

Institute for Healthcare Improvement
Team Meeting Fishbowl

- Volunteer actors for team leader and members
- Class will be the facilitators
- Stop action for interventions
  1. Identify issue or behavior
  2. Craft a statement (what would you say)

Patient Admissions Team

MEETING AGENDA

Objective: Decide which key process variables to collect data on

Roles: Leader: ____________ Recorder: ____________
       Time Keeper: ____________ Facilitator: ____________

Agenda items:
A. Generate process variable list by brainstorming
B. Decide on key process variables by multi-voting

Review Meeting Record

Plan Next Steps & Agenda

Evaluate
Facilitation Challenge

✓ Pick a table facilitator
✓ Brainstorm ways to overcome the team facilitation challenges for your assigned “what if” scenarios, (10 minutes)
✓ Summarize your most effective strategies on a flip chart (5 minutes)
✓ Large group report outs and debrief (25 minutes)

<table>
<thead>
<tr>
<th>Table 1: A, B</th>
<th>Table 6: K, L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2: C, D</td>
<td>Table 7: M, N</td>
</tr>
<tr>
<td>Table 3: E, F</td>
<td>Table 8: O, P</td>
</tr>
<tr>
<td>Table 4: G, H</td>
<td>Table 9: Q, R</td>
</tr>
<tr>
<td>Table 5: I, J</td>
<td></td>
</tr>
</tbody>
</table>

Remember a skilled facilitator will...

A. Recognize and embrace the team journey
B. Know when and how to intervene
C. Practice the art of questioning and active listening
D. Understand and manage conflict
E. Take stalk on a periodic basis
F. Hone skills thru practice and experience...

Developed by the New York State Department of Health AIDS Institute National Quality Center. Funded through a cooperative agreement with the Health Resources and Services Administration HIV/AIDS Bureau.

Adapted from John S. Dowd, Consultant in Continual Improvement, by Phyllis M. Virgil, used with permission.
Reference Books

- **The Team Handbook**, Peter R. Scholtes, Brian L. Joiner, and Barbara J. Streibel, 2003

Breakouts
Session objective

- Summarize how surveys can be used to gather information and for data collection to enhance your improvement effort
Session agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Written surveys</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Developing and using surveys, analyzing the results</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Kano method</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>

Reflection

- Think about the last survey you participated in.
  - What was it?
  - What did you like about the survey?
  - What didn’t you like about it?
Surveys (as we’ll define it here)

- A method of collecting information directly from people about their feelings, motivations, plans, beliefs, experiences, and backgrounds
- In relation to the Model for Improvement and PDSA cycles, a survey is a type of data collection process to answer a question(s) posed in Question 2 and the planning phase of the cycle

Reasons to survey

- To build the knowledge of those obtaining the information (duh!)
- To obtain a desired effect on the relationship between those obtaining the information and those providing the information
Methods for obtaining information

- Informal conversation
- Written surveys
- Personal interviews
- Group interviews
- Observations
- Trading places

Considerations:
- Purpose
- Reliability and validity
- Usefulness and credibility of results
- Cost
- Anonymity
- Convenience
- Complexity of information
- Time – to administer and respond
- What you will do with the information

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement

Written survey example

Thank you for participating in our workshop today. Please help us improve our service to you by completing this survey.

Please list three ways we can improve our service to you.

1. __________________________
2. __________________________
3. __________________________

Please rate your experience with our services today (circle one)

Poor          Fair          Good          Very Good          Excellent

Other suggestions:

________________________________________________________________________
Written surveys

- Delivery: intentional or opportunistic?
- Design considerations:
  - Order of the questions
  - Selection of response options
  - Wording

Written surveys

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficial for those who are better at written than verbal communication</td>
<td>Respondent has no say about what is covered</td>
</tr>
<tr>
<td>Can be administered to preserve confidentiality</td>
<td>Usually a large percent do not complete</td>
</tr>
<tr>
<td>Less expensive than interviews</td>
<td>Questioner cannot build on answers</td>
</tr>
<tr>
<td>Useful in reaching a geographically diverse group of people</td>
<td>Respondents have to interpret the questions</td>
</tr>
<tr>
<td></td>
<td>Respondent assumes most of the work</td>
</tr>
</tbody>
</table>
Steps for conducting a survey

1. Clarify the purpose of the survey
2. Consider why a survey is the best method for obtaining the desired information
3. What questions are to be answered by the survey?
4. Decide on the type of survey (e.g., written, phone, interview)
5. Select the survey design, content, questions, and test the form
6. Decide who should participate and when (will sampling be used?)
7. Will there be follow-up surveys?
8. Attend to the survey administer (e.g., collecting forms, conducting interviews) (Do!)
9. Analyze, interpret, and report results (Study!)
10. Act (if appropriate) on the results

Survey questions

• Consider the respondents’ point of view – how complicated should the questions be and at what level should they be written?
• Open-ended
  – Offers insight as to why people believe what they do
  – Interpretation can be difficult
• Closed-ended
  – Easy to use, score, and code
  – Reliable to the extent they provide uniform data
  – Validity usually requires extensive testing
Closed-ended questions

- Each question should be meaningful to the respondents
- Use standard, simple language
- Make questions concrete
- Avoid biased words and phrases
- Check your own biases
- Don’t get too personal
- Each question should have just one thought (no double-barreled questions)
- Make sure the response options match the question
- Tip: State questions/statements in the extreme

Written survey examples

### CMS Learning System Fellows Program, Workshop 4

**End-of-Event Evaluation**

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Participating in this event will improve my ability to lead change in my organization.

2. The overall quality of this event was excellent.

3. The service offered by HII’s staff and faculty at this event was exceptional.

4. How many new ideas did you learn as a result of participating in this workshop?
   a. No ideas
   b. One idea
   c. Two or four ideas
   d. Five ideas or more

5. If you responded that you learned one or more new ideas during this workshop, will you be testing those ideas within your organization during the next month?
   a. Yes (I will definitely be testing the idea/s learned during the next month)
   b. Maybe (I would like to test the new idea/s I learned during the next month but doubt that I will have time)
   c. Probably not (I seriously doubt that I will have a chance to test the new idea/s I learned)

6. Did this event have the right mix of presentations, discussions, and exercises?

   Please circle your response for each category below:

   - Presentations: Too Much Right Amount Not Enough
   - Discussions: Too Much Right Amount Not Enough
   - Exercises: Too Much Right Amount Not Enough

---

Institute for Healthcare Improvement
Learning in real time


Methods for analyzing survey data

- Depends on the type of questions asked
- Closed-ended questions:
  - Frequency plots (possibly with stratification)
  - If collected over time, run and control charts
- Open-ended questions:
  - Clustering techniques with written summaries of the clusters/themes – e.g., affinity diagram or Pareto chart

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement
Kano survey method

- Useful for testing new ideas and innovations with customers to determine if the ideas might change their expectations (future needs and wants)
- Incorporates the concept of “attractive” and “must-be” quality elements

Kano two-dimensional recognition mode

Three classifications of quality-characteristics of a product or service:

- One-dimensional Element – gives satisfaction when fulfilled and results in dissatisfaction when not fulfilled
- Attractive Quality Element – give satisfaction when fulfilled but is acceptable when not fulfilled
- Must-be Quality Element – take for granted when fulfilled but results in dissatisfaction when not fulfilled
Method

- Ask questions in pairs
  - How would you feel if you had coffee at the workshop?
    - Delighted, I expect it and like it, No feeling, Live with it, Do not like, Other
  - How do you feel when you do not have coffee at the workshop?
    - Delighted, I expect it and like it, No feeling, Live with it, Do not like, Other

Two-dimensional chart of survey results for each quality element

<table>
<thead>
<tr>
<th>Response to “Positive Wording” of Question</th>
<th>Delighted</th>
<th>I expect and like it</th>
<th>No feeling</th>
<th>Live with it</th>
<th>Do not like</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delighted</td>
<td>Skeptical</td>
<td>Attractive</td>
<td>Attractive</td>
<td>Attractive</td>
<td>One-dimensional</td>
<td>Other</td>
</tr>
<tr>
<td>I expect and like it</td>
<td>Reverse</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Must-be</td>
<td>Other</td>
</tr>
<tr>
<td>No feeling</td>
<td>Reverse</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Must-be</td>
<td>Other</td>
</tr>
<tr>
<td>Live with it</td>
<td>Reverse</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Indifferent</td>
<td>Must-be</td>
<td>Other</td>
</tr>
<tr>
<td>Do not like</td>
<td>Reverse</td>
<td>Reverse</td>
<td>Reverse</td>
<td>Reverse</td>
<td>Skeptical</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

- **One-dimensional**: Satisfied when fulfilled, dissatisfied when not fulfilled
- **Attractive**: Satisfied when fulfilled, no feeling when not fulfilled
- **Must-be**: No feeling when fulfilled, dissatisfied when not fulfilled
- **Indifferent**: No feeling of satisfaction or dissatisfaction regardless of fulfillment
- **Reverse**: Not expected, dissatisfied when fulfilled or satisfied when not fulfilled
- **Skeptical**: Doubtful if question is understood; difficult question, poor expression
- **Other**: None of the responses apply; other consideration
Summary Survey Results Example:
Trends in Quality Elements

<table>
<thead>
<tr>
<th>Quality Element</th>
<th>Add-on</th>
<th>One shot</th>
<th>Must be</th>
<th>Indiff</th>
<th>Reverse</th>
<th>Shock</th>
<th>Total</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VCR in room</td>
<td>88</td>
<td>11</td>
<td>4</td>
<td>123</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>Indifferent</td>
</tr>
<tr>
<td>2. Work desk</td>
<td>33</td>
<td>17</td>
<td>128</td>
<td>48</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>Must-be</td>
</tr>
<tr>
<td>3. Coffee in room</td>
<td>47</td>
<td>92</td>
<td>15</td>
<td>67</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>One-shot</td>
</tr>
<tr>
<td>4. Speaker phone</td>
<td>86</td>
<td>11</td>
<td>4</td>
<td>113</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>Indifferent</td>
</tr>
<tr>
<td>5. Shampoo/Co.</td>
<td>17</td>
<td>27</td>
<td>157</td>
<td>17</td>
<td>8</td>
<td>1</td>
<td>210</td>
<td>Must-be</td>
</tr>
<tr>
<td>6. Check In</td>
<td>129</td>
<td>13</td>
<td>5</td>
<td>74</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>Attractive</td>
</tr>
<tr>
<td>7. FAX in room</td>
<td>130</td>
<td>3</td>
<td>2</td>
<td>70</td>
<td>38</td>
<td>17</td>
<td>220</td>
<td>Attractive</td>
</tr>
</tbody>
</table>

Surveys

Appendix
## Personal Interviews

- Discussion between an interviewer and a respondent to obtain information on a pre-arranged set of topics
- Can be specific questions or set of topics
- Emphasis on a particular topic depends on value of the information being obtained and effect we hope to get

## Advantages and Disadvantages of Personal Interviews

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent can provide input into what will be discussed</td>
<td>Difficult to administer to people in varied locations</td>
</tr>
<tr>
<td>Interviewer can:</td>
<td>Variation is introduced by multiple interviewers</td>
</tr>
<tr>
<td>• Check for understanding and clarify</td>
<td></td>
</tr>
<tr>
<td>• Change which topics are emphasized</td>
<td></td>
</tr>
<tr>
<td>• Pursue fruitful unforeseen areas</td>
<td></td>
</tr>
<tr>
<td>• Observe body language</td>
<td></td>
</tr>
<tr>
<td>Presents an opportunity to build or enhance relationships</td>
<td>Lacks confidentiality</td>
</tr>
<tr>
<td>Less work for interview than a written survey</td>
<td>Time-consuming for interviewers</td>
</tr>
<tr>
<td></td>
<td>Expensive compared to written surveys</td>
</tr>
<tr>
<td></td>
<td>Format is not standard</td>
</tr>
</tbody>
</table>

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement
Group interviews or focus groups

- Like personal interviews
- Discussion between an interviewer and a group of respondents to obtain information on a pre-arranged set of topics

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement

Group interviews

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual stimulation of the group can result in more information than individual interviews</td>
<td>Respondents may be reluctant to discuss sensitive issues in a group</td>
</tr>
<tr>
<td>Fruitful unforeseen areas can be pursued by the entire group</td>
<td>Interviewer must be more skilled than for a personal interview</td>
</tr>
<tr>
<td>Can help to establish or enhance relationships between members of the group</td>
<td>Interactions between members of the group may suppress or bias information from one or more members</td>
</tr>
<tr>
<td>Less time consuming than personal interviews</td>
<td>Expensive if the group is geographically diverse</td>
</tr>
<tr>
<td></td>
<td>May create other agendas for some members of the group</td>
</tr>
</tbody>
</table>

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement
Observation

- Observe users of your product, process, equipment, performing a function
- Can be used as the basis for innovation

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information obtained under realistic conditions</td>
<td>The presence of an observer may create artificial conditions</td>
</tr>
<tr>
<td>Observer needs less skill to obtain the information than an interviewer</td>
<td>Limited to the conditions under which the observations were made</td>
</tr>
<tr>
<td>Useful for generating ideas for innovation</td>
<td>The use of many products and services is difficult to observe</td>
</tr>
<tr>
<td>Simple</td>
<td>May miss important but infrequently occurring events</td>
</tr>
<tr>
<td>Useful for validation of personal or group interviews</td>
<td>If not careful to be objective, observers can sometimes see what they want to see</td>
</tr>
</tbody>
</table>

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement
Trading places

- Experience the product or service for yourself

Trading places

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows the person trading places to experience feelings that could not be</td>
<td>Perceptions are obtained from only one or a few people who assume the role</td>
</tr>
<tr>
<td>expressed by respondents in an interview</td>
<td></td>
</tr>
<tr>
<td>Very useful for building or enhancing a relationship</td>
<td>Presence of the person assuming the role may create artificial conditions</td>
</tr>
<tr>
<td>Important, but minute, level of detail can be experienced</td>
<td>May need certain skills to assume someone’s role</td>
</tr>
<tr>
<td></td>
<td>May be too short to form a useful perception</td>
</tr>
<tr>
<td></td>
<td>Familiarity with the product or service may make it impossible to assume the</td>
</tr>
<tr>
<td></td>
<td>position of a first time user</td>
</tr>
</tbody>
</table>

Adapted from: The Improvement Handbook: Model, Methods, and Tools for Improvement
Day 1 debrief and assignments

Improvement Coach Professional Development Program

Karen Baldoza

The Art of Coaching Set-up

Phyllis Virgil

October 26, 2016
Day 2
The Art of Coaching…

Session Objectives

• Using an assigned case scenario, demonstrate improvement coaching skill by role playing a coach/client interaction.

• Apply improvement and coaching knowledge to provide feedback to coach/client role-plays.
The Art of Coaching

- The coaching case scenarios have been designed to provide a forum to practice and receive feedback on the art of coaching thru a role playing.
- This exercise will be held twice, giving each person the chance to play the role of coach & client.

Case Scenarios (pick up at sign-up station)

ROUND ONE
1. Aim Statement for Hand-Off Team
2. Cardiology Staffing Data
3. The Stalled Primary Care Team
4. Fetal Risk Management Data
5. Aim Statement for Healthy Habits
6. The Dysfunctional Waste Reduction Team
7. Intent to Automate
8. The Confused Family Involvement Team
9. The Divided Medical Staff
10. Working with Run Charts

ROUND TWO
1. Adverse Drug Events (ADE) Aim Statement
2. The Struggling Team
3. Ventilator Associated Pneumonia (VAP) Bundle Data
4. The Stuck Team
5. Childhood Obesity Data Collection
6. The Enthusiastic Medication Advising Team
7. No More Razors Team
8. The Results Driven Leader
9. Team Tensions Rising
10. Working with Run Charts
Role Play Process

- Role playing scenarios will be conducted in 4 breakout rooms with 8 or 9 scenarios per breakout.
- Setup: (1 minute)
  - Organize your references, flipchart or other resources
  - Tells us the situation or build the situation into the role playing scenario
- Role play the scenario (5 minutes)
  - After your brief introduction enact your coach/client role play
  - May use any supporting materials or props you want (flip chart, texts, tool box, etc)
- Feedback from colleagues (4 minute rapid round robin)
  - Went well, will take home
  - Other ideas and things to consider

Agenda and Logistics

Coaching Scenario Role Play

<table>
<thead>
<tr>
<th>Tues and Wed 1-3 pm</th>
<th>Start</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Room Set-up</td>
<td>1:00</td>
<td>5</td>
</tr>
<tr>
<td>Transition to Breakout Rooms</td>
<td>1:05</td>
<td>5</td>
</tr>
<tr>
<td>Role Play (10 min each Total)</td>
<td>1:10</td>
<td>80</td>
</tr>
<tr>
<td>Insights &amp; Learnings</td>
<td>2:30</td>
<td>10</td>
</tr>
<tr>
<td>Transition to Main Room</td>
<td>2:40</td>
<td>5</td>
</tr>
<tr>
<td>Key Learning Report Outs</td>
<td>2:45</td>
<td>15</td>
</tr>
<tr>
<td>Afternoon Break</td>
<td>3:00</td>
<td>15</td>
</tr>
</tbody>
</table>
Coaching Case Scenarios
Paired Sign Up Coach/Client

We need 2 names in per cell – Coach & Client.

You must keep the same partner for round two, but trade roles for your second case.

This means your names must appear twice on the sign up flipchart, once on Wednesday (1-10) and then again on Thursday (11-20).

<table>
<thead>
<tr>
<th>Coaching Case Scenario</th>
<th>Paired Sign-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Break Out #</strong></td>
<td><strong>Room</strong></td>
</tr>
<tr>
<td>Round ONE Wednesday 1:00-3:00</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Round TWO Thursday 1:00-3:00</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>16</td>
<td>17</td>
</tr>
</tbody>
</table>

Role Play Breakout Rooms

Breakout A =
Breakout B =
Breakout C =
Breakout D =