Quality Improvement as a Change Process

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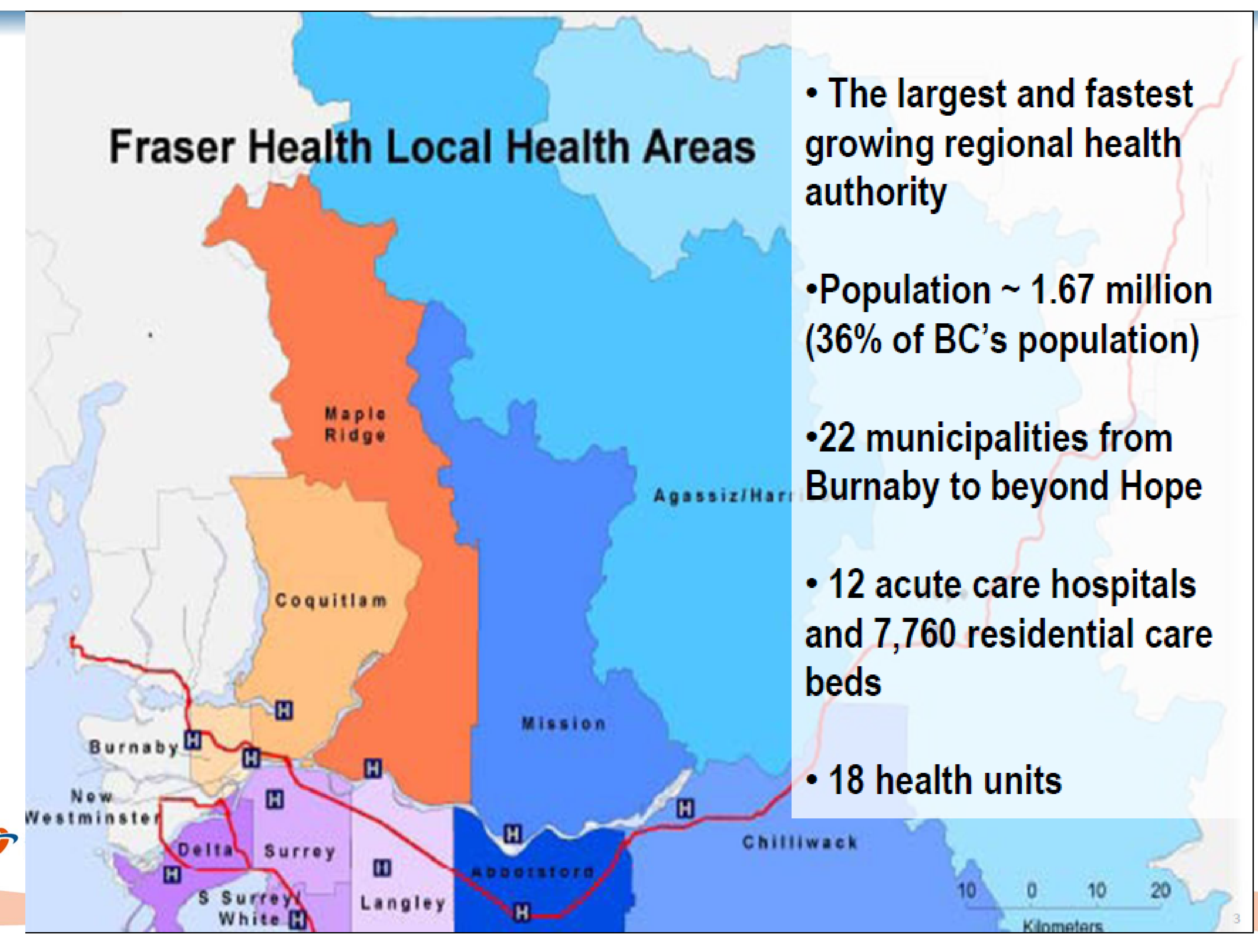
Director, Strategic Transformation
Fraser Health Authority

Content

- Fraser Health Authority
- Quality - strategic context
- Defining Quality in Healthcare
- Quality Improvement as a change process
- Q&A


Fraser Health Local Health Areas
• The largest and fastest growing regional health authority
•Population ~ 1.67 million (36% of BC's population)
•22 municipalities from Burnaby to beyond Hope
• 12 acute care hospitals and 7,760 residential care beds
• 18 health units
Maple Ridge
Coquitlam
Agassiz/Harr
Mission
Burnaby
New Westminster
Delta
Surrey
S Surrey/ White
Langley
Abbotsford
Chilliwack
10 0 10 20
Kilometers

Fraser Health – Average Daily Numbers

Everyday on average…

- 42 babies born
- 125 hearing evaluations
- 1,208 Emergency Department visits
- 2,065 patients in acute care beds
- 457 patients have surgery
- 290 clients in adult day programs
- 630 home care nursing visits
- 7,760 residents in long term care facilities
- 740 clients access mental health community services
- 1,547 mental health residents and 371 clients in addictions/treatment housing
- 27 deaths

My role…

- Supports identification, planning and execution of strategic initiatives in FHA
- Strategic Transformation team brings expertise in strategy consulting, project, and change management
- Not a ‘QI professional’ but 100% of my work relates to ‘Improving Quality’

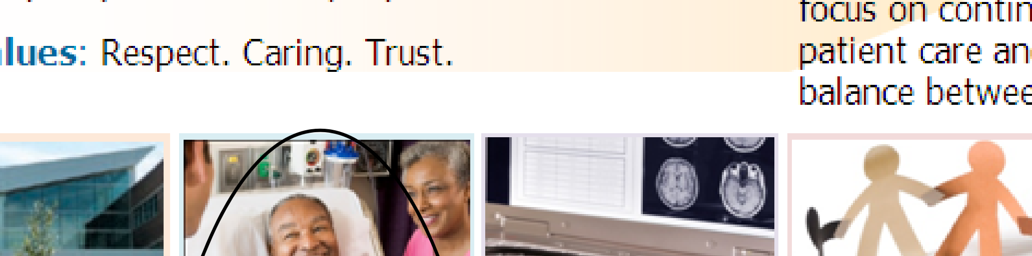
Putting Quality in Context – Strategic Imperatives

Our Vision: Better health. Best in health care.

Our Purpose: To improve the health of the population and the quality of life of the people we serve.

Our Values: Respect. Caring. Trust.

Fraser Health's six strategic imperatives guide organizational improvements required to meet the health needs of the people we serve now and into the future. The strategic imperatives emphasize a need to focus on continuous quality improvement in all our patient care and business operations while maintaining a balance between financial and human resources.



Capacity

Objectives:

Increase health service capacity.

Optimize existing capacity.

Advance capital plans.

Quality and Safety

Objectives:

Increase patient, client and resident satisfaction.

Decrease waiting times.

Increase patient, client, resident and staff safety.

Remove unnecessary variation in care.

Improve accountability for quality.

Integration

Objectives:

Strengthen integrated service, planning and delivery.

Advance integration and quality of care.

Strengthen shared services with other health authorities.

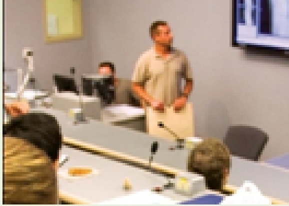
Progressive Partnerships

Objectives:

Engage "citizens as partners" to support healthy living.

Create collaborative partnerships internally.

Create collaborative partnerships externally with municipalities and community agencies.



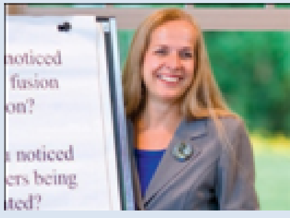
Research and Academic Development

Objectives:

Foster a "culture of curiosity".

Support new models of inter-professional education and training.

Develop networks to support grant and industry-sponsored research.



Great Workplaces

Objectives:

Ensure the well-being and safety of our people.

Provide meaningful, regular feedback and recognition.

Retain and recruit the best.

Foster a work/life balance.

Encourage personal and professional development.

Enable our people to take a lead in achieving our goals.

A note about Frameworks, Models and Methods…

Q: What's the difference between a methodologist and a terrorist?

A: You can negotiate with a terrorist.

OECD

HEALTHCARE SYSTEM PERFORMANCE How does the healthcare system perform? What is the level of care across the range of patient care needs? What does this performance cost?					
	Dimensions of Healthcare Performance				
Healthcare Needs	Quality			Access	Cost / Expenditure
	Effectiveness	Safety	Responsiveness / Patient-centeredness	Accessibility	
Staying healthy					
Getting better					
Living with illness or disability					
Coping with end-of-life					

Equity

Efficiency
(Macro- and micro-economic efficiency)

Source: Onyebuchi, A et al. A Conceptual Framework for the OECD Health Care Quality Indicators Project; International Journal for Quality in Health Care; Sep 2006: 5-13.

BC Health Quality Matrix

DIMENSIONS OF QUALITY →	ACCEPTABILITY	APPROPRIATENESS	ACCESSIBILITY	SAFETY	EFFECTIVENESS
AREAS OF CARE	Care that is respectful to patient and family needs, preferences, and values	Care provided is evidence based and specific to individual clinical needs	Ease with which health services are reached	Avoiding harm resulting from care	Care that is known to achieve intended outcomes
STAYING HEALTHY Preventing injuries, illness, and disabilities					
GETTING BETTER Care for acute illness or injury					
LIVING WITH ILLNESS OR DISABILITY Care and support for chronic illness and/or disability					
COPING WITH END OF LIFE Planning, care and support for life-limiting illness and bereavement[4]					

EQUITY Distribution of health care and its benefits fairly according to population need

EFFICIENCY Optimal use of resources to yield maximum benefits and results

DIMENSIONS OF QUALITY

4 Descriptor reflects direction of the Ministry of Health and input from the Provincial End of Life Standing Committee.

In 2008, the BC Health Quality Matrix was developed in collaboration with the members of the Health Quality Network which included BC's Health Authorities, Ministry of Health Services, academic institutions and provincial quality improvement groups and organizations.

www.bcpsqc.ca

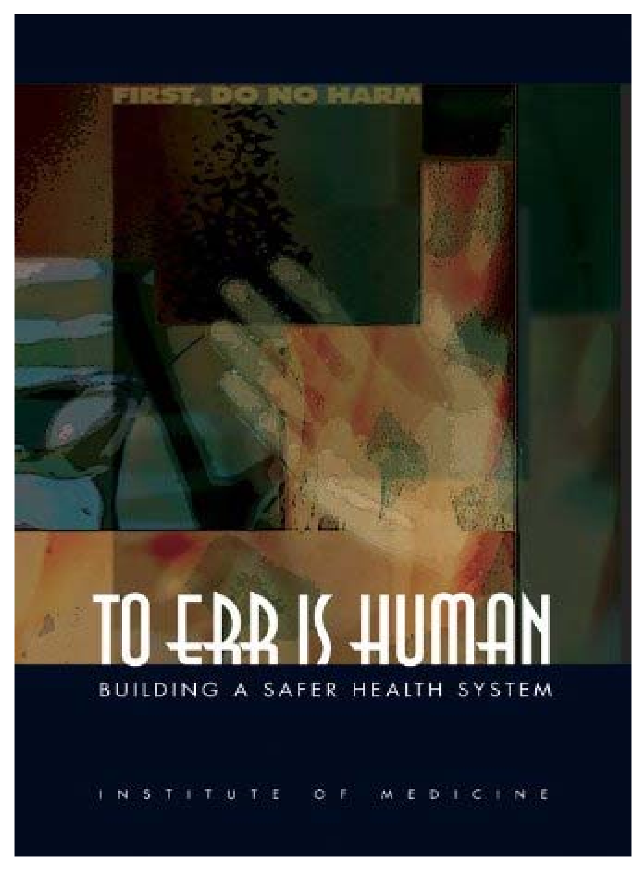
Source: BC Patient Safety & Quality Council. http://bcpsqc.ca/documents/2012/09/BCPSQC-Matrix_FEB20.pdf

Accreditation Canada

QUALITY DIMENSIONS	
DIMENSION	TAG LINE
POPULATION FOCUS	Working with communities to anticipate and meet needs
ACCESSIBILITY	Providing timely and equitable services
SAFETY	Keeping people safe
WORKLIFE	Supporting wellness in the work environment
CLIENT-CENTRED SERVICES	Putting clients and families first
CONTINUITY OF SERVICES	Experiencing coordinated and seamless services
EFFECTIVENESS	Doing the right thing to achieve the best possible results
EFFICIENCY	Making the best use of resources

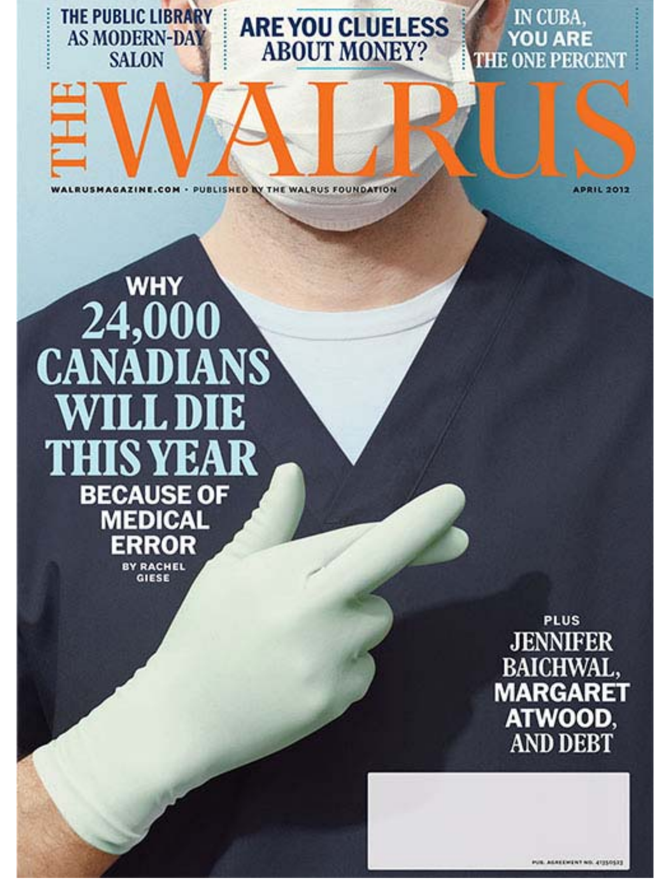
Source: Accreditation Canada (2010). 2010 Canadian Health Accreditation Report.

Example – Patient Safety



At least 44,000 people, and perhaps as many as 98,000 people, die in [US] hospitals each year as a result of medical errors that could have been prevented.

Institute of Medicine, 1999



Example – Population Focus

Progressive Partnerships

~

Committing to a Healthy Community

(http://www.youtube.com/watch?v=E8OJBMXr55k)

Example - Access – wait times

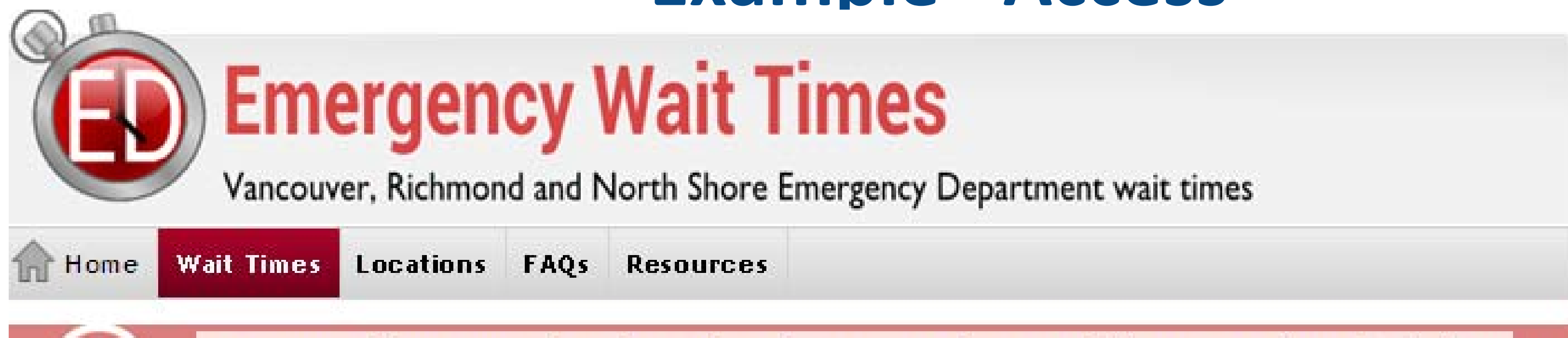
Legend:
- Hip replacement
- Knee replacement
- Hip fracture repair
- Cataract*
- Radiation therapy

▲ At least a 5-percentage-point increase in percentage meeting benchmark since 2010 (after rounding to nearest percent).
▼ At least a 5-percentage-point decrease in percentage meeting benchmark since 2010 (after rounding to nearest percent).
– No substantial change in percentage meeting benchmark since 2010.

Province	Hip replacement	Knee replacement	Hip fracture repair	Cataract*	Radiation therapy
BC	73% ▼	65% ▼	81% –	83% –	94% –
AB	84% ▲	79% ▲	80% –	69% ▲	97% –
SK	69% –	55% ▼	79% ▲	57% ▼	98% –
MB	56% ▼	46% ▼	86% –	61% ▼	100% –
ON	89% –	84% ▼	82% ▲	86% –	98% –
QC	79% ▼	76% ▼	†	88% –	98% –
NB	72% ▼	61% ▼	80% –	85% –	94% ▲
NS	60% –	42% –	76% –	67% –	89% –
PE	52% ▼	35% ▼	73% –	67% ▼	99% –
NL	83% ▲	81% ▲	81%	82% –	98% –

Source: Health Council of Canada (2013). Progress Report 2013: Healthcare Renewal in Canada.

Example - Access



Average wait times are updated approximately every 5 minutes and this page was last refreshed on Mon, May 27, 2013 at 4:50 PM

	Average wait times in past 2 hours What does this show me?	Average wait times What does this show me?	9 out of 10 times you will see a doctor within What does this show me?
Mount Saint Joseph Hospital Patients of all ages seen		00:31	00:45
Lions Gate Hospital Patients of all ages seen		00:54	02:04
Vancouver General Hospital Patients of ages 17 and older seen		00:43	01:11
St. Paul's Hospital Patients of all ages seen		00:13	00:51
Richmond Hospital Patients of all ages seen		00:53	01:59

Source: http://www.edwaittimes.ca/WaitTimes.aspx

Example - Continuity of Services

Care **and** Service

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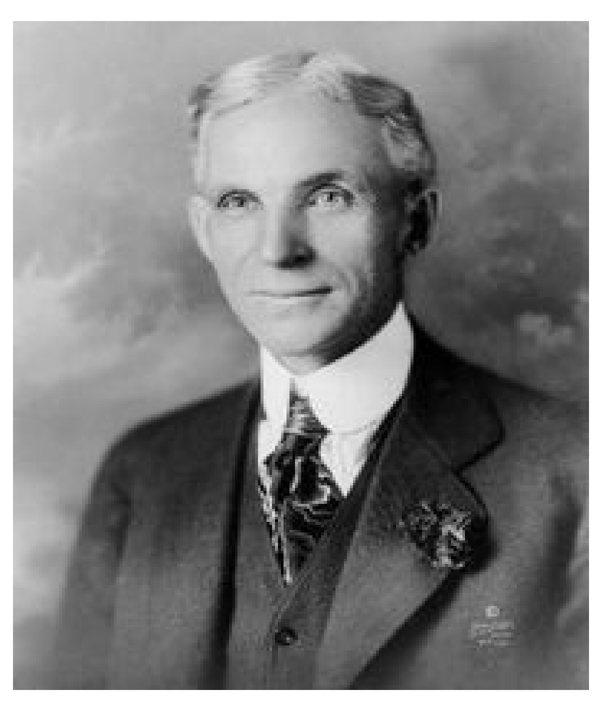
If Air Travel Worked Like Healthcare

(http://www.youtube.com/watch?v=5J67xJKpB6c)

Creating a Culture of Quality



"Quality means doing it right when no one is looking."

Henry Ford

Quality Performance Management System (QPMS)

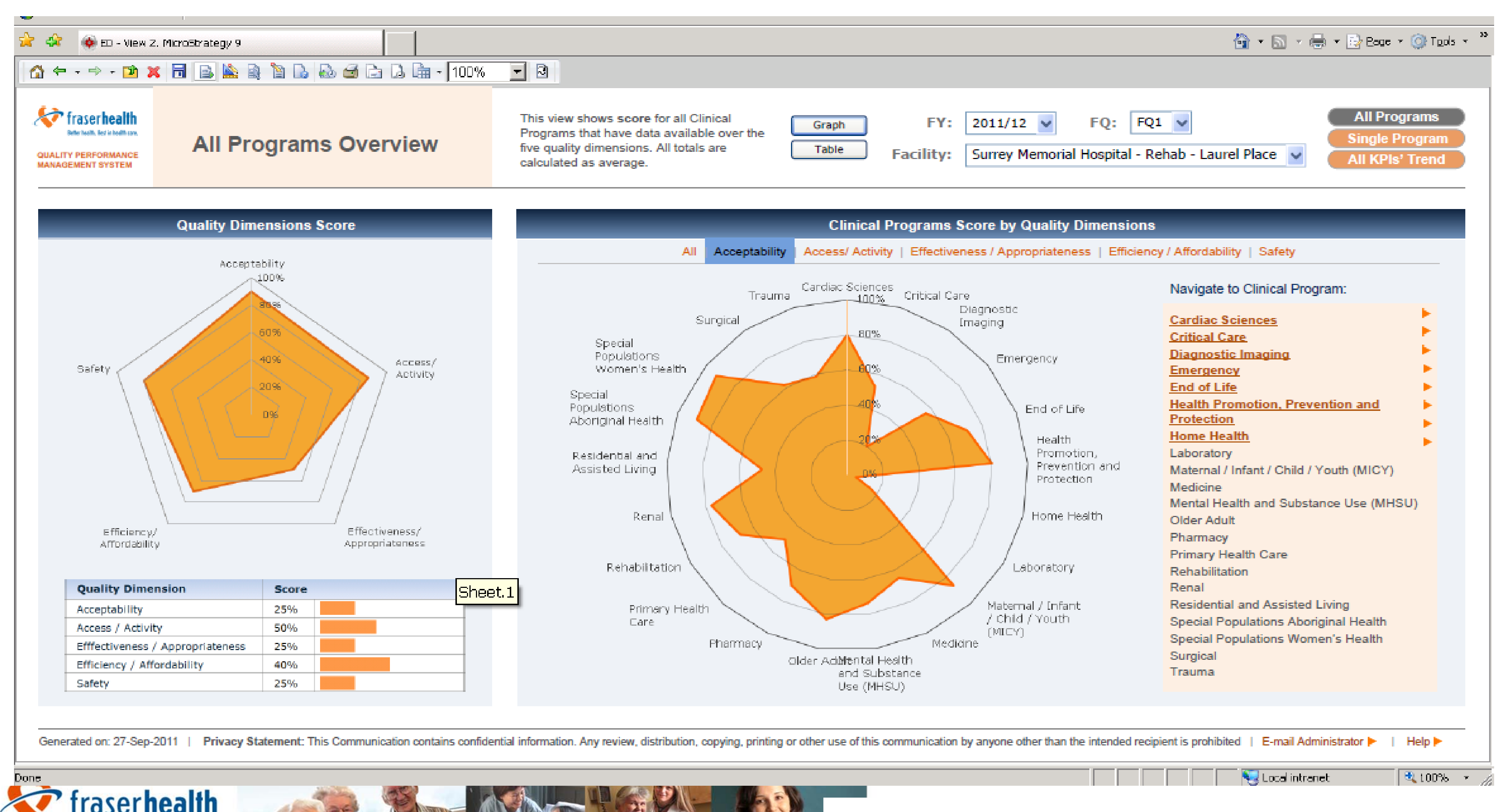
- Fraser Health is committed to creating a culture of quality throughout the organization
- Quality is everyone’s responsibility
- QPMS will provide programs an ability to effectively identify and track areas for clinical improvement that will have the most impact
- QPMS will reflect a level of rigor commensurate with financial accounting practices

QPMS is a strategic performance and quality management system that uses financial accountability to model accountability for quality

Quality Dimensions Defined

- Safety: Care that avoids preventable harm
- Effectiveness/Appropriateness: Care which is evidence-based and reflects the individual's personal goals in achieving optimal health outcomes
- Accessibility/Activity: Patients' ability to access/utilize the care and services they need in a timely and responsive manner
- Acceptability: Patient and family-centered care which promotes respect, caring and trust
- Efficiency/Affordability: Appropriate cost/benefit balance based on finite resources (value for money)

View 1: Organizational View*



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View 2- Program Summary View

View 2. MicroStrategy 9 - Windows Internet Explorer provided by Fraser Health Authority

http://msgd0002/MicroStrategy/asp/Main.aspx

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QUALITY PERFORMANCE MANAGEMENT SYSTEM

Critical Care

Program View - Level 2

This view shows KPIs of Critical Care Program over the five Quality Dimensions.

FY: FY 2011/2012
FP: FP01
Facility: Fraser Health Authority

Organizational View
Program View
KPIs Trend View

Quality Dimensions Score

Acceptability 100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Access / Activity
Effectiveness / Appropriateness
Efficiency / Affordability
Safety

Measure: KPI Score

Quality Dimension	Score
Acceptability	50.00%
Access / Activity	58.30%
Effectiveness / Appropriateness	100.00%
Efficiency / Affordability	75.00%
Safety	25.00%

Quality Dimension	KPI	KPI Value	KPI Target	KPI Weight	Amber Threshold	Score
Acceptability	ICU Patient/Family Satisfaction Survey detail	--	--	--	--	0.00%
	Percentage of Patients Ventilated Outside the ICU detail	67.50%	100.00%	50.00%	100%	50.00%
	Quality Dimension Total	--	--	--	--	50.00%
Access / Activity	ICU Occupancy Rate detail	97.50%	80.00%	33.30%	100.00%	25.00%
	ICU Night Discharge Rate detail	9.70%	16.00%	33.30%	20.00%	33.30%
	Total Avoidable Days detail	271.22	1	33.30%	1.25	0.00%
	Quality Dimension Total	--	--	--	--	58.30%
Effectiveness / Appropriateness	Hospital Standardized Mortality Rate (HSMR) detail	0.577	1	100.00%	1.25	100.00%
	Quality Dimension Total	--	--	--	--	100.00%
Efficiency / Affordability	Length of Stay (APACHE IV) detail	0.919	1	33.30%	0.75	25.00%
	Level of Care on Admission to ICU detail	86.60%	100.00%	33.30%	75.00%	25.00%
	Median ICU LOS (Patients LOS <29 days) detail	3.212	3	33.30%	3.75	25.00%
	Quality Dimension Total	--	--	--	--	75.00%
Safety	Catheter Related Blood Stream Infection (CRBSI) Rate detail	1.349	1	33.30%	1.25	0.00%
	New Cases of C. Difficile detail	1.462	0.7	33.30%	0.88	0.00%
	Ventilator Management Bundle detail	38.30%	50.00%	33.30%	37.50%	25.00%
	Quality Dimension Total	--	--	--	--	25.00%

Meeting Target   Near Target   Not Meeting Target   Data Unavailable

Program notes Off On

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View 3 – KPI Trend

View 3 - Critical Care. MicroStrategy 9 - Windows Internet Explorer provided by Fraser Health Authority

http://msgd0002/MicroStrategy/asp/Main.aspx?evt=2048001&src=Main.aspx.2048001&visMode=0&documentID=8B3E636544ECEC2CABCC4398B085FE1D¤tViewMedia=2&elementsPromptAnswers=A6737C814A196093ECE350AD23986D2E;A6737C814A1

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Critical Care

All KPIs Trend - Level 3

Overview | Acceptability | Access / Activity | Effectiveness / Appropriateness | Efficiency / Affordability | Safety

Graphs | Tables

Facility: Fraser Health Authority

Organizational View
Program View
All KPIs Trend View

Acceptability	Access / Activity	Effectiveness / Appropriateness	Efficiency / Affordability	Safety
ICU Patient/Family Satisfaction Survey (detail)	ICU Night Discharge Rate (detail)	Hospital Standardized Mortality Rate (HSMR) (detail)	Length of Stay (APACHE IV) (detail)	Catheter Related Blood Stream Infection (CRBSI) Rate (detail)
No data returned for this view. This might be because the applied filter excludes all data.	ICU Occupancy Rate (detail)		Level of Care on Admission to ICU (detail)	New Cases of C. Difficile (detail)
Percentage of Patients Ventilated Outside the ICU (detail)	Total Avoidable Days (detail)		Median ICU LOS (Patients LOS <29 days) (detail)	Ventilator Management Bundle (detail)

Fiscal Year: 07/08, 08/09, 09/10, 10/11, 11/12

KPI Value   KPI Target

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View 4a – KPI Detail

View 4 - Time. MicroStrategy 9 - Windows Internet Explorer provided by Fraser Health Authority

http://msgd0002/MicroStrategy/asp/Main.aspx

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Critical Care

KPI Detail

ICU Occupancy Rate - (Percentage)

Overview | Meeting Target Status | Yearly Trend | Year over Year

Time Periods / Facilities — FY: FY 2011/201 — Facility: Fraser Health Authority

Organizational View | Program View | KPIs Trend View

Select KPI

- Catheter Related Blood Stream Infection (CRBSI) Rate
- Hospital Standardized Mortality Rate (HSMR)
- ICU Night Discharge Rate
- ICU Occupancy Rate
- Length of Stay (APACHE IV)
- Level of Care on Admission to ICU
- Median ICU LOS (Patients LOS <29 days)
- New Cases of C. Difficile
- Percentage of Patients Ventilated Outside the ICU
- Total Avoidable Days
- Ventilator Management Bundle

Selected KPI Information

Quality Dimension | Definition | Rationale | Data Source

Occupancy can be used to monitor ICU bed capacity, document and plan for surges, and guide staffing levels.

Meeting Target Status

Fiscal Period	KPI Value	KPI Target
FP01	0.975	0.8
FP02	0.867	0.8
FP03	0.687	0.8
FP04	1.882	0.8
FP05	1.232	0.8
FP06	0.815	0.8
FP07	--	--
FP08	--	--

Meeting Target / Near Target / Not Meeting Target / Data Unavailable

Yearly Trend

2, 1.6, 1.2, 0.8, 0.4, 0, -0.4

FY 2008/2009, FY 2009/2010, FY 2010/2011, FY 2011/2012

KPI Value — KPI Target

Year over Year

Metric: KPI Value, KPI Value LY, KPI Target, KPI Target LY

2, 1.6, 1.2, 0.8, 0.4, 0

FP01, FP02, FP03, FP04, FP05, FP06, FP07, FP08

KPI Value — KPI Value LY — KPI Target — KPI Target LY

Analytical Comments - FQ?

Performance Analysis:
Some performance analysis text.

Action Plan:
Selected Action.

Strategy: Open Strategy Detail >
Selected Strategy.

Time Frame:
Time Frame entered.

Plan of Execution:
Some text describing a plan of execution.

Responsibility Of:
Team/person responsible.

Last Modified:
N/A

Last Modified By:
N/A

Add Comment

Single Comment | All Comments

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Level 4b – KPI detail

View 4 - Facility. MicroStrategy 9 - Windows Internet Explorer provided by Fraser Health Authority

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Critical Care
KPI Detail

ICU Occupancy Rate - (Percentage)

Time Periods
Facilities

FY: FY 2011/201 FP: FP01

Organizational View
Program View
KPIs Trend View

Select KPI

- Catheter Related Blood Stream Infection (CRBSI) Rate
- Hospital Standardized Mortality Rate (HSMR)
- ICU Night Discharge Rate
- ICU Occupancy Rate
- Length of Stay (APACHE IV)
- Level of Care on Admission to ICU
- Median ICU LOS (Patients LOS <29 days)
- New Cases of C. Difficile
- Percentage of Patients Ventilated Outside the ICU
- Total Avoidable Days
- Ventilator Management Bundle

Selected KPI Information

Quality Dimension
Definition
Rationale
Data Source

Num: ICU Database Den: Finance

Facility Comparison

- (All)
- Fraser Health Authority
- Abbotsford Regional Hospital
- Burnaby Hospital(BH)
- Chilliwack General Hospital
- Langley Memorial Hospital
- Peace Arch Hospital
- Ridge Meadows Hospital
- Royal Columbian Hospital
- Surrey Memorial Hospital

Order:
A-Z by Facility Name
Asc. by KPI Value
Desc. by KPI Value

Meeting Target
Near Target
Not Meeting Target
Data Unavailable

Fit to View
Zoom-in

Facility		KPI Value	KPI Target
FHA	Fraser Health Authority	1.88	0.80
ARH	Abbotsford Regional Hospital	1.59	0.80
BH	Burnaby Hospital(BH)	1.08	0.80
CGH	Chilliwack General Hospital	1.02	0.80
LMH	Langley Memorial Hospital	1.18	0.80
PAH	Peace Arch Hospital	1.18	0.80
RMH	Ridge Meadows Hospital	1.12	0.80
RCH	Royal Columbian Hospital	1.51	0.80
SMH	Surrey Memorial Hospital	1.33	0.80

2.00
1.60
1.20
0.80
0.40
0.00

FHA ARH BH CGH LMH PAH RMH RCH SMH

KPI Value — KPI Target

Analytical Comments - FQ?

Performance Analysis:
Some performance analysis text.

Action Plan:
Selected Action.

Strategy: Open Strategy Detail >
Selected Strategy.

Time Frame:
Time Frame entered.

Plan of Execution:
Some text describing a plan of execution.

Responsibility Of:
Team/person responsible.

Last Modified:
N/A

Last Modified By:
N/A

Add Comment

Single Comment | All Comments

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View 4c – Analysis and Next Steps

TR Storyboard - Emergency + Overall Flow v9 - View 4.pdf - Adobe Reader

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1 / 1 80% Find

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Share Browser WebEx

ED - View 2. MicroStrategy 9

100%

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QUALITY PERFORMANCE MANAGEMENT SYSTEM

Emergency KPI Detail

Patients Seen within Guideline (Triage to Physician) (%)

Graphs | Tables

Variable: CTAS 2 — FY: 2011/12

Facility: Fraser Health Authority — FQ|FP: FQ1 FP2

All Programs | Single Program | All KPIs Trend | Single KPI

Select KPI

Click on KPI name to see detail — Target Met?

- % Outpatients Treated & Discharged w/n 5hrs
- % Patient Satisfied with Illness Danger Signals
- % Patients Admitted within 10Hrs.
- % Patients Left Without Being Seen (LWBS)
- % Patients Satisfied with ED Visit Privacy
- % Patients Seen within Guideline (Triage to Physician)
- % STEMI Patients Transferred to RCH w/n30min
- Patient Satisfaction with Overall ED Visit

Selected KPI:

Quality Dim. | Assoc.Prc.KPIs | Definition | Rational | Program Goal | Data Source

The percentage of ED patients who left without being seen by a physician. Note, that measure includes patients seen by a nurse. Note, that measure includes patients seen by a nurse

Analytical Comments

Submitted by: Ferguson, B
On date: Oct 11th 2011

Performance Analysis
performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance

Action Plan — Open Plan detail
action plan detail action plan detail

Selected Strategy — Open Strategy detail
selected strategy detail selected strategy

Time Frame
time frame detail time frame detail

Team Responsible
team responsible name

Plan of Execution
plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail execution detail plan execution detail plan execution detail plan execution detail plan execution detail plan execution detail plan execution detail plan

Edit | Delete

Submitted by: Ferguson, B
On date: Oct 11th 2011

Performance Analysis
performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance analysis detail performance

Action Plan — Open Plan detail
action plan detail action plan detail

Selected Strategy — Open Strategy detail
selected strategy detail selected strategy

Time Frame
time frame detail time frame detail

Team Responsible
team responsible name

Plan of Execution
plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail plan of execution detail

Edit | Delete

Sheet.540

Submitted by: Ferguson, B

Performance Analysis
performance analysis detail performance analysis detail performance analysis detail performance analysis detail

Action Plan — Open Plan detail
action plan detail action plan detail

Team Responsible
team responsible name

Edit | Delete

Enter New Comment | Single Comment | All Comments

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QPMS accountabilities

Board Level

Structure

Board Quality Committee

Role

Sign off on FHA quality performance and acceptable tolerance levels

Process

Review FHA wide performance at each meeting

Output

Publish Quality Account (date to be confirmed)

Executive Level

Structure

Standing agenda item on Executive meetings and FHA QPC meetings

Role

Improve the quality of care within own portfolio and across all portfolios; set tolerance levels within individual programs

Process

- Review FHA wide performance at Executive and FH QPC meetings with program specific reviews on a regular basis
- Review with each PMD/ED on quarterly basis

Output

- Identification of areas of focus within own portfolio
- Inclusion of quality objectives in personal performance plans

ED/PMD & PROGRAM QPC CHAIR Level

Structure

- Program QPC meetings
- Regularly scheduled program level meetings

Role

Improve the quality of care within own program and support improvement in other programs

Process

Review program level performance and identify opportunities for improvement

Output

- Quarterly update of Analysis and Next Steps at program level*
- Inclusion of quality objectives in personal performance plans

*capture the improvement activities that are underway to address any areas that are not meeting their target, or which may be achieving target, but showing a downward trend

Director Level

Structure

- Program QPC
- Facility level meetings

Role

Improve the quality of care within own program and support improvement in other programs

Process

Review program performance at facility level and identify opportunities for improvement

Output

- Quarterly update of Analysis and Next Steps for programs at facility/local level*
- Inclusion of quality objectives in personal performance plans

*capture the improvement activities that are underway to address any areas that are not meeting their target, or which may be achieving target, but showing a downward trend

Manager Level

Structure

- Program QPC
- Unit level meetings

Role

Improve the quality of care within own program

Process

Review program performance at unit level, and identify opportunities for improvement

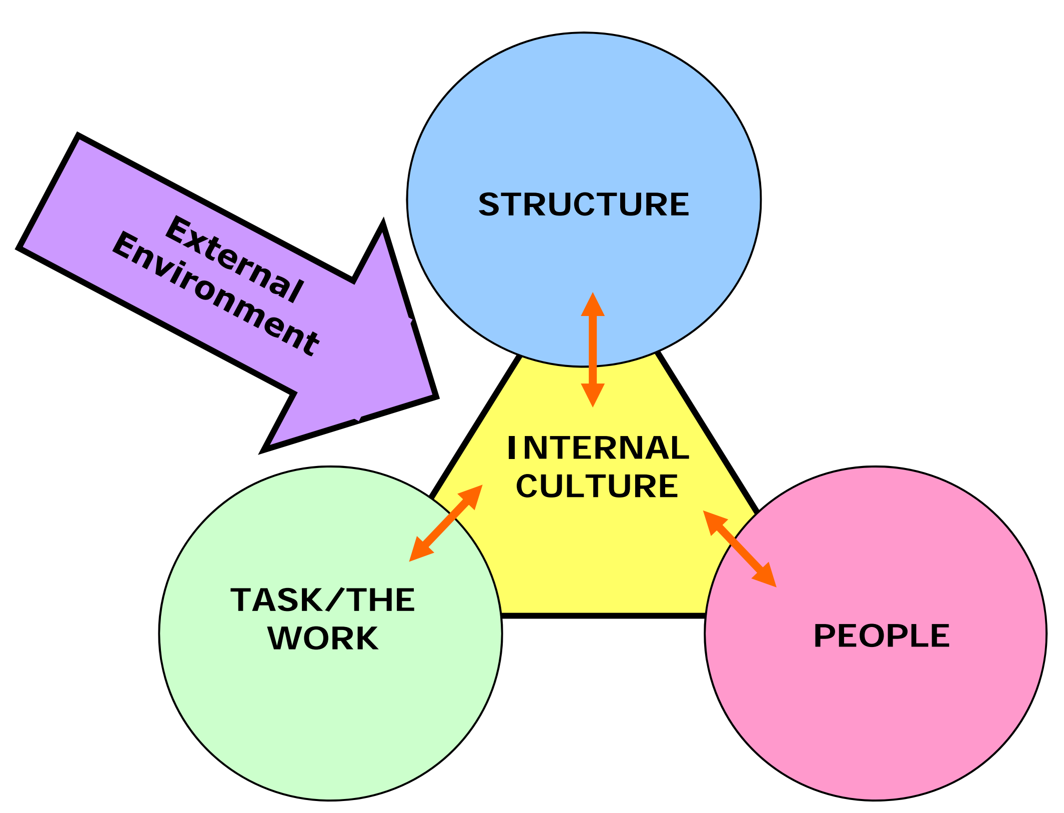
Output

- Quarterly update of analysis and next steps for programs at unit level*
- Inclusion of quality objectives in personal performance plans

*capture the improvement activities that are underway to address any areas that are not meeting their target, or which may be achieving target, but showing a downward trend

Quality Improvement as a change process

Taking a systems view
STEP Model – Org Design



Dynamic Enterprises

Structures – reporting relationships, decision making, job descriptions, physical facilities, information systems, policies, reward systems

Tasks – goals, workflow, quality, products and services, standards

Environment – external: regulations, partners, suppliers, community and society, the economy/market forces; internal: vision, values, leadership, culture and org climate

People – technical and managerial talent, needs and expectations, communication, diversity, teamwork

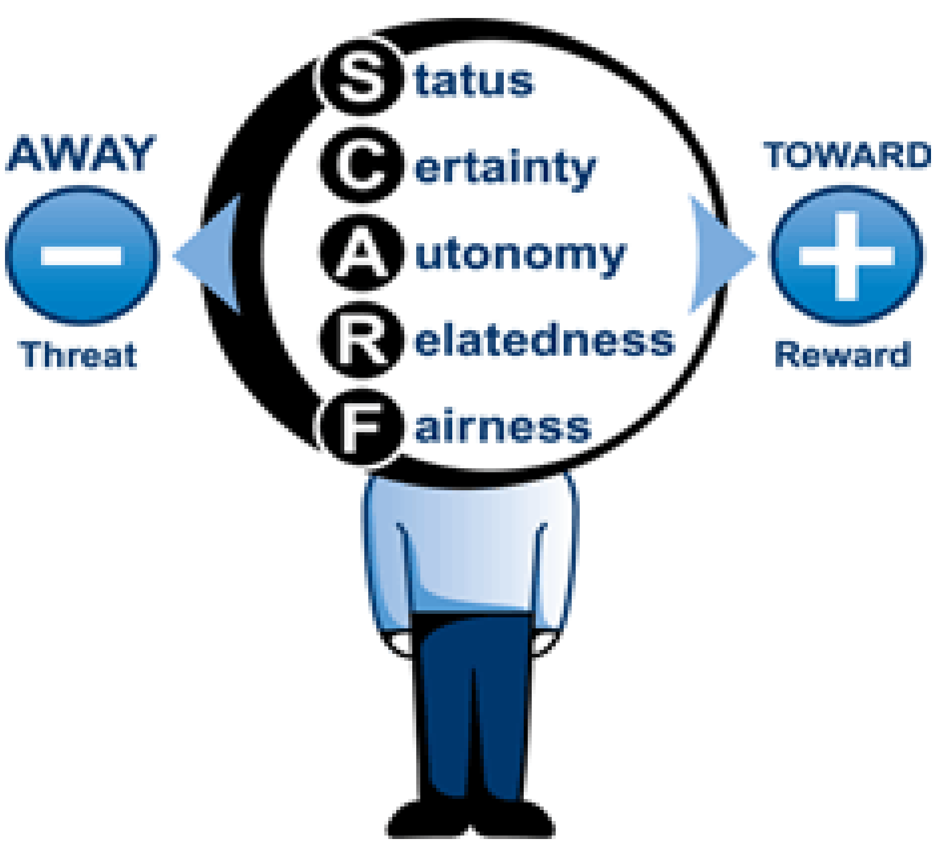
Source: Friedman L, Herman G. *The Dynamic Enterprise-Tools for Turning Chaos into Strategy and Strategy into Action.* San Francisco: Jossey-Bass, 1998.

Approach to Change

	Incremental Change	Step Change
Performance Gain	Small – Medium	Medium – large
Underpinning thinking about the “way it has always been”	Largely unchallenged and unchanged	Fundamentally challenged and changed

Source: Creating the Culture for Innovation – a Practical Guide for Leaders. National Health Service.

SCARF



- Triggers that stimulate either a threat or reward response.

Source: David Rock . http://www.scarfsolutions.com/

SCARF

Figure Two: "Toward" and "Away" states of the SCARF model.

AWAY	TOWARD
Threat	Reward

Threat

- Distracted
- Anxious
- Think less clearly
- Reduced memory
- Poorer performance
- Weakened immune system
- Cortisol / stress

Reward

- Positive
- More focused
- Willing to collaborate
- Innovative
- Creative
- Willing to get involved
- Increased resilience

Source: https://www.melcrum.com/research/engage-employees-strategy-and-change/neuroscience-helping-employees-through-change

ADKAR ®

- **A** Awareness of the need for change
- **D** Desire to participate & support the change
- **K** Knowledge on how to change
- **A** Ability to implement required skills & behaviour
- **R** Reinforcement to sustain the change

Source: Prosci ADKAR Model (2013). http://www.prosci.com/main/adkar_overview.html

ADKAR Elements	Factors Influencing Success
Awareness of the need for change	• A person's view of the current state • How a person perceives problems • Credibility of the sender of awareness messages • Circulation of misinformation or rumors • Contestability of the reasons for change
Desire to support and participate in the change	• The nature of the change (what change is and how it will impact each person) • The organizational or environmental context for the change (his or her perception of the organization or environment that is subject for change) • Each individual person's situation • What motivates a person (those intrinsic motivators that are unique to an individual)
Knowledge of how to change	• The current knowledge base of an individual • The capability of this person to gain additional knowledge • Resources available for education and training • Access to or existence of the required knowledge
Ability to implement required skills and behavior	• Psychological blocks • Physical capabilities • Intellectual capability • The time available to develop the needed skills • The availability of resources to support the development of new abilities
Reinforcement to sustain the change	• The degree to which reinforcement is meaningful and specific to the person impacted by the change • The association of the reinforcement with actual demonstrated progress or accomplishment • The absence of negative consequences • An accountability system that creates an ongoing mechanism to reinforce the change

Source: Prosci ADKAR Model (2013). http://www.prosci.com/main/adkar_overview.html

Knowledge Management

- Healthcare is a knowledge intensive industry with vast amounts of new knowledge generated everyday
  - How to better prevent illness to stay healthy
  - How to better diagnose, treat disease
  - Efficacy of new drugs, technologies, etc.

- QI requires converting knowledge into action … challenging for many reasons (e.g., SCARF, ADKAR, etc.)

Recap

- Quality in healthcare is defined by multiple dimensions
- Measurement is critical
- Improving Quality is a change process that involves changing Structures, Tasks, Environmental factors, and (most importantly) how People work
- SCARF – identifies key triggers for threat / reward responses
- ADKAR – simple model to understand individual barrier points to change