Improvement as an Everyday Leadership Philosophy:

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Session Objectives

- Identify process-oriented thinking as the key to overall organizational improvement

- Describe two key data tools that save up to 50% of executive time in meetings and at least one hour a day of middle management time

- Explain several leadership mantras and simple tools for more effectively applying this leadership philosophy
"Now, in health care, among the people at this Forum, we have made the needed preparations for change. Our preparations are sufficient. We have studied enough. We have reviewed our cultures enough. We have spent the time we needed, enough time, in training and planning and filling our kit with new and useful tools and methods. We know how. Now, we must remember why..."

1993

"I want to see health care become world class. I want us to promise our patients and their families things that we have never before been able to promise them...I am not satisfied with what we give them today...And as much respect as I have for the stresses and demoralizing erosion of trust in our industry, I am getting tired of excuses...

"To get there we must become bold. We are never going to get there if timidity guides our aims...Marginal aims can be achieved with marginal change, but bold aims require bold changes. The managerial systems and culture that support progress at the world-class level...don't look like business as usual."

1997
**From Jim Clemmer: [www.jimclemmer.com](http://www.jimclemmer.com)**

“Too often, companies rely on lectures (‘spray and pray’), inspirational speeches or videos, discussion groups and simulation exercises. While these methods may get high marks from participants, research (ignored by many training professionals) shows they rarely change behavior on the job. Knowing isn't the same as doing; good intentions are too easily crushed by old habits. Theoretical or inspirational training approaches are where the rubber meets the sky.”

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**Today’s Rationale...a warning...and a challenge**

- Awareness
- Breakthrough in Knowledge
- **Breakthrough in Thinking**
- Breakthrough in Behavior

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It’s not about the problems that march into your offices…

Today’s emphasis: The important problems are the ones of which no one is aware!

[Everyday work…and its management]

Cutting costs does not eliminate the causes of costs

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Improvement as DNA…and an everyday language

- The words “statistical” and “quality” should be dropped as adjectives because they should be “givens.”
- People don’t need “statistics”…they need to know how to solve their problems
  - Very few tools needed!
**TQM, CQI, Six Sigma, Lean: In a nutshell**

- **SAME theory**: Obsession with waste (Seeing “time” as inventory: Flow)… using data… teamwork…statistical **thinking** (**NOT** techniques)... disciplined approach to problem-solving (**P-D-S-A** or **DMAIC**)

**What I am teaching today**

- **Holistic improvement**: a system that can successfully create and sustain significant improvements of **any** type, in **any** culture for **any** business

- **KEY framework to ANY improvement**...
...ALL Work is a Process!

LEADER – “How I would like to think things work…or SHOULD work” Just DO it!

FRONT-LINE – How things REALLY work: unintended variation Undocumented
Confusion…Conflict…Complexity…Chaos

Process-oriented Thinking

- **All work is a process**
- If a process does not “go right,” that is variation
- There is benefit to understanding variation and reducing *inappropriate* & *unintended* variation [Better prediction]
- Processes speak to us through **data**
- The use of data is a process—actually, **four** processes

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**MOST Important**

**Any variation can be one of two types: Treating one as the other makes things worse**

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**New Mindset: Process-oriented thinking**

- Your current processes are *perfectly* designed to get the results they are already getting

  – Are you perfectly designed to get what you are observing (even if you “shouldn’t”)?

  - “NEVER” events
  - “Unexpected” death
Your BIGGEST Hidden Opportunity…and Catalyst: “Data Sanity”

- Senior management meeting time
  - 50% is WASTE
- Daily managerial review of unimportant performance data
  - 1 hour a day is waste
- Daily pounds of published performance reports [“Backup” data]
  - 60% is waste

Don’t believe me?

Let’s create some déjà vu

“MBFC” Goal Table

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Given THREE numbers: The Myth of Trends

- “Upward Trend” (?)
- “Downturn” (?)
- “Rebound” (?)
- “Setback” (?)
- “Turnaround” (?)
- “Downward Trend” (?)

This month…
vs. last month…
vs. 12 months ago

3 Months of Quarterly results…

This quarter…
vs. last quarter…
vs. same quarter last year

Oh…Shall we “Benchmark”?  

- Who got 2-3 double heads?

“Whether or not you understand statistics, you are already using statistics.”

- Let’s generate one more number…
**P.A.R.C. Analysis**

- Practical
- Accumulated
- Records
- Compilation
- Passive
- Analysis
- Regressions
- Correlations
  - Including trend lines

**Goal: Improve bundle implementation from 50 to 75%**

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<td>50.00%</td>
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<tr>
<td>69.44%</td>
<td>3/99</td>
</tr>
</tbody>
</table>

Average: 58.1%

R-squared: 36.5%, p-value: 0.003

Wrong! Only 3 – 4 more months to go!
Statistics is neither “number crunching” nor “massaging” reams and reams of data

“Data Torturing” (Mills):
NEJM, 10/14/1993

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Routine “How’re we doin’?” Meetings

RUBBISH!
Bar graphs, trend lines, traffic lights are virtually WORTHLESS (Special cause)
Vague data responding to… Vague problems will yield… Vague meetings, yielding… Vague questions yielding… Vague solutions, yielding… Vague results.

Meetings to “discuss”…Benchmarking?

“The target is for 90% of the bottom quartile to perform at the 2010 average by the end of 2012.”

????????????????????????????????????

“Make it so!”
Transition to More “Advanced” Skills

- From “Human” Variation (Ouija board):
  - Data tables, drawing circles, “traffic lights,” smiley faces, bar graphs, trend lines, variance from goals

- To Reducing Variation (common theory):
  - Counting up to “8”
  - Subtracting two numbers
  - Sorting a list of numbers
  - Plotting the dots!
  - Changed conversations: Asking better questions
  - Reacting appropriately to variation
  - Common cause vs. special cause response
**Statistical definition of “Trend” (Theory)**

**Upward Trend**

**Downward Trend**

Special Cause – A sequence of SIX *successive* increases or decreases [< 20 data points: Use FIVE]

**Used only with NO context of variation**

*RARE:* Usually indicates a process “in transition”

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**Executive chorus:** “But, Davis, this takes too much data – I can’t wait for six increases!”

❖ Really? What did we learn from three coin flips?

❖ We changed the “process”…
  – Too much data?

❖ OH…and, by the way, what about “pay for performance?”
  – Didn’t we “find” the top 15%?

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**Tampering: An Insidious, Destructive Force**

- Specifically:

  **Treating common cause as special cause**

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*Given two numbers…*

![Graph showing a trend from yesterday to today with labels: Yesterday, Today, Something Important.](https://www.davisdatasanity.com)

*…one will be larger!*

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[Source](https://www.davisdatasanity.com)
In an *everyday* world: Does it look like this…?

…or this?

**Context of variation**

Start here: *Bread-and-butter tool Run Chart*

A time ordered data plot with the MEDIAN as a reference
**Don Berwick: 1995 Forum Plenary**

"Plotting measurements over time turns out, in my view, to be one of the most powerful devices we have for systemic learning... Several important things happen when you plot data over time. First, you have to ask what data to plot. In the exploration of the answer you begin to clarify aims, and also to see the system from a wider viewpoint. Where are the data? What do they mean? To whom? Who should see them? Why? These are questions that integrate and clarify aims and systems all at once...If you follow only one piece of advice from this lecture when you get home, pick a measurement you care about and begin to plot it regularly over time. You won't be sorry."

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**Special Cause: A consecutive sequence of 8 or more points on one side of the median (Theory)**

Indicates a probable shift *somewhere* during this time period

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**Same data as before -- How are they doing relative to the 75% goal?**

<table>
<thead>
<tr>
<th>Month</th>
<th>% Compliance</th>
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<tr>
<td>6/97</td>
<td>44.44%</td>
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<tr>
<td>3/99</td>
<td>69.44%</td>
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</table>

Note: DIFFERENT questions!

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**Déjà vu all over again?**

**Board Member #1:** “After that trend in improvement over the past three years, why did we go back up?”

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Board Member #2: “Yes, but what’s the overall trend?”

You tell me…

(Alleged) "Trend" Analysis of Bacteraemia Data

What would you do now? - Plot the dots!

Have they improved?

Average: ~8
What if: Automatic response in meetings?

10, 7, 3, 10, 10, 8, 12, 8, 6, 7, 13, 6, 9, 3, 10, 2, 9, 12, 5

1. Determine the 18 MOVING RANGES:

   **Absolute value**: 
   
   \[
   (7 - 10) = 3, (3 - 7) = 4 \ldots (5 - 12) = 7
   \]

   ALL positive! [Consecutive differences]

2. Sort the 18 moving ranges to find the MEDIAN: MRmed

   The average of the 9th and 10th observations in the SORTED sequence

   **POWERFUL!**

   • Reduce “human variation” in analysis

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<th>Sorted Moving Ranges</th>
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<td><strong>10TH</strong></td>
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**KEY to process variation**

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**YIKES – PERFECTLY designed!**

**Need “common cause” strategy**

\[ \text{MR}_{\text{med}} = 4 \]

\[ \text{MR}_{\text{max}} = 4 \times 3.865^* \approx 15 \]

Process Common cause: \( 8 + (4 \times 3.14^*) \approx [0–20] \)

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**Goals a la Dilbert**

- **Boss:**
  - Our goal this year is ZERO disabling injuries.
  - Last year our goal was 25 disabling injuries; however, in retrospect, that was a mistake…

NEW thinking: Are we at the *lowest inherent level* for which we are perfectly designed… *which can then be improved?*
“Process-oriented” definition of accident / incident

❖ “A hazardous situation that was unsuccessfully avoided.”

– “But, Davis, we shouldn’t have incidents!”

– I know...but are you *perfectly designed* to have incidents?

TRUE Story: “We made a difference!” – Reduced NICU Infections

“Our hard work of 149 root cause analyses paid off!”

Really?
Levels of Fix (Brian Joiner)

- **Level 1** – fix the *incident*
- **Level 2** – fix the *process* that produced the incident [Most Root Cause Analyses]
- **Level 3** – fix the *system* that tolerates this *and similar processes*
  - Perhaps do a RCA of all of your individual RCAs?

Push for “Deep Level” Fixes

- **Level 1**: The incident
  - Was this a one time event or is it symptomatic of deeper issues?
  - “Fire”/discipline the guilty: COULD it happen again with new people?
- **Level 2**: The process producing the incident
  - Careful: Is this just a matter of everything that could possibly go wrong going wrong all at once (“Red lights”)?
- **Level 3**: The system (including ‘culture’)
  - What allows processes like this to be tolerated and designed?
  - *Where else is a similar or identical process lurking...and “ticking”?*
"Common cause" strategy

❖ So...how do we go about improving the Guideline, Bacteraemia and NICU infection “processes”?

❖ We need a common cause strategy.

❖ Misconception:
  – Common cause = “accept”
  – Process redesign needed

❖ NOTHING COULD BE FURTHER FROM THE TRUTH!

Remember the “Bundle” data...“Perfectly designed” for 68% compliance

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<td>66.67</td>
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“Perfectly designed” for 32% NON-compliance
Common cause strategy #1: Stratification

- “What is the 20% of the process causing 80% of the problem” [FOCUS!]
- Stability is the bad news...AND the good news
- Grab, say, 25 non-compliances from each hospital (or system or physician) and record which element(s) of the bundle were not followed
  - “How much data?” – ENOUGH!
- Don’t treat each individual non-compliance as a special cause

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“Common cause” strategy

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<tr>
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<th>A</th>
<th>B</th>
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<td>54</td>
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IMMEDIATE potential for ~40% reduction in errors

Now the REAL work begins

Are you trying to improve quality or meet a goal?

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The Step Everyone Seems to Skip

Figure 6.11: Ishikawa Cause and Effect Diagram: Vague vs. Localized

"You've got a big, vague problem, you're going to have big, vague solutions that aren't going to work very well. You've got to focus, focus, focus so you get the effective solutions. So the purpose of the Pareto charting and stratification analysis... is to focus in so you get right to the solution..."

—Brian L. Joiner

Common Cause Strategies (recent newsletters / QD articles)

In this order (Easy to difficult):

1. Exhaust in-house data
   - The more you know what's wrong with it, the more useful it becomes
   - BASELINE: Common or Special?

2. Stratification (Identify the VITAL 20%)

3. Dissection (on the VITAL 20%)

4. Designed test / intervention

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Getting Better Results

- Improve the process (Recommended)
- Distort the process (Frightened people are VERY clever!)
- Distort the numbers

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West

Do you do “% Compliance?”

IF you do the math...

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Lesson #1: Common Traps with Percents

- Traffic light trap: Don’t treat every deviation from the goal as a special cause

- “Shouldn’t”: Don’t treat every non-compliance as a special cause
  - A non-compliance on a green day / month could very well be the same as a non-compliance on a red day / month

  - **Explaining something “after the fact” does NOT mean it’s a special cause**
Resolving Complaints is a Process

% Complaints Resolved within 20 days

Not resolved within 20 days: Common or special cause?

Lesson #2: (Arbitrary) Numerical goals aren’t useful

- Use in-house data on KEY processes
  - What 20% of the numbers cause 80% of the “sweat”?
  - Get a baseline: “Plot the dots!”
  - What are you “perfectly designed” to get vis-à-vis the goal?
    - Is the gap from the goal a common cause or a special cause?

- Baseline is used to test changes
  - Most projects fail due to lack of baseline
### Falls Scenario

CEO reports: “We’re up quite a bit from same-period-last-year, but I’m pretty proud of a program I instituted in April. If you look at the 12-month trend graph on the next page, I noticed that December 2011 through March 2012 were all way above average. So I insisted on a root cause analysis for every fall since then. It worked the first month, but trended up the next three months. So I gave them a budget to have a safety fair and give everyone a key chain to “Fall” in Love with Quality.” The message finally got through: They got zero falls in October and I bought them pizza. But, darn it, last month, they got NINE – the highest number since March! So, I’ve sprung big bucks for you to be part of that HIH initiative. Find out what happened, do some benchmarking, and give me some recommendations on how to keep the zero in place. To help you out…”

“…the left graph trends the last 12-months of performance and the graph on the right is the 3-month rolling average so we can get an idea of the short term trend. It looks a little better recently thanks to the program, but the longer term trend analysis below is disturbing.”

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“Here’s the 4-quarter rolling average showing the longer term trend. I didn’t realize how far we’d crept up. I’m glad we started the root cause analyses, but the results aren’t as dramatic as I’d hoped. It had better start coming down soon. I hope December’s result will make that last dot a little lower to make it look like an outlier. Get some good ideas from the HIH initiative, will you? Maybe even investigate becoming part of Studer’s falls initiative as well, but that’s a last resort – they’re very expensive. Regardless, I want results and I’m holding you accountable...so NO excuses! ” [“When I die...”]

**Six Everyday Statistical Traps**

1. **Treating all** observed variation in a time series data sequence as special cause

2. **Treating things that “shouldn’t”** happen as special cause

3. **Fitting inappropriate “trend” lines to a** time series data sequence.
   - NEVER!
What part of “NEVER” don’t you understand? This...

Annualised Attrition rate

...or this?
4. Unnecessary obsession with and incorrect application of the Normal distribution
   - How often did I mention it?

5. Choosing **arbitrary** cutoffs for “above” average and “below” average
   - The process WILL tell you

6. Improving processes through the use of **arbitrary** numerical goals and standards
   - Goal = “Fact of life”
   - “Is the ‘gap’ from the goal common or special cause?”

---

**One More Trap:**
**A Frequently Occurring Issue**

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![Process Snapshot 1](image1.png)

![Process Snapshot 2](image2.png)
Has the process changed?

Combined Process Snapshots

Each Half w/ its Rolling Average of 4
Each Half w/ its Rolling Average of 12

By the way…”But our execs LIKE red…yellow…green!” [P-G scores]
Short term Roadmap to EMBED Improvement into DNA

1. Top management awareness and education

- Learn and apply in everyday work:
  - Process thinking
  - Problem-solving tools
  - Statistical thinking & “plotting the dots”

SOUNDS easy…(NEVER addressed at a Forum)

My experience? Exec resistance is FIERCE!

Warning: The tip of yet another iceberg

Process

Tools

Tech/Adm information

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**FUEL – “Quality” of:**

- **Personal feedback** processes
- **Relationships** through which information flows
- **Perceptions and Feelings** influencing relationships: **CULTURE**

(And STILL one more layer to go…)

---

**One more Pyramid Level: ITS BASE**

7. **Quality of individuals’ mind-sets**
   - *Unique* personal values and “baggage” *every individual* brings to work
   - The base of the pyramid
   - Interacts with Level 6 [Culture]

**Individual Mindsets**
"When we are dealing with people, let us remember we are not dealing with creatures of logic. We are dealing with creatures of emotion, creatures bustling with prejudices and motivated by pride and vanity."

— Dale Carnegie, personal effectiveness pioneer and author

And working in this doesn’t help

Confusion…conflict…complexity…and chaos
Only about 15 percent of [problems] can be traced to someone who didn’t care or wasn’t conscientious enough. But the last person to touch the process, pass the product, or deliver the service may have been burned out by ceaseless [problem-solving]; overwhelmed with the volume of work or problems; turned off by a “snoopervising” manager; out of touch with who his or her team’s customers are and what they value; unrewarded and unrecognized for efforts to improve things; poorly trained; given shoddy material, tools, or information to work with; not given feedback on when and how products or services went wrong; measured (and rewarded or punished) by management for results conflicting with his or her immediate customer’s needs; unsure of how to resolve issues and jointly fix a process with other functions; trying to protect himself or herself or the team from searches for the guilty; unaware of where to go for help. All this lies within the system, processes, structure, or practices of the organization…

--Jim Clemmer *Firing on All Cylinders*

---

**Cultural transformation Leadership Mantra #1:**

- **ZERO tolerance for blame**

- Blame processes…not people

  - 85-97% of the time, you will be right

  - I will shortly share a technique that will go a long way to dealing with the 3-15%

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**Your current processes are **perfectly**
designed to get the results you are already
getting…and will continue to get

- Organizational results…and culture
  “results”
  - **Tolerated** organizational behaviors
  - **Tolerated** individual behaviors

*Whatever is tolerated reinforces culture*

---

**Human behavior? As “simple” as “ABC”**

- **Activating events** ➔
  - **Beliefs** ➔
  - **Consequential Behaviors** ➔
    - **Results**

*Burn this into your brains*
Human behavior? As “simple” as “ABC”

Activating events ⇒

(unconscious) Beliefs ⇒

(observable, describable)

Consequential Behaviors ⇒

Leading to...

(observable, describable) Results

(Relationship and/or work result)

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A1 TRAP:
“Describing R2 and C2” is not enough!
Awareness/Breakthrough in Knowledge

A1 ⇒ B1 ⇒ C1 ⇒ R1
A2 ⇒ B2 ⇒ C2 ⇒ R2

1 = Present
2 = Future ( Desired)

➢ New results require new “beliefs”
➢ What A2 would motivate a B2?

➢ Organizational AND Human behavior
Want a Quick Cultural Audit?

- What B1 beliefs do current C1 patterns of everyday culture telegraph?
  - Meetings, schedules, budgets, promotions
  - Are you satisfied with its R1?

- IF YOU ALLOW THESE TO CONTINUE…
  - …will you attain your desired R2?

Ponder: What do you (and your culture) need to “stop” doing, “start” doing, and “continue” doing?

---

EVERY Organization Has a Culture

- The critical question is whether it’s by design (B2) or by default (B1)
Clemmer: The Behavior-shaping role of structure and systems

“‘It’s like the strange pumpkin I once saw at a county fair. It had been grown in a four-cornered Mason jar. The jar had since been broken and removed. The remaining pumpkin was shaped exactly like a small Mason jar. Beside it was a pumpkin from the same batch of seeds that was allowed to grow without constraints. It was about five times bigger. Organization structures and systems have the same affect on the people in them. They either limit or liberate their performance potential.”

“I suffer simultaneously from amnesia and déjà vu. I have the feeling that I keep forgetting the same thing over and over again.”

--Steven Wright

New results = New beliefs
People don’t mind change…

✧ …they just HATE being changed!

Biggest barrier: Cultural impact of ANY change

✧ ALL change has a social / cultural consequence

✧ ANY change WILL be perceived as a threat to SOMETHING

✧ Juran: “Troublemaker and uninvited guest”
Given: Humans THRIVE on predictability

✧ “Culture” will eat your best intentions for lunch!

...“Stated” vs. “Real” Reason

✧ What people say in reaction to a change (“Stated reason”) may not necessarily be what they really mean (“Real reason”)

Juran: Managerial Breakthrough

✧ Ever heard this one?

“Cookbook medicine!”
Even the BEST proposal: ALL Change is a Perceived Threat (Loss)

- Affected sub-cultures WILL perceive loss…and WILL try hard to find a way to “win”
- Common B1: “There have never been consequences before (A1). It will go away (B1). I will stonewall this (C1).”

Paperboy wisdom (for YOUR sanity!)

1.
2.
3.

[Leadership Mantra #2]
IF the issue is forced (A2) because “Stonewalling is not an option” (B2)...

- ...expect “10% jerk time” / Strong reaction
- What is the “loss?”
  - LISTEN to the “stated” reasons
  - What NEED is perceived as threatened?
    • Usually related to survival, love, feeling important, autonomy

Cultural leadership transformation mantra #3

- “Those darn humans...God bless ‘em!”

“Most human problems are permanent.”

--Peter Block
One of Balestracci’s “Quality Commandments”

- “Quality may be very interesting to thee, but realize that thy neighbor perceives their job to already take up 100% of their time…
- “…and thinks they are already doing ‘quality’ work because they are working so hard.” [Especially physicians]
- Front-line B1? – Working hard = Quality
  - Great “stated reason?”
  - B2?

****So: One more piece of advice****

- Mantra #4: Strong reactions are NEVER for the reasons we think! (US, too!)
  - The person/group PERCEIVES what you are proposing as a threat (loss) **GIVEN!**
  - The “stated” reasons are probably not the “real” reasons
  - It has NOTHING to do with you
    - “‘How’ do ‘I’ ‘create an A2’?”
    - Maybe ask, “Help me understand.”
DB to YOU

- Some of you having strong reactions?
- “Help me understand’ what this threatens for you.”
  - Notice your “stated” reasons
  - What might possibly be your “real” reasons?

“Homework”: New A2 via B2

- ZERO tolerance for blame
- QBQ! (Next)
- Everyday B2 mantras
A Complicating “GIVEN”

- Our processes are perfectly designed to produce victim behavior in any work culture

What was your survey score?

- > 40?
- 30-40? (Most of you)
- 11-29?
- 10? “Inoculation” has taken hold!
  - How would it feel to work in a ‘10’?
A2:  GENTLY Confront via the “QBQ!”
[www.qbq.com]

- “Lack of…” is *never* acceptable as a barrier

- ZERO tolerance for (whiny) “Who…”, “Why…”, or “When…” questions

[Google search: John Miller QBQ YouTube ~10 minutes]

(A2) Restate the Issue via a Question that:

1. Begins with the word “What” or “How”

2. Includes the word “I,” [NOT “We”]

3. Contains an ACTION
In other words…

- No whining will be allowed…

…to go (gently) unchallenged

[New belief: B2]

A2: Manager / Executive Response

- “How” can “I” “help you” make that happen?”

- “What” barriers can “I” “remove” for you?

- “How” can “I” “help you” stay appropriately accountable?
  
  Support their risk

- “Lack of time” is not an option… for either party!

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This A2 Creates B2 in the Front-line Culture

✧ “Stonewalling is not an option”

✧ “This is important”

✧ “I am accountable, but empowered, and will succeed”

Would these beliefs allow you to attain R2?

New Ground Rules…for YOU and your Cultures

✧ B2_1: We will let you visit “pity city”...but we won’t let you live there!!

✧ B2_2: “Lack of...” is never an option!

**FUEL – “Quality” of:**

- **Personal feedback** processes
- **Relationships** through which information flows
- **Perceptions and Feelings** influencing relationships: **CULTURE**

---

**Mantras**

- “ZERO tolerance for blame.”
- “Allow 10% ‘jerk time’.”
  
  [Mine behind closed doors]
- “Those darn humans…God bless ‘em!”
- “Strong reactions are NEVER for the reasons I think”

A few more:

- “New results = New Beliefs”
- “That’s the ‘stated reason’ – What’s the real reason?” [the perceived loss]
- “No whining allowed…to go (gently) unchallenged”
- “Lack of time = Lack of priority”
“I will insulate my hot buttons and…

...think of it all as entertainment!”

“It’s in the interval between the stimulus and response that the leader emerges.”

The “quality” of YOUR relationship w/ Execs?

- **Personal feedback** processes (Feedback on their behaviors?)
- **Relationships** through which information flows (How often are you in contact?)
- **Perceptions and Feelings** influencing relationships: **CULTURE** (Execs’ signals about ‘improvement’)
Short term Roadmap to EMBED Improvement into DNA

1. Top management awareness and education…via A2 events
   - Learn and apply in everyday work:
     - Process thinking
     - Problem-solving tools
     - Statistical thinking
     - Apply to “vital 20%” of organizational data / issues
     - **A2: YOU solve one of these to create “awareness”**
       - Such as the falls scenario?

2. Post IHI: **Build a critical mass**…via A2
   - **KEY: 25-30% of management demonstrating** their commitment to improvement (to create cultural B2)
     - A2: “New conversations” via “plotting the dots”
     - A2: Fewer “account for” meetings
     - A2: “Process” vs. “Goal” focus
     - A2: Promotions reflect behaviors committed to improvement
2. Post IHI: **Build a critical mass…via A2**
   - A2: STOP the “training mills” via “A1 logic” that knowledge = changed behavior
     - *(Only)* 20-30% of organization needs to be educated in improvement theory
     - *(Only)* 10-20% of organization needs to be trained in basic tools for improvement
     - *(Only)* 1-2% of organization needs to be trained in advanced tools (“belts?”)
   - A2: Teach via “solving problems”
     - **Universal language (100%):** Process, variation, common/special cause, “Plot the dots!” , “count to 8”
       - “Are we ‘perfectly designed’?”
       - “Is this a common or special cause?”

---

**A2: Overcome Seven “Root Causes”**

- Placing budgetary considerations ahead of quality,
  - A1? Tolerating “Costs” vs. “the four Cs”
- Placing schedule considerations ahead of quality,
  - A1? Tolerating arbitrary goals & deadlines
- Placing political considerations ahead of quality,
  - A1? Tolerating manipulation for personal gain
A2: Overcome Seven “Root Causes”

  – Management C1: “Give me the 5-minute overview.”
  – [Management B1: “I have nothing to learn”]

❖ [A1? Tolerating] Lack of fundamental knowledge, research or education,
  – C1: Blind benchmarking and copying (alleged) solutions
  – Vague problems/solutions/results

A2: Overcome Seven “Root Causes”

❖ [A1? Tolerating] a pervasive belief in entitlement (management, culture, and MD),
  – Write me for Peter Block’s “Employee Manifesto”

❖ [A1? Tolerating] C1 autocratic leadership behaviors, resulting in "endullment” rather than empowerment.
  – Cultural B1? “Learned helplessness”
Joiner: “I’ve found that I can take any five problems from anywhere in a company, and if I push deeper and deeper, I find that they all stem from the same core issues.”

- Lack of a clear direction
- Barriers between departments
- Management by rewards and punishments based on goals
- Reliance on inspection and rework rather than prevention
- Failure to understand that suppliers are part of the system (including “internal customers”)

Where is the “time” ("priority") for improvement going to come from?

- **50% reduction in monthly senior management meeting time**
  - 80% reduction in monthly corporate financial reports (and “account for” meetings)
- **Eliminating up to one hour each day of managerial review of unimportant data**
  - 60% reduction in daily pounds of published performance reports (“Backup data”)
  - Drawing circles and asking “Why?”
NO MORE BAR GRAPHS!
This…

Nursing Attrition Rate (Monthly)

…or this?

Combined Hospitals’ Attrition

Hospital 1 Attrition

Hospital 2 Attrition

Hospital 3 Attrition

Hospital 4 Attrition

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Your culture awaits…

**VARIATION**
Confusion…Conflict…Complexity…Chaos

**FRONT-LINE reality**

**LEADER perception**

**DIALOGUE: What are YOUR B1 beliefs about your role?**

- If I observed YOUR C1:
  - “Do quality improvement projects” (activity) or
  - “Integrate improvement into the DNA?”
  - Are you satisfied with your R1?
  - What are you “tolerating?”

*Have I created (A2) a new “belief” (B2) about ‘quality’ and your role to help you get desired R2?*
Cultural Message about “Improvement” and your Role?

- What B1 beliefs do current C1 patterns of everyday culture telegraph?
  - Meetings, schedules, budgets, promotions
  - Are you satisfied with its R1?
- B1: “Quality is something we do in our spare time” [“Bolt-on”]
- B2: “Improvement is part of everyone’s everyday work” [“Built-in”]

“If I am not attaining the results I desire, then I must examine and change some of my beliefs.”

--Individuals AND Organizations

MOST important theme of today:

New results = New beliefs
Your parting “QBQ!”

❖ Is your culture by design (B2) or by default (B1)?

– “How” do “I” “design a B2 culture” that will get us R2 results?

– “What” do “I” need to “start doing,” “stop doing,” and “continue doing?”

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– STOP: “What I do that doesn’t make sense is…”
– STOP: “If I were brave, I would stop doing…”
– STOP: “I question the effectiveness of the following activities but do them anyway: …”
– STOP: “I could immediately stop doing…”

– START: “I can better understand why…”
– START: “I can improve the way we…”
– START: “I don’t do the things in the six statements above because I need to START…”

– CONTINUE: “Meanwhile, I must CONTINUE to…”

“How” do “I” “create B2” by doing these in an A2 way?

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Your QBQ! Challenge

• “How” do “I” “create A2 activating events” to motivate the B2 beliefs to drive the right C2 consequential behaviors that will achieve desired organizational R2 results? AND…

1 = Current
2 = Future

AND…

• “How” do “I” “STOP recreating A1 activating events” (or even perceptions of A1) that reinforce old B1 beliefs that drive unwanted C1 consequential behaviors and produce undesired R1 results?

1 = Current
2 = Future
B2 AND C2: “ENOUGH!”

"Enough of attending meetings that lead to building a bridge to nowhere, enough of asking what I'm supposed to ask rather than what needs to be asked, enough of praising people who are undeserving of praise, enough of valuing form over substance, enough of accepting good when what is needed is outstanding, enough of enabling people to act as victims when they need to take personal responsibility. “Inevitably, this kind of shift doesn’t happen unless a substantial number of leaders put their collective foot down and say 'Enough!' in unison.”

Mariela Dabbah

B2 AND C2: Commit to Excellence

“In such a culture, employees manage their own morale. Employees are in charge of their own happiness. You can’t do it for them. You can create an atmosphere for the person to make good choices, but you can’t make them happy.”

Quint Studer, Hardwiring Excellence p. 56

A2: ALWAYS connect results back to purpose, worthwhile work, and making a difference

It’s all about “hardwiring”!
KEY A2: Not a matter of “if,” but “when”

- The gap between good/excellent work and poor performance will become intolerable
  - “There are no secrets.”
  - The culture will be watching
- Will you deal with these performers via A1 (which includes doing nothing) or A2?
- **MAJOR trump card for creating B2 and getting leadership respect…and cultural buy-in.**

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Back to Work: ENOUGH!

**LEADER** – “How I think things work…or SHOULD work. Just DO it!”

“Gap” between ‘REALLY’ and ‘SHOULD’ = **VARIATION**

**UNAWARE?**

**FRONT-LINE** – How things REALLY work: unintended variation

*Undocumented*

Confusion…conflict…complexity…and chaos
As You Listen to Presentations at this Forum…

- Benchmarking is NOT arbitrarily choosing “We want to be there” or “Let’s do what they did”
  - It is the “art” of ASKING PROCESS-ORIENTED QUESTIONS about the gap (variation) between your performance and the chosen “benchmark”
  - “What works for whom and why?”
  - Especially: What is THEIR operational definition of the indicator?

- Presence of enabling factors does not assure ‘success’ but their absence makes ‘failure’ more likely

Wisdom from The TEAM Handbook

- “Things are the way they are because they got that way,” [C1 & R1]
- “Unless you know how they got that way, they are heavily vested in staying that way.” [B1]
- The “20% of your process causing 80% of your problem” is different from presenters’ “20% of their process causing 80% of their problem.”
  - Listen closely: Did they “bolt on?” -- If they make implementation sound somewhat easy or gloss over it, BEWARE!
“If we’re actually trying to do the wrong thing, we may only be saved from disaster because we are doing it badly.”

--David Kerridge

Vague solutions to vague problems yield vague results

ENOUGH!

Vague problem

+ vague solution

+ data sanity “AHA!”

+ A2 events

= (Right) problem SOLVED

How many “tools” did I teach?
**Good to Great: Leverage your 3 to 5 Strengths [jimclemmer.com]**

### Differentiating Competencies

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### Contact me ANY time post-Forum

- **207.899.0962**: I will usually personally answer the phone and GLADLY chat
- **davis@davisdatasanity.com**
- **www.davisdatasanity.com**
  - Sign up for bi-weekly newsletter
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- **BOOK: Data Sanity: a quantum leap to unprecedented results** (bookstore)
  - Foreword by Dr. Donald Berwick