



الجمعية السعودية للعلاج الطبيعي
Saudi Physical Therapy Association

Medical^{K P I S}
Infinite Giving
عطاء بلا حدود



PERFORMANCE MANAGEMENT AND PROCESS IMPROVEMENT

Chapter 3-Part 1

Mohamed Eldeeb

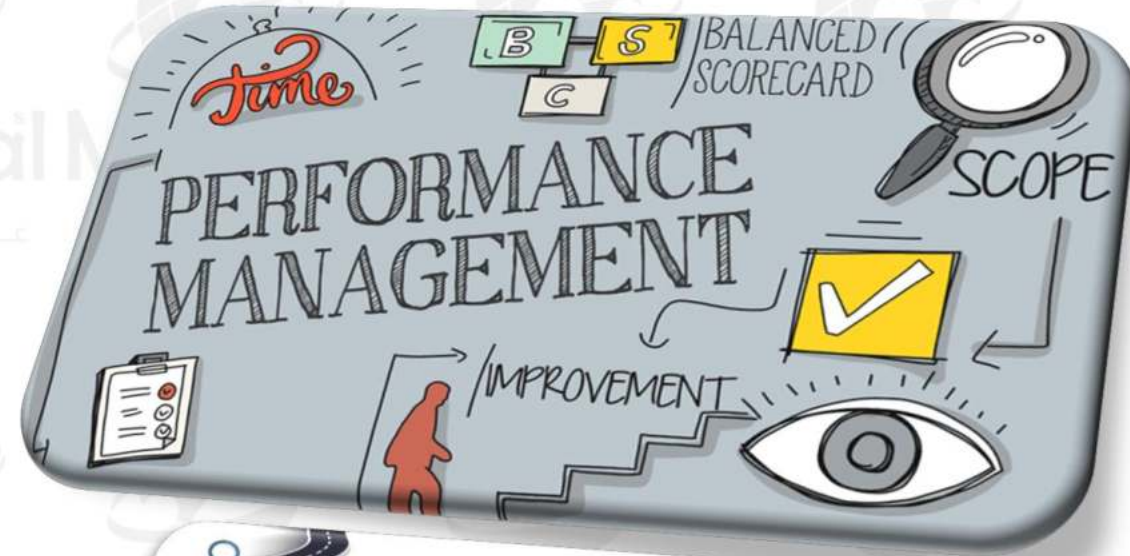
CPHQ,CPHRM,LSSBB,TQM,SCRUM Master ,TOT , Team STEPPS master
training

Definitions of performance management

process of ensuring that a **set of activities and outputs** meets an **organization's goals** in an **effective and efficient manner**

process of **identifying , measuring and developing the performance** of **individual or team** with the goal of **aligning** performance with the strategic goal of Org

- **System :** Roadmap of creating a high performance organization through the integration of organization vision.



Performance management and improvement process:

- It **shifts** the primary **focus** from the **performance of individuals** to the **performance of the organization's systems** and processes, while continuing to **recognize** the importance **individual competence** of medical staff

1. Performance improvement program **structure**
2. Performance improvement **plan**
3. **Implementation** of performance improvement program
4. **Dissemination** of performance improvement information
5. **Team**
6. Practitioner **appraisal** process
7. QM & PI **orientation** and **training and education**

Performance:
what is done and
how well it is done
to provide
healthcare .





Building an Effective Quality Improvement Program Structure:

organization must be **involved** in improving the quality of services and products



structure should be based on the organization's mission and vision

NOW quality is **imbedded** in the structure



then develop the **process to engage the people** to serve the patient will lead to better out come

should be assessed to determine if they are producing the desired outcomes or do they need to be improved .



1. Performance improvement program structure
2. Performance improvement plan
3. Implementation of performance improvement program
4. Dissemination of performance improvement information
5. Team
6. Practitioner appraisal process
7. QM & PI orientation and training and education



Building an Effective Quality Improvement Program Structure:

1. Definition of the term quality for the organization
2. Clarify leadership roles
3. Create an accountability structure
4. Determine what the name of your program will be (i.e., quality or performance improvement)
5. Identify the important functions of the organization
6. Identify approaches to process improvement framework
7. Develop an information flow chart
8. Establish reporting routines
9. Integrate quality principles into organization's policies and procedures
10. Identify educational needs



Building an Effective Quality Improvement Program Structure:

1-Determine the Definition of Quality for the Organization:

Every healthcare **organization must define how they view quality for their organization** .

➤ This definition will be impacted by :

1. the type of organization . (gov or non gov)
2. it is for profit or not for profit.
3. the mission, vision, and values of the organization.
4. patient population.
5. type of **services offered, type of practitioners utilized.**
6. **geographic** and environmental factors .

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2-clarify Leadership Roles

The program and quality strategy should be shared and acknowledged

Leaders must know their roles and meet the expectation in the Q.strategy

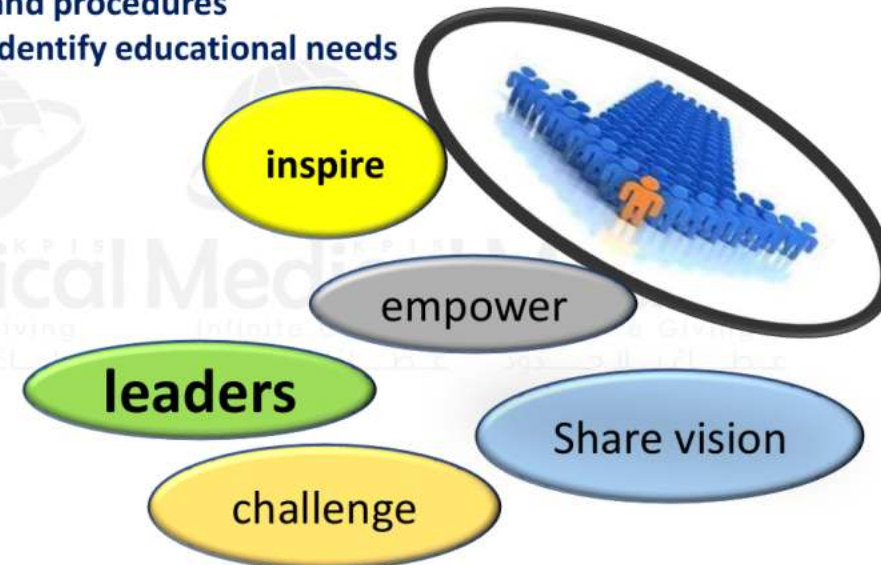
working together toward a common quality strategy,

The role delineated in writing, perhaps within the quality plan itself.

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There should be one group held accountable for the organization's quality strategy for both clinical and nonclinical processes and outcomes; that group is typically called the Quality Council.

1. eliminate all redundant bodies.
2. reduce the need for multiple meetings and duplicative reporting.
3. ensure appropriate and timely communication throughout the organization



Quality council

- body of senior managers representing within a firm and quality specialists who meet periodically to identify quality problems and devise appropriate solutions of these problems.
- consists of the administrative, physician, and nurse leaders and key organization staff who serve as an oversight committee for all quality activities (clinical and non-clinical) of the organization and including community members and/or previous patients.
- ideally include members from all aspects of the organization to prove that there is cross communication throughout the organization.
- All members of the Quality Council should be required to sign annual confidentiality and conflict of interest forms, which should be kept on file wherever the minutes are kept.

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Quality council:

1. Promote quality improvement.
2. Provide technical support.
3. Set goal and time frame.
4. Prioritize the opportunities of improvement.
5. Establish performance improvement team.



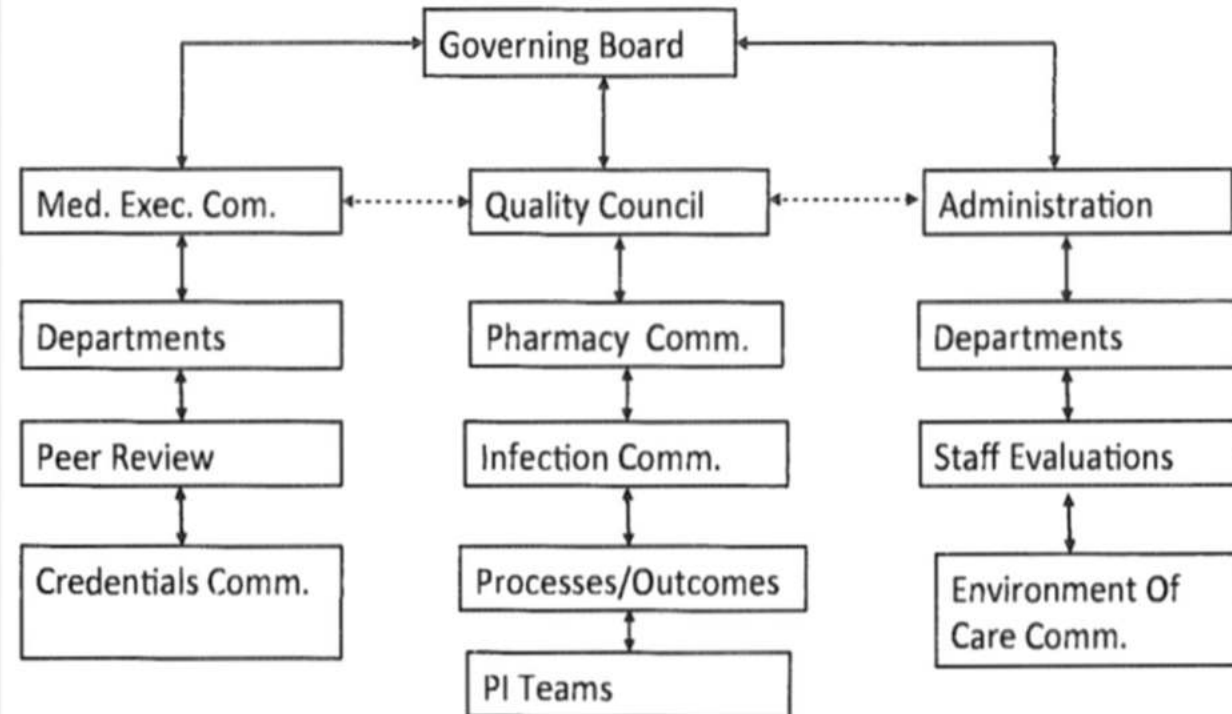
- The Quality Council reports directly to the Governing Board through minutes also shares quality information with the medical staff and the administration of the organization.
- The frequency of the Quality Council meetings is determined by the organization e.g. monthly or quarterly. If the Quality Council is established in the medical staff bylaws, the meeting expectations should be stated in a manner that does not violate the bylaws should a meeting not occur as stated in the bylaws.



Information which presented at quality council:

1: QM/PI Information Flow

QM/PI INFORMATION FLOW



- is **high level**, aggregated, and **trended data and information** regarding the status of improvement efforts.
- Quality Council is usually **identified in the medical staff bylaws as a committee of the medical staff** which is chaired by a physician.
- Quality Council is a **subcommittee of the governing board**, and thus has at least one governing board member on the council.



Councils and Committees:

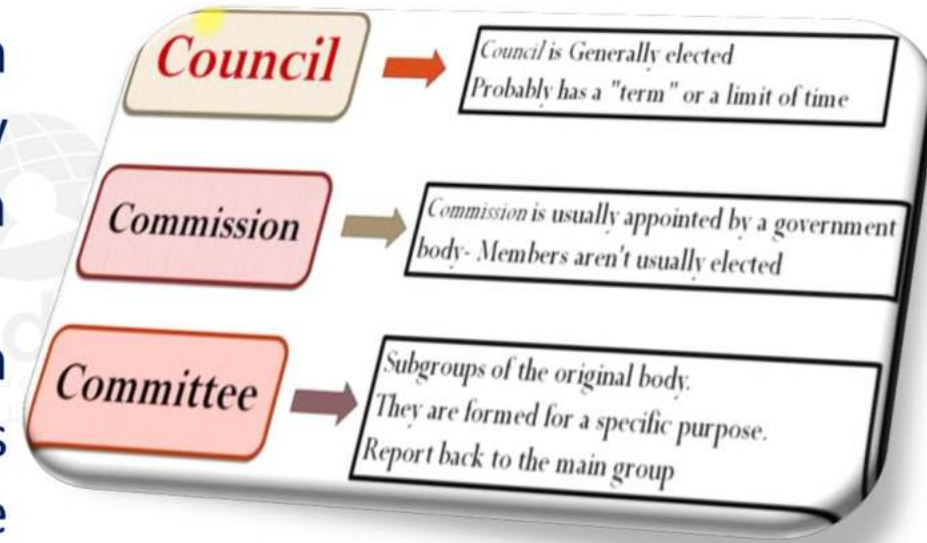
- Other councils and committees may be needed in the organization. There are committees **established by the administration and the medical staff**. The medical staff bylaws describe many other committees that are interdisciplinary, and that relate to the healthcare quality management of the organization.

(**related to Q.management:** the Infection Control/Prevention, Medication Use, Morbidity/Mortality (M&M) and other such committees are also mentioned in the bylaws.)

(**Departments** of the organization in conjunction with the medical staff departments also have committees such as the Emergency Department, or the Critical Care committees.)

Commission is a group of people who is entrusted by GB to carry out specific task.

Committee is subgroup for original body formed for specific function and report back to the main group.





Initiatives and Collaboration:

➤ Part of the Quality Council's prioritization and development of **the strategic quality plan** is to determine if there are external collaborative and/or quality initiatives that the organization would benefit from participating with them.

➤ **collaborative:**

involves individuals working with others to do a task and to achieve shared goals

➤ **Initiative:**

1- The power or opportunities to do something before others do.

2- Formed when stakeholders come together to solve dilemmas.

Proposing or confirming change in current status.





3-Accountability Structure :

- Org. should **be account of their activities** and responsible of them and provide many or other supportive issue for its activities .
- Obligation to **support** and **justify** something (**answerable**)
- Government ha accountability for decision and law which affect citizen.
- In work place : **responsibilities** of employee to complete the tasks they are **assigned** to perform the task , they are assigned , to perform the duties required by their job.

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10. Identify educational needs

Accountable

Responsible

Responsible for what u do and giving **satisfactory** reason

Duty to work or help some one who in position of authority

Can not be shared

Can be shared

U r blamed for mistakes

No liability

RACI Definitions

R	Who is Responsible	The person who is assigned to do the work
A	Who is Accountable	The person who makes the final decision and has the ultimate ownership
C	Who is Consulted	The person who must be consulted before a decision or action is taken
I	Who is Informed	The person who must be informed that a decision or action has been taken



4-Quality Language :

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➤ It is important to **determine the quality language** that the organization will utilize for their quality program. Just as there **must be an organization wide** commitment and strategy, there must be a **common quality language with well-defined terminology**

➤ A common quality language facilitates leaders' ability to articulate clearly the corporate passion for quality and to be consistent and organized in the **development and rollout of the selected quality strategy** The language of the organization communicates the culture.

➤ The staff must also know what the **common terms** are so that when talking with others, they can be talking about the same things.



5-Organizational Important Functions :

- Determination of **what should be measured and then improved if needed**, there are many things to consider.
- It is well known that the **organization cannot measure and improve everything at the same time** due to the **lack of resources available**. Nevertheless, the organization needs to focus their improvement efforts on the issues that provide the most value to the organization and its patients/clients.

مصنع حلويات العلبه فيها 50 كاندى مش هرهق نفسى ان كل علبه فيها 50 بالظبط واقعد اعد لا ممكن ابقى (+/- اتنين قشط يبقى ممكن اوزن واريح دماغى

➤ Hip replacement:

I would assess only

- 1- walking certain distances
- 2- pain control
- 3-bleeding and infection

But not in my priorities if pt eating well or not

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6-Approaches to Performance improvement :

- Several methodologies can be **used to establish an organization wide approach for Quality/Performance Improvement (Q/PI) activities.**
- These possible approaches/models focus on process improvements and are generally **designed for use by cross-functional, interdisciplinary teams**
Leadership and planning are essential for integrating existing and new improvement activities and for gaining consensus across the organization or system.

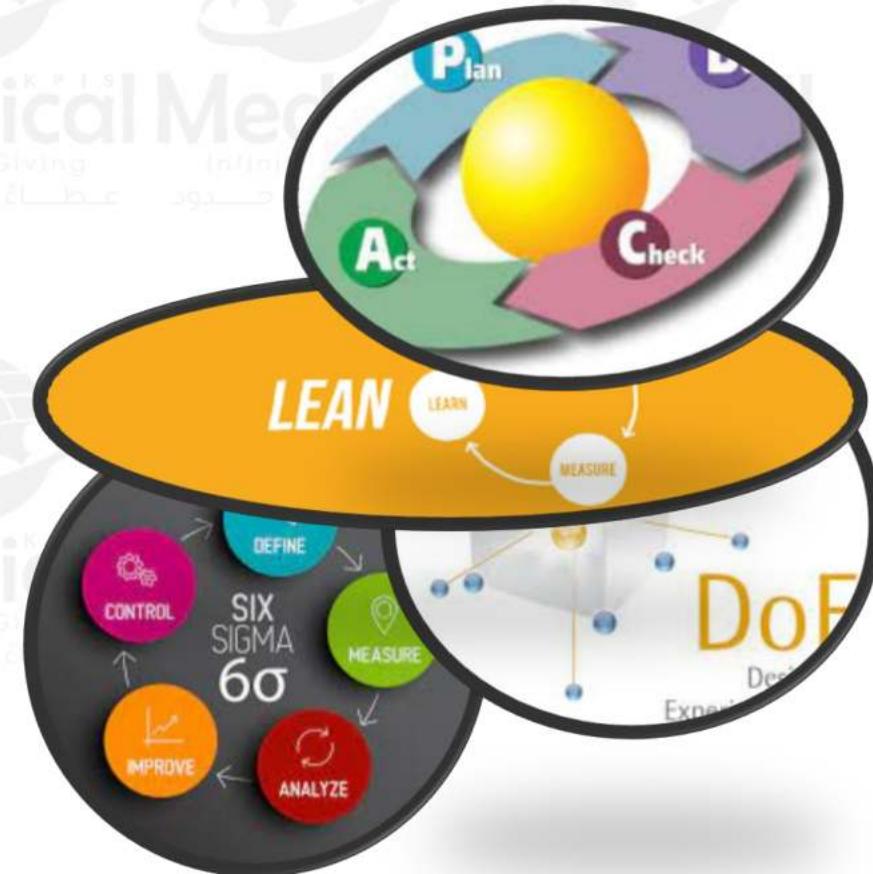
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➤ Common characteristics of all approaches/models:

1. Identifying/**focusing on prioritized areas** in the organization
 2. **Developing measures and collecting data**
 3. **Assessing performance** taking action for improvement
 4. **Assessing improvement**
 5. Effective team development and interaction
 6. Use of **statistical, analytical, and consensus tools** at all steps
- ❖ The key to **successful selection** (meaning buy-in and adoption by the organization) is making certain that the approach(es) make good, **common sense to clinicians**, quality professionals, top-level leaders and directors/managers, and teams.



Shewhart Cycle - PDCA Cycle or PDSA Cycle:

Shewhart developed the **Plan-Do-Check-Act (PDCA)** cycle for planning and improvement in the 1920s. **W. Edwards Deming** adapted PDCA and called it the **Plan-Do-Study-Act (PDSA)** cycle. Both are conceptually the same with a slight variation as to whether you 'check' or 'study' as the third part of the cycle.





- Take **action** based on what you learned in the **study** step.
 - If the change did not work, **go through the cycle again with a different plan.**
 - If you were successful, incorporate what you learned from the test into wider changes.
 - Use what you learned to plan new improvements, beginning the cycle again.
-
- Data is **collected again** as it was before the improvement efforts began.
 - Analyze of this data **compared** to the previous data
 - The team **determines** if the goal /**target have been reached**
 - Determine **what action or modification** are necessary prior to the full implementation of the action plan (**decide u will repeat the cycle or not?**)



- plan **what needs to be done.**
- Recognize **an opportunity** and plan a change.
- you need to be sure that you **answered some basic concerns**
 1. What is the core **problem** we need to solve?
 1. What **resources** do we **need**?
 2. What resources do we have?
 3. What is the **best solution** for fixing the problem with the available resources?
 4. In what **conditions** the plan will be considered **successful**? What are the goals?
- **An action plan is developed with goals and targets that have been identified.**
- **Design New process.**
- **the action plan is implemented, usually on a small scale in a trial basis (Pilot study)**
- **This stage include education and training.**

Benefits of PDCA:

- 1- It stimulates continuous improvement of people and processes.
- 2- It lets your team test possible solutions on a small scale and in controlled environment.
- 3- It prevents the work process from recurring mistakes

Accelerated/Rapid Cycle Change Approach:

Mergers and **acquisitions** continue to accelerate change in healthcare organizational structure and culture. Reengineering efforts change systems, functions, and processes radically, not incrementally, as continuous quality improvement theory **would dictate**.

- ❖ Healthcare purchasers want "**proof of quality**" now in order to make appropriate contract decisions about health plans and providers.

Keep
pacing





- ❖ changes are made in a less **disruptive** environment, **resistance** to change **is reduced**, and everyone is **learning** from ideas that work and those that do not.
- ❖ Rapid-cycle change models utilize the traditional **quality tools**, but **expediting** the change and the results. Instead of 3-6 months for a team to implement and measure a change, rapid cycle change occurs within several days up to 4 to 6 weeks
- ❖ This process is **labor intensive** and must have the **support of the leadership**. The leadership must commit to the staff time and the financial resources.
- ❖ Rapid cycle improvements cause the team to **focus on reducing failure** rather than just improving performance.
- ❖ Benefits of rapid cycle improvement consist of **quick improvements** resulting from small tests, **failures are noted quickly and affect few individuals**, measurement is concurrent and on small samples.



Lean:

- Lean management strives towards **elimination of waste and non-value added activities** from the poor application of resources and the supply of equipment/supplies (too little or too much) does not meet the demand.
- The **goal is to match the supply with the demand exactly.**
- **lean** is about providing the most value for the customer while minimising resources, time, energy and effort.



- **Lean thinking**

to organize human activities to deliver more benefits

how



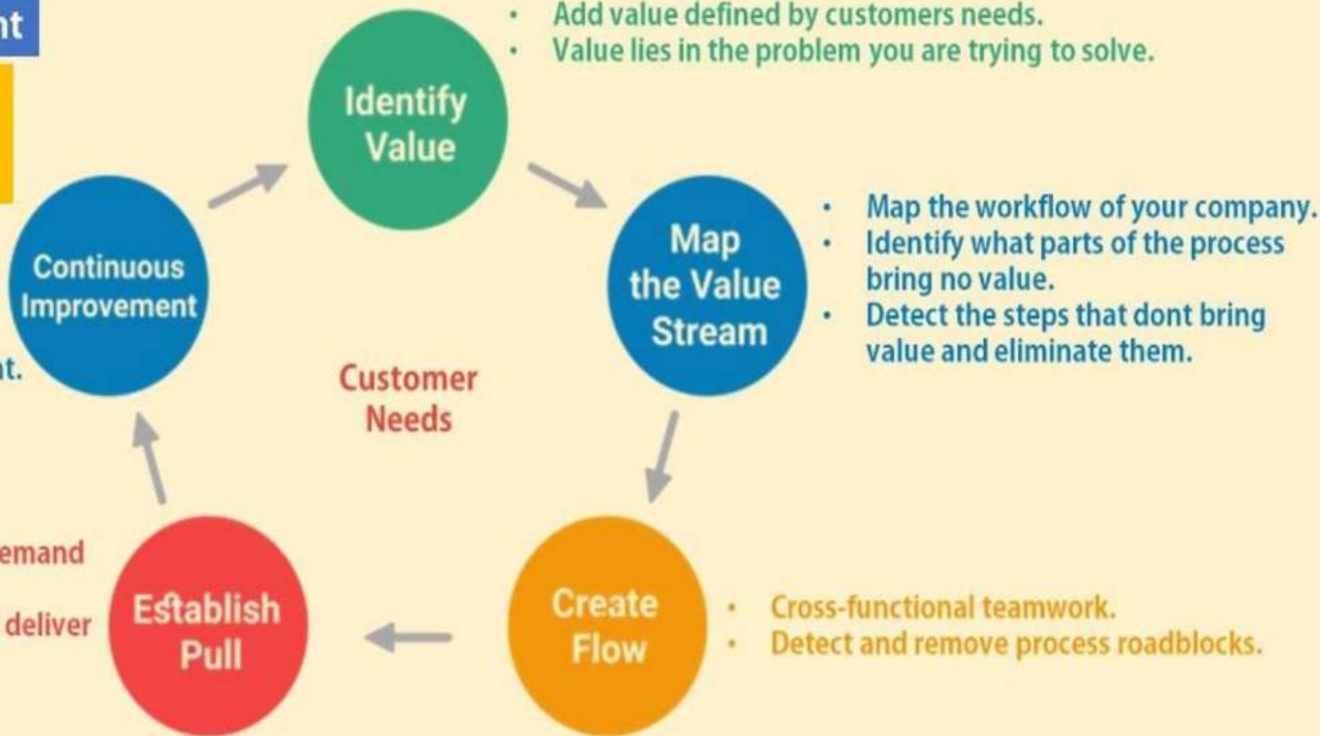
Lean Principles

Benefits of Lean Management

- Focus.
- Improving productivity & efficiency.
- Smarter process (pull system).
- Better use of resources.

- Most important step.
- Problems may occur at any of the previous steps.
- Encourage continuous improvement.

- Work is pulled only if there is a demand for it.
- Optimize resources capacity and deliver products



Muda
無駄
Uselessness in processes, machinery and people

Mura
斑
Unevenness in customer demand, process times or other variations

Muri
無理
Overburden resulting from Mura and from removing too much Muda

Eliminate waste:



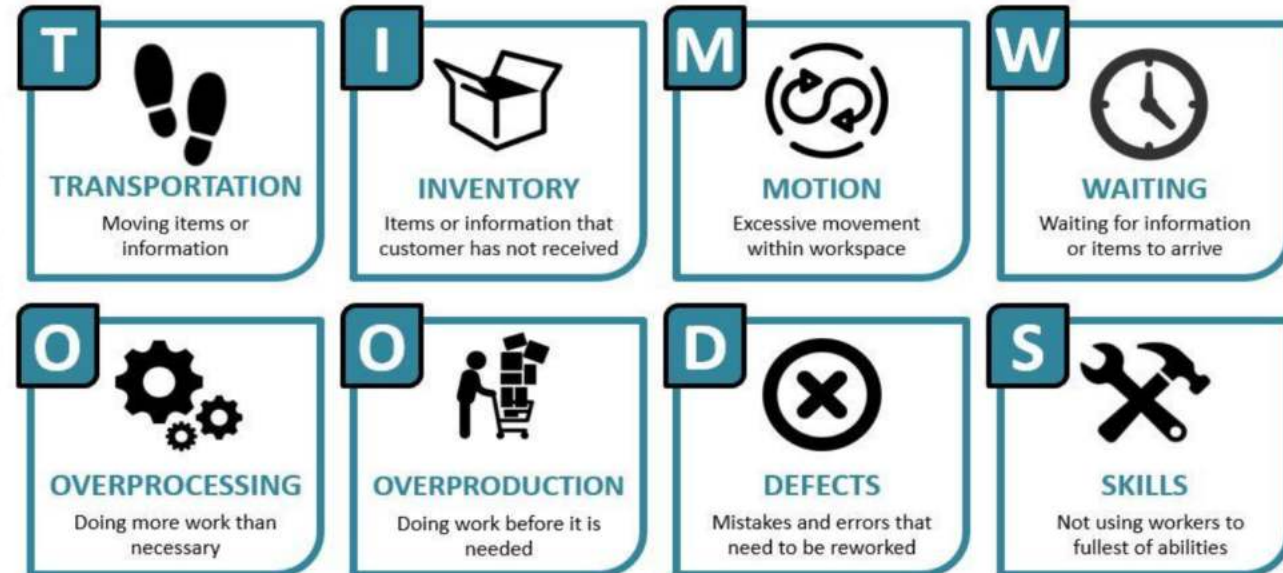


Wast

is defined as "any activity or resource that destroys value or consumes resources without creating value for the patient or the healthcare enterprise"
It involves variation, and overburden within processes.

❖ There are eight forms of waste:

1. Defects.
2. Oversupply.
3. Waiting.
4. not fully utilizing people's abilities.
5. Transportation.
6. Inventory motion.
7. excess processing.



5S tool:

- This is extremely important to the lean methodology.
- This tool utilizes a systematic approach that is effective and simple to use model for process design and improvement.
- There are five phases in this tool: (Sort, Store, Shine, Standardize, and Sustain)
- ❖ .The current state process map is drawn first to display how the process currently functions prior to any improvements and to determine the overall processing time.

5s Methodology

5S is a method for workplace organization which uses a list of five Japanese words
seiri (整理), seiton (整顿), seisō (清掃), seiketsu(清潔), and shitsuke (躰)

1. Sort (Seiri)

Seiri is sorting through all items and removing all unnecessary items .

2. Set in order (Seiton)

Seiton is putting all necessary items in the optimal place for fulfilling their function in the workplace.

3. Shine/Sweep (Seiso)

Seiton is putting all necessary items in the optimal place for fulfilling their function in the workplace.

4. Seiketsu (Standardise)

Setting up standards and specifications

5. Shitsuke (Sustain)

Sustain the developed processes by self-discipline of the workers.





5 STEPS :

SORT

evaluates what is needed and what non-value added items/steps can be deleted.

STORE

consists of examining the effectiveness of the order of steps in the process, and reorganized to increase efficiency and productivity.

SHINE

consists of streamlining the process to eliminate additional processing time. Standardize work phase is when the process steps are standardized

Standardize

work phase is when the process steps are standardized.

SUSTAIN

the process can be monitored and refined in order to maintain the new processing time..



Kaizen is a compound of two Japanese words that together translate as "good change" or "improvement." However, Kaizen has come to mean "continuous improvement" through its association with lean methodology and principles.



KANBAN : scheduling system for lean manufacturing

BENEFITS OF KANBAN IN SOFTWARE DEVELOPMENT



Improved visualization of the workflow



Improved efficiency and productivity



Better team collaboration

Kanban Best Practices





➤ Several components are required for successful :

1. The **scientific method** is utilized to solve problems .
 2. There must **be a manager** who is a facilitator, mentor, and coach .
 3. The **frontline** workers are the ones who identify and solve the problems .
- The quality manager must move the organization toward **reducing the risk** of adverse events and assisting staff and practitioners in the redesign of processes that **improve the quality of the services** provided.
 - One of the first things that must be done is to begin to change the organization culture to one of focusing on the process and not blaming the individual.





Six sigma

Is a disciplined approach to process improvement, used for redesigning or designing new processes. It is a concept **representing the amount of common cause variation** in a process relative to customer needs, expectations, requirements, and/or specifications.

- **Variation** in a process creates waste and errors. Eliminating this variation makes the process more cost-effective, more efficient, and more error-free.
- elimination of defects and **reduce variation**



Six sigma

❖ is a business strategy, **focusing on:**

- Continuous improvement.
- Understanding **customer needs**
- Analyzing business processes (evaluate process capability)
- Utilizing appropriate performance measures and statistical methodology.

➤ It was **developed** by Motorola in the mid-1980.

□ **Goal:** is the near elimination of defects and **reduce variation** [Juran's "**zero defects**" concept from any process, product, or service.





Key Concepts for Six Sigma:

Key Concepts for Six Sigma	
Critical to Quality	Attributes most important to the customer
Defect	Failing to deliver what the customer wants
Process Capability	What your process can deliver
Variation	What the customer sees and feels
Stable Operations	Ensuring consistent, predictable processes to improve what the customer sees and feels
Design for Six Sigma	Designing to meet customer needs and process capability

Utilizes the DMAIC approach:

1-DEFINE:

Translate the "**voice of the customer**" (complaints, unmet needs, interests, quality perceptions).

Costs and benefits to be realized when the proposed change/project is complete; **develop the purpose, scope, charter; map the process**

2-MEASURE:

Collect baseline data on defects and possible causes, aggregate, display, perform initial analysis
Develop key, realistic input, process, and output measures; establish specific unit cost measures for each critical step in the flow-charted process ; flowchart process in detail to understand the current process

COST UNIT:

cost of unit production included storage till selling.

UNIT COST:

cost include fixing and all variable costs involved in the production.

3-ANALYZE:

Root or **potential causes of current or anticipated** defects, respectively; confirm them with data; and **discover** non value-added process steps, translating both into cost of poor quality.

4-IMPROVE:

Create **possible solutions for root causes** and select solutions, develop plans; pilot each plan, then implement; measure results.

Determine unit cost savings as well as all other benefits to customers

5-CONTROL:

Standardize the work processes; develop the monitoring system.





D



DEFINE

- Launch Team
- Establish Charter
- Plan Project
- Gather the Voice of the Customer
- Plan for Change

M



MEASURE

- Document the Process
- Collect Baseline data
- Narrow project focus

A



ANALYZE

- Analyze Data
- Identify Root Cause
- Identify and Remove Wastes

I



IMPROVE

- Generate Solutions
- Evaluate Solutions
- Optimize Solutions
- Pilot
- Plan and implement

C



CONTROL

- Control the Process
- Validate project benefits



SIPOC: Expanded Example

If you recall, a **SIPOC** is a high-level view of a process. It stands for **Suppliers, Inputs, Process, Outputs** and **Customers**:



SUPPLIER

Person/Organization that provides Input to a Process.



INPUT

Resource that is added to a Process by a Supplier.



PROCESS

Series of steps where an Input converts to an Output.



OUTPUT

Resource that is the result of a Process.



CUSTOMER

Person/Organization that receives products or services.



Step 1

We have identified a process that will involve a patient, ward clerk and nurse...

Supplier	Input	Process	Output	Customer
Patient	Patient Information / Systems	<ul style="list-style-type: none"> • Triage/Reception • Patient Assessment • Assign bed & Admissions • Deliver Care 	<ul style="list-style-type: none"> • Discharge Decision 	Ward Clerk
Ward Clerk	Discharge Decision	<ul style="list-style-type: none"> • Discharge decision/activities 	<ul style="list-style-type: none"> • Patient discharge papers 	Nurse
Nurse	Patient Discharge Papers	<ul style="list-style-type: none"> • Patient discharge 	<ul style="list-style-type: none"> • Discharge 	Patient

Step 6

Identify the Supplier(s) of the corresponding input(s). This will be the supplier from the previous row.

Step 5

Identify the input(s) necessary for the Process to function properly (this will typically be the output of the previous row)

Step 2

In some cases, such as the first row of processes, we link together multiple high level processes.

Step 3

The outputs of one process become the input of the next row

Step 4

Identify the Customer(s) that will receive the corresponding outputs from each process step.



There are **five levels of expertise** in Six Sigma methodology, designated by a **color-belt system**:

Work on local problem-solving teams but not part of Six Sigma teams Have an awareness of Six Sigma aspects

Participate as project team member Reviews process improvements that support the project

Leads Green belt projects and teams Assist with the data collection and analysis for Black Belt projects Integrate Six Sigma implementation into their primary jobs

Leads problem-solving projects Trains & coaches project teams Dedicate all their professional efforts to Six Sigma

Concentrates on Six Sigma implementation Trains and coaches Black and Green Belts Functions at the Six Sigma program level Develops key metrics and strategic direction Assures that Six Sigma processes are applied correctly throughout the organization



➤ There are two additional positions that provide organizational support to the team:

Champions:

are **upper management** who are concerned about the overall Six Sigma implementation and work with mentoring lower-level Six Sigma practitioners, **identifying resources and removing road bloc**

They translate the company's **mission, vision, goals** and measures that will identify individual projects and determine a **project deployment plan**.

Executive leadership:

is the **highest level** and includes the CEO and senior managers. The executives determine the overall strategy for Six Sigma implementation, and establish the strategic focus for the program

CHAMPIONS





LEAN

Focuses on efficiency through the minimization of waste errors and delays.



SIX SIGMA

Focuses on quality and consistency, through process improvement and variation reduction.



LEAN SIX SIGMA

Delivers Customer Value through efficient operations and quality standards.



Speed



Accuracy



Develop an Information Flow Chart :

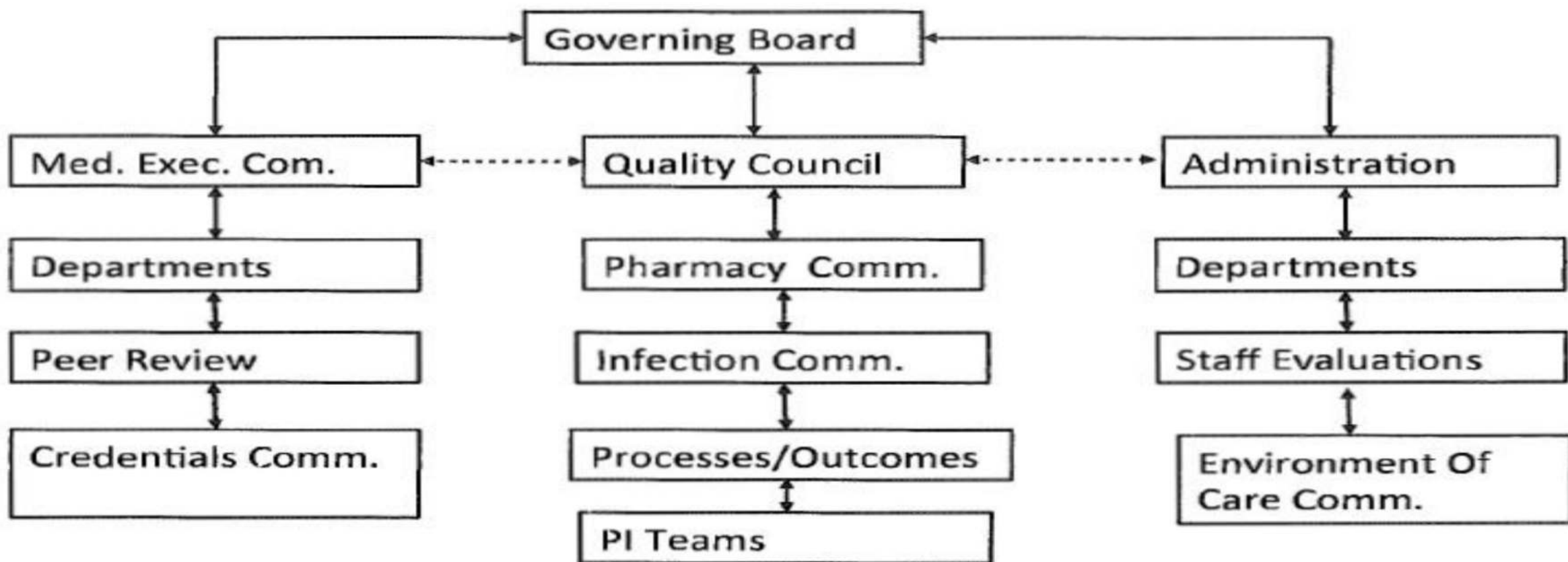
- There must be some form of information flow that is developed for all kinds of information if communication is to be effective .
- As previously discussed, the Quality Council has a flow of information of **how quality information flows** to and from that council
- The committees and departmental meeting minutes also need to have an information flow designated for them.
- This information flow information can be **documented in policies and procedures**, as part of the performance improvement plan, and other such locations. It may also be useful to develop timeframes and expectations of the flow of information

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10. Identify educational needs





QM/PI INFORMATION FLOW





Establish Reporting Routines :

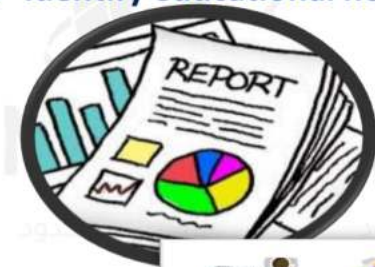
All quality, risk, and utilization management activities should **be reported periodically** in summary form to the **Quality Council**.

Certain information ,should be identified and documented **in the Plan or in policy** and **should be reported** to the various **medical staff** departments and committees or other physician groups, as applicable, and to the governing body.

Teams and departments/services are **calendared** to **present the current status of quality or performance improvement activities** with a written (ideally one-page) **"Outcome Summary"** for distribution.

All directors and/or **managers** are then responsible for dissemination of the information to all staff at department meetings.

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9. Integrate quality principles into organization's policies and procedures
10. Identify educational needs





Integrate Quality Principles into the Organization's Policies and Procedures :

- Quality principles and processes that are utilized in an organization **should be integrated into the policies** and procedures of the organization .
 - Develop, **clarify, confirm or revise**, and integrate all organization policies and guiding statements concerning patient safety, quality of care and service, and performance improvement efforts .
 - If a process is **improved**, the **improvements/changes need to be changed in the policy** and procedures, as appropriate.
1. Definition of the term quality for the organization
 2. Clarify leadership roles
 3. Create an accountability structure
 4. Determine what the name of your program will be (i.e., quality or performance improvement)
 5. Identify the important functions of the organization
 6. Identify approaches to process improvement framework
 7. Develop an information flow chart
 8. Establish reporting routines
 9. Integrate quality principles into organization's policies and procedures
 10. Identify educational needs

Identify Educational Needs:

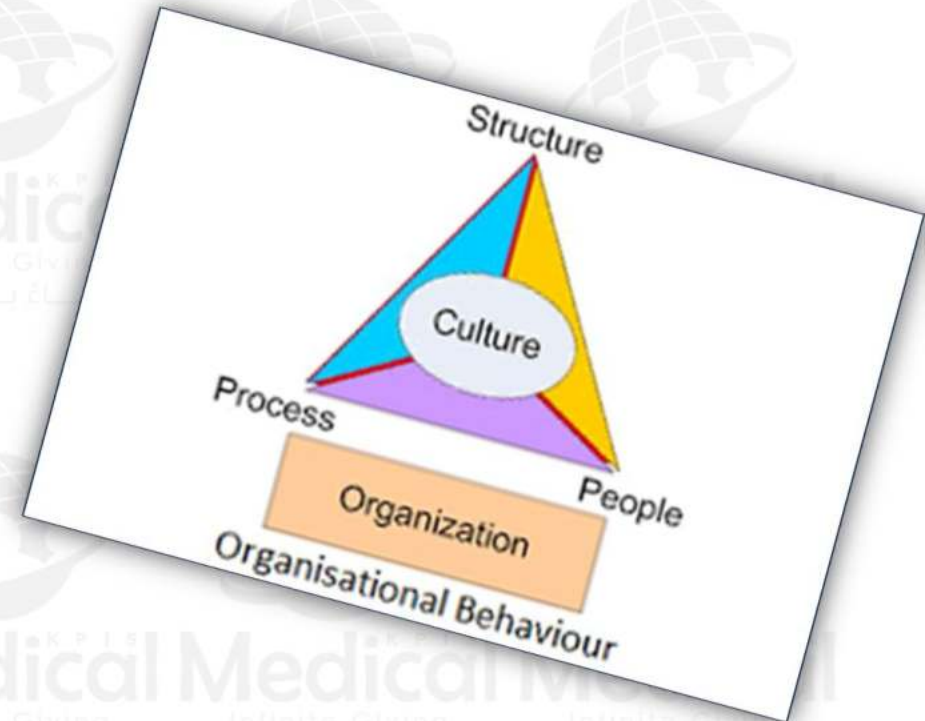
- The educational needs in regard to quality/performance improvement ,risk management and utilization management will vary in each type of healthcare organization.
- It is up to the quality management leaders to **determine** who? requires what? education and to determine the best methodology to deliver that education.
- Specific **educational goals** should be developed along with ways to measure the effectiveness of the teaching.
- The effectiveness should be measured at the conclusion of the educational event, but also later in time to assure that information learned is applied as appropriate in the organization.

1. Definition of the term quality for the organization
2. Clarify leadership roles
3. Create an accountability structure
4. Determine what the name of your program will be (i.e., quality or performance improvement)
5. Identify the important functions of the organization
6. Identify approaches to process improvement framework
7. Develop an information flow chart
8. Establish reporting routines
9. Integrate quality principles into and procedures



The structure and processes are determined by:

1. Organizational culture (degree of leadership commitment to mission, vision, values, people, and the community served)
2. Ability to trust and empower individuals and groups (with information, to make decisions, to change and make change)
3. Ability to relinquish and/or share power and control (information, delegation, resources, influence)
4. Degree to which willingness to change accompanies the "buy-in" to quality (changes in policies, procedures, budgets, schedules, organizational charts, roles and responsibilities, reporting relationships, etc)
5. Depth of understanding of the practical implications of QM :
 - Relationships between board, administration, and physicians (committee structure, flow of reports, leadership participation on QI Council, etc.)
 - Value of networked information management systems, staff time for QI Team activity, and ongoing education.





Organizational Influences for Program Effectiveness :

➤ There are many organizational influences impacting program effectiveness, and these must be considered throughout the development.

1. Organizational culture
2. Governing body support and **involvement**
3. Administrative and management **leadership support** and involvement
4. Medical/professional staff or medical group/IPA support and involvement, as applicable
5. Organizational, team, and committee structures
Scope of services and programs
7. Important organization wide functions
8. Strategic quality **initiatives**.
9. Care and service delivery functions, systems, and processes
- 10. Information** system resources
11. Financial budget and resources
12. Political environment



Quality/Performance Improvement Plan :

- The Quality/Performance Improvement (PI) Plan should be developed by the executive and clinical leadership and must be **approved by the organization's governing body.**
- The plan is **the road map** for all quality related activities, clinical and service related, for the organization.
- The Quality/Performance Improvement plan, generally outlines, the quality performance improvement focus areas for the current and future years.
- The **prioritization of improvement opportunities** should include appropriate strategic initiatives of the organization.
- The **annual PI plan** should be derived from the evaluation of the previous year's plan's activities, organizational priorities, and organizational requirements.

1. Performance improvement program structure
2. Performance improvement plan
3. Implementation of performance improvement program
4. Dissemination of performance improvement information
5. Team
6. Practitioner appraisal process
7. QM & PI orientation and training and education





➤ **five characteristics of a Quality/Performance Improvement Plan:**

- 1. **systematic process** that includes leadership, accountability, and dedicated resources .
- 2. Use of **data and measurable outcomes** in the progress towards evidence-based benchmarks .
- 3. Focuses on linkages, efficiencies, and provider and client expectations when improving outcomes .
- 4. Continuous process that adapts to change within the organization's quality Improvement arena .
- 5. **Data collected** is utilized to assure that the goals of the program are accomplished and they are concurrent with the improved outcomes .





Balance score card

1. It Organize the data with key performance measures (indicators).
2. **Performance measurement** system based on and organized **around the strategic plan**.
3. It is a translation of **mission, vision, and strategic plan** into actions.
4. It gives an **overall snapshot of the organization's status**.
5. It answers “ **How are we doing?**” and “ **Are we there yet?**”.
6. Reflect the priorities of both the organization and its customers & Vision Innovation.
7. It's better than looking for financial issues only . It's **balanced**.





➤ The importance of BSC

1. The main goal to link organisation mission and vision with the strategic plan.
2. Align day to day work which every one is doing with strategy.
3. Prioritise the projects, products and services.
4. Measure the progress toward strategic target.

The four strategic choices:

- **Objectives:** High-level, long-term goals.
- **Measures:** Metrics that help you check your progress toward your objectives.
- **Initiatives:** Key large-scale actions that you're taking to meet your objectives.
- **Action items:** Small-scale actions that you're taking to support your initiatives.

It covers four aspects of your business:

- **Financial:** Your income and outflow. Decreasing costs, increasing income, and opening new sources of revenue.
- **Customer:** How your customers relate to you. Satisfaction levels, market share, brand awareness, and brand sentiment.
- **Internal Processes:** streamlining processes, improving production quality, boosting efficiency.
- **Learning and Growth:** employee skills, knowledge transfer, intellectual property, company culture.

It's called a *Balanced Scorecard* because it helps you balance your strategy across all business areas. This is a key component for creating successful growth in a company.

Dashboard

Support Operational decision

Monitor in real time (Performance monitoring)(snapshot of business performance)

Real time feed

Display performance (KPI)

Visualise performance to understand the current status (NOW)

Balance score card

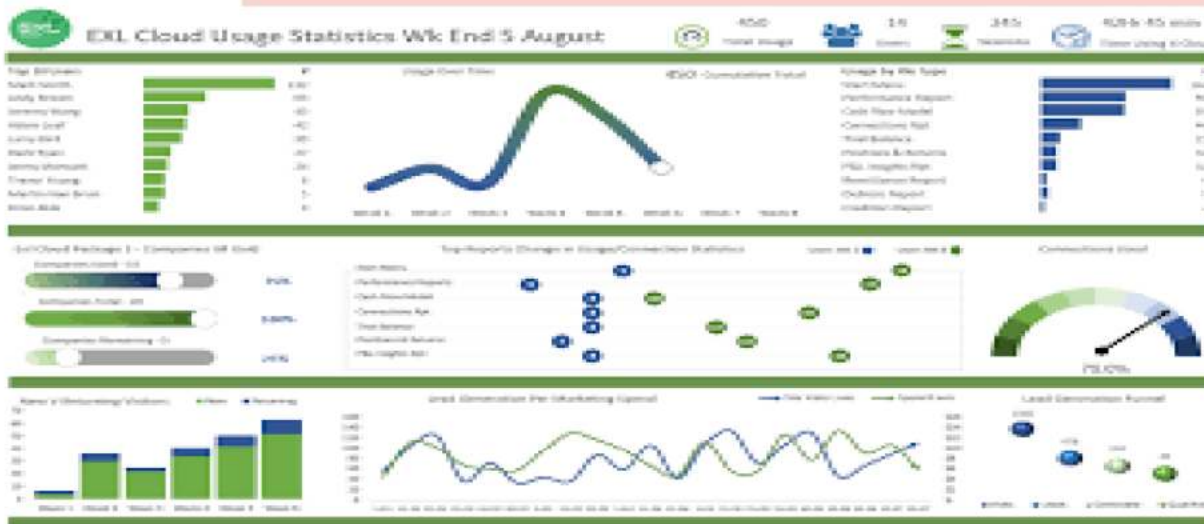
Support strategic plan

Performance management(Progress toward target)

Monthly snapshot (retrospective)

Display Progress (metric against target)

Align KPI, Objective and action to see the connection between them



Objective	Measure	Owner	Target (Mo)	Actuals (Mo)	Trend	On Target	Notes
Acme Corp: Balanced Scorecard							
Financial							
Revenue (\$ millions)	Revenue (USD)	Chris K.	\$100	\$90	↓	●	10% below forecast after
Profit (\$ millions)	Profitability (USD)	Chris K.	\$16.0	\$15.5	→	●	Slightly below plan after
Customers	# of customers	Greta L.	1000	975	↓	●	#1 in sight by EOY on c
Market Share	Market share ranking	John J.	#1	#2	↓	●	Working with team to r
EBITDA	Earnings before Taxes & Depreciation	Chris K.	\$24.0	\$22.5	→	●	Slightly below plan after
Customers							
Number of customers	Number of customers	Jeffrey L.	250	236	↓	●	Trending up from Q1's f
Customer loss	Number of canceled customers	Peter D.	5%	6.5%	↓	●	Working with our cust why this loss has reac
New customers onboarded	Quarterly count of new customers	Jeffrey L.	20	15	→	●	Pipeline looks good for 1 acquisition.
Learning & Growth							
Update New Sales Messaging Training	Quarterly Sales Reviews	Bob S.	150	150	↑	●	Just completed new sal quarterly review session presented.
Intra-Team Dynamics Workshop - Product Team	360 Degree Reviews	Mary S.	50 Employees	25	→	●	Running a bit behind pri people had to miss the v
Lean Six Sigma Workshop for Manufacturing Team	Mfg. Output	Tom T.	100 Employees 1	75	→	●	Tracking to plan here
Internal Business Processes							
Deploy Expense Management Controls	Install new Expense Management offering	Curt S.	5/31/2018	On Time	→	●	Tracking to plan here
Upgrade CRM System to New Release Pak	Upgrade to new CRM service pak release	Andrew I.	6/30/2018	On Time	→	●	New managed service p expected. Should be ab
Finalize ERP Implementation	Complete phase 1 of ERP	Jim O.	12/31/2018	On Time	→	●	Master Data project hc

Table 13: Potential Scorecard Objectives and Measures

Potential Scorecard Objectives and Measures	
Objectives	Possible Measures
Community Perspective	<ul style="list-style-type: none"> • # community-based services or projects (new/linked to needs assessment) • # volunteers • # uninsured patients
Customer Perspective (patients, physicians, employees, other customers)	<ul style="list-style-type: none"> • Satisfaction (patients, physicians, employees) • Point of service survey results (patient services, key suppliers/partners) • Complaints/compliments • (patients, physicians, employees, other customers) • Time to first appointment (selected patient services)
Financial Perspective	<ul style="list-style-type: none"> • Revenue and cost per unit of service; cost/adjusted discharge; reimbursement minus cost per case • Operating and total margins, days accounts receivable, and days cash on hand • FTEs/adjusted occupied bed
Innovation and Growth	<ul style="list-style-type: none"> • Market share • % of revenue from new services • # referring MDs; # patients per referring MD
Operations / Internal Perspective	<ul style="list-style-type: none"> • Utilization: acute/subacute inpatient length of stay; ambulatory encounters per day/month/year by practitioner; case length for key surgical procedures • Access: aggregate wait times; % patients in disease management (actual/ potential); treatment of underserved/uninsured • Clinical Outcomes and Health Status: prioritized by high volume/risk/cost and links to strategic goals. In a corporate setting, some may be applicable to all services and some specific to each service type
Research & Teaching (academic medical center)	<ul style="list-style-type: none"> • # new/# completed research projects • # hours worked per week per resident



الجمعية السعودية للعلاج الطبيعي
Saudi Physical Therapy Association

Medical^{K P I S}
Infinite Giving
عطاء بلا حدود



Thanks

