

Improvement Academy



Institute for Healthcare Quality,
Safety and Efficiency

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Emily Gottenborg, MD
Laura Rosenthal, DNP

Agenda

- 1 Team Introductions
 - 2 Introduction to QI: Why?
 - 3 The 5 Steps of QI
-
- LUNCH
- 4 The Business Case
 - 5 Creating your Action Plan



Introductions

Who are you?

Why are you here?

What improvement project are you working on?

What do you do to relieve stress?



Why are we here?



765 – 50 – 4

QI = Quality Improvement

Systematic and ***continuous*** actions that lead to ***measurable*** improvement in health care services and the health status of targeted patient groups.



Value

QI = ~~Quality~~ Improvement

Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.



$$\text{VALUE} = \frac{\text{Quality} + \text{Safety} + \text{Experience}}{\text{Cost}}$$

The diagram illustrates the concept of Value as a ratio. The numerator consists of three components: Quality (represented by a thumbs-up icon), Safety (represented by an icon of two people), and Experience (represented by a smiling face icon). These three components are summed together. The denominator is Cost, represented by a price tag icon with a dollar sign. A horizontal line separates the numerator from the denominator.

Model of Quality Improvement

DMAIC

Define, Measure, Analyze, Improve, Control



6σ

Six Sigma

“six” standard deviations from mean
(error rate of one per 3.4 per million)

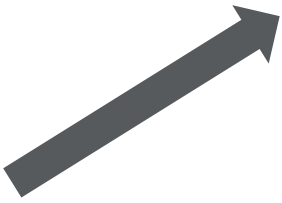
DMAIC

Define, Measure, Analyze, Improve, Control





Sense a problem



No improvement

DMAIC (*də-MAY-ick*)

Define, Measure, Analyze, Improve, Control



Sense a problem



D – M – A – I – C



Sustained improvement



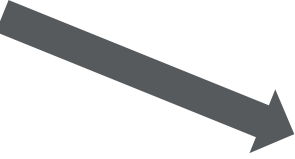
Part 1: Defining the Problem



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No improvement

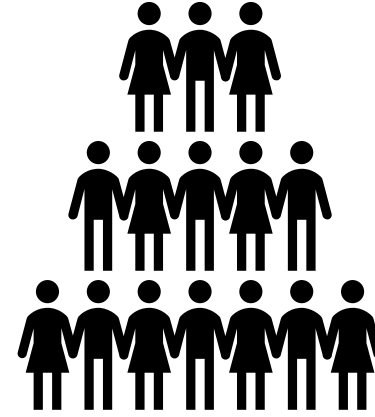
Define: So WHAT?



Sense a problem



Describe
in detail



Understand
stakeholders – Voice
of Customer



Define
Scope



Tool 1: The Problem Statement



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What is your Scope?

What are you fixing?



ER Triage Problem

Patients are not happy with their experience in the ED.

The ER Triage Problem

There have been several complaints regarding ER Triage

Data review shows excessive wait times at triage

ER patient satisfaction in the 25th percentile

Excessive 'Left Without Being Seen' is leading to loss of patients and patient safety concerns

Door to Doctor time was nearly 80 minutes

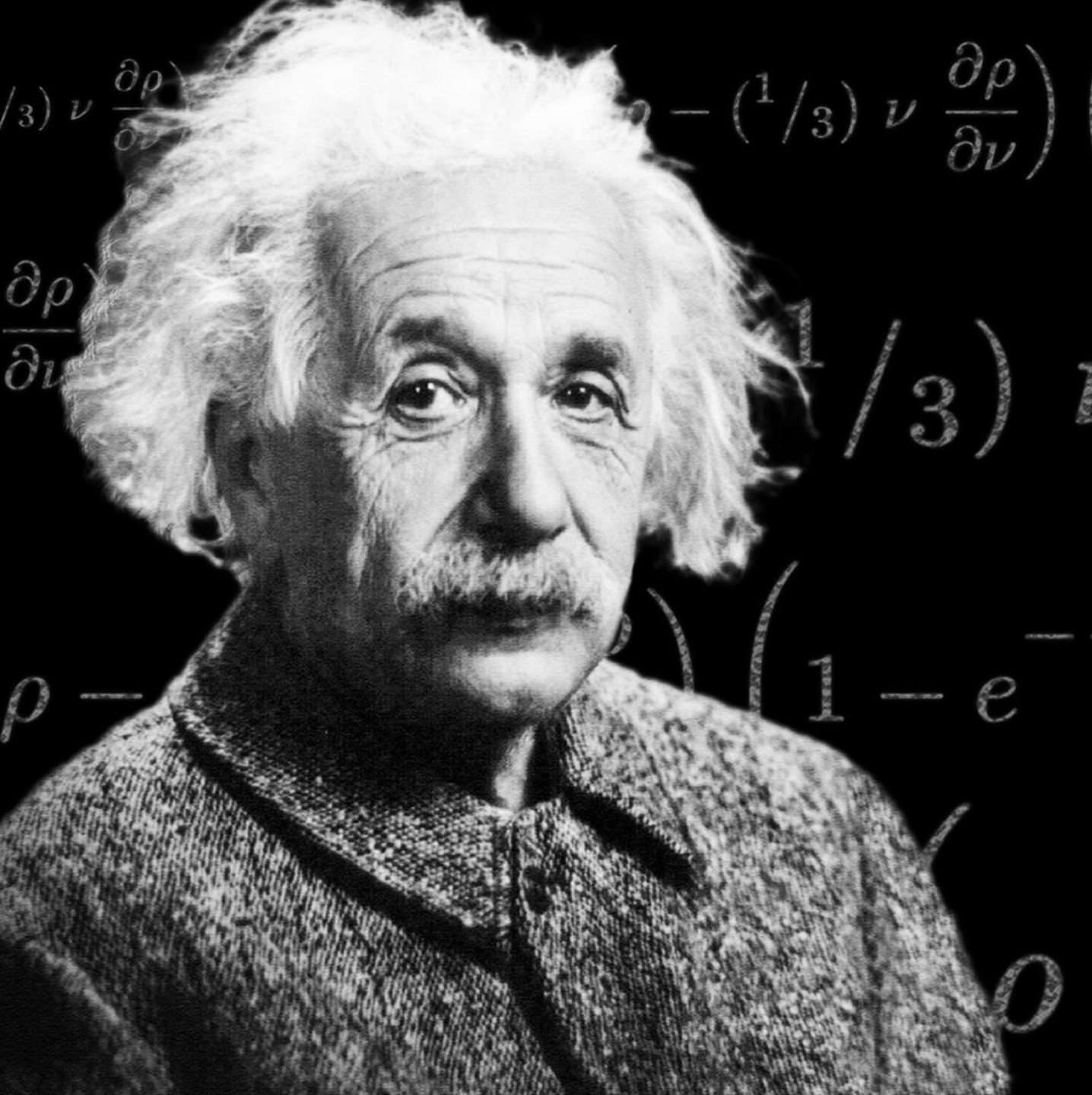
$$\text{VALUE} = \frac{\text{Quality} + \text{Safety} + \text{Experience}}{\text{Cost}}$$


Problem Statement

Our patients wait too long in the Emergency Room before they see a provider (an average of 80 minutes), as evidenced by recent complaints on HCAPHS surveys, poor satisfaction scores, excessive wait times and long Door to Doctor times, ultimately resulting in patients leaving the ER without being evaluated.







“If I had an hour to solve a problem, I'd spend 55 minutes thinking about the problem and five minutes thinking about solutions.”

Define the problem

How do you know it's a problem?

Who is affected?

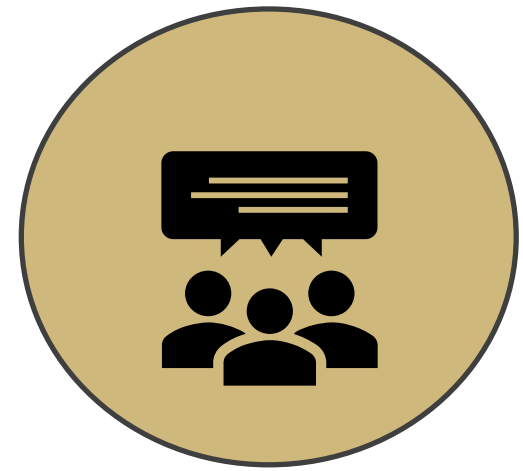


By how much?

Are there guidelines / best practices to refer to?



Breakout 1: Problem Statement Workshop



- Work with your team
- Discuss your problem (come back to Value equation if needed)
- Write down a problem statement
- Identify missing information
- Report Out

Return in 20 minutes



Tool 2: Voice of the Customers



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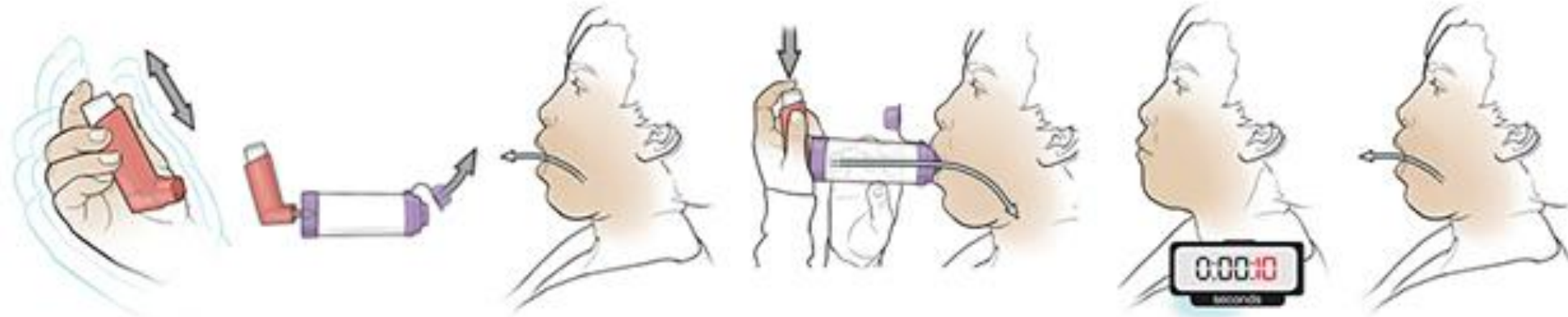
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A Story





Remove cap and shake inhaler.

Insert inhaler into spacer.

Breathe out all the way.

Press down on the inhaler. Slowly breathe in.

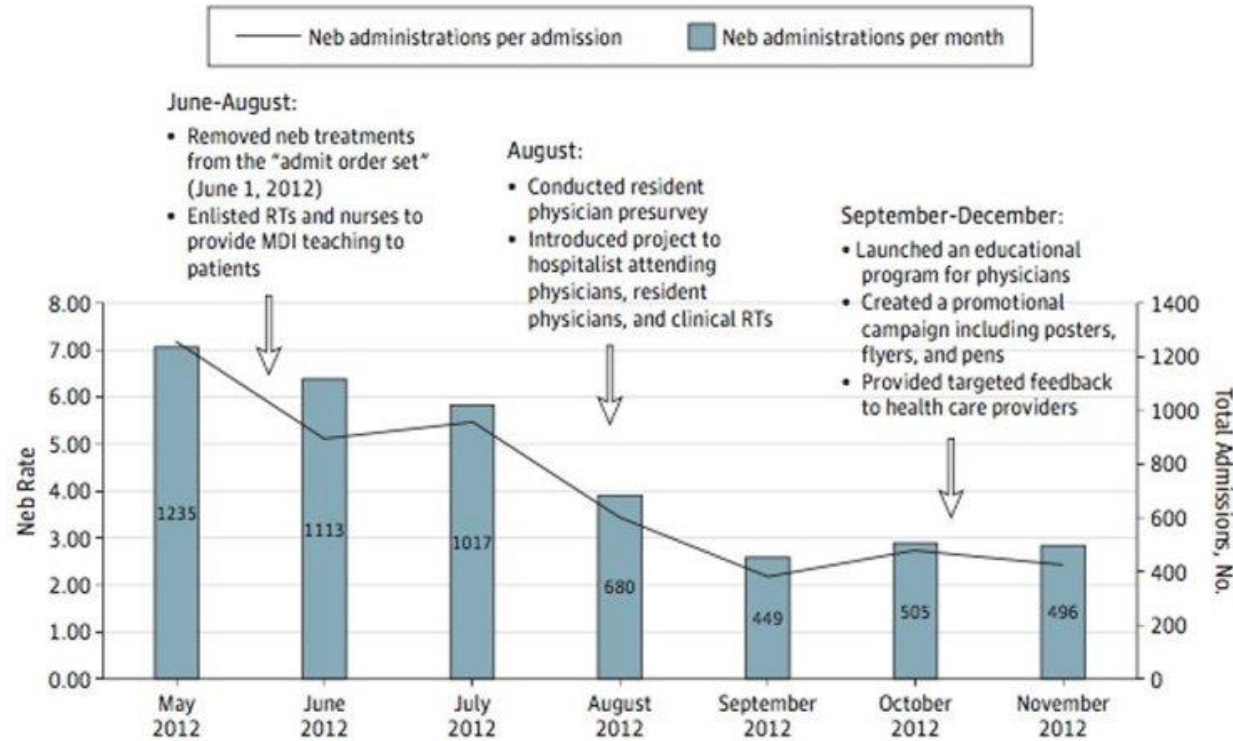
Hold your breath for a count of 10.

Slowly breathe out.

A Story



Figure. Multifaceted Intervention and Nebulizer Rates on a High-Acuity Medical Ward



Decreased labor cost

Fewer readmissions
- 20% of patients with COPD readmitted within 30 days

A Story



Who are your
customers?



Voice of the Patient

Who are the patients?

What are their needs?

What are their perceptions of current state process?

Voice of the Provider & Staff

Who are the
staff &
providers?

What are their
needs?

What are their
perceptions of
current state
process?

The ER Triage Problem

There have been several complaints regarding ER Triage
Data review shows excessive wait times at triage
ER patient satisfaction in the 25th percentile
Excessive 'Left Without Being Seen' is leading to loss of patients and patient safety concerns
Door to Doctor time was nearly 80 minutes

$$\text{VALUE} = \frac{\text{Quality} + \text{Safety} + \text{Experience}}{\text{Cost}}$$
The diagram illustrates the components of Value. It features a horizontal line with three plus signs above it, indicating addition. Above the line are three circular icons: a thumbs up (Quality), two people (Safety), and a smiling face (Experience). Below the line is one circular icon: a dollar sign with a slash (Cost). The word 'VALUE' is written to the left of the equals sign.

Patients, Providers & Nurses

I get **more worried** the longer I wait to see a doctor – the reason I came here is to see a doc.

I just wanted some **reassurance** that I was OK – after 2 hours of waiting, I assumed I was and left.

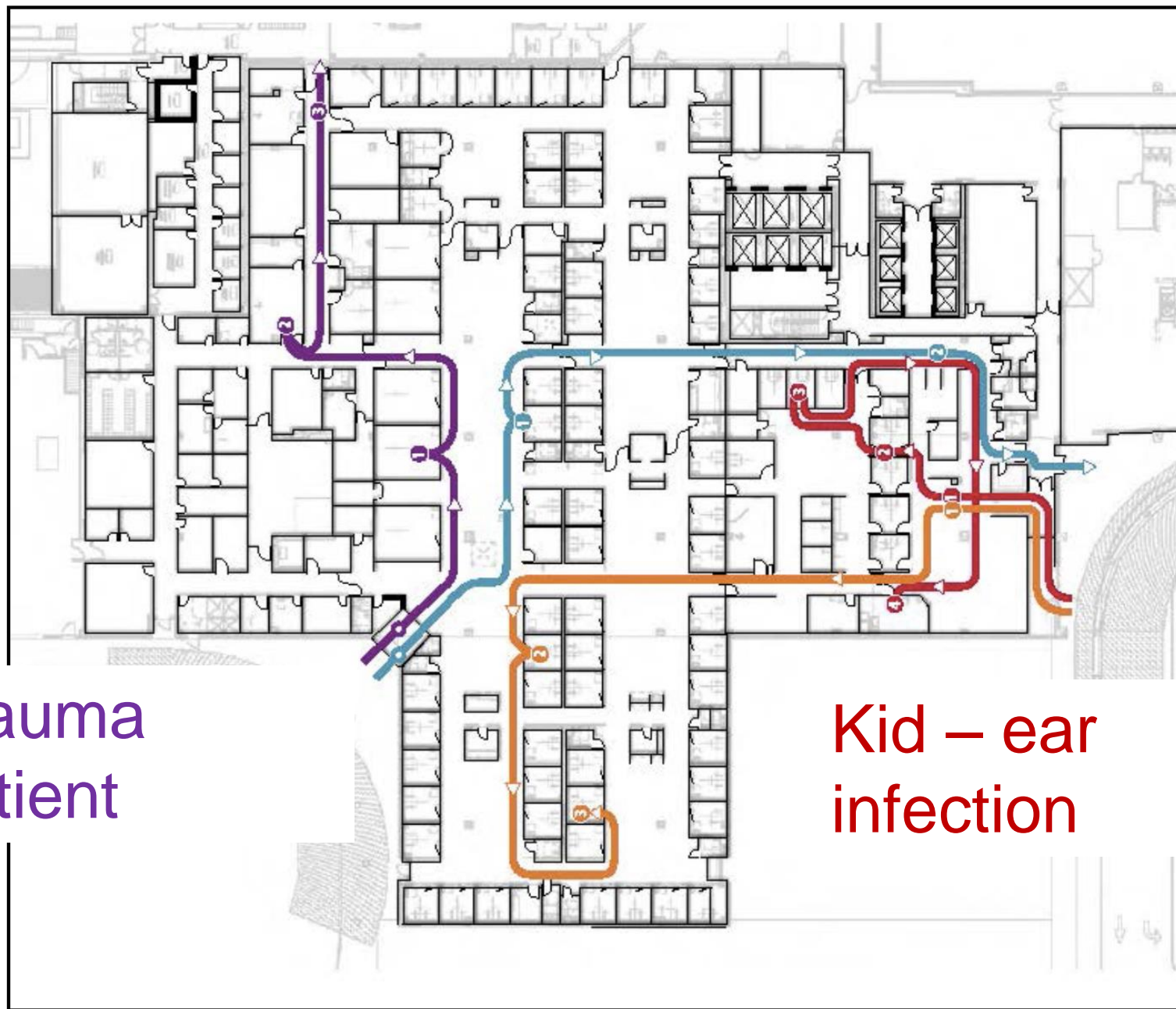
It is **so stressful** to know that patients are waiting - and may be having heart attacks, strokes, or other life-threatening illnesses!

It's hard to be **in pain**, and in a noisy, crowded waiting room until help arrives.

I could easily **triage** within 5 minutes how sick my patients are!



Redesign



Trauma
patient

Kid – ear
infection



The Outcome

Patients

Care for non-urgent patients under 30 minutes

Business

Door to provider time less than 7 minutes

Developed a supertrack team – RN, APP, techs

Providers



Breakout 2: Voice of the Customers



Identify your Customers (Patients, Providers, Staff, Business)

Discuss how to facilitate a VOC for your project

Document your plan

Report Out

15 minutes





Voice of the Business

Who
represents the
business?

What do they
care about?

What are the
financial
implications?

The Business – Hospital Leadership

Other hospitals are **marketing** shorter wait times!

If we require EMS to go on divert, we will **lose patients/customers.**

We get dinged for high rates of 'left without being seen'

We won't achieve **Level 1 Trauma** accreditation.



Business Case

How to Show Your Value
(and get what you need)



A Story

The oncology infusion center was struggling with poor patient experience scores related to the duration of their visits.

They wanted support in the form of a QI specialist to help address this problem.

How do they make the case for more support?



The Business Case

Why?



Gets you resources



Shows executives what you're going to do (in their language)



Triages *your* improvement work to the top of the list

How?

$$\text{VALUE} = \frac{\text{Quality} + \text{Safety} + \text{Experience}}{\text{Cost}}$$


Step 1: What are you planning to do?

Step 2: What is the benefit?

Step 3: How do I show the benefit?

Step 4: What data do I need?



A Story: Infusion Center

1 What are you trying to do? (process measure)

Reduce time from check-in to completed drug infusion by 72 minutes

2 What is the benefit? (outcome measure)

Patient's happier

Staff happier - less down time

Timely Access - open more chair time for other patients

More patients for same amount of staff



3 How will you convey benefit?

Number of patients per month: **107**

Current time needed per patient: **272** minutes

Goal time needed per patient: **200** minutes

Average Reimbursement for patient: **\$1585**

Baseline # of mins of patient care / month = **29,104 mins** (107 x 272 mins)



3 How will you convey benefit?

Goal # of mins of patient care / month = 21,400 minutes (107 x 200 mins)

Goal minutes saved / month = 7,704 minutes (29,104-21,400 mins)

Potential new encounters / month = 38 (7,704 mins saved/200 mins/pt)

Potential increase in reimbursement = \$60,230 (38 pts/mo x \$1585)

Potential increase in reimbursement per year = **\$722,760** (\$60,230/mo x 12)



4 What data points would you need?

- Baseline time from check in to completion
- Current time from check in to completion
- Goal time from check in to completion
- Baseline number of patients per month
- Contribution margin per case

Data
Collection Plan



A Personal Story

I want to go on vacation...



Eleuthera, Bahamas

1. What am I trying to do? Vacation

2. What is the benefit? Happier, More Productive Emily

3. How will I convey benefit?

- due to relief of burnout – ability to work extra moonlighting shifts (1k per month)
- due to increased productivity – take kids to soccer practice
- allows husband to have more productive workdays (4 hours / week, \$100/hour)
- $1k + (16 \text{ hours} \times \$100 / \text{hour}) \times 6 \text{ months} = \mathbf{\$15,600}$





Eleuthera < \$15,000

Next Steps

Dear Executive Stakeholder,

I plan to save you \$700k next year.

To do this, I will need 20% of support from a QI specialist, roughly \$20K.

Your ROI will be \$680k.

Thanks!



Future Action Item: Create a Business Case



Step 1: What are you trying to do?

Step 2: What is the benefit?

Step 3: How will you show this benefit?

Break-out to Discuss

Complete in Coaching Session



Part 2: Understanding your Problem



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DMAIC

Define, **Measure, Analyze**, Improve, Control



Sense a problem



D – M – A – I – C



Sustained improvement





37% of Physical
Therapy Consults Are
Inappropriate

10,000 hours of work
(wasted) per year



Measure 

現場

Gemba (the Actual Place, Walk)

WHAT is the
problem

Epic





Gemba 現場



Go See.
Ask Why?
Show Respect.



Why do we order PT?

Reason for PT?

???????

Comments:

 [Add Comments](#)

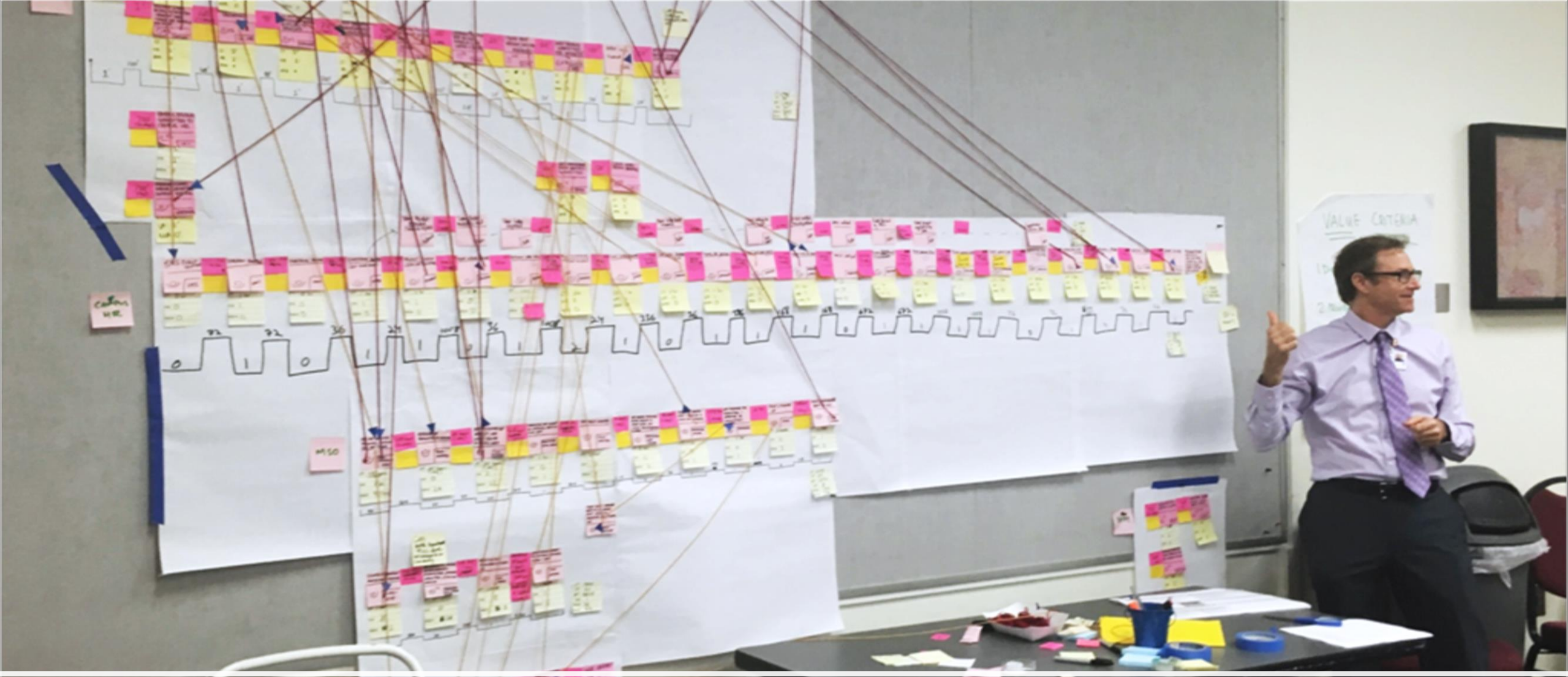
Tool 3: Process Map



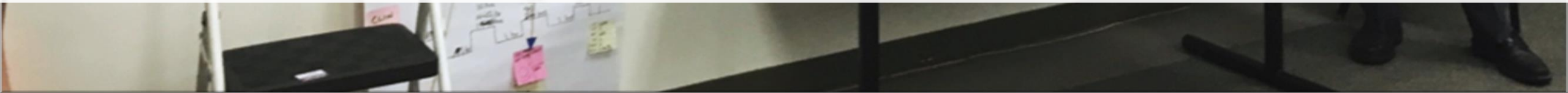
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Process Mapping: Making the Invisible, Visible

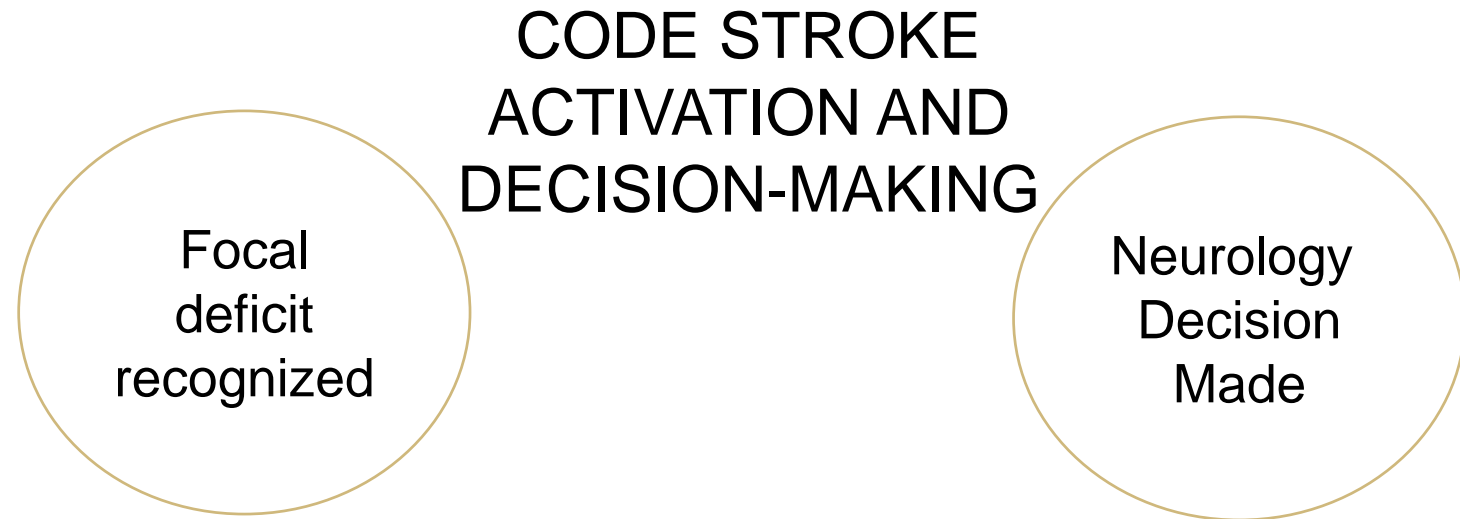


Code Stroke:
Satellite
COVID
Hospital



Step 1: Defining your Process

1. What is the name of this process?
2. What starts the process?
3. What ends the process?



Step 2:
Determine
your 'Entity'



HUMAN



INANIMATE
OBJECT



INFORMATION

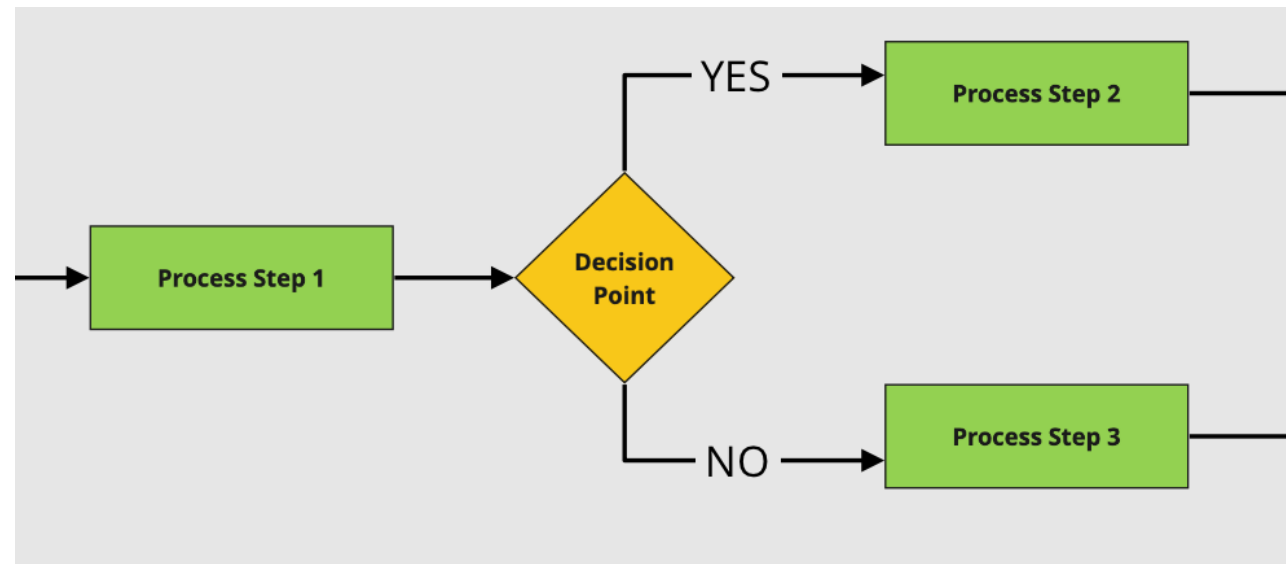
Step 3: Add Process Steps

- Steps, Tasks, Operations
- Verb / Noun
- Granularity may vary



Step 3: Include Decision Points

- A decision separates branches in the process flow map
- Label decisions as questions
- Each arrow is labeled as an answer to the question

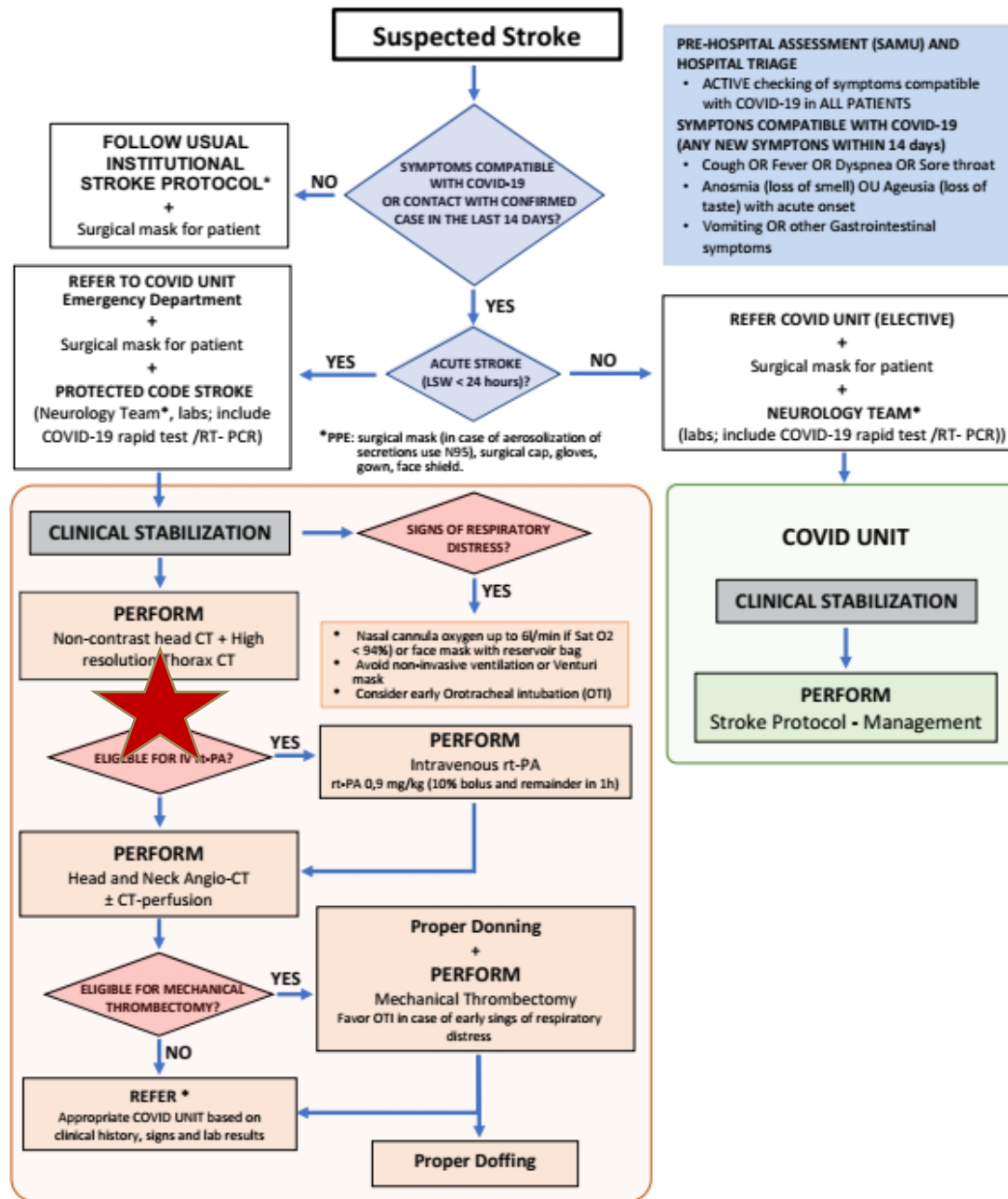


Step 4: Identify Pain Points

- Confusion, variability
- Opportunities for improvement
- Waste, Inefficiency
 - Defects
 - Waiting times
 - Extra Motion
 - Over Processing
 - Underutilized talent
 - Transportation
 - Over production
 - Excess Inventory



Process Map



Break-out 3: Process Map



Name the process you want to map, identify start / stop

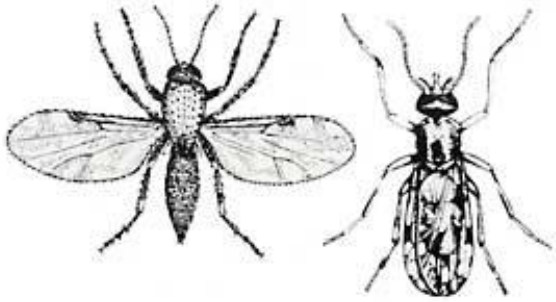
Name the entity you are following

Identify individuals you want engaged in this process – plan event

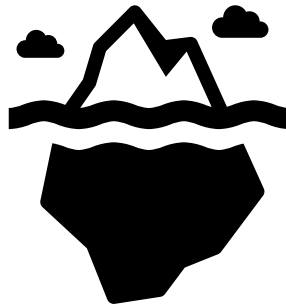
Begin to develop process map

10 minutes

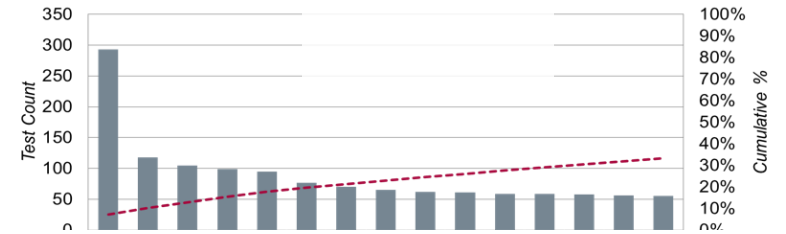
Analyze: WHY?



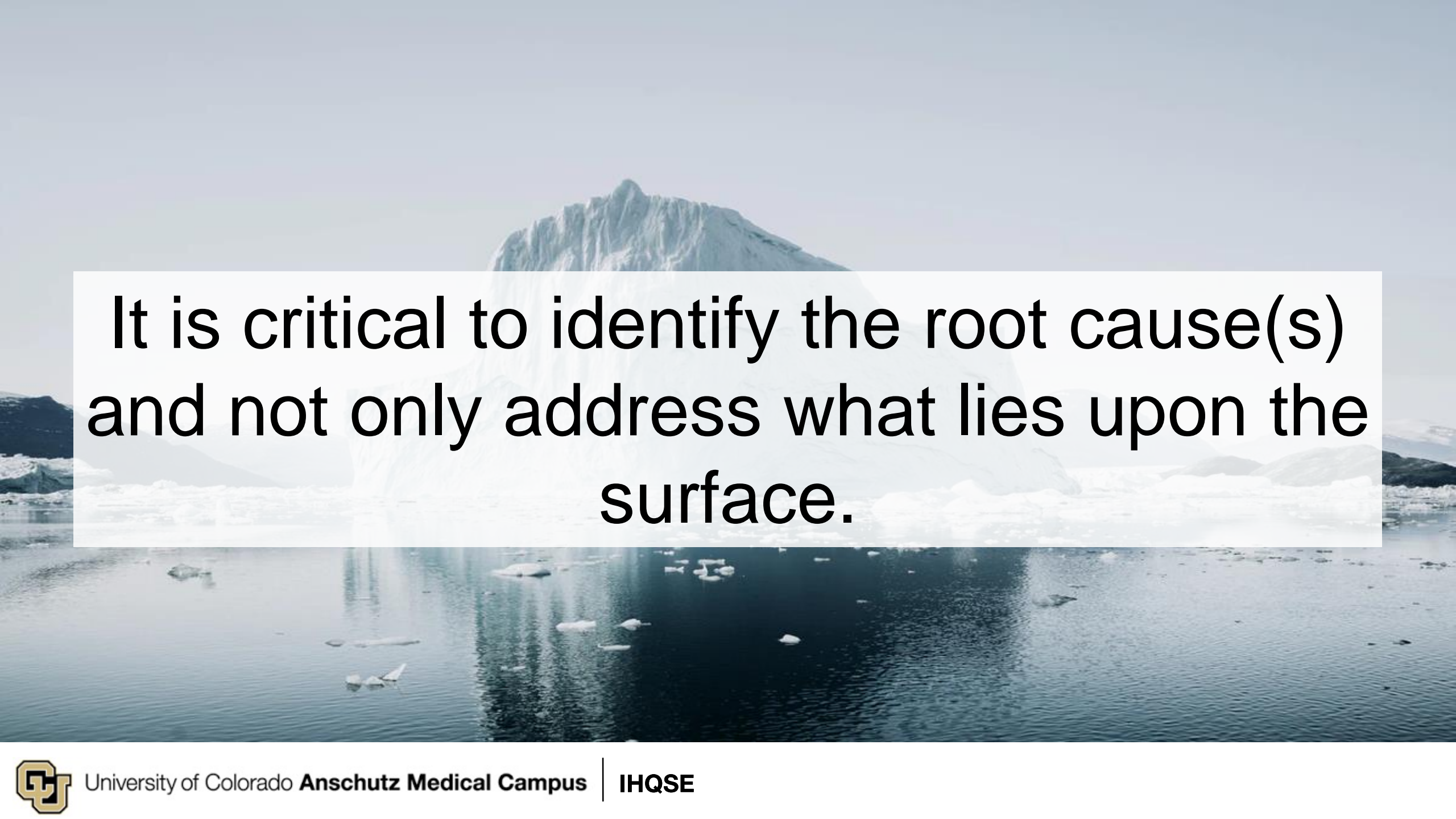
5-Why's



Root Cause Analysis
Affinity Diagram



Pareto Chart



It is critical to identify the root cause(s)
and not only address what lies upon the
surface.



Tool 4: Understanding Root Causes



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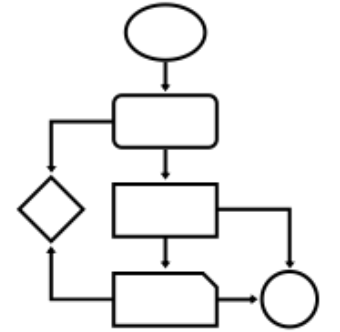


Voice of the customer



現場

Gemba (Walk)



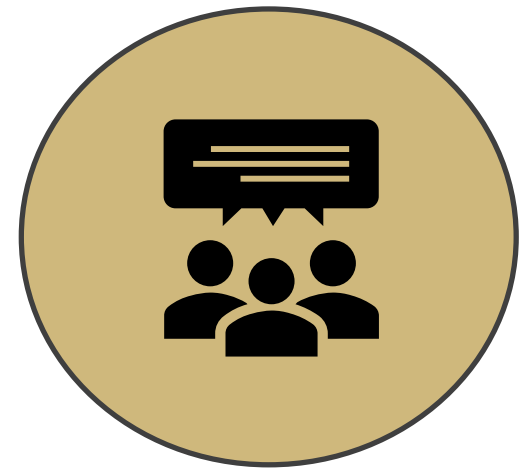
Process Map



Step 1: Brainstorm



Breakout 4: Contributing Factors



Consider WHY you have a problem

Brainstorm as many causes of this problem as possible.

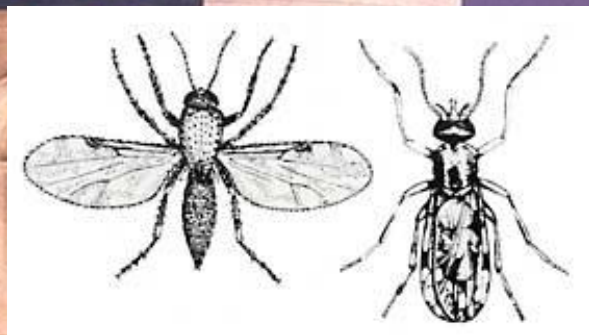
Put each on 1 sticky note.

Report Out

15 minutes



Five Why's



5 WHYs?

Why don't providers order PT appropriately?

They don't know what is appropriate

Why don't they know the indications?

It is part of the nursing assessment. Epic doesn't guide them.

Why don't we understand the nursing assessment?

It's a different language and training than providers use.

Why doesn't Epic guide them?

No list of indications.

Why don't nurses place the PT orders?

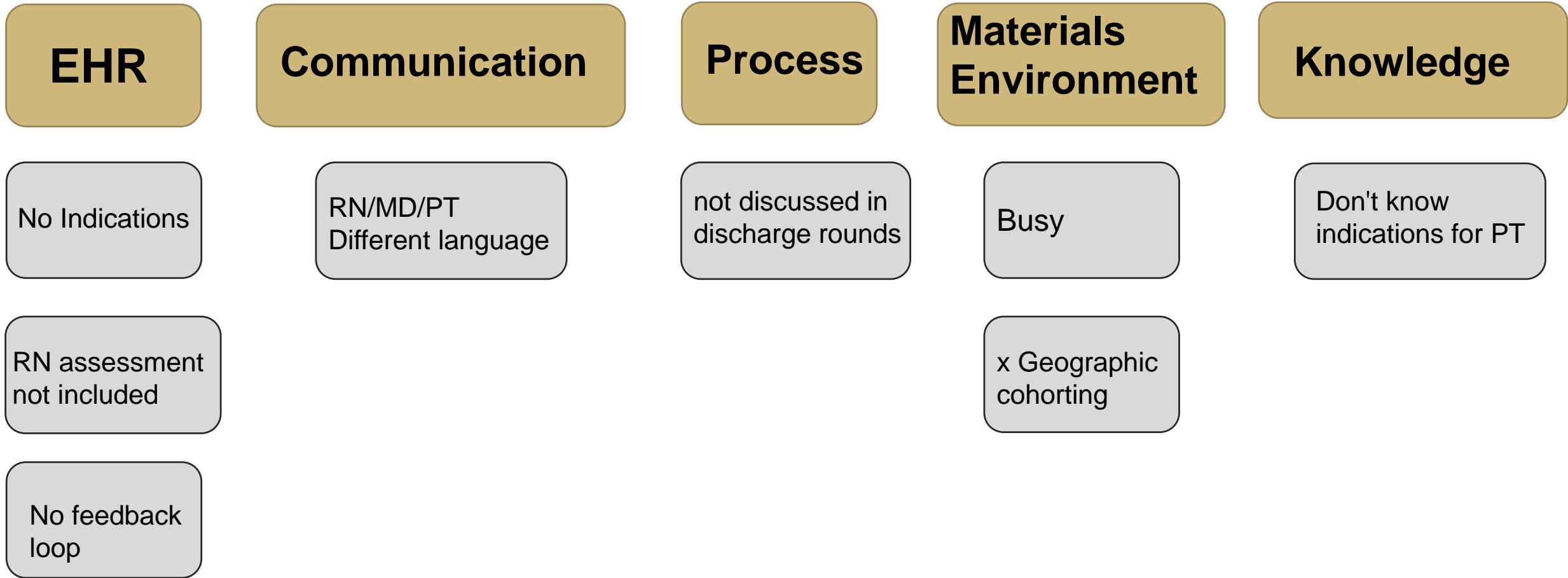


Step 2: Sort by Themes

Communication
Environment
Materials
Processes
EHR
Policies



Step 3: Create Affinity Diagram





Step 4: Vote on Importance

EHR

No Indications

RN assessment
not included

No feedback
loop

7

Communication

RN/MD/PT
Different language

6

Process

not discussed in
discharge rounds

2

Materials Environment

Busy

x Geographic
cohorting

1

Knowledge

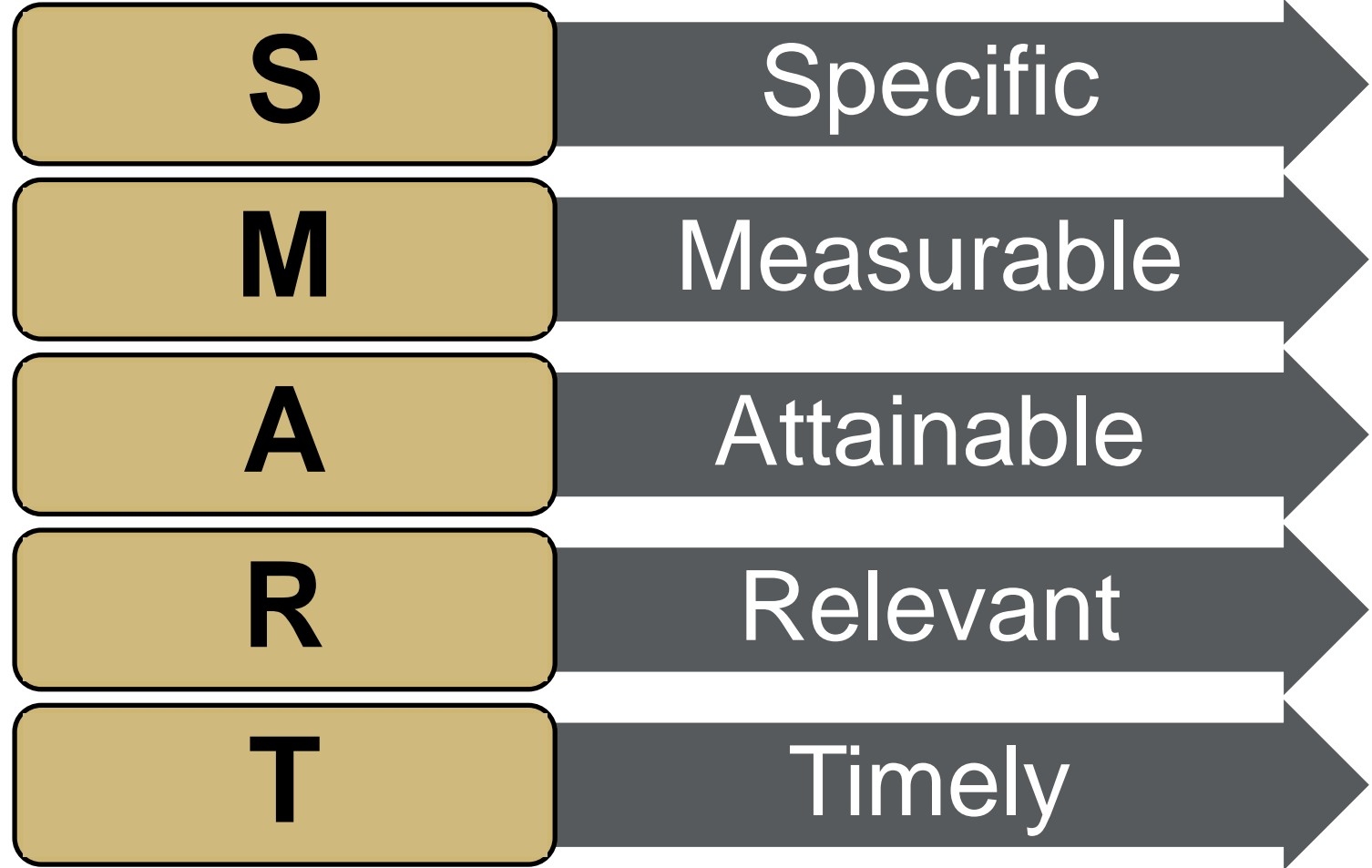
Don't know
indications for PT

2



Analyze

Aim statement



Matter to Patients

OUTCOME

- Patient Satisfaction
- LOS
- Readmission Rate
- Throughput
- Adverse Events

Can act as proxy for outcomes

PROCESS

- Use of checklists
- Patient Centered Rounds
- Lab orders

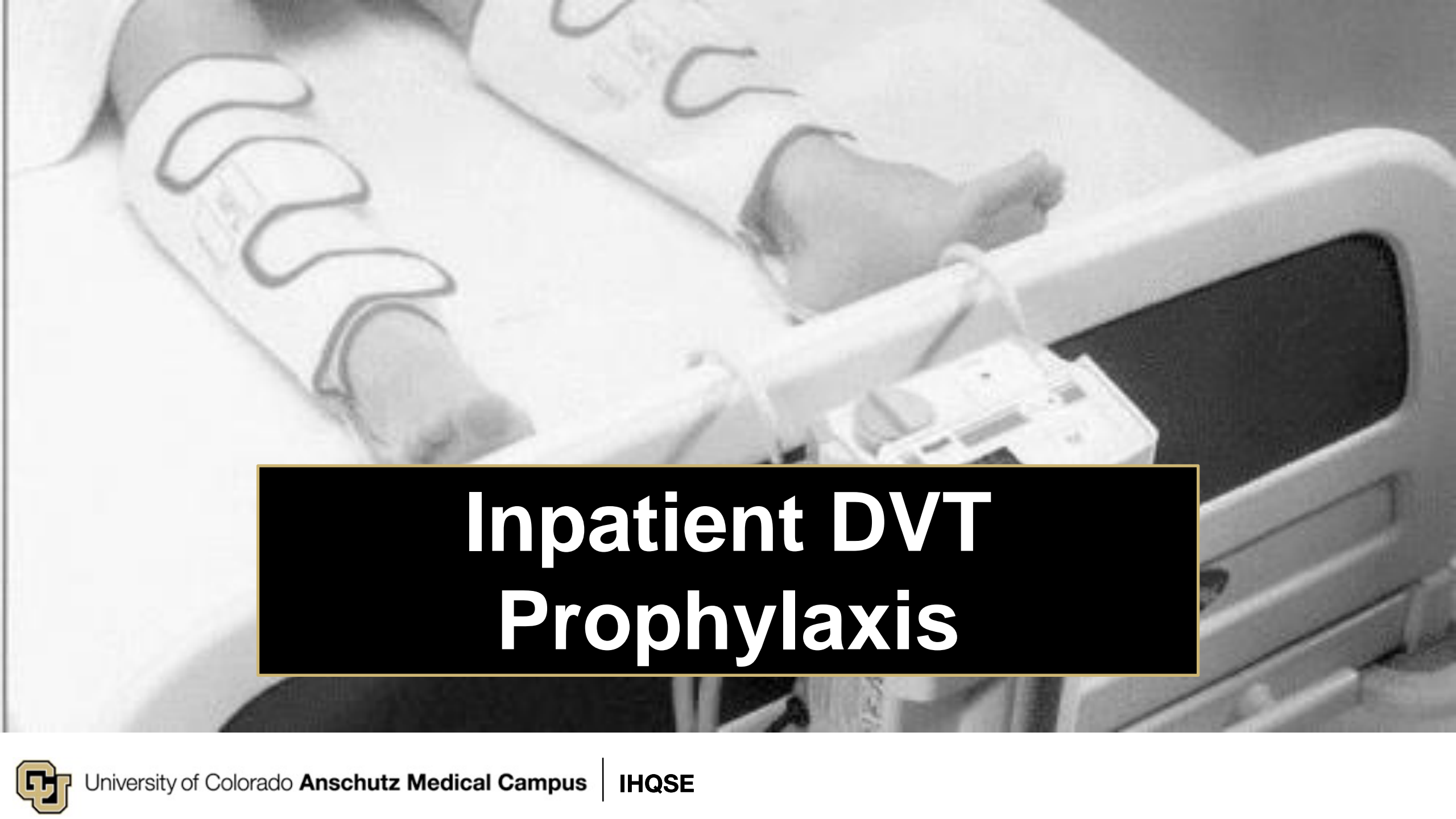
STRUCTURE

- Order Sets
- Regionalized
- Nurse:Patient ratio
- Discharge navigators

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A black and white photograph showing a patient's legs in a hospital bed. The patient is wearing white compression stockings with dark, wavy patterns. The legs are positioned on a white surface, likely a bed or gurney. A white medical device, possibly a scale or a piece of equipment, is visible in the foreground. The background is slightly blurred, showing the side of the hospital bed.

Inpatient DVT Prophylaxis



OUTCOME

DVT rates
PE rates
Mortality

PROCESS

Use of Rx
prophylaxis

Risk scoring

STRUCTURE

Anti-coagulants stock
RNs to administer

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BALANCE

Bleeding
Rate



OUTCOME

PROCESS

STRUCTURE

The thing you want to affect = PROJECT GOAL

10,000 hours of PT work (wasted) per year

The things you think contribute to the outcome
= AIM STATEMENT

Inappropriate orders (37% of consults)
+/- Order Set Creation

Focus on the process, not the results. Take one step at a time. You don't climb a mountain by simply looking at the top.



By the end of Measure & Analyze....

SMART AIM:

Our AIM is to reduce inappropriate consults to Physical Therapy for medicine inpatients from **37%** to **10%** by May, 2021.



A note on data...



“In God we trust. All others must bring data.”

- W. Edwards Deming



“The goal is to turn data into information, and information into insight.”

- Carly Fiorina, former executive, president, and chair of Hewlett-Packard Co.

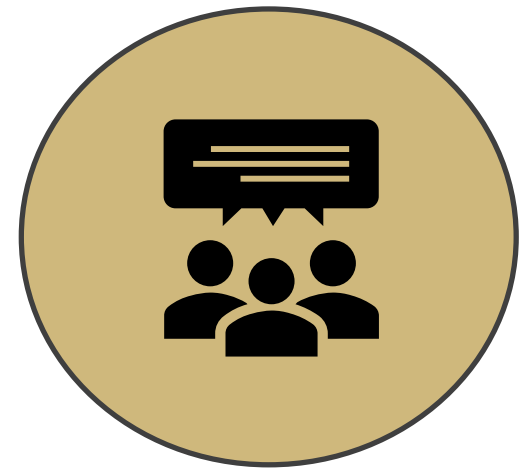


Data Collection Plan

Key Question	Data Element Name	Operational Definition	Parameters	Source	Who	Frequency
What is the length of stay?	Length of stay (LOS)	LOS = Admit time to Discharge time	<ul style="list-style-type: none"> • Date range: 1/1/2020 - 12/31/2020 • One listed for every patient by CSN • Format: time in hours 	EHR -- ADT	Which team member is in charge of collecting?	Monthly data pull, 1st of month



Breakout 5: Create an AIM Statement, Data Plan



Identify your process, outcome measures
Create or Refine a SMART AIM Statement
Data Collection Plan
Report Out

10 minutes



Part 3: Making Improvements



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DMAIC (*də-MAY-ick*)

Define, Measure, Analyze, Improve, Control



Sense a problem

D - M - A - I - C

Sustained improvement



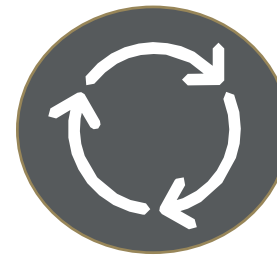
Define, Measure, Analyze, Improve, Control



Understand your
problem



Fix it



Sustain



1. Target the root causes

2. Design the right solutions

3. Choose the most impactful

4. Trouble Shoot



Tool: The Pareto Principle



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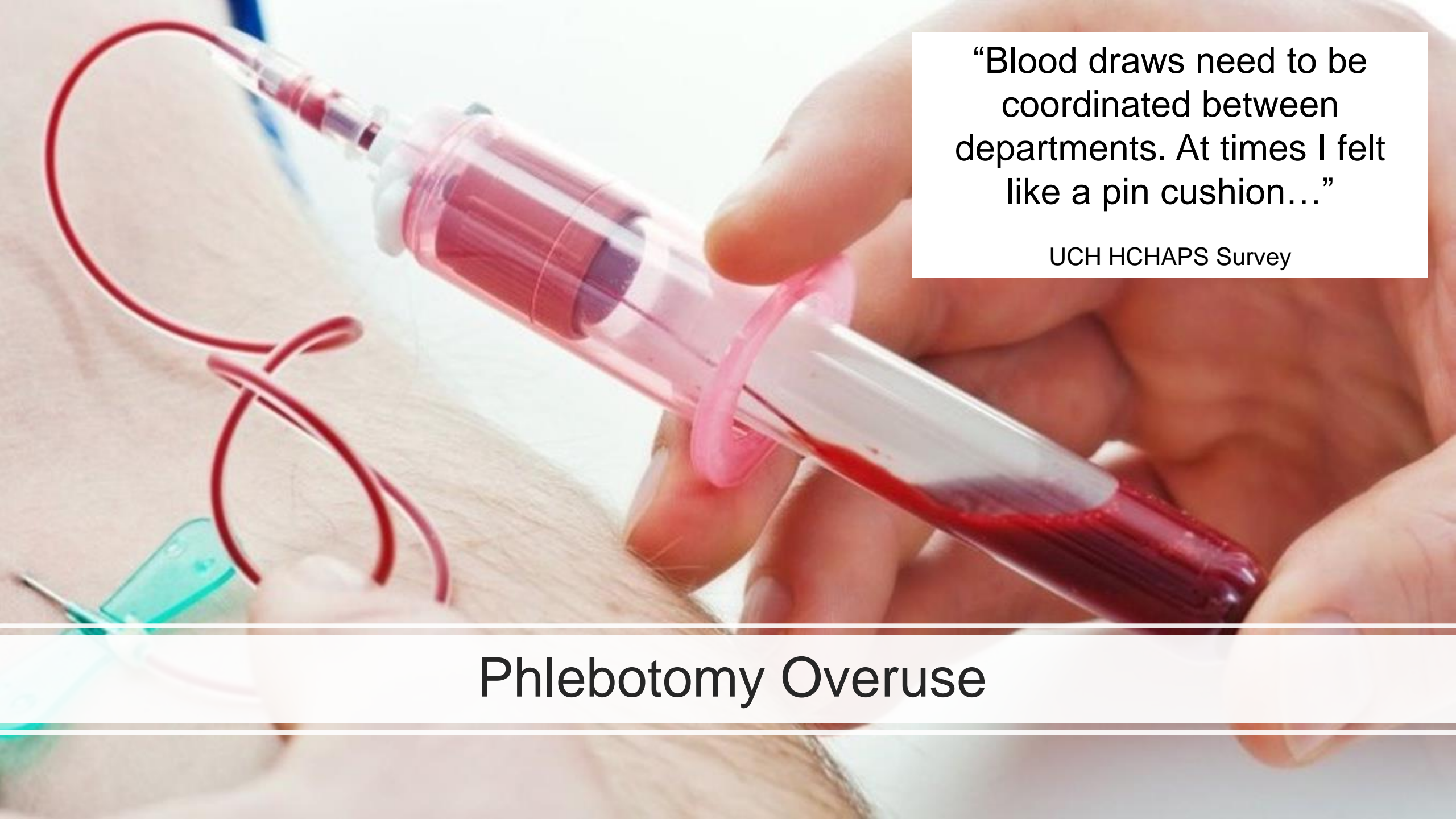
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80/20



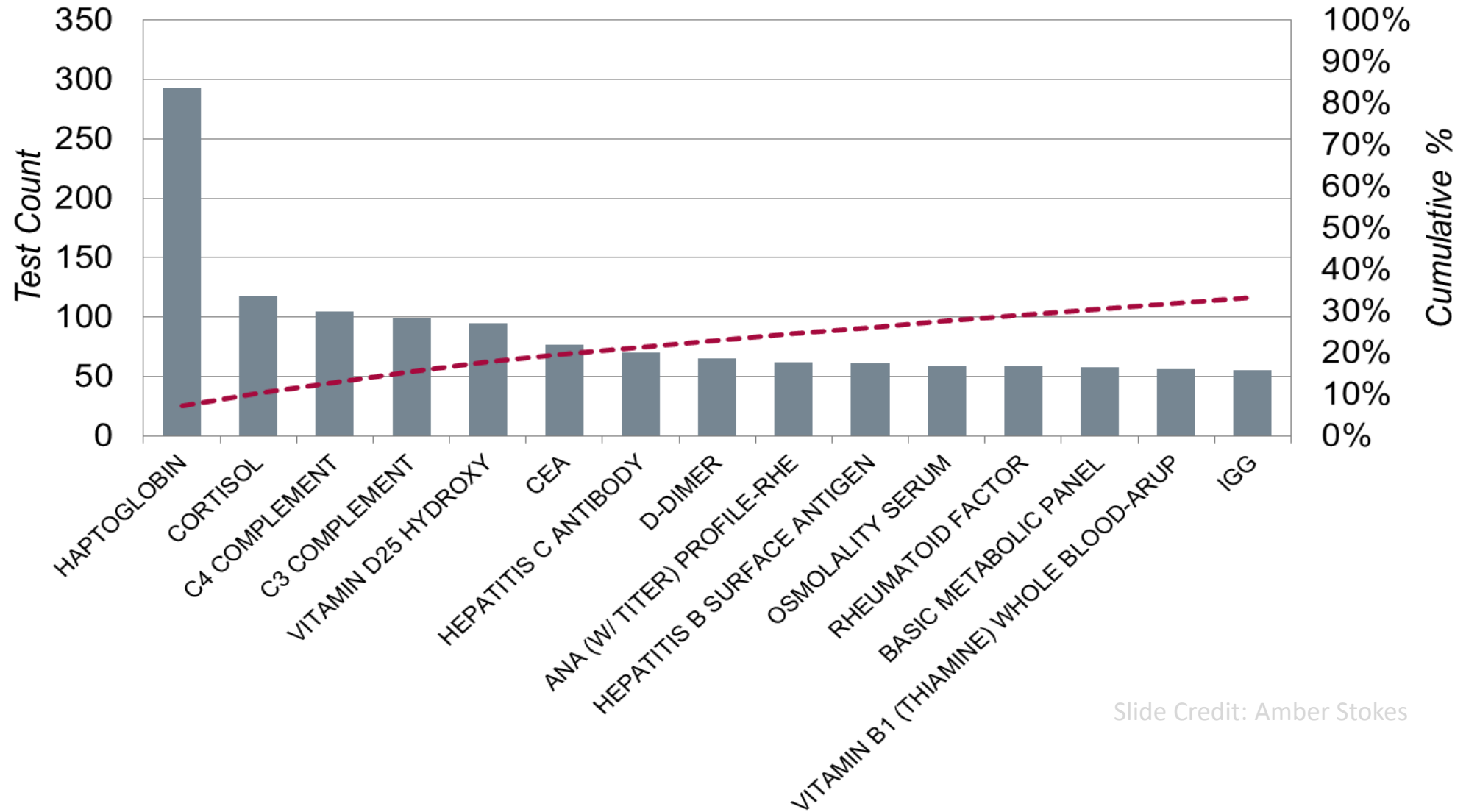


“Blood draws need to be coordinated between departments. At times I felt like a pin cushion...”

UCH HCHAPS Survey

Phlebotomy Overuse

Top 15 Add-On Failures: UCH Inpatient January – August 2017



Slide Credit: Amber Stokes



Using a Pareto Chart

List of Reasons for Problem
or areas where problems is
occurring



Gather data on these reasons

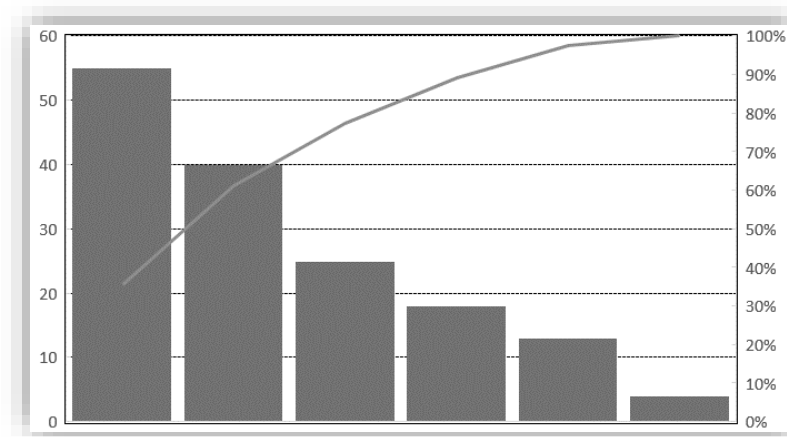


Create Pareto Chart



Use to Target Interventions

	-	-	-
-			
-			
-			
-			

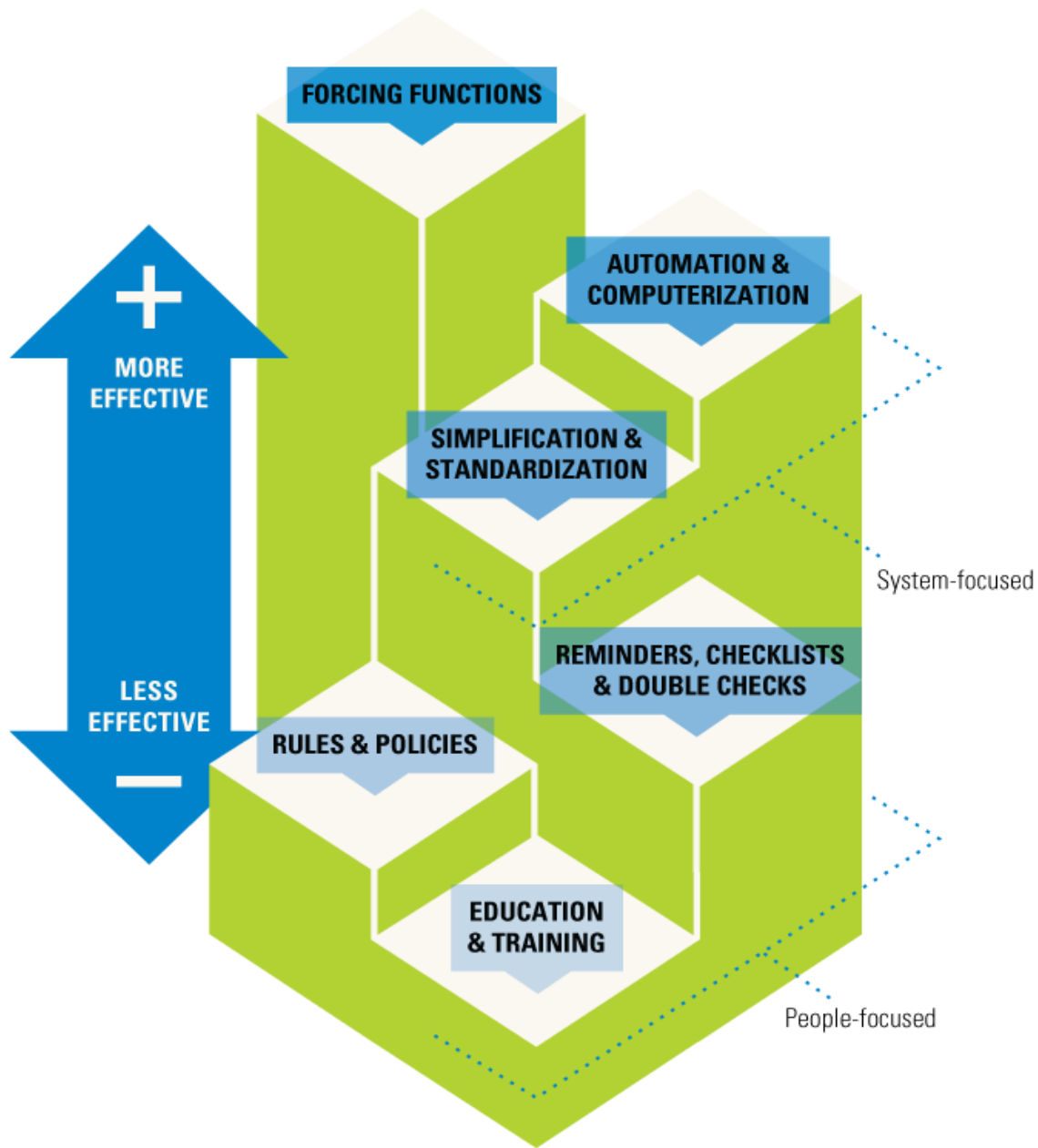


1. Target the root causes
- 2. Design the right solutions**
3. Choose the most impactful
4. Trouble Shoot



Improve

1. Hierarchy of Interventions
2. Double Diamond – Design Thinking
3. Positive Deviance



Please order contact precautions (BPA# 1183)

- Contact precautions until result is negative, if result is positive precautions will continue for duration of therapy.
- Please refer to Gastroenteritis table on the [Infection Control](#) page on The Source for more information.
- If you have questions regarding isolation precautions, please contact Infection Control at 720-848-6978.

Order Do Not Order Special contact isolation status

Acknowledge Reason _____

Isolation not required Deferred at this time

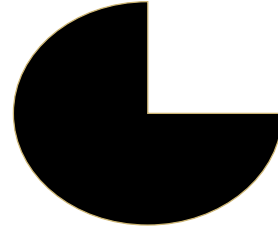
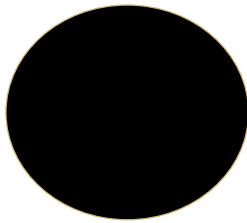
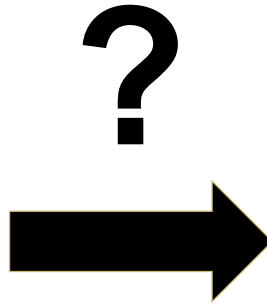
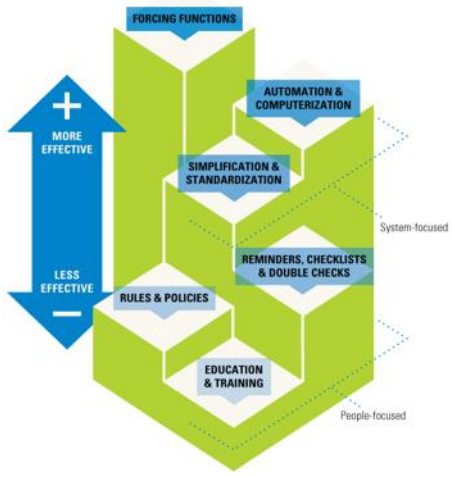
WHO Surgical Safety Checklist
(adapted for England and Wales)

NHS National Patient Safety Agency
National Reporting and Learning Service

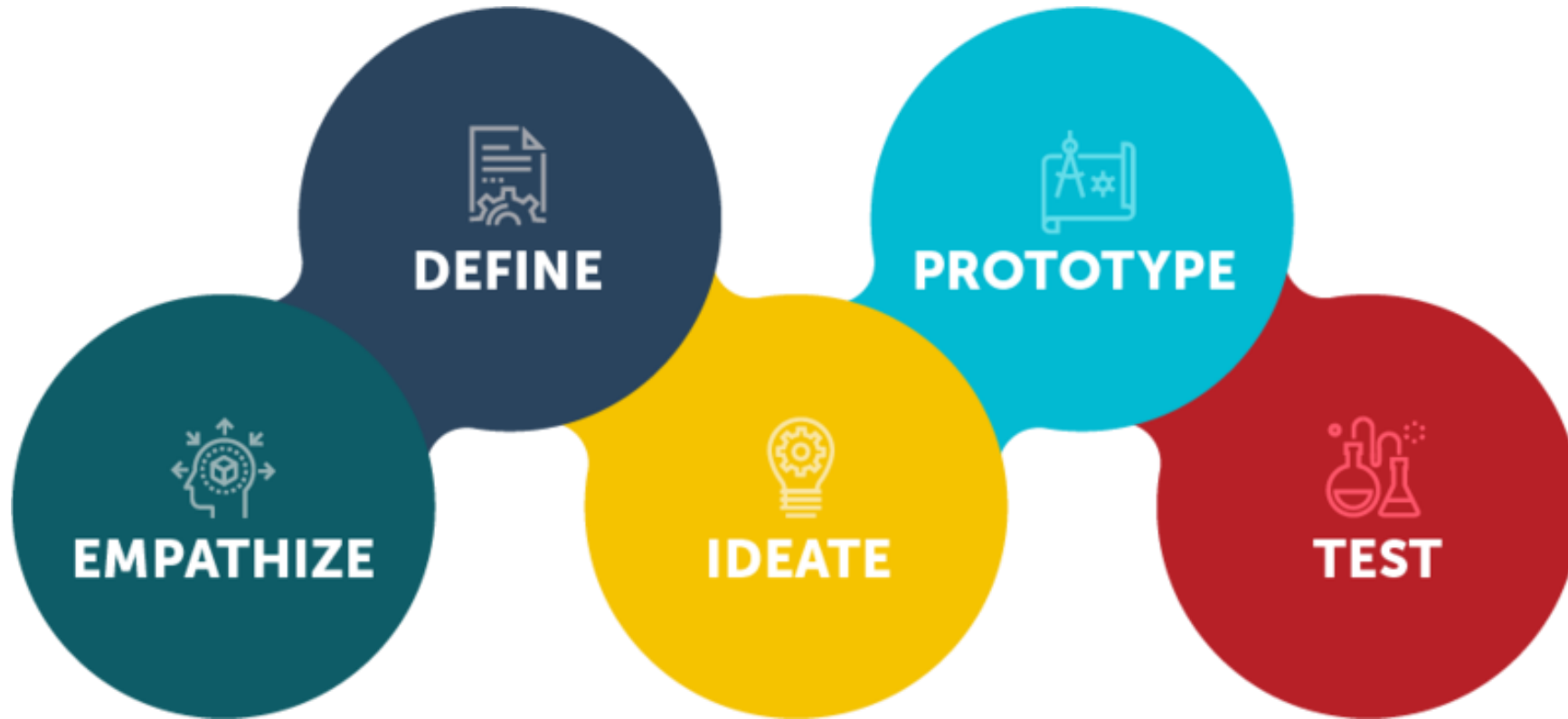
SIGN IN (to be read out loud)	TIME OUT (to be read out loud)	SIGN OUT (to be read out loud)
<p>Before induction of anaesthesia</p> <p>Has the patient confirmed his/her identity, site, procedure and consent?</p> <p><input type="checkbox"/> No</p> <p>Is the surgical site marked?</p> <p><input type="checkbox"/> Not applicable</p> <p>Is the anaesthesia machine and medication check complete?</p> <p><input type="checkbox"/> No</p> <p>Does the patient have a known allergy?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>Difficult airway/ventilation risk?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, and equipment/assistance available</p> <p>Risk of >500ml blood loss (only in children)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, and adequate IV access/fluids planned</p>	<p>Before start of surgical intervention for example, skin incision</p> <p>Have all team members introduced themselves by name and role?</p> <p><input type="checkbox"/> No</p> <p>Surgeon, Anaesthetist and Registered Practitioner verbally confirm:</p> <p><input type="checkbox"/> What is the patient's name?</p> <p><input type="checkbox"/> What procedure, site and position are planned?</p> <p>Anticipated critical events</p> <p>Surgeon:</p> <p><input type="checkbox"/> How much blood loss is anticipated?</p> <p><input type="checkbox"/> Are there any specific equipment requirements or special investigations?</p> <p><input type="checkbox"/> Are there any critical or unexpected steps you want the team to know about?</p> <p>Anaesthetist:</p> <p><input type="checkbox"/> Are there any patient specific concerns?</p> <p><input type="checkbox"/> What is the patient's ASA grade?</p> <p><input type="checkbox"/> What monitoring equipment and other specific levels of support are required, for example blood?</p> <p>Team/ODP:</p> <p><input type="checkbox"/> Has the sterility of the instrumentation been confirmed including indicator results?</p> <p><input type="checkbox"/> Are there any equipment issues or concerns?</p> <p>Has the surgical site infection (SSI) bundle been undertaken?</p>	<p>Before any member of the team leaves the operating room</p> <p>Registered Practitioner verbally confirms with the team:</p> <p><input type="checkbox"/> Has the name of the procedure been recorded?</p> <p><input type="checkbox"/> Has it been confirmed that instruments, swabs and sponges counts are complete (or not applicable)?</p> <p><input type="checkbox"/> Have the specimens been labelled (including patient name)?</p> <p><input type="checkbox"/> Have any equipment problems been identified that need to be addressed?</p> <p>Surgeon, Anaesthetist and Registered Practitioner:</p> <p><input type="checkbox"/> What are the key concerns for recovery and management of this patient?</p>

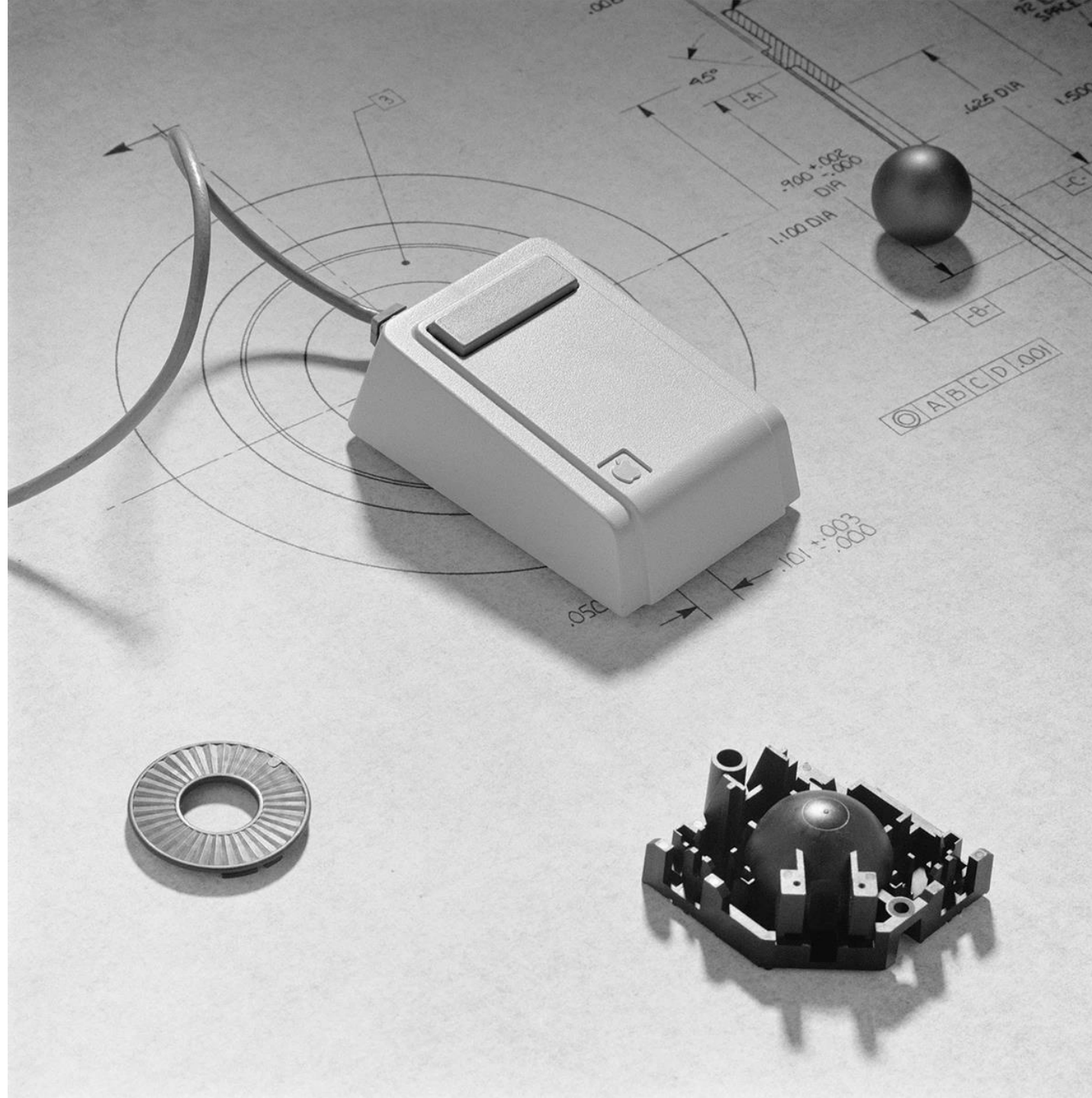
This checklist contains the core content for England and Wales





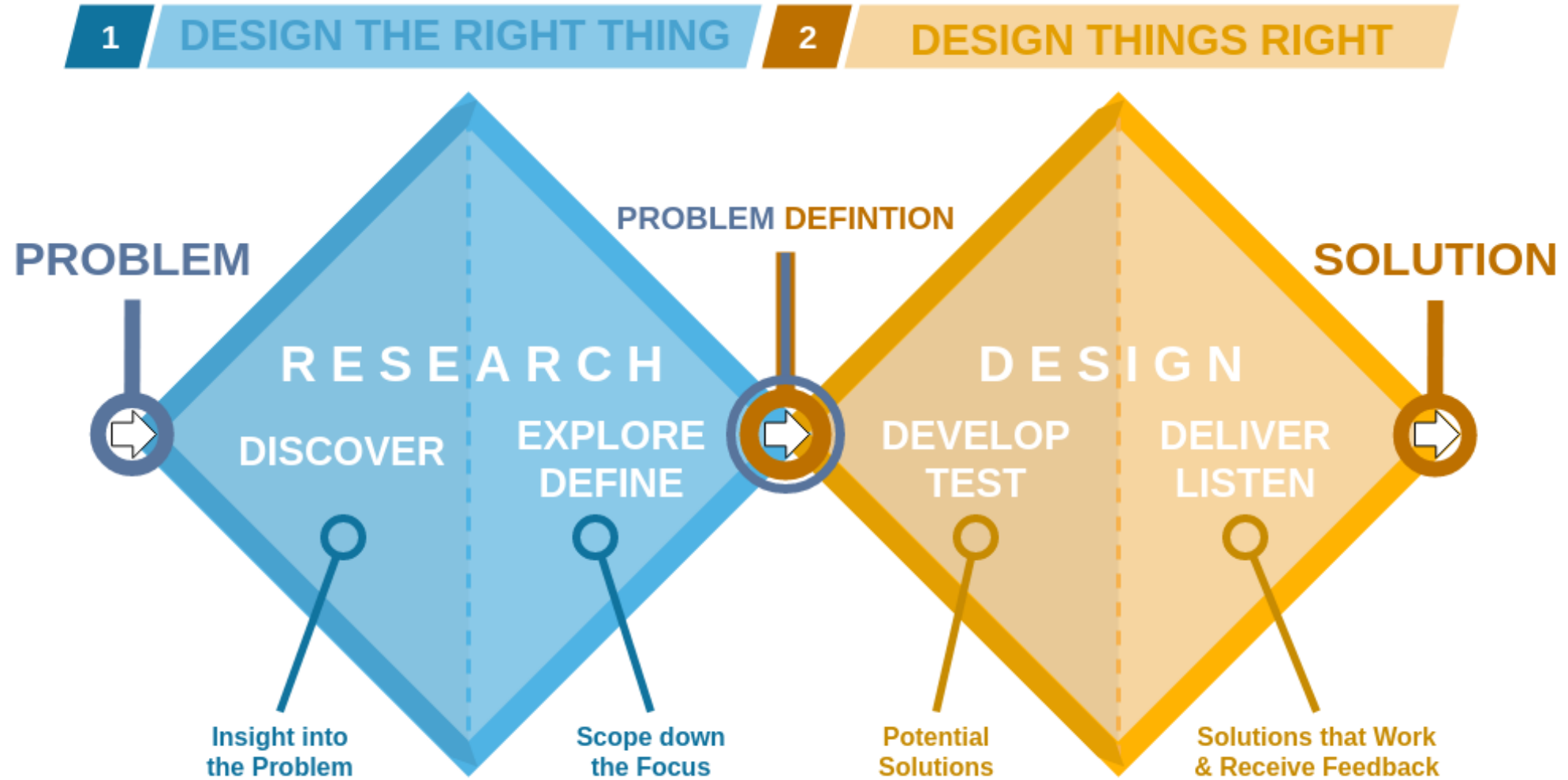
Improve: Design Thinking







Improve

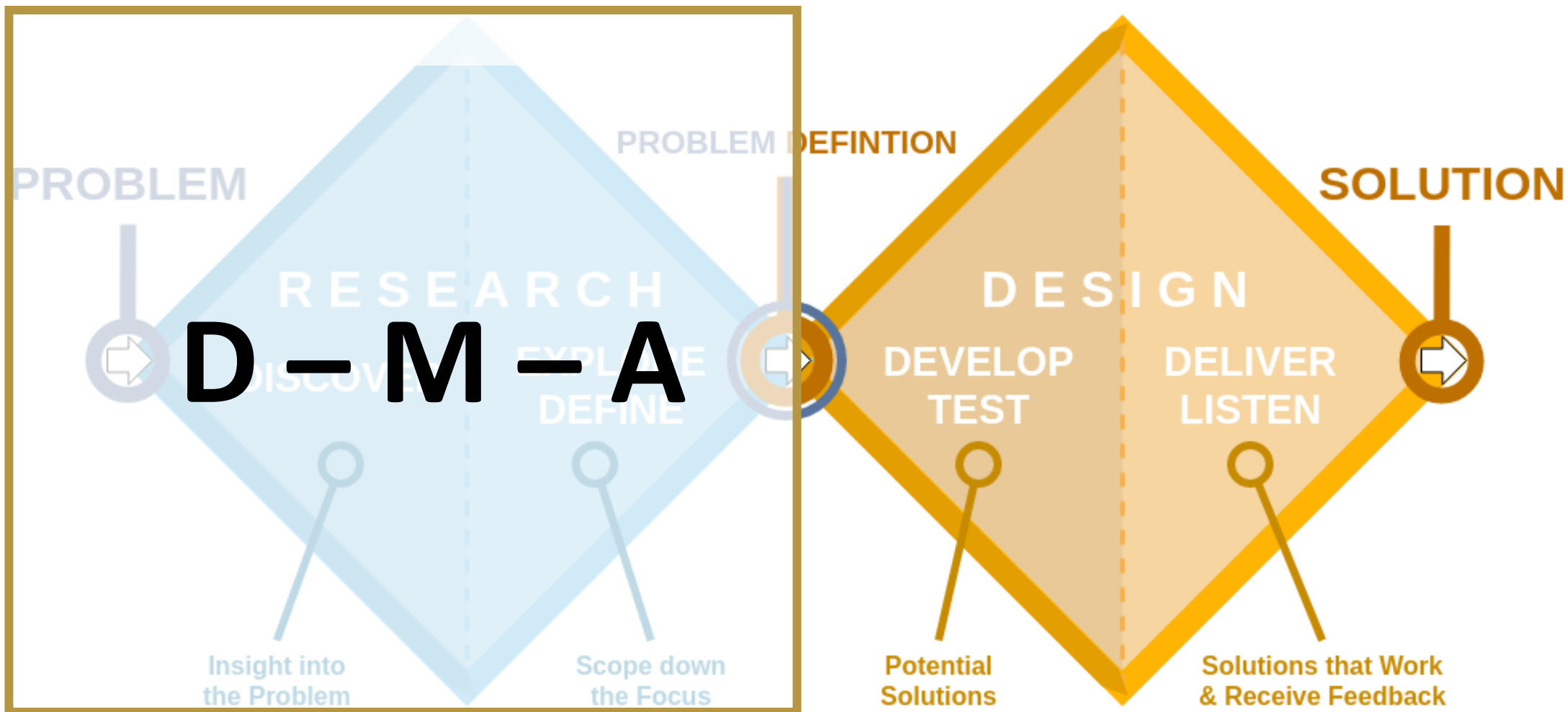


1

DESIGN THE RIGHT THING

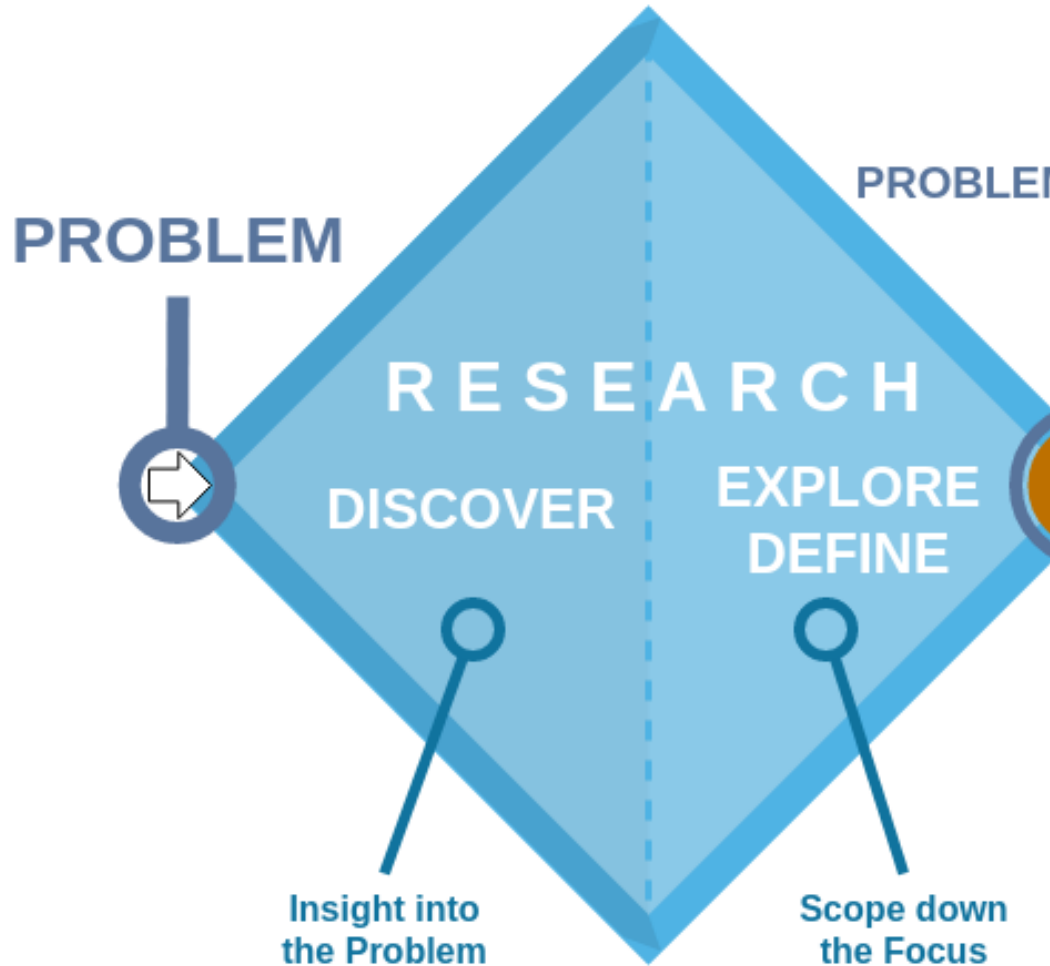
2

DESIGN THINGS RIGHT



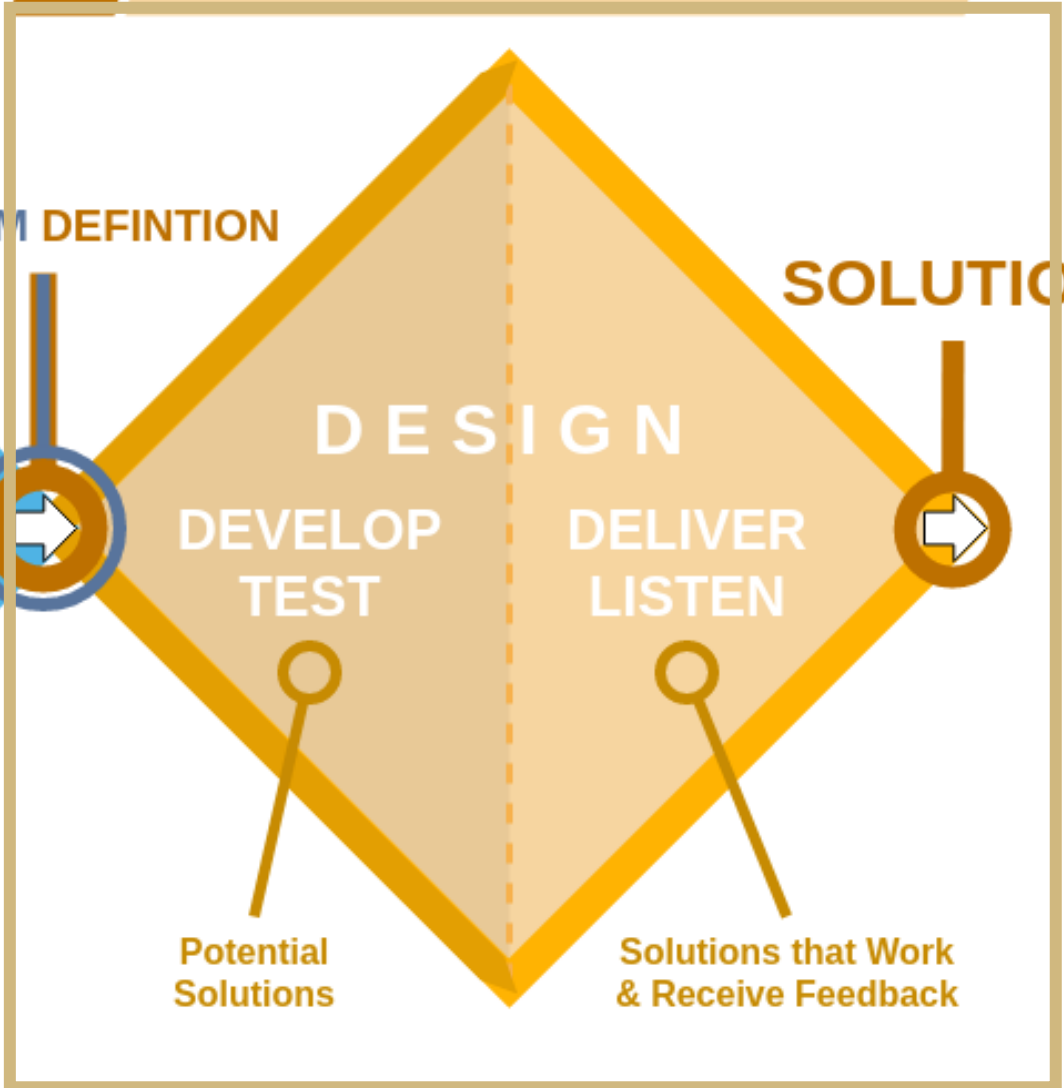
1

DESIGN THE RIGHT THING



2

DESIGN THINGS RIGHT





Broadway

Empathize & Define:

"Impatient."
"Bored."

We need to design a better stoplight to keep people entertained so they stay safe at intersections.



Ideate:



WHAT MAKE IT GREAT FOR EVERYONE?

- Sensible interactive design.
- Obviously see how long to wait or be hurry for everyone, no more reading from number.
- Countdown number, 3-2-1, appears while yellow light's turn on. Warning people to stop or ready to go.



WAIT



READY



GO!

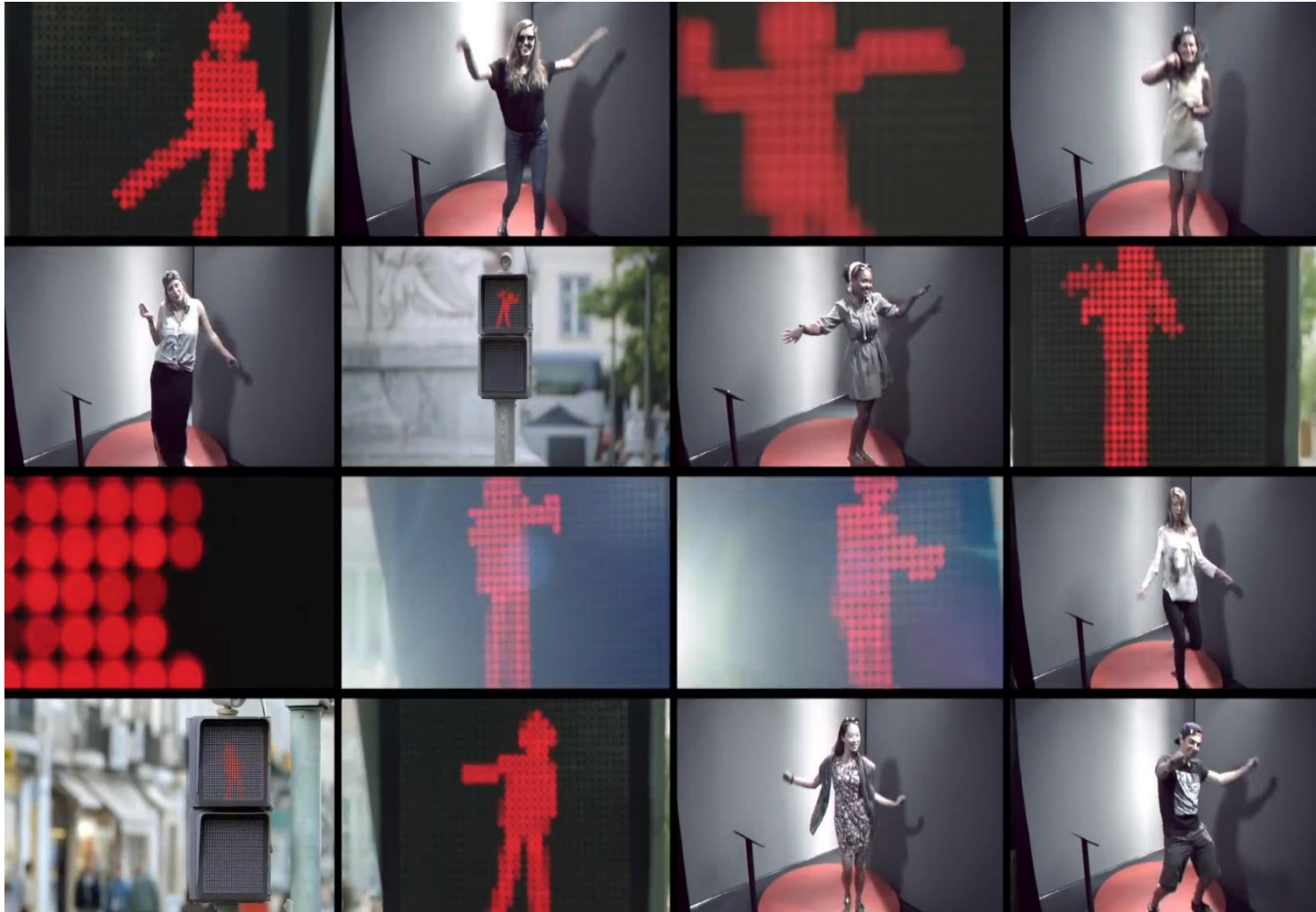
SAND GLASS
TRAFFIC LIGHTS, MAKE SENSE

"Sand Glass" the LED traffic lights which inspired from the hour glass, one of the original timer that we've use for over century. Easy to see the light's color and estimate how long to wait or hurry to go obviously from the dropping pixels interface like a real sand glass. The countdown number, 3-2-1, appears only while the yellow light's turn on to warn that the light's color will change in a few seconds. That's all make Sand Glass is a sensible communication design for everyone.

Prototype: The Dancing Stoplight



Test: Reduction in traffic deaths by 81%.



Design thinking to drive innovation.

Human centered, **empathy driven**, immersion in the experience of your user

Attitude of prototyping - **iterative process**, feedback open

Collaborative

A bias toward **action**

Improve: Positive Deviance





Positive Deviance is applied in settings where certain groups or individuals solve problems better than others given the same resources.

Assumes that there is an answer out there but not widely known



What if I could draw blood without poking the patient?



How do you correctly identify positive outliers?



Reputational Scores (USNWR, Award Winners)



Snowball methodology



Outcome Metrics



“What would this look like if it were easy?”

- Tim Ferris

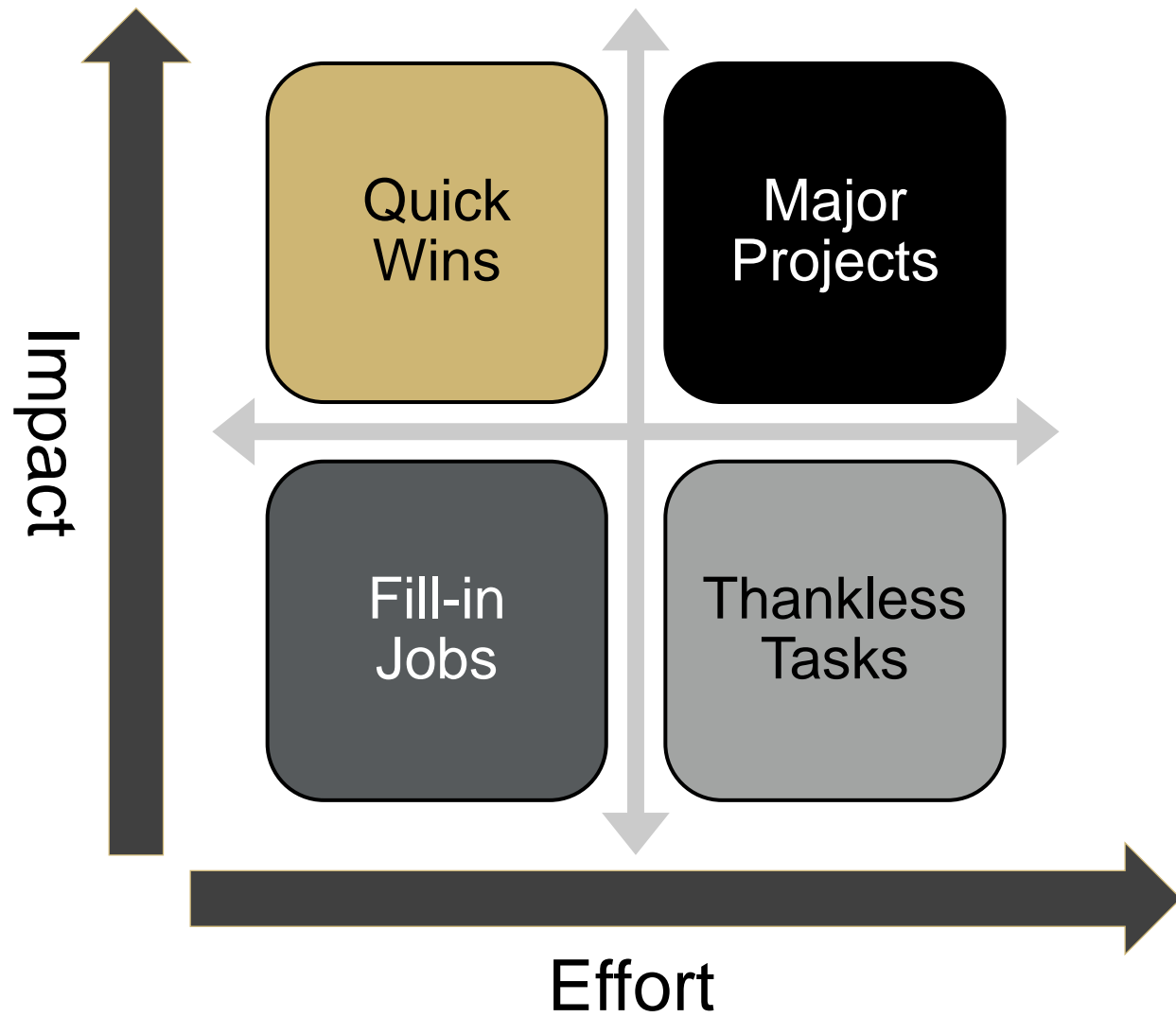
“Perfection is achieved, not when there is nothing more to add, but when there is nothing left to take away.”

- Antoine de Saint-Exupéry, French pioneering aviator, poet, aristocrat

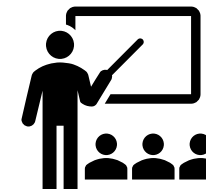


1. Target the root causes
2. Design the right solutions
- 3. Choose the most impactful**
4. Trouble Shoot

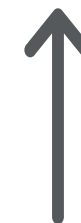




Epic



Education



You now understand your problem and its' root causes through your ***D-M-A*** work.

You know which root causes you will target using ***Pareto Principle***.

You've designed multiple solutions using the ***Hierarchy of Interventions, Design Thinking*** and ***Positive Deviance***.

You've used your ***Effort/Impact*** to decide which intervention to roll out first.



1. Target the root causes
2. Design the right solutions
3. Choose the most impactful
- 4. Trouble Shoot**



Improve: Brainwriting Pre - Mortem



The Program has been running for 1 year.

It has failed miserably.

What went wrong?



Breakout 6: Interventions



Brainstorm THREE possible interventions.

- Based on your D-M-A work
- What would this look like if it were easy?
- Consider who does this THE BEST.
- Consider what solution "defies gravity."

10 minutes



Part 4: Sustaining Improvements



Institute for Healthcare Quality,
Safety and Efficiency

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

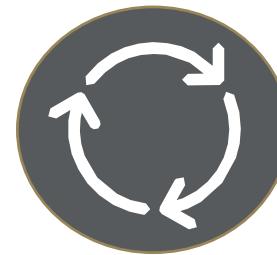
Define, Measure, Analyze, Improve, Control



Understand your
problem



Fix it



Sustain



Define

- Problem Statement
- Voice of Customer

Measure

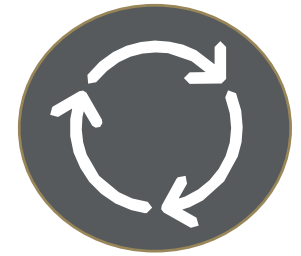
- Gemba
- Process Map
- Identify Process, Outcome, Balancing

Analyze

- Affinity Diagram – ID Root Causes
- Pareto – Rank Root Causes



D, M, A - SMART AIM



Improve

- Identify Key Targets for Intervention from Pareto Chart
- Design Interventions using Positive Deviance, Pre-Mortem

Control

- Sustainability Plan



Define, Measure, Analyze,



Understand your
problem



Next Steps

Second session July

- How to Make People Follow
- Presenting to Influence
- Approach to Data
- Overcoming Resistance

Biweekly coaching meetings

Set a timeline for success (6 months)

Deliverables: Presentation to stakeholders

Improvement is continuous...



Action Plan

1. Communication plan (set biweekly meetings with team & coach)
2. Building your team (who else needs to be engaged)
3. Where are you in DMAIC (look at project charter together)
4. Create agenda for first meeting
5. Discuss data collection plan



The Charter

Project Charter

Project Title: _____

Team Members <small>Responsible for accomplishing a project. They drive the project to completion. There will be individuals who are closest to the process and also have a direct impact on it.</small>	Executive Sponsor <small>Responsible for supporting the team through resources, budget, communication, and championing.</small>	Project Coach <small>Coach serves as a mentor to facilitate your success and provide guidance. They work with you across your personal and project development.</small>	SCOPE OF PROJECT Process Start: Process Stop:
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DEFINE

BACKGROUND

Summarize the background information as to what originally caused your project to be initiated which someone who is unaware of the process/department may be able to read and quickly understand the general information. Mention information and details back to the earliest relevant time.

PROBLEM STATEMENT

Explain the "What" and "Why" of your project. Think of this as a "So What" explanation, why is your project important. The "What" should include a concise description of the issues that need to be addressed by a problem solving team. The "Why" should define the problem and help you scope your project.

VOICE OF THE CUSTOMER/BUSINESS

MEASURE

PROCESS MAP

List 3-5 key findings from your process map.

KEY MEASURE	DESCRIPTION	BASELINE
Outcome		
Process		
Balancing		
Structural/ Financial		

ANALYZE

AFFINITY DIAGRAM

List the 3-5 key findings from your Affinity Diagram.

AIM STATEMENT

The Aim Statement should be a SMART (Specific, Measurable, Attainable, Relevant, and Time Bound) goal. It should explain what you are trying to achieve and include the outcome metric you are striving to improve and an estimated completion date.

IMPROVE

INTERVENTION TARGET	INTERVENTION IDEA	IMPLEMENTATION PLAN (brief)
#1		
#2		
#3		
#4		
#5		

CONTROL

CONTROL PLAN

What is your plan to put your project into the control phase?

Screenshot



