LakeCounty
Health Department and
Community Health Center

Quality Management System Guide

2018-2019

The Executive Director approves, and the Governing Council and Board of Health authorize the QMS and adoption of this guide as noted by their review and signatures.

Mark Pfister

Executive Director

Date

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Governing Council Chair

Date

Timothy Sashko

Board of Health President

Date

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Appendix

I. Purpose

The Lake County Health Department/Community Health Center (LCHD/CHC) Quality Management System (QMS) Guide is established to provide a context and framework for quality improvement activities at our agency to ensure that we become a high-performing organization that provides safe, high-quality care and services in an efficient and effective manner. The QMS is a tool that helps us measure and improve the work we are already doing by empowering staff at all levels of the organization to think critically, learn by doing, and share suggestions and ideas for improvement. The aim is to promote a systematic approach to continuous quality improvement. This involves establishing and monitoring key quality measures and using this data to initiate rapid cycle improvement and sustain and spread the gains.

II. Aim

The aim of the QMS is to continuously assess and improve the quality of care and service delivery to positively affect health outcomes in our Lake County community.

III. Objectives

- To design effective processes to meet the needs of our Lake County community in a manner consistent with the organization's mission, vision, goals, and plans.
- To collect, analyze, visualize, and monitor data on an ongoing basis to assess performance and identify improvement opportunities, test changes that may lead to improvement, and to spread and sustain the gains.
- To educate staff regarding their responsibilities and ensure they have the confidence, knowledge, skills, and abilities to effectively participate in quality improvement activities.
- To empower staff at all levels of the agency to think critically and to share suggestions for improvement.
- To create and foster a non-punitive culture of quality that encourages collaboration, learning, and innovation.

IV. Scope of QMS and Integration with Mission, Vision, and Values

The QMS guide applies to all staff and programs and will help establish a culture of quality to assist LCHD/CHC staff in actively achieving our mission to promote the health and well-being of all who live, work, and play in Lake County. The guide aligns to the mission, vision, and values through the following activities:

- Setting key performance indicators (KPIs).
- Reviewing and monitoring of KPIs and the overall quality of care and services delivered.
- Establishing a comprehensive approach to quality improvement when KPIs fall below target for two consecutive reporting periods.
- Utilizing comparative data to evaluate program processes and outcomes.
- Reporting and communicating results.
- Recognizing quality initiatives that resulted in meaningful measurable improvements.

Key Performance Indicators

Key performance indicators (KPIs) align with our strategic plan, community health improvement plan, accreditation standards, and Health Resources and Services Administration (HRSA) Uniform Data Set (UDS) clinical quality measures. Indictors are reviewed by program leaders monthly and UDS measures are reported to the Governing Council monthly. When KPIs fall below target for two consecutive reporting periods, a Program Leader will assemble a team to review and create a plan to address the KPI per Section **XIV**.

Standard Practice Guidelines

Standard practice guidelines (SPGs) have been established based upon the most current evidence-based or consensus-based clinical information. This framework seeks to improve the quality and consistency of care in specified clinical situations and promote the best outcomes for our patients. Peer reviews and chart audits are evaluated using SPGs. All LCHD/CHC healthcare providers are expected to review and adhere to SPGs.

SPGs are intended to:

- Improve the quality of patient care and healthcare outcomes
- Summarize research findings and make clinical decisions more transparent
- Reduce inappropriate variation in practice
- Promote efficient use of resources
- Identify gaps in knowledge
- Support quality control, including audits of clinician's practices

Peer Review

All full-time and permanent part-time LCHD/CHC healthcare providers participate in peer review of their peers monthly based on patient encounters. The purpose of peer review is to assess the appropriateness of the utilization of services and quality of services provided. Each provider shall review one patient encounter per month using a standard score card. Any provider who is operating outside the standard of care will be evaluated by the Medical Director and coached as necessary.

V. Key Quality Terms

Aim-The goal you want to accomplish for a project or an initiative. The aim must be specific, measurable, achievable, realistic, and time-bound (SMART).

Baseline measurement-Used to determine the process parameters prior to any improvement effort; the basis against which change is measured.

Continuous Quality Improvement (CQI)- A customer-driven philosophy and positive attitude for analyzing processes and improving them repeatedly to prevent problems and maximize quality of care and service; systematic and continuous actions that lead to measurable improvement in health care and population health services.

Goal- Something you are trying to do or achieve.

Just-in-time- Providing training just before it is needed to protect against information loss.

Key Performance Indicator- A quantitative tool that provides information about the performance of a process, service, or outcome.

Measure- An indication of something; how you determine if a change lead to an improvement.

Model for Improvement- The Model for Improvement was developed by a group called Associated for Process Improvement. It is an improvement framework that involves asking three key questions, and then testing change ideas using Plan Do Study Act (PDSA) cycles.

Plan Do Study Act (PDSA)- An iterative, four-stage problem solving model used to improve a process or carry out change.

Outcome-Something that happens because of an activity.

Program Leaders- Practice managers, program managers, coordinators, supervisors and other delegated program leads.

Process Improvement-Seeking to learn what causes things to happen in a process and to use this knowledge to reduce variation, remove waste, and improve customer satisfaction.

Quality- Meeting or exceeding the customer's expectations.

Quality Academy- Hands on, experiential training for agency leaders comprised of the Institute for Healthcare Improvement's Open School curriculum and monthly in person meetings.

Quality Assurance- Ensuring services meet specific standards. Examples- checking that equipment works, running controls on point of care tests.

Quality Improvement- Formal approach to measuring current performance and determining what changes to make to do our work better.

Quality Improvement Tools- Tools used to assist a team when solving a problem or throughout the process of implementing a quality improvement initiative. Various tools can be used in different stages of quality improvement and can be accessed on the Quality Toolbox SharePoint page.

Quality Toolbox- An employee SharePoint site that houses all quality related data and information including quality KPI dashboards, quality improvement tools and resources, and a place to share quality improvement initiatives.

Value- Providing what the customer wants, when they want it, in the right amount or frequency, at the right price.

Variation- A departure from a former or normal condition or action or amount or from a standard or type and the amount by which this occurs.

Voice of the Customer (VOC)- Listening to customers to focus on what is important to them and to improve processes.

Waste- Activities that use resources, but don't add value; activities for which the customer would not be willing to pay or desire. Seven common wastes include overproduction; unnecessary transportation; inventory; motion; defects; over-processing; and waiting.

VI. Governance and Organization

Board of Health and Governing Council

The Lake County Health Department is governed by a 12-member Board of Health. Members are appointed by the Chairman of the County Board with approval of the Lake County Board and are Lake County residents of various backgrounds as required by State Statute and Board of Health by-laws.

The Lake County Health Department and Community Health Center Governing Council is a volunteer board that oversees the planning and direction of the health department's seven community health centers. To ensure the community is represented and is required, a majority of Governing Council members are also Community Health Center consumers. Progress toward clinical quality indicators are reported to the Governing Council monthly.

The respective boards have the final authority and are ultimately responsible for the QMS, including approving this guide.

Quality Improvement Committee

The Quality Improvement Committee will monitor and assess QI efforts and activities across the agency to improve the quality of care and services for our customers. Committee members will represent all program areas and will serve a two-year term, which may be extended or shortened based on agency need.

Responsibilities for the QI Committee include, but are not limited to the following:

- Monitor and assess QI activities
- Ensure QI efforts align with strategic goals and priorities
- Monitor compliance with regulatory and accrediting body standards relating to quality improvement activities and initiatives
- Review KPIs and recommend revisions as appropriate
- Review KPIs to identify key quality improvement initiatives and ensure implementation
- Promote an interdisciplinary and interdepartmental approach to QI
- Drives action when opportunities for improvement are identified
- Recognize and communicate achievements
- Review practicum projects of Quality Academy members

PHAB Accreditation Sub-Committee

The PHAB Accreditation sub-committee will oversee QI efforts and activities for PHAB accredited programs, assure compliance with Public Health Accreditation Board (PHAB) standards and measures, and support the work of department improvement projects. Sub-committee members will represent all PHAB accredited program areas and will serve a two-year term, which may be extended or shortened based on agency need.

VII. Quality Improvement Principles

Customer Focus

The customer is at the center of our work, and they drive our activities. The implementation of our quality improvement efforts must use customer feedback to assure we are addressing and meeting internal and external customer needs. Reducing waste and inefficiencies benefits internal customers by making their daily work simpler and easier, which in turn benefits external customers by allowing more time and resources to be focused on them. Customer experience survey data must be collected, analyzed and acted upon on a regular basis.

Employee Engagement

All levels of staff must be engaged in providing quality care and service to produce effective and efficient operations. The people closest to the work know the process best and can provide valuable insight into how the process functions and to potential improvements. Engaged employees feel supported and empowered to make suggestions and to improve daily work.

Leadership Involvement

Strong leadership, direction and support of quality improvement activities by the LCHD/CHC executive team and governing bodies are key to reaching the department's strategic and operational goals. Leaders encourage and promote the use of rapid cycle improvement as a means of learning what works and what does not. Failure is a natural part of the learning process and should be expected at times and should not be a deterrent to testing new ideas.

Data Driven Decisions

Data is the backbone of sound decision-making. Successful improvement activities require valid data and subsequent analysis to drive quality improvement activities and maximize the resources available to accomplish program and department goals.

Application of Quality Improvement (QI) Tools

For continuous improvement efforts to be successful and sustainable, tools are available to foster knowledge and understanding of potential problems and improvement opportunities. A wide range of tools and resources are available on The Quality Toolbox, which is an LCHD/CHC employee SharePoint site. Common tools include run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts.

Culture of Continuous Improvement

A culture of quality requires that staff feel empowered and continuously look for ways to do their job better through eliminating waste, improving process flows, and organizing staff activities to reach program and department goals and outcomes.

Critical Thinking

Critical thinking and problem-solving skills across all levels of the organization are essential for improvement. We must fully understand the situation, focus on the root cause of problems, try out potential solutions, and sustain the gains. Staff are expected to foster a learning environment with open communication and are receptive to trying new ideas, taking small risks, and accepting that failure is a

part of the learning process. Staff are expected and encouraged to share problems and potential solutions with their supervisor, so improvements can be implemented.

VIII. Roles and Responsibilities

Staff at all levels in the agency are responsible for providing high quality customer-focused care and service. The QMS guides our ability to improve the work we are already doing. The key activities of the QMS require a coordinated approach with defined roles and responsibilities of all staff to work together to advance the culture of quality. The following represents the roles and responsibilities of the various staff levels to reach that goal:

The Executive Team

The executive team establishes the Health Department's commitment to quality, reviews the effectiveness of the QMS, and ensures that adequate resources are committed to reach department goals. The team will demonstrate leadership support for building our culture of quality through fostering an optimistic environment where failure is part of the learning process that leads to improvement. The team is responsible for assuring implementation of the the QMS and reviewing quality indicators across programs.

Senior Leaders

Senior leaders are expected to understand quality and quality improvement (definition, purpose, basic concepts). The primary role of this group of leaders is to support the adoption of a culture of quality. Their responsibilities include assessing and addressing QI training needs; referral of potential improvement activities to the Quality Program; encouraging managers/supervisors to integrate QI into their daily work; and recognizing those who contribute to quality, efficiencies and improvement in programs. Associate and Deputy Directors are responsible for using key indicators to manage the work of the programs they oversee. Identified opportunities for improvement should be acted upon or referred to Program Leaders or another appropriate group or committee.

Program Leaders

Program leaders are expected to understand quality and quality improvement (definition, purpose, basic concepts). Their responsibilities include addressing QI training needs; referring any potential program QI opportunities to staff; encouraging staff to use QI tools and integrate QI into their daily work; and recognizing those who contribute to quality, efficiencies, and improvement. This group uses key indicators to make data driven decisions. They are expected to identify and actively seek opportunities for improvement based on key indicators and other relevant data to improve program outcomes (See Appendix D).

All Staff

All employees are expected to continually look for ways to do their work better, share those ideas with their colleagues and supervisors, and to contribute and adapt to positive change. Employees are expected to participate in quality improvement efforts as assigned.

IX. Staffing and Administration Support

The continuous quality improvement analyst position is tasked with implementing organization-wide attempts to ensure that quality improvement (QI) efforts are developed and managed using a data driven focus that sets priorities for improvements aligned with strategic priorities. This role maintains responsibility for the QMS, planning and executing quality improvement efforts, and measuring intervention metrics.

X. Budget and Resource Allocation

Given available funds, LCHD/CHC receives an annual quality payment from the HRSA. The supplemental funding is added to LCHD/CHC's overall Section 330 grant award and is based on performance with the previous year's Clinical Performance Indicators as recorded on the annual UDS report. Per the Notice of Award, funds should be used to "continue to strengthen quality improvement activities, including achieving new and/or maintaining existing patient centered medical home recognition." LCHD/CHC is required to report on activities completed with these funds as part of its annual Budget Period Renewal (BPR). Historically, the annual amount has been between $35k-$105k depending on performance and amount of available funds at a federal level.

XI. Quality Improvement Training/Staff Development

LCHD/CHC is committed to implementing QI methods and tools throughout the agency to improve organizational performance, efficiency and effectiveness of processes, programs, and services. The purpose of quality training is to ensure that employees have the knowledge, skills, and abilities to integrate QI theories and tools into their daily work. Employees should feel supported and empowered to make suggestions and improve daily work. This training curriculum will be the foundation that moves LCHD/CHC towards cultivating a culture of quality and implementing the QMS across the agency.

<u>New Employee Orientation</u>

During the new employee orientation process, all newly hired LCHD staff will attend an in-person presentation to introduce them to what quality means to the agency, their role, and our customers.

<u>SnapComms</u>

SnapComms are interactive screensavers that are used to communicate information to employees. Twice a month the Quality team publishes a SnapComm highlighting a key component of the QMS. This enables passive exposure to quality concepts to all LCHD/CHC employees.

<u>Foundations of Quality 101</u>

One agency-wide course will be required of all staff. The course consists of key quality terms, quality improvement theory and methodology, and staff roles and responsibilities. Courses will be assigned through BOSS and completed in Online Learning Management.

<u>Quality Academy</u>

The purpose of the Quality Academy is to provide in-depth quality training to agency leaders and disseminate a culture of quality throughout the organization. The Quality Academy includes core quality

courses from the Institute for Healthcare Improvement (IHI) Open School. The Open School is a comprehensive quality curriculum with courses in quality, safety, leadership, the Triple Aim, and patient-centered care. Courses consist of mixed media to engage multiple learning styles, and include introductory and intermediate courses, as well as a project-based learning module. Participants will attend monthly meetings and complete a practicum. Those serving on the Quality Academy will be expected to mentor other LCHD/CHC staff in leading quality improvement initiatives during and after their appointment.

XII. Program-level Quality Improvement Goals, Objectives, and Measures

The process to identify agency and program-level goals and objectives as part of the agency's QMS is ongoing throughout the year. Key quality indicators are documented and visualized through dashboards that are available for all staff to view. These indicators are used to assess program performance and initiate quality improvement efforts when indicated.

Key quality indicators align to the strategic plan, community health improvement plan, and other recognized performance standards, such as the Public Health Accreditation Board and Joint Commission standards and measures. Each program has indicators that are specific to the functions of that program. Key quality indicators for all FQHC sites consist of the HRSA UDS Clinical Quality of Care and Health Outcomes and Disparities Indicators. The indicators are accessible electronically on the Quality Toolbox SharePoint site. http://sphd.lakeco.org/QMS/SitePages/KPI%20Dashboards.aspx

XIII. Collection, Visualization and Continuous Monitoring of Data

The organization collects and monitors data on an ongoing basis. Quality indicators include operational, customer experience and clinical and non-clinical outcome measures. Decision making will be based upon collected data. Program leaders are responsible for monitoring data for their program or health center site, reporting this data out to staff, and initiating improvement efforts when indicated. Non-clinical program leaders are responsible for collecting and reporting their program's quality data, populating their KPI dashboards each month, monitoring program data, sharing data with staff, and initiating improvement efforts when indicated. Quality indicators are monitored monthly or quarterly depending on the reporting period of the data for the indicator.

The purpose of measurement and assessment of quality indicators is to:

- Assess performance to determine whether there is a failure to execute at an expected level
- Identify problems and opportunities to improve program outcomes
- Assess the outcome of the service provided
- Evaluate whether a new or improved process meets performance expectations
- Recognize areas of high performance and celebrate strengths

When program quality indicators reflect that they are not progressing towards their desired targets, managers will use the Model for Improvement (see figure 1), which includes the Plan, Do, Study Act (PDSA) methodology, as the primary tool for quality improvement activities. The criteria for when programs will initiate quality improvement activities is based on their indicator measurement periods. At a minimum, when indicators fail to reach their targets for two consecutive measurement periods, then quality improvement efforts will be initiated.

XIV. Initiation of Quality Improvement Efforts

Information from data analysis will be used to make changes that improve performance and customer satisfaction. All staff are responsible for looking for and sharing improvement opportunities. Program leaders are ultimately responsible for initiating quality improvement efforts based upon available data in coordination with their staff and submit their plan to their direct supervisor for review.

When an opportunity for improvement is identified, the following steps should occur:

- Form a team that is representative of all staff integral to the service/issue to be improved.
- Identify the team leader or sponsor.
- Allocate time and resources to the team.
- Designate team member's responsibilities.
- Develop a timeline for reporting findings and improvement strategies.

Once the team is formed, the following steps should occur:

- Fully understand and clarify the problem using QI tools such as process mapping and root cause analysis.
- Recommend steps needed for improvement.
- Pilot test the process using iterative PDSA cycles.
- Standardize the new process once the aim is reached and there is confidence that the process will be successful on a larger scale.
- Spread the new processes throughout the department as appropriate.

The PDSA Guide (See Appendix A), Worksheet (See Appendix B) and Tracking Form (See Appendix C) can be used to help teams work through improvement efforts.

To effectively and efficiently utilize resources, the following shall be considered when prioritizing quality improvement efforts:

- Facilitates achievement of the strategic plan and the community health improvement plan
- Addresses concerns and expectations of customers and staff
- Financial factors
- Capacity and resource availability
- Expectations of funders and accreditation and regulatory agencies

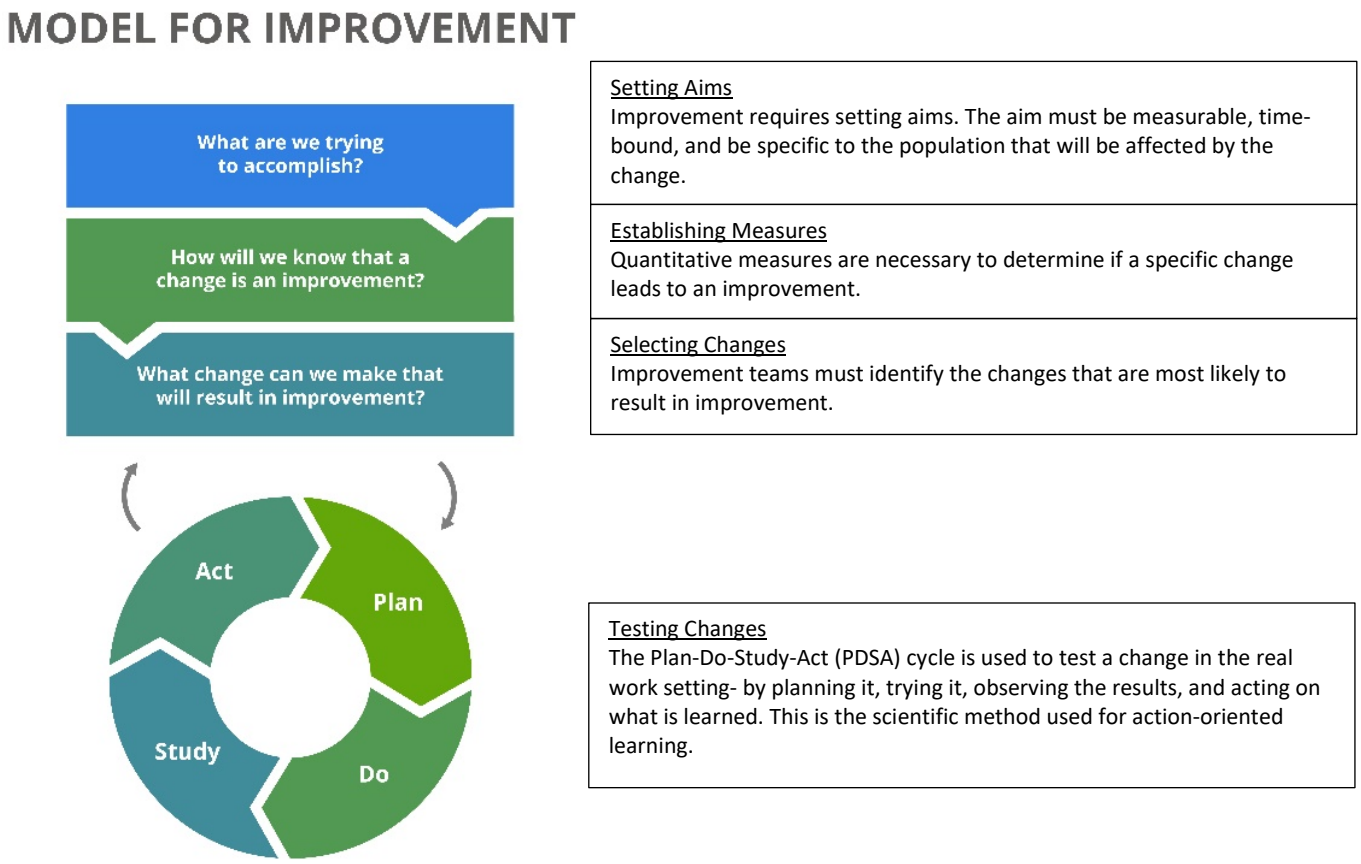

Figure 1: The Model for Improvement

XV. Customer Feedback, Results, and Actions Taken

Customer Experience Surveys

All programs and business units have customer-focused quality indicators that are measured using a survey tool. Programs and business units may use different survey tools and reporting to meet individual program needs. In general, surveys are implemented continuously, with results generally reported quarterly. Program leaders are responsible for reviewing customer experience data and initiating improvement efforts when customer experience indicators fall below target.

Client Grievances

The agency maintains a grievance policy to ensure that client grievances are resolved in a swift and professional manner. Verbal client grievances that cannot be resolved at the staff level and all written complaints will be addressed at the program level by the appropriate program leader. If the complaint cannot be resolved to the client's satisfaction at the program level, then it will be elevated to a grievance. LCHD/CHC employees shall follow the Complaints and Grievances policy.

XVI. Communication of Quality Management System Activities

The Quality Toolbox is an employee SharePoint site that is used to share key quality indicator dashboards, quality improvement tools and resources, and QMS materials. The Toolbox is also used to communicate quality improvement efforts across the agency. Key QMS activities, such as progress toward quality indicators and other meaningful improvements, are shared at key staff meetings and with our Governing Council and Board of Health as appropriate.

XVII. Monitoring & Evaluation of QI Plan

The overall effectiveness of the QMS will be evaluated annually by the QI Committee. In addition, the QI Committee will perform quarterly assessments of QI activities occurring throughout the agency. Progress toward established goals and objectives will be assessed through KPI dashboards, customer experience surveys, and strategic plan measures. Data from these reports will be used to ensure the effectiveness of the QMS. All quality related activities will be evaluated by the following means.

1. A review of the process and progress toward achieving goals and objectives
2. A summary of quality improvement projects and results, and lessons learned
3. Progress on quality KPIs
4. Effectiveness of the KPI system
5. Effectiveness of QI training curriculum

Plan Do Study Act (PDSA)

What is a PDSA?

PDSA, or Plan-Do-Study-Act, is an iterative, four-stage problem-solving model used for improving a process or carrying out change. Several tools are available to help you during the PDSA process. Click here to select the template(s) that work best for you.

Key Performance Indicators (KPI) are a great starting point to determine the most important areas to focus efforts. This may include KPIs that are farthest from the target, consistently below target, or aligned with the strategic plan.

When using the PDSA cycle, it's important to include internal and/or external customers, because they can provide feedback about what works and what doesn't. The customer defines quality, so it would make sense to also involve them in the process when appropriate or feasible, to increase acceptance of the end result.

In applying PDSA, ask yourself three questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

Stage 1: Plan

A. Getting Started
   a. Identify problem or opportunity for improvement
   b. Estimate and obtain needed resources
   c. Share your idea with your direct supervisor for feedback and support

B. Recruit a Team
   Assemble a team that has knowledge of the problem or opportunity for improvement. Involve staff most closely involved in the process. Consider the strengths each team member brings—look for engaged, forward-thinking staff.
   After recruiting team members, identify roles and responsibilities, set timelines, and establish a meeting schedule.

C. Draft an Aim Statement
   Describe what you want to accomplish in an aim statement. Make it SMART- specific, measurable, attainable, relevant and time bound! Refer back to these three fundamental questions:
   1.What are we trying to accomplish?
   2.How will we know that a change is an improvement?

3.What change can we make that will result in improvement?

D. Describe Current Context and Process

Examine your current process through brainstorming. Start by asking the team these basic questions:

- What are we doing now?
- How do we do it?
- What are the major steps in the process?
- Who is involved?
- What do they do?
- What is done well?
- What could be done better?

Map the current state, using a flowchart, to visually describe your process. Creating a process flow or at least depicting the current process can be very useful. If your team runs into road blocks, you might have found where the problem is occurring—or maybe the right person for identifying a missing step is not at the table.

Gather More Detail-

Once the general structure is completed, these can be some more helpful questions to ask:

- How long does the process currently take? Each step?
- Is there variation in the way the process is currently completed?

Add these details to the flowchart.

Collect, analyze, and display baseline data

Make a plan for data collection that will be carried out during the “Do” phase

E. Describe the Problem

Using the aim statement created in Step B, state your desired accomplishments, or future state, and use data and information to measure how your organization meets/does not meet those accomplishments.

For example: If your objective is to maximize your staff's quality of work life, you might find evidence by surveying employees on workplace stressors.

Map the future state process using a flowchart. Compare the current and future state process maps and determine how best to move from current to future state, during Step E.

Write a problem statement to clearly summarize your team's consensus on the problem. You may find it helpful to prioritize problems, if your team has identified more than one, and/or include a justification of why you chose your problem(s).

F. Identify Causes and Alternatives

Analyze Causes-

For the problem in your problem statement, work to identify causes of the problem using tools such as control charts, fishbones, and work flow process maps (e.g., flowcharts, swim lane maps). The end of the cause analysis should summarize the cause analysis by describing and justifying the root causes.

Examine your process, and ask:

Is this process efficient? What is the cost (including money, time, or other resources)?

Are we doing the right steps in the right way?

Does someone else do this same process in a different way?

Identify Potential Solutions-

Choose a solution (or a few alternatives) that you believe will best help you reach your objective and maximize your resources.

Make a prediction on what you think will happen when you test the chosen solution(s).

Develop an improvement theory by completing the statement,

"If we do _____, then _____ will happen."

Develop an action plan, including necessary staff/resources and a timeline.

Consider these factors:

- What will be tested? How? When? By Whom?
- Who needs to know about the test?

Try to account for risks you might face as you implement your action plan.

Stage 2: Do

Test the theory.

Begin implementing your action plan.

Carry out the test on a small scale.

Be sure to collect data as you go, to help you evaluate your plan in Stage 3: Study.

Your team might find it helpful to use a check sheet, flowchart, swim lane map, or run chart to capture data/occurrences as they happen or over time.

Your team should also document problems, unexpected effects, unintended side effects, and general observations.

Stage 3: Study

Using the aim statement drafted in Stage 1: Plan, and data gathered during Stage 2: Do, determine:

- Compare baseline data with measures of success written into the aim statement.
- Did your plan result in an improvement? By how much/little?

- Did the results match the theory/prediction?
- Was the action worth the investment?
- Do you see trends?
- Were there unintended side effects?
- Do you need to test the theory under other conditions?
- Describe and report what you learned from the test cycle.

You can use a number of different tools to visually review and evaluate an improvement, like a Pareto chart, control chart, or run chart.

Stage 4: Act

Reflect on Plan and Outcomes

- If the test was successful on a small scale, test it again on a broader scale.
- If your team determined the plan resulted in success, standardize the improvement and begin to use it regularly. After some time, return to Stage 1: Plan and re-examine the process to learn where it can be further improved.
- If your team believes a different approach would be more successful, return to Stage 1: Plan, and develop a new and different plan that might result in success.
- Continue to test changes using the PDSA cycle until you reach your aim statement.

The PDSA cycle is ongoing, and programs will become more efficient as they intuitively adopt PDSA into their planning. PDSAs are used for learning and making rapid improvements.

Celebrate Improvements and Lessons Learned

- Communicate your successes when you reach your aim statement
- Take steps to preserve your gains and sustain your accomplishments

Make long-term plans for additional improvements

Plan Do Study Act (PDSA) Worksheet

PLAN

1) What is your objective for this cycle? *(Must be measurable, time-bound, and specific to the population or the system that will be affected by the change).*

2) What do you think will happen when the test is done? *If I do____, then ____ will happen.*

3) Plan your test cycle

   What, when, where, how will you test?

   Who will be affected by this test?

4) Plan for data collection

   When, where, how will data be collected?

   Who will collect the data?

DO Carry out the test.

1) Collect data- record when completed, observations, problems encountered, and special circumstances

STUDY Analyze and summarize data (quantitative and qualitative)

1) What went well?

2) What could be improved?

ACT Document what was learned and plan next cycle

1) Should you adapt, adopt, or abandon the change?

2) What adaptations, if any, are needed?

3) Are you confident that you should expand the size/scope of test

PDSA Cycle Tracking Form *(use with PDSA Worksheet)*

Name of Person Testing the Change: _____

Change Tested: _____

Cycle #	**PLAN** What did you test? How did you test it? Who and how many did you test it with?	**DO** Date Tested	**STUDY** What did you learn? What worked well? What could be improved?	**ACT** How will you adapt the change for the next test?
1				
2				
3				
4				