Introduction to A3 thinking

AUR ARRALD Program
Session 5: Introduction to Process Improvement and Quality Tools
Objectives and Process

- Learn the basics of A3 Thinking/Project development
- Understand the role of Standard Work in Process Improvement
- How
  - Didactic presentation
  - Interactive mockup of a known improvement opportunity
A3 Thinking: Story without a storyteller

**UNDERSTANDING**

1. Reason for Action
   - ‘Burning Platform’
   - 30 sec elevator speech
   - Why are we doing this?
   - Scope

2. Current State
   - Map
   - Attributes
   - Metrics
   - Picture

3. Target State
   - Map
   - Attributes
   - Metrics
   - Picture

**SOLVING & DOING**

4. Gap Analysis
   - Why Box 2 ≠ Box 3

5. Solution Approach
   - Hypothesis: if we do ‘A’ then we get ‘B’
   - GAP
   - if we... then we...
   - EXP
   - 
   - 
   - 

6. Rapid Experiments
   - WHY: improve solutions build Gemba ownership
   - P-D-C-A

**SUSTAINING**

7. Completion Plan
   - WHO
   - WHAT
   - WHEN

8. Confirmed State
   - CURR
   - TAR
   - CONF
   - Are we seeing results sustained 30/60/90 days?

9. Insights
   - ‘AHA MOMENTS’
   - What did we/I learn?
   - TECHNIQUE: capture daily summarized at end
   - BELIEF: sharing promotes learning/team
PROBLEM STATEMENT

A well-defined problem statement should fill in these details:

1. What is the Problem?
2. Why is it a Problem?
3. How does the problem impact the customer & the process?
4. When does the problem occur?
5. Where does the problem take place?
GAP ANALYSIS

- Go to the GEMBA: you cannot understand the process from a conference room.
- How do you understand the process?
- How often is the problem happening?
- What is causing the problem?

What did you learn?
What root causes will you address?
Types of Standard Work Documents

**Operational Level**
- Used to document the overall flow, usually including more than one job role (i.e. clinic flow from front desk to exam)

**Task Level**
- Step-by-step explanation, at the individual role level
- Used for training; steps are memorized
- Includes safety, quality, and patient experience requirements

**Job Aid**
- A reference in the work area: checklist, tables/charts, color coding, references, etc.
**ATTEMPT CHANGES**

- Experiment with new workflow
  - Assign responsibility
  - Measure change

### Category | Action Item | Who | By When / Update | 1/9/19 Updates
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**Just Do It** | Dissection protocol update | Radiology Informatics/Pratick | Work order submitted | RadNet team backed up and short staffed
**Just Do It** | Use walkie-talkie to communicate with RNs to bring patients | Philip Haum + Derek Close/CT Techs | Currently in progress; Philip - CT has a radio now and can begin this immediately (Update 12/28) Philip - will check with Shared Governance Council for the ED (Update 1/2) Philip - Going to meet with UPC team on Monday to discuss to gain their input (Update 1/3) | 1/23 - UPC meeting. Go-live 1/28
**Just Do It** | Track number of times IV access is an issue (no IV, inadequate gauge of IV, location of IV etc.) | CT Techs | In progress | Progress made with communication at ER huddles
**Just Do It** | ER-CT Faculty collaboration – bi-annual meetings to review protocols and processes | Dr. Pendley | Mid 2019 | Amber to help schedule meeting in April. ER Rad + CT team will get together a list of protocols to discuss.
**Just Do It** | Optimize time between stroke alert page and patient arrival: Scan stable Head w/o patient if there is a > 15 minute window between stroke alert and patient ETA | CT Techs | In progress | Neuro team fine with optimizing time. If non-stroke patient on table, stroke pt. can be taken to the high acuity room
**Just Do It** | POC Testing - QC schedule | CT Techs | TBD - discuss at 1/9 meeting | Need to develop a standard process
COMMON MISTAKES:

- SMART goals – missing at least 1 of the SMART points. Often timing
- Baseline analysis is not clear. Description of major findings missing.
- Interventions are not clearly assigned. I.e. who or what role is responsible for making each of these steps happen?
- Missing measures in the ‘Monitor’ section (despite having goals, which are your measures).
- Impact is used to write out what you can read in the measures (repetitive, missed opportunity)
SUMMARY

• Quality Improvement is a science with unique methodology
• A critical aspect is stepping back from proposing a solution to define the problem first*
• The baseline analysis is going to reveal both potential solutions and the improvement targets
• Success depends on tying SM-RT problem statements and SMART goals together

*This is applicable to initiating all research problems