Improvement Science Toolkit
Toolkit Overview

**Improvement Science Tools Introduction**
1. Process Mapping (Swim Lane Diagram)
2. Brainstorming
3. Affinitizing
4. Prioritizing (Priority Payoff Matrix)
5. Voting (N3)
6. WWW
7. PDSA Form
8. Run Charts

**Additional Tools**
1. Cause and Effect Diagram
2. Failure Mode & Effects Analysis (FMEA)
3. Stakeholder Analysis
4. Elevator Speech

**References**
The tools and techniques shown in this presentation are not an exhaustive list of process improvement tools, but key items that provide the foundations for teams to stay organized, directed, and focused.

Using the tools presented today separately, or in conjunction with one another, will enable teams to examine their processes and observe opportunities for improvement.
Process Mapping

Overview

• Graphical portrait of the steps in a process
  • Clarify the start, end, and key decision points
  • Agree on what the current process is

• Helps to identify areas for improvement

• Built with a good understanding of the process
Good Work...but I think we need just a little more detail right here
Process Mapping
Methods

Swim Lane Diagram

Value Stream Mapping
## Process Mapping Methods

<table>
<thead>
<tr>
<th>Swimlane</th>
<th>SIPOC</th>
<th>Value Stream Maps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactions between different roles</td>
<td>5 to 7 high level process steps</td>
<td>Perspective of the customer or patient</td>
</tr>
<tr>
<td>Task distribution</td>
<td>Identifies key stakeholders of the process</td>
<td>Measures time of the steps &amp; overall process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blueprint for a “Leaner” future state</td>
</tr>
</tbody>
</table>
Process Mapping
Swim Lane Diagram

Cross Functional Process Map

Attributes
1) Steps of the process
2) Sequence of the process
3) Roles and Responsibilities
4) Time of occurrence for each step

Usage
1) Understand the process
2) Determine the scope
3) Identify opportunities for improvement
4) Handouts between different roles/departments
5) Identify resources that are used
Process Mapping
Swim Lane Diagram

**Formation Steps**

**Step 1:** Define problem statement

**Step 2:** Identify the core service and scope

**Step 3:** Set goal and expectations

**Step 4:** Select the team of experts to map the process

**Step 5:** Map the current process

**Step 6:** Validate the mapped process (walkthrough)

**Step 7:** Critique the current process

**Step 8:** Identify the bottlenecks/challenges in the current process
Process Mapping
Swim Lane Diagram

*How to Map the current process*

- Go through each step in the process
- Be specific
- Map the process as it currently is, *not how we wish it was or should be!*
- Use the 80/20 rule when deciding if a process should be mapped
- Use sticky notes to label process steps (they can easily be moved or changed)
- Let the experts of the process step speak to their work
- Keep the process in time order across the flip chart paper
- Clear packing tape can be used at the end to ensure sticky notes remain in place
## Process Mapping

### Swim Lane Diagram

- Identifying bottlenecks/challenges

<table>
<thead>
<tr>
<th>Department</th>
<th>Process</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Start</td>
<td>Preparation</td>
</tr>
<tr>
<td>2</td>
<td>Process 1</td>
<td>Execution</td>
</tr>
<tr>
<td>3</td>
<td>Decision 1</td>
<td>Execution</td>
</tr>
<tr>
<td>4</td>
<td>Process 2</td>
<td>Execution</td>
</tr>
<tr>
<td>5</td>
<td>Process 5</td>
<td>Final</td>
</tr>
<tr>
<td>6</td>
<td>Process 3</td>
<td>Final</td>
</tr>
<tr>
<td>7</td>
<td>Decision 2</td>
<td>Final</td>
</tr>
<tr>
<td>8</td>
<td>Process 4</td>
<td>Final</td>
</tr>
<tr>
<td>9</td>
<td>Process 6</td>
<td>Final</td>
</tr>
<tr>
<td>10</td>
<td>Finish</td>
<td>Final</td>
</tr>
</tbody>
</table>
Process Mapping
Swim Lane Diagram

**Seven Sources of Waste (Non-Value Added)**

1. **Transportation** (moving “things from one place to another)
2. **Inventory** (“things” waiting to be processed)
3. **Motion** (excess movement and/or poor ergonomics)
4. **Waiting** (delays caused by shortages, approvals, downtime)
5. **Overproduction** (producing more than is needed)
6. **Over-processing** (adding more value than the customer is paying for)
7. **Defects/Rework** (correcting mistakes)

- Remembered using the acronym **T.I.M.W.O.O.D.**
- Another waste is: People (untapped or misused resources)
Supplies Needed for Swim Lane Diagrams

1. Flip Chart paper
2. Markers
3. Sticky notes
4. Page marker flags
5. Painter’s tape
6. Clear packing tape
7. Adequate wall space
Decision-Making Process

Brainstorming

Uses:

• To gather a large number of creative ideas
• To identify general process improvement opportunities
• To determine problem areas to analyze
• To identify possible causes
• To generate possible solutions
• To develop content of an implementation plan

Heartburn issues...Remember?
Decision-Making Process

*Brainstorming*

**Rules:**

1. No discussion is needed during the activity
2. Activity is done in a group/team setting
3. All team members should use a marker to write ideas for enhance group visualization and participation
4. Only place one idea per sticky note
Directions:

1. Designate a facilitator
2. Hand out post-its and markers to all team members
3. Ask the team members:
   “Please list all the causes for the areas identified with the colored post-its on the Swim Lane diagram having a negative impact on our goal”
4. The facilitator(s) will collect all sticky notes and place them on a wall for the team to see
5. These steps can be used when brainstorming either causes or solutions
Supplies Needed for Brainstorming

1. Markers
2. Sticky notes
Decision-Making Process

Affinitizing

• Affinitizing also called categorizing
• Organizes a large number of ideas into their natural relationships: Are we saying the same thing?

Directions

1. Designate a facilitator
2. Take any one brainstormed post-it to start the first category
3. Facilitator takes another post-it and asks one question, “Is this post-it similar to the other?”
4. If not similar start a new category
5. Repeat one post-it at a time until all are categorized
6. Create title headings for each category
7. Label the post-its of each category numerically
Decision-Making Process

Affinitizing

- Meeting Compliance
  - No Show
  - Late to Meeting
  - Leaving meeting early

- Meeting Content
  - Off topic discussions
  - No meeting focus

- Distractions
  - Checking emails on phone
  - Using laptop during meeting
  - No agenda
  - Side conversations

Phones
People texting in meeting
**Decision-Making Process**

**Prioritizing (Priority Payoff Matrix)**

**Purpose:** to prioritize each of the challenges or issues into a 2x2 matrix based on 2 factors

<table>
<thead>
<tr>
<th>Payoff / Impact</th>
<th>Ease of Implementation / In our Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td><strong>Easy/In</strong></td>
</tr>
<tr>
<td><strong>“Jewels”</strong></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td><strong>Difficult/Out</strong></td>
</tr>
<tr>
<td><strong>“Low Hanging”</strong></td>
<td></td>
</tr>
<tr>
<td><strong>“High-Hards”</strong></td>
<td></td>
</tr>
<tr>
<td><strong>“DROP”</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Jewels* - High payoff and high ease of implementation.
*High-Hards* - High payoff but low ease of implementation.
*Low Hanging* - Low payoff but high ease of implementation.
*DROP* - Low payoff and low ease of implementation.
Decision-Making Process

Prioritizing (Priority Payoff Matrix)

Rules:
1. Group discussion is highly encouraged during the activity
2. Activity is done in a group/team setting
3. A post-it can straddle a quadrant if the impact or ease to fix is “medium”
Directions:
1. Designate a facilitator
2. Take one of the challenges/issues (post-its) and read it to the team members
3. Ask the team members:
   - “Does the team think this cause/solution would be low or high impact on the process or metric”
   - “Does the team think this cause/solution would be easy or hard to fix”
4. Based on the team’s responses, place the challenge/issue (post-it) into the appropriate quadrant
5. Repeat steps until all post-its have been placed into quadrants
Supplies Needed for Priority Payoff Matrix

1. Flip Chart paper
2. Markers
3. Sticky Notes
4. Painter’s tape
5. Clear packing tape
Decision-Making Process

Voting (N3)

Techniques to Reach Agreement

• Voting – one choice

• Multi-voting – everyone gets number of categories/3 votes

• Full ranking – rank order of preference for each category

There is a time and place for each.
Supplies Needed for Voting

1. Colored circle stickers
Action Plan Form

WWW

• Specifies the goals of the intended change
• Actions to do to achieve goal
• Name(s) of persons responsible for the actions
• Time frame for completing the changes
• Action Plans are critical to document and make visually available all action items planned by the team.

<table>
<thead>
<tr>
<th>What: Action/Commitment</th>
<th>Who: Responsibility</th>
<th>When: Deadline</th>
</tr>
</thead>
</table>
PDSA

**Application of the PDSA Cycle**

- Planning requires prediction
- Prediction requires a theory
- A single observation may require us to modify our theory
- Multiple PDSA cycles can accelerate the learning process
- Choice of plan depends on our “degree of belief” about the change
PDSA Plan

- Describe objective & specific change
- Identify possible “upstream/downstream” impacts
- Specify where fits into process flow
- Who, does what, when, with what tools and training
- Data collection plan: who measures what and displays how and where
- Timeline, owners
- Small sample
- Short period of time

PLAN - Plan for your Test of Change

ISSUE: What is the issue in your process that you will address in this PDSA?

TEST OF CHANGE: What will be changed in the current process?

METRIC: How will the team know if the Test of Change is successful?

PDSA Metric(s) Described in Detail

Sample Size (3-10 data points)

Who is Responsible

Numeric Goal

*For compliance metrics include numerator and denominator or for Turn-Around Time (TAT) metrics include units

**Numeric goal should be either a percentage or a Turn-Around Time (TAT)

WWW: List the steps and responsibilities that will help the team carry out the Test of Change

What are the Steps? Who is Responsible? When Will They Start?

FILL OUT DO STUDY ACT SECTIONS AFTER YOU CARRY OUT THIS PLAN
PDSA

Do

• Carry out the detailed plan
• Provide support
  • Huddle before starting the pilot
  • Check midway
• Encourage debriefs end of day . . .
• Participants keep notes

DO – Observations after carrying out the Plan
List what worked well:

List what could have gone better:
Debrief at end of pilot
What went well?
What could be improved?
Lessons learned

**STUDY** – Feedback and Lessons Learned after carrying out the Plan

Based on the team’s data: Did the metric improve, worsen, or remain the same compared to your last cycle?

- Improve □
- Worsen □
- Remain the Same □

Did the team meet the goal?
- No □
- Yes □

If No: What is the current average? Please explain the Root Causes

If Yes: Are there any data points that do not meet the goal? Why did they not meet the goal? Please explain the Root Causes.
PDSA

Act

- Plan next steps
  - Adjust
  - Expand
  - Discard

ACT – What did the team conclude from this cycle?
As a result of this PDSA cycle, select a decision about this Test of Change:

Adjust □  Expand □  Discard □

Explain the team’s selected decision for your next PLAN:

Congratulations on completing this PDSA cycle: Continue on to the next PDSA cycle and PLAN for your decision!
Run Charts
Overview

• Graphical display of data plotted in some type of order.
• Easy to construct & interpret
• Enables team to determine if a change resulted in an improvement
• Visual tool for sustainability
• Can be computer generated or constructed manually
Run Charts

Overview

- Improvements are made over time, in order to facilitate learning and communication, measures should be displayed on run charts.

- Time-ordered charts provide the primary way to assess the impact of each PDSA cycle.

- Better than Before-and-After, feedback is constant & ongoing.

- Key changes can be annotated on the charts to begin analysis of the impact of the changes.
Run Charts

Seven Steps for Creation

1. State the question the run chart will answer
2. Label the horizontal scale (time, each patient....)
3. Label the vertical scale - easy to read. Ample room for future data
4. Plot the data points and connect with the line
5. Title the graph
6. Calculate the median (number in the middle of the data set)
7. Annotate unusual events

![Run Chart of Customer Complaints](image)
Additional Tools

The following tools will assist teams in discovering areas to focus on, assess stakeholders and gain buy-in
Additional Tools

Cause and Effect Diagram

“Fishbone Diagram”

• Helps to ID possible causes related to a problem or a condition
• The team focuses on the content of the problem “not the history”
• Creates a snapshot of collective knowledge
• Builds support for resulting solutions
Challenges to Implement the 3 Hrs Bundle on the Floor

- Lab Delay
  - Lab Volume
  - Specimen Labeling
    - No one to Deliver Specimen
  - Lactates Ordered Routine
    - Phlebotomy Resources
- Med Delay
  - Short Staff to deliver Meds
  - Incorrect Dose
    - Specimen Labeling
  - Drug Interaction
- Allergy to Meds
  - HT/WT Discrepancies
  - Hospitalist Doesn’t Recognize SIRS
    - MD Availability
      - Not on Board with Bundle
        - Not repeat Lactate
          - MD Issues
  - RN Obtain Specimen
    - Critical Call – Getting RN
      - RN Cannot Visualize MEWS Score
        - RN Not Assessing Right Away
          - RN Not Assessing Appropriately
            - RN/NA Education
  - Specimen Labeling
    - Nurse Doesn’t Know ABX is on UNIT
      - RN Not Aware of Importance of ABX Administration
FMEA is a simple, but powerful tool

A process for systematically identifying potential problems before they occur.

**FMEA is used to:**
- Identify What Can Fail
- Identify How It Can Fail
- Estimate Risk of Failure
- Determine Effect of Failure
- Evaluate Control Plans
- Prioritize Actions

**FMEA can be used for:**
- Complex Processes
- New Products
- Safety, Environmental and Financial Concerns
- Customer Requirement Planning

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**FMEA is a simple, but powerful tool**
## Additional Tools

**Failure Mode & Effects Analysis (FMEA)**

<table>
<thead>
<tr>
<th>Process Step / Input</th>
<th>Potential Failure Mode</th>
<th>Potential Failure Effects</th>
<th>Potential Causes</th>
<th>Current Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the process step and Input under investigation?</strong></td>
<td>In what ways does the Key Input go wrong?</td>
<td>What is the impact on the Key Output Variables (Customer Requirements)?</td>
<td>What causes the Key Input to go wrong?</td>
<td>What are the existing controls and procedures (inspection and test) that prevent the cause or the Failure Mode?</td>
</tr>
</tbody>
</table>

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**Additional Tools**

- Failure Mode & Effects Analysis (FMEA)
Ratings to Risk Factors

- **Severity (SEV)**: How significant is the impact of the Effect to the customer (internal or external)?
- **Occurrence (OCC)**: How likely is the Cause of the Failure Mode to occur?
- **Detection (DET)**: How likely are the current controls to detect the Cause if it occurs before the risk is passed to the customer?

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Least Significant</th>
<th>Most Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Likely to Occur</td>
<td>Likely to Occur</td>
</tr>
<tr>
<td>10</td>
<td>Likely to Detect</td>
<td>Not Likely to Detect</td>
</tr>
</tbody>
</table>

FMEA includes detection in the risk equation
Additional Tools

**Failure Mode & Effects Analysis (FMEA)**

Quantifying Overall Risk

**Risk Priority Number (RPN)**

- A numerical calculation of the relative risk of a particular Failure Mode
- RPN = Severity x Occurrence x Detection
  
  SEV x OCC x DET
- This number is then used to place priority on which items need additional quality planning or to have an abatement plan developed
- Lower rating means less risk

*The RPN provides an action point for our FMEA*
### Standardization of Ratings

<table>
<thead>
<tr>
<th>Rating</th>
<th>Degree of Severity</th>
<th>Likelihood of Occurrence</th>
<th>Ability to Detect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Customer will not notice the adverse effect or it is insignificant</td>
<td>Likelihood of occurrence is remote</td>
<td>Sure that the potential failure will be found or prevented before reach the next customer</td>
</tr>
<tr>
<td>2</td>
<td>Customer will probably experience slight annoyance</td>
<td>Low failure rate with supporting documentation</td>
<td>Almost certain that the potential failure will be found or prevented before reaching the next customer</td>
</tr>
<tr>
<td>3</td>
<td>Customer will experience annoyance due to the slight degradation of performance</td>
<td>Low failure rate without supporting documentation</td>
<td>Low likelihood that the potential failure will reach the next customer undetected</td>
</tr>
<tr>
<td>4</td>
<td>Customer dissatisfaction due to reduced performance</td>
<td>Occasional failures</td>
<td>Controls may detect or prevent the potential failure from reaching the next customer</td>
</tr>
<tr>
<td>5</td>
<td>Customer is made uncomfortable or their productivity is reduce by the continued degradation of the effect</td>
<td>Relatively moderate failure rate with supporting documentation</td>
<td>Moderate likelihood that the potential failure will reach the next customer</td>
</tr>
<tr>
<td>6</td>
<td>Warranty repair or significant manufacturing or assembly complaint</td>
<td>Moderate failure rate without supporting documentation</td>
<td>Controls are unlikely to detect or prevent the potential failure from reaching the next customer</td>
</tr>
<tr>
<td>7</td>
<td>High degree of customer dissatisfaction due to component failure without complete loss of function. Productivity impacted by high scrap or rework levels,</td>
<td>Relatively high failure rate with supporting documentation</td>
<td>Poor likelihood that the potential failure will be detected or prevented before reaching the next customer</td>
</tr>
<tr>
<td>8</td>
<td>Very high degree of dissatisfaction due to the loss of function without a negative impact on safety or governmental regulations</td>
<td>High failure rate without supporting documentation</td>
<td>Very poor likelihood that the potential failure will be detected or prevented before reaching the next customer</td>
</tr>
<tr>
<td>9</td>
<td>Customer endangered due to the adverse effect on safe system performance with warning before failure or violation of governmental regulations</td>
<td>Failure is almost certain based on warranty data or significant DV testing</td>
<td>Current controls probably will not even detect the potential failure</td>
</tr>
<tr>
<td>10</td>
<td>Customer endangered due to the adverse effect on safe system performance without warning before failure or violation of governmental regulations</td>
<td>Assured of failure based on warranty data or significant DV testing</td>
<td>Absolute certainty that the current controls will not detect the potential failure</td>
</tr>
</tbody>
</table>
## Additional Tools

### Failure Mode & Effects Analysis (FMEA)

<table>
<thead>
<tr>
<th>Process Steps</th>
<th>Potential Failure Mode</th>
<th>SEV</th>
<th>Potential Causes</th>
<th>OCC</th>
<th>Current Controls</th>
<th>DET</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Identified as Septic</td>
<td>Delay in Diagnosis</td>
<td>10</td>
<td>Infection present but not suspected</td>
<td>3</td>
<td>7</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>Labs not ordered</td>
<td>4</td>
<td>8</td>
<td>320</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>Labs not resulted, timely</td>
<td>4</td>
<td>7</td>
<td>280</td>
<td></td>
</tr>
<tr>
<td>Surgical Consult Ordered</td>
<td>Delay in consult</td>
<td>8</td>
<td>Order not written at time of triage, etc</td>
<td>2</td>
<td>10</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>Surgeon failed to arrive for consultation within 24 hours of consult being written</td>
<td>3</td>
<td>Policy &amp; Procedure</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>OR slots not available at immediate moment</td>
<td>5</td>
<td>Work w/OR booking</td>
<td>4</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>Delay in surgeons determination for intervention</td>
<td>5</td>
<td>7</td>
<td>280</td>
<td></td>
</tr>
<tr>
<td>Abnormal Labs/Vital Signs (indicative of sepsis)</td>
<td>Not reviewed by physician in prescribed time</td>
<td>7</td>
<td>Not resulted timely</td>
<td>7</td>
<td>Review EDIS/Series</td>
<td>6</td>
<td>294</td>
</tr>
<tr>
<td>EGDT: 3 Hour Elements Completed</td>
<td>Patient not treated within prescribed time</td>
<td>10</td>
<td>Labs/Blood Cultures not drawn</td>
<td>3</td>
<td>10</td>
<td>340</td>
<td></td>
</tr>
<tr>
<td>EGDT: 6 Hour Elements Completed</td>
<td>Elements stopped – patient still septic</td>
<td>10</td>
<td>Labs/Vitals not repeated</td>
<td>2</td>
<td>10</td>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

### VARIABLES

- TAT Time Zero to lactate ordered
- Y/N blood cultures drawn
- TAT Time Zero to 1st dose of antibiotics administered
- Fluid bolus ordered
- Volume of fluid bolus sufficient
- TAT decision to admit until transfer to unit
The effectiveness ($E$) of the result is equal to the Quality ($Q$) of the solution times the Acceptance ($A$) of the idea.

$$Q \times A = E$$

Six Sigma, Lean and PDSA Methodologies

Change Acceleration Process

Effective Results

Fast Track Decision-Making

LEAN

A proven formula for results.
Additional Tools

**Stakeholder Analysis**

**Uses:**

- Helps the team answer the questions:
  - “Who are the key stakeholders?”
  - “Where do they stand on the issues associated with this change initiative?”
  - “Where do we need them to be in terms of their level of support?”

- Help the team discover influence relationships and strategies that will be effective for each key stakeholder
Types of Resistance- Technical-Political-Cultural

Uses:
• Seek to identify, label and understand “sources of resistance” as either:
  • Technical (lack of skills, lack of critical resources, etc.)
  • Political (issues of influence and authority, threats to the “old guard”, etc.)
  • Cultural (“sacred cows”, mindsets, habits, etc.)
• Enable the team to thoroughly understand the nature of resistance and the specific strategy to use to influence and gain support
## Stakeholder Analysis

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>WHERE THEY ARE NOW</th>
<th>WHERE WE WANT THEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DEFINE</td>
<td>MEASURE</td>
</tr>
<tr>
<td>SA (-2)</td>
<td>MA (-1)</td>
<td>N</td>
</tr>
<tr>
<td>STAKEHOLDER A</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>STAKEHOLDER B</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER C</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER D</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAKEHOLDER F</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER G</td>
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<tr>
<td>STAKEHOLDER H</td>
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<td>STAKEHOLDER I</td>
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<tr>
<td>STAKEHOLDER J</td>
<td></td>
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<tr>
<td>STAKEHOLDER K</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER L</td>
<td></td>
<td></td>
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<tr>
<td>STAKEHOLDER M</td>
<td></td>
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Additional Tools

Elevator Speech

• You are in an elevator with a key stakeholder in your project. You have 90 seconds to describe the vision and need of this project.

• What is your project about?
• Why are you doing it?
• How is it going to benefit the organization?
• What do you expect from the stakeholder?

Communication with a clear purpose helps to overcome resistance.
Team Time

1. Create a swim lane diagram of your current process
2. Identify bottlenecks/issues
3. Brainstorm issue causes
4. Affinitize & prioritize causes
5. Brainstorm & prioritize solutions
6. Design a PDSA

90 minutes
References

