QI Project Report Back

Session 2 – June 21st, 2022

Facilitators: Lori and Hrishi

e-QiP
Excellence through Quality
Improvement Project
Community-focused. Data-driven.

Land Acknowledgement

Agenda

#1 Welcome & Opening Remarks

#2 AMHS-HPE

#3 CMHA Grey Bruce

#4 The Vitanova Foundation

#5 Youth Habilitation Quinte INC

#6 Next Steps

#7 Staying Connected

Addictions and Mental Health Services - Hastings Prince Edward

Organization: Addictions and Mental Health Services
Project Title: Building the Justice House

Project Status as of: June 13, 2022

THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)

COHORT 6 REPORT BACK

PRESENTATION DATE: June 21, 2022

Project Story:

Begin with a brief story to describe your improvement project:

- Our team grew quickly and following that COVID happened
- We knew that there was some disconnection within the team, and we wanted to work on our flow

Our team came together and worked on finding opportunities for growth

and improvement, and improved process flows. We learned new tools, and

strategies to help us focus on building a more cohesive team.
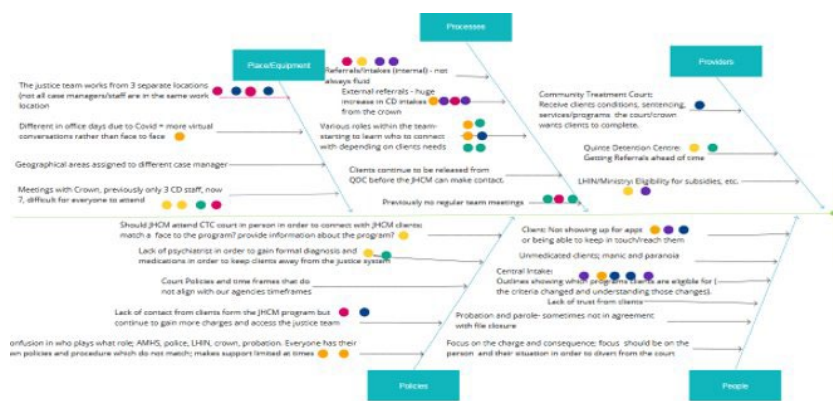
Problem/Opportunity Statement

Since December 2019, the program has expanded and there was a pandemic. There was not sufficient time to build a cohesive team and standardize process/protocols. We have an opportunity to develop a cohesive program that manages growth, improves the client experience and ensure future sustainability
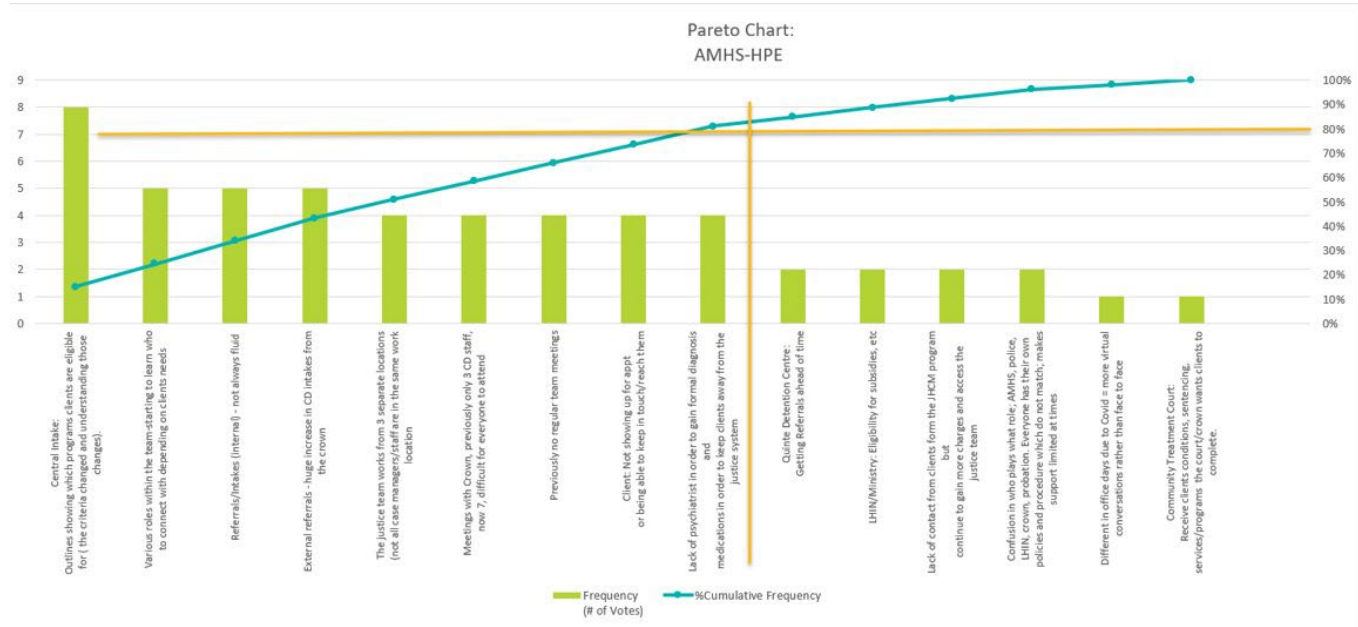
AIM Statement

By March 31, 2023, we aim to improve team processes and client flow and we will utilize OPOC data to measure overall client experiences.
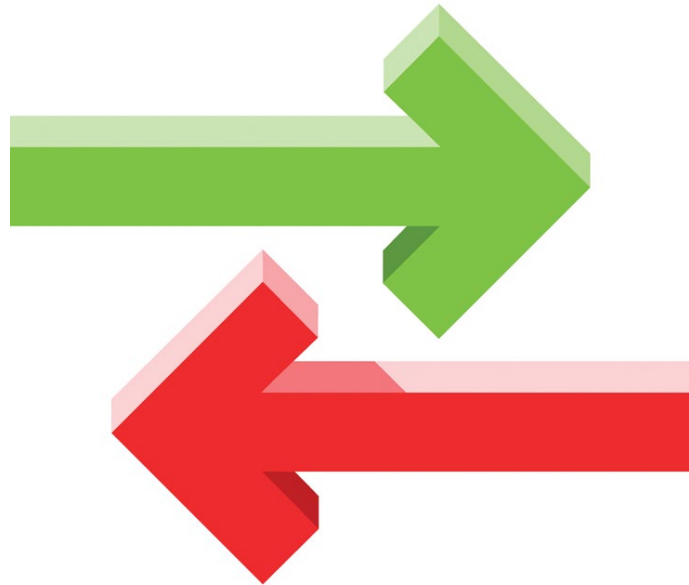
Diagnostic Tools – The Vital Few.

Change Ideas:
TRIZ
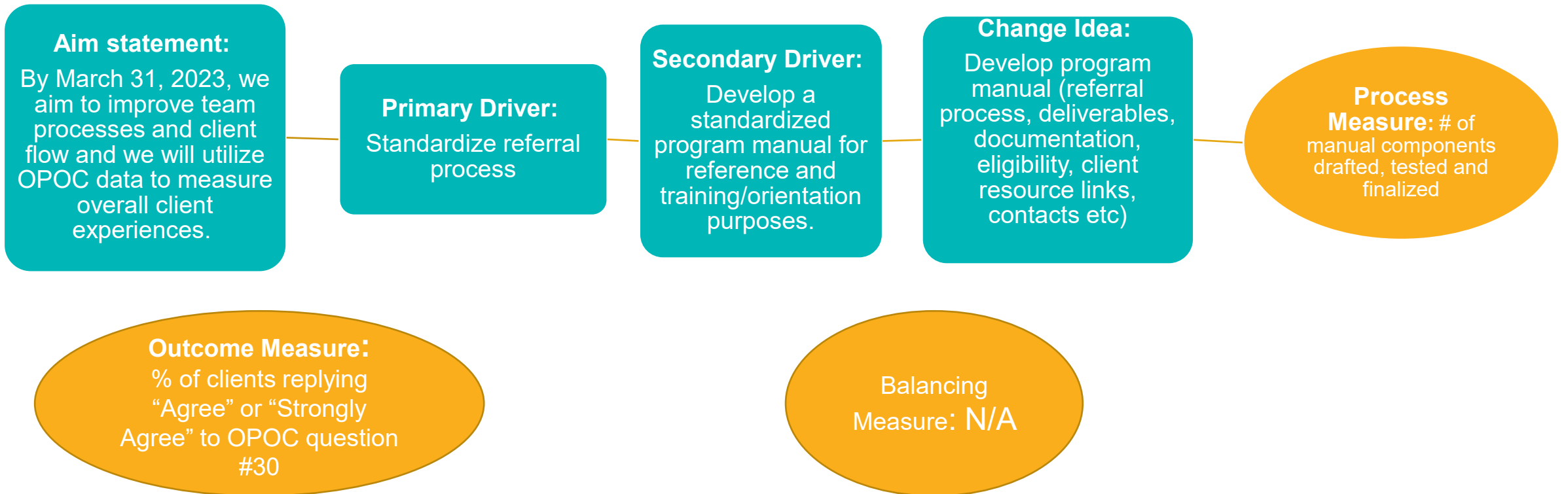# (an exercise of opposites)

We tested the idea of having staff in one office, to promote communication and collaboration. We will know it is successful when move is completed and staff have regular team contact.
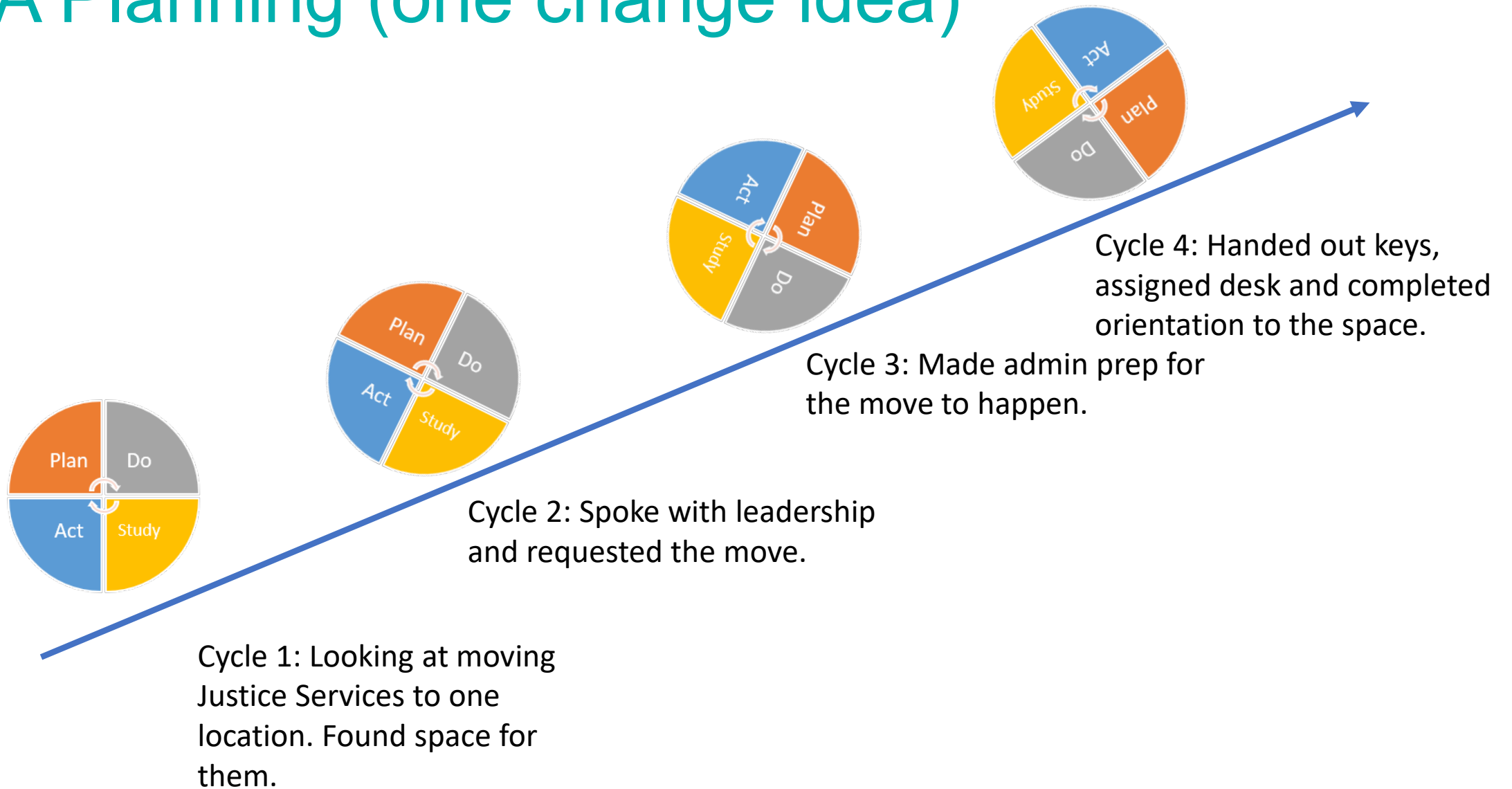
TRIZ Exercise

Problem Statement or Root Cause: Since December 2019, the program has expanded and there was a pandemic. There was not sufficient time to build a cohesive team and standardized processes/protocols. We have an opportunity to develop a cohesive program that manages growth, improves the client experience and ensures future sustainability.

How could you and your team make the problem worse?	Reversed Ideas (Positive)
Less communication between team members	Schedule regular meetings with "team" to discuss new clients, referrals, protocols etc
Still not having targets to meet or being aware of these	At the beginning of each fiscal, Data Analyst will provide the team with their mandatory targets, goals and supplementary indicators.
Not making the referral process into the program more seamless	Developing a step by step referral guide within the program as a reference point
More agency wide and staffing changes	Develop a process for a warm transfer of clients between previous case manager and new case manager. / Agency to provide lunch and learns on new programs within the agency and share recordings to all staff
No standardized program manual - for current staff to reference and new staff to be trained from	Develop program manual (referral process, deliverables, documentation, eligibility, client resource links, contacts etc) / Store the program manual in a location that the whole team can access (online?) / Review manual on an annual basis / Develop orientation process
Clients being thrown into virtual appointments right away	Transition clients to virtual smoothly create the steps for clients to access and use Zoom • Showing clients how to use zoom • Emailing client resource links
Pandemic/Lockdowns: losing clients' interest/motivation due to lack of face-to-face interactions or province protocols changing continuously	Providing clients with a covid kit of supports in community and at the organizational level during lockdown that are continuing to operate face to face if they prefer or virtually
Workloads increasing	Monitor workloads regularly through direct supervision and develop process to mitigate if they reach a threshold / Direction on how to slowly close out client files that have reached their goals (EMHWare instruction)
Continue having several different office locations.	Move staff into the same office locations in 2022. / If office locations remain dispersed, then plan specific times to touch base weekly. Team meetings with program staff regularly if not in the same location due to office space availability (check in 2x week within the programs JCM, JHCM and CD if not in same location)
Increased waitlist times for services / supports within agency including psychiatry (staff switching programs, staff time off, psychiatry appts on hold)	If there is a delay with Dr Zimmerman appointments, then identify where to direct clients externally for psychiatry if services are on hold or restricted via agency wide email. Perhaps in the resource list.
Forms not being up to date online (emhware)	Send forms to Data Analyst to revise as required (this can also go into the manual) / Update forms to be more user friendly

Driver Diagram (mini)

Aim statement:
By March 31, 2023, we aim to improve team processes and client flow and we will utilize OPOC data to measure overall client experiences.

Primary Driver:
Standardize referral process

Secondary Driver:
Develop a standardized program manual for reference and training/orientation purposes.

Change Idea:
Develop program manual (referral process, deliverables, documentation, eligibility, client resource links, contacts etc)

Process Measure: # of manual components drafted, tested and finalized

Outcome Measure:
% of clients replying "Agree" or "Strongly Agree" to OPOC question #30

Balancing Measure: N/A

PDSA Planning (one change idea)

Cycle 4: Handed out keys, assigned desk and completed orientation to the space.

Cycle 3: Made admin prep for the move to happen.

Cycle 2: Spoke with leadership and requested the move.

Cycle 1: Looking at moving Justice Services to one location. Found space for them.

PDSA Planning #2 (one change idea)

Cycle 4: Shared manual with another program to ask for input and ensure clarity with work so far.

Cycle 3: Made necessary changes and showed program flow and descriptions

Cycle 2: Created a shared to do list for coordinating the team and tasks

Cycle 1: Find a template manual to start from

Lessons Learned / Ah-ha Moments

- *Highlight **ONE** of your most significant learning moments:*
  - *Utilizing the tools provided and making time weekly has gone a long way to making a potentially overwhelming project seem doable. We have worked well as a team and this was a huge success.*

- *How will you know when your project is at the point of 'sustainability'?*
- *Our project was about building a program foundation and that has happened just with participation in the project. Successfully completing our change ideas with continue by giving us our guidelines for sustainability.*

CMHA Grey Bruce

Project Title: Client Feedback Project

Project Story:

- We don't collect enough client feedback data to effectively monitor our successes and opportunities.

- We met with staff to learn what processes they are using to collect client feedback, and what challenges they face.

- We introduced standardization and survey administration procedures.

- We learned the value of PDSA cycles and the need to pivot when things don't go as planned

- We learned the value of reporting back data for staff buy-in

Problem/Opportunity Statement

- CMHAGB is missing opportunities to improve client services and shape organizational QI and data culture. We are currently unable to use client and family feedback in determining objective measures that align to our strategic directions. We lack a standardized procedure for collecting and evaluating client and family experience feedback and analyzing the data for quality improvement and organizational enhancement.
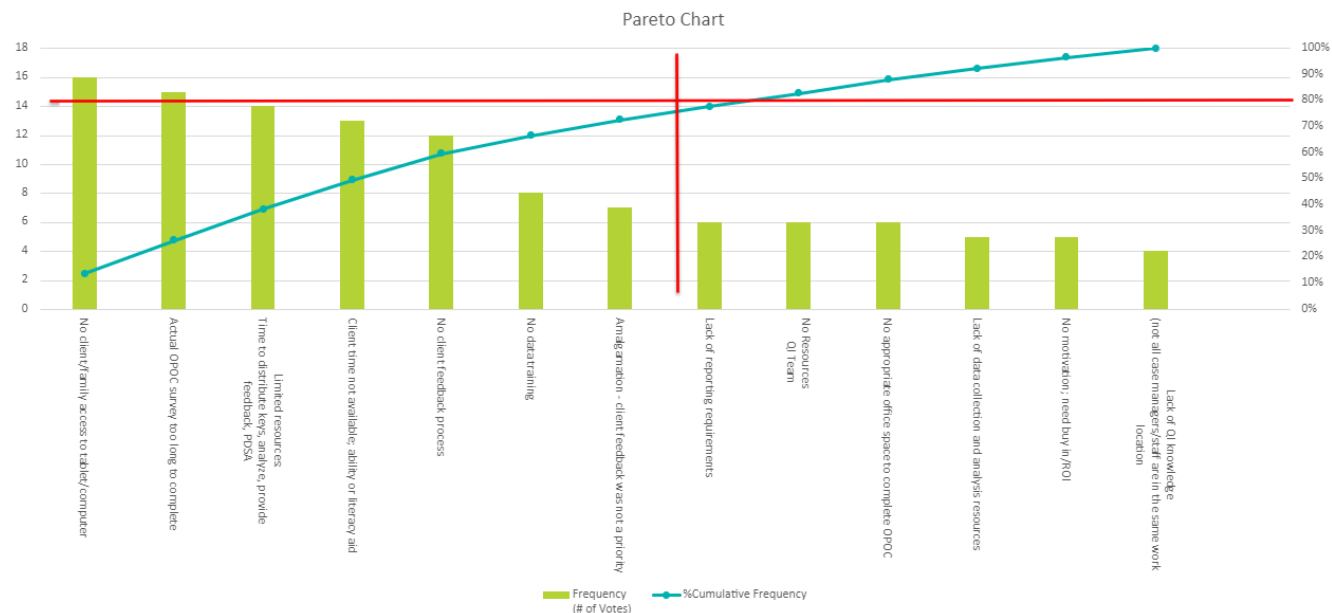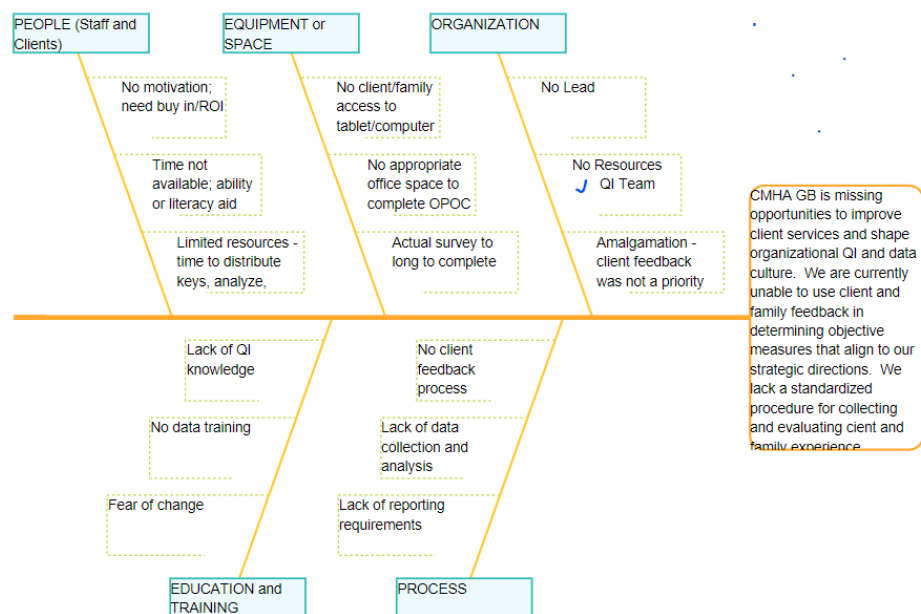
AIM Statement

- By December 31, 2022, we will increase CMHAGB's % return rate of the OPOC from 9 to 40%.

Diagnostic Tools – The Vital Few.

Pareto Chart

Frequency values (bars): 16, 15, 14, 13, 12, 8, 7, 6, 6, 6, 5, 5, 4

Y-axis left: 0, 2, 4, 6, 8, 10, 12, 14, 16, 18
Y-axis right: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%

Categories:
- No client/family access to tablet/computer
- Actual OPOC survey too long to complete
- Time to distribute keys, analyze, provide feedback, PDSA
- Limited resources
- Client time not available, ability or literacy aid
- No client feedback process
- No data training
- Amalgamation - client feedback was not a priority
- Lack of reporting requirements
- No Resources QI Team
- No appropriate office space to complete OPOC
- Lack of data collection and analysis resources
- No motivation; need buy in/ROI
- Lack of QI knowledge (not all case managers/staff are in the same work location)

Legend:
- Frequency (# of Votes)
- %Cumulative Frequency

FISHBONE TEMPLATE

PEOPLE (Staff and Clients)
- No motivation; need buy in/ROI
- Time not available; ability or literacy aid
- Limited resources - time to distribute keys, analyze,

EQUIPMENT or SPACE
- No client/family access to tablet/computer
- No appropriate office space to complete OPOC
- Actual survey to long to complete

ORGANIZATION
- No Lead
- No Resources ✓ QI Team
- Amalgamation - client feedback was not a priority

CMHA GB is missing opportunities to improve client services and shape organizational QI and data culture. We are currently unable to use client and family feedback in determining objective measures that align to our strategic directions. We lack a standardized procedure for collecting and evaluating client and family experience

EDUCATION and TRAINING
- Lack of QI knowledge
- No data training
- Fear of change

PROCESS
- No client feedback process
- Lack of data collection and analysis
- Lack of reporting requirements

Change Ideas

- Change Concept List
  - #51: Standardization
  - #13: Schedule into multiple processes
  - #31: Conduct Training

  - Develop program specific OPOC survey administration plans (standardize administration within each program).

  - We will know that the change is an improvement when we see an increase in OPOC survey distribution and rate of return.
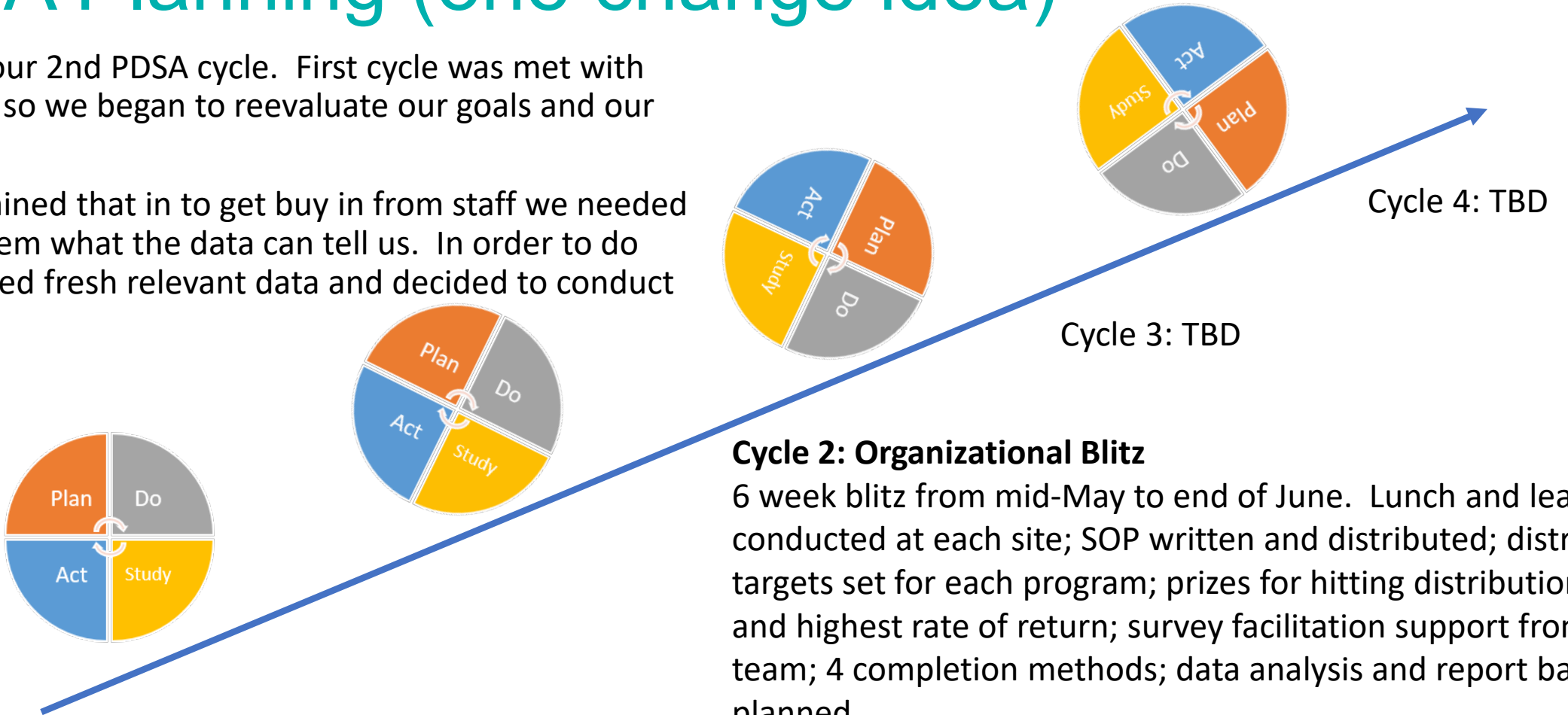
Impact/Effort Grid

- What did you learn from the Impact/Effort grid for the PDSA cycles?

  - Most of our change ideas are major projects that will require a significant amount of effort.

  - No changes ideas to rethink ☺

  - Our quick wins and change ideas to schedule will be part of our major project PDSA cycles (example: "Set monthly targets for a gradual increase" included in PDSA for "Using process mapping, document implementation plans and procedures for each program's feedback collection plan" and is directly related to "Determine increase required to reach 40% for each program")
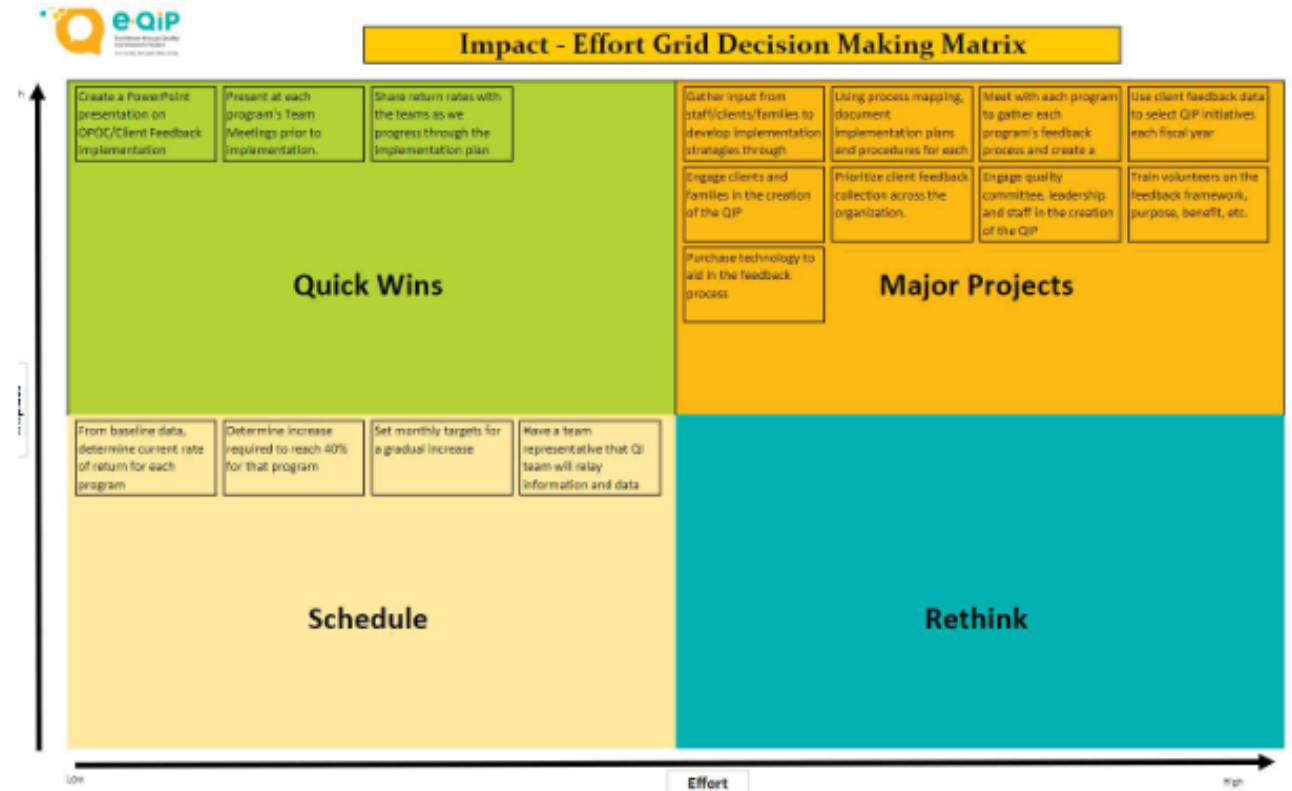
PDSA Planning (one change idea)

We are in our 2nd PDSA cycle. First cycle was met with resistance, so we began to reevaluate our goals and our approach.

We determined that in to get buy in from staff we needed to show them what the data can tell us. In order to do this, we need fresh relevant data and decided to conduct a blitz.

Cycle 4: TBD

Cycle 3: TBD

Cycle 2: Organizational Blitz
6 week blitz from mid-May to end of June. Lunch and learns conducted at each site; SOP written and distributed; distribution targets set for each program; prizes for hitting distribution targets and highest rate of return; survey facilitation support from QI team; 4 completion methods; data analysis and report back planned.

Cycle 1: Clients of Mental Health and Addiction Services; Group Sessions
This plan was met with resistance from staff. We re-evaluated our goals and decided to pivot to a different approach.

Run Chart for Process Measures
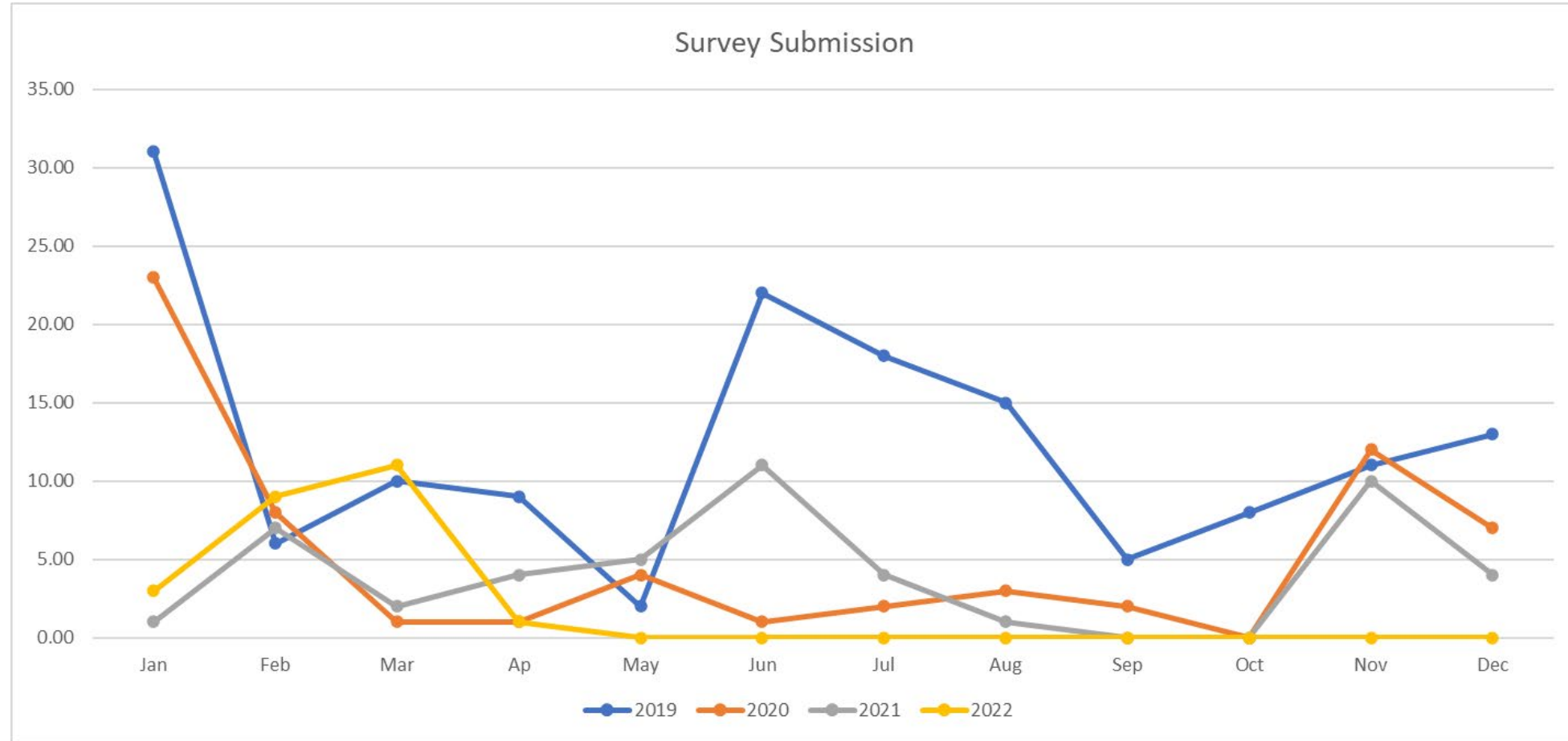
Lessons Learned / Ah-ha Moments

- Next time, we would prioritize meeting with clients/families earlier in the process.

- We learned that one of the most significant barriers in this project was staff buy-in regarding the OPOC in general.

- We will know we're at a point of sustainability once we have run chart data that demonstrates that our distribution and rate of return targets are being met consistently, and that procedures are being followed in each program.

The Vitanova Foundation

Project Story:

Since Vitanova has embarked on a paperless journey, we have also been reviewing processes and administrative functions as it relates to the clients journey through our program. It was determined by staff feedback that current administrative processes relating to the discharge process/tools were strenuous and as a result were not completed consistently resulting in a lack of discharge statistics.

This also used up the counsellors time/resources that could otherwise be dedicated to enhancing the clients overall discharge process and planning.

This resulted in an identified need for:

1. A more user friendly discharge tool

2. More consistent data collection tool

3. Overall staff training on new processes

Problem/Opportunity Statement

QUESTIONS	SAMPLE RESPONSES	OUR RESPONSES TO THE QUESTIONS
WHAT is the problem?	*Client discharge plans not being completed.*	The discharge planning process is more administrative in nature and not as client centered as it could be. It also requires more efforts and time as it is not yet fully paperless. The discharge summary is not user friendly therefore is not being completed by counsellors consistently
WHY is it a problem?	*When discharge plans are not completed, crisis staff don't have the information needed to support the client.*	This is a problem as the client and counsellor may verbally speak of plans but not make them concrete with the better utilization of the discharge tool. The clients time is not being utilized as effectively as it could be with a more formal process in place for discharge planning. The referral process may be negatively impacted by this as well
WHERE do we observe the prob.?	*In the crisis call centre.*	This is observed in our day and residential program upon discharge
WHO is impacted?	*Crisis workers, but ultimately the clients*	The client is negatively impacted as their discharge process may not be as thorough, the counsellor struggles to navigate a complicated discharge package
WHEN did we first observe the problem?	*One month after the implementation of one clients discharge plan*	It has been on-going, but primarily since the move to paperless files was initiated as we have been revamping forms used in the client's file
HOW does it affect clients/staff	*Crisis workers are frustrated*	The client is not always sufficiently prepared for discharge (e.g. relapse prevention plan, 1-month plan, 3-month plan etc.), supports are not always prepped with the discharge plan (e.g. family meeting isn't scheduled before discharge)
HOW often does it occur?	*Daily*	At every discharge

Problem/Opportunity based on the above responses:

The client discharge process is administrative in nature and thereby lacks the client centered approach that is found in the client's other phases of care. This can result in the client not leaving as confident and informed about their next steps as possible.

AIM STATEMENT

100% of clients will be discharged with the updated discharge planning process by June 2022)

5 WHYS

Use the boxes on this worksheet to write down your answers to the question "Why is this happening?" until you arrive at a cause you can take action on. Write your five whys in the boxes below.

ROOT CAUSE/CONTRIBUTING FACTOR:

A-Tool is asking for irrelevant information
B-Tool is confusing to staff
C-Any such tool requires adequate staff training, as is obvious with the current tool

WHY?

A-The principal discharge questionnaire is based on the program logic model Vitanova developed probably two decades ago
B-There lacks a standard checklist to help guide staff through discharge process
C-Time for training is limited, alot of new staff have come on board. Covid has drained many resources

WHY?

A- This was the form of program assessment at that time (The whole process needs to be revamped in order to develop)
B- It wasn't until accreditation and OPOC that we realized that the tool may not be suffcient for present day programming and the agencies development over the years
C- In response to moving paperless and improvements provoked by accreditation, the agency has revamped many documents and procedures that has been a time demanding task for managment
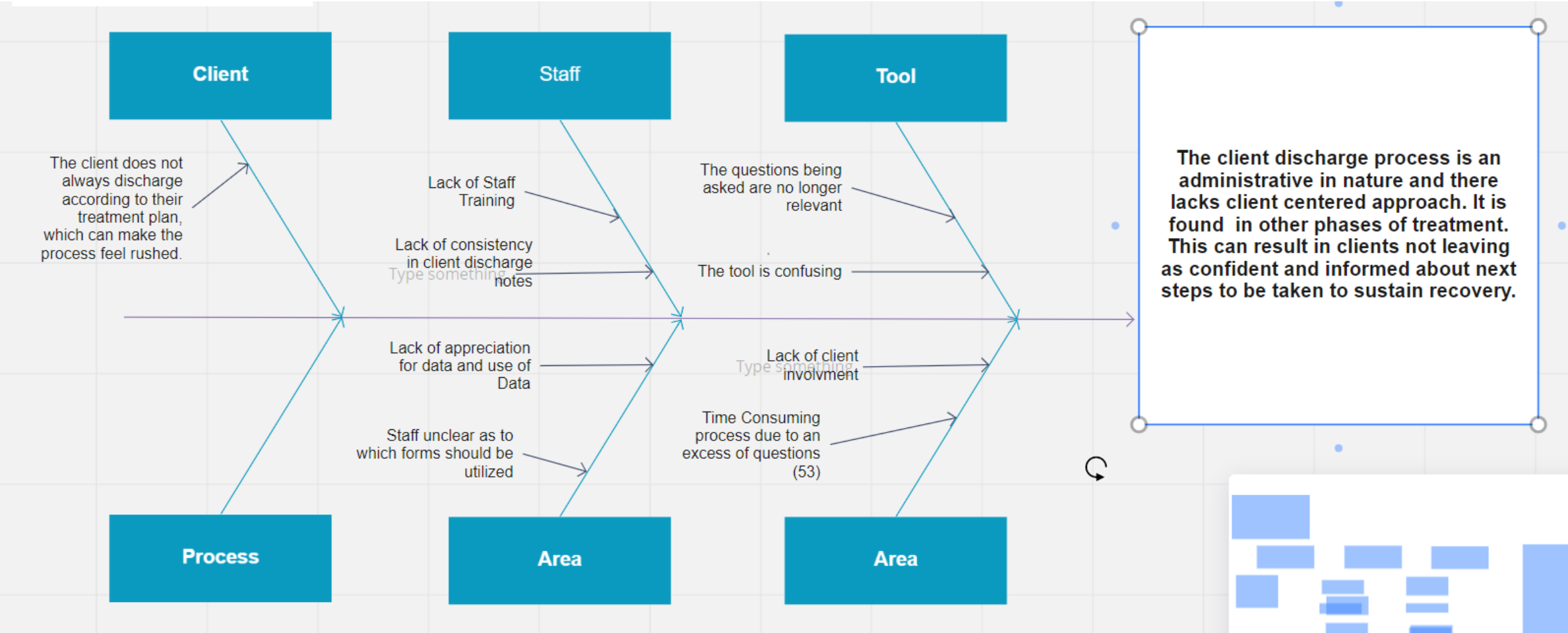
WHY?

A-
B-
C-We only have one principle individual who would develop and implement these changes

Diagnostic Tool(s) Used

Client

The client does not always discharge according to their treatment plan, which can make the process feel rushed.

Staff

Lack of Staff Training

Lack of consistency in client discharge notes

Tool

The questions being asked are no longer relevant

The tool is confusing

The client discharge process is an administrative in nature and there lacks client centered approach. It is found in other phases of treatment. This can result in clients not leaving as confident and informed about next steps to be taken to sustain recovery.

Lack of appreciation for data and use of Data

Lack of client involvment

Time Consuming process due to an excess of questions (53)

Staff unclear as to which forms should be utilized

Process

Area

Area

Fishbone Diagram

- The utilization of the fishbone really encouraged us to marinate in the problem and not jump to solution focused thinking too prematurely.

- This was helpful to fully diagnose the depths of the problem so that when we implement solutions, we are accurately targeting the problem

- The visual tool made it easy to present to staff to generate more in depth discussions

- Although our current focus is not too complex in nature, we can appreciate how using this breakdown in the future will be helpful when identified problems have multiple layers

Staff Feedback from Fishbone

The issue was addressed and staff cited the following problems, with the "top 3" identified below

- *Tool is confusing to staff (No. 1)*
- *Tool is asking for irrelevant information (No. 2)*
- *Tool is time-consuming*
- *Tool needs to be paperless*
- *Any such tool requires adequate staff training, as is obvious with the current tool (No. 3)*

What is clear is that assessing the discharge process is an important step in the process, and if done via Survey Monkey, will provide a consistent platform for the exercise (also helps to maintain objectivity in results)

Family of Measures

Outcome Measure (what are we trying to achieve at the end?)
- 100% of clients rate their discharge experience 10/10 on the Likert scale by April 2022 (maintaining the rate that currently exists)

Process Measure (pulse check- done once we implement the process):
**N/A**

Balancing Measure (consequence of the project):
- More efficient and therefore less use of staff time.

Responses to date:15 clients

Clients include those currently enrolled in our Aftercare group as well as clients who have completed the program in the last 4 months

On a scale of 1-10, how would you rate your overall discharge experience from Vitanova with your primary counsellor?
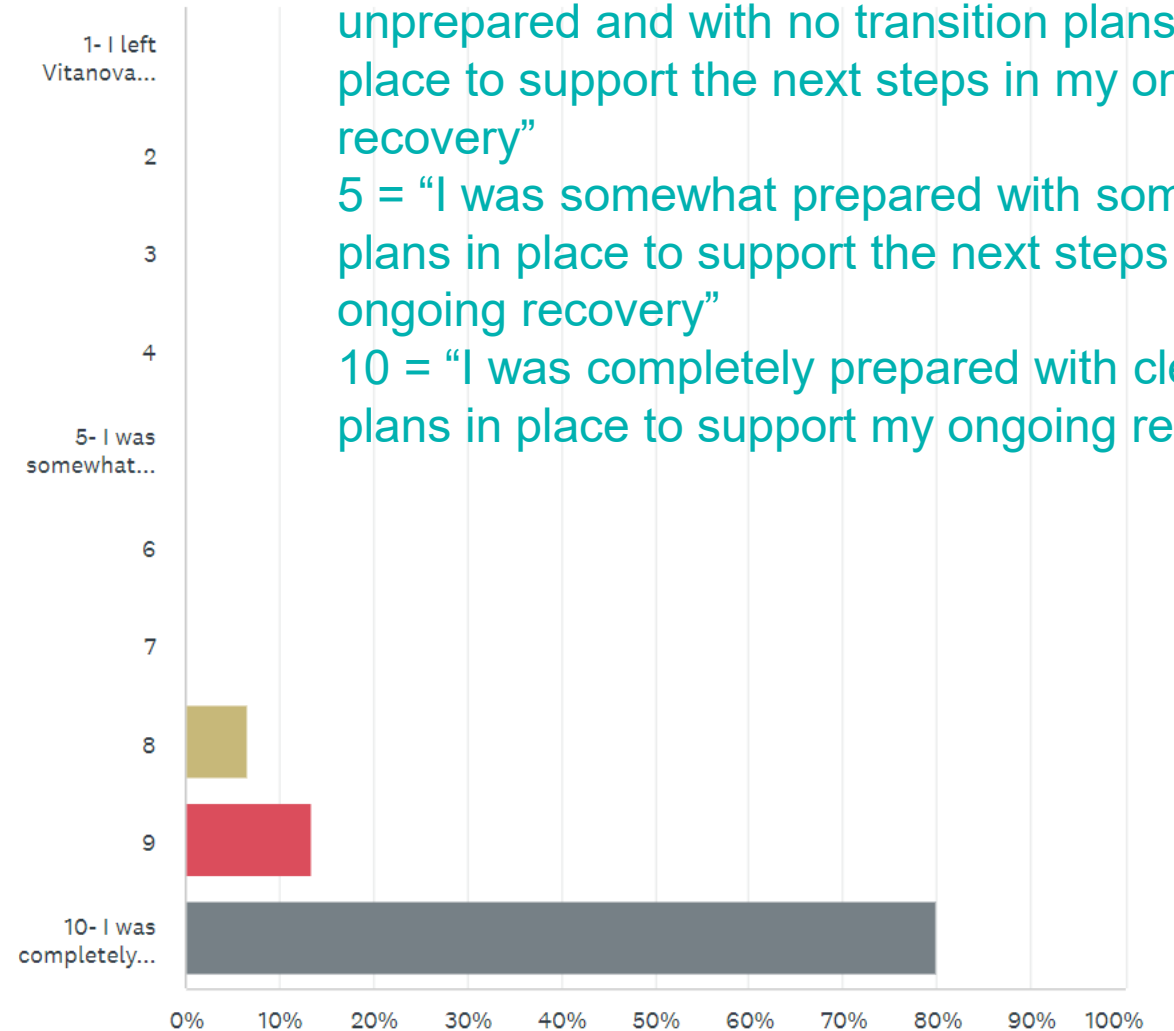
1 = "I left Vitanova feeling completely unprepared and with no transition plans in place to support the next steps in my ongoing recovery"
5 = "I was somewhat prepared with some plans in place to support the next steps in my ongoing recovery"
10 = "I was completely prepared with clear plans in place to support my ongoing recovery"
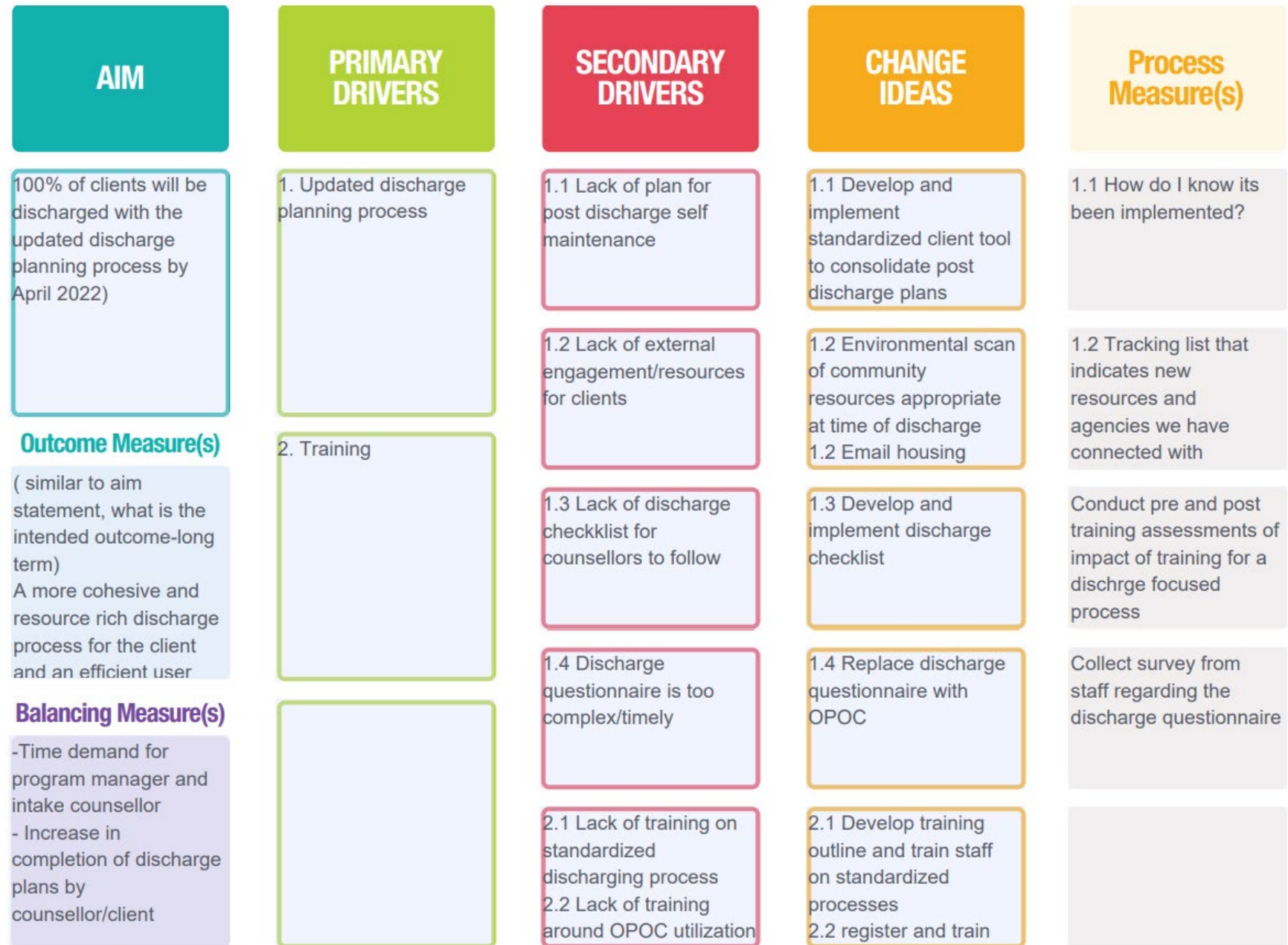
Source of Baseline Data

- The question for which we need to establish a base-line is to what degree the client's experience of the discharge process re-enforces his/her recovery, on a scale of 1 to 10 with differing assessments attached to each level.

- 1 = "I left Vitanova feeling completely unprepared and with no transition plans in place to support the next steps in my ongoing recovery"

- 5 = "I was somewhat prepared with some plans in place to support the next steps in my ongoing recovery"

- 10 = "I was completely prepared with clear plans in place to support my ongoing recovery"

Baseline Data: Survey Structure

Vitanova is committed to continuously improving the experience of our clients and we do so by collecting feedback directly from you.
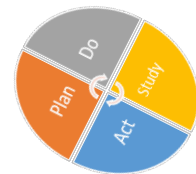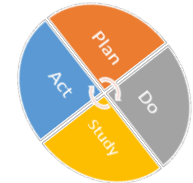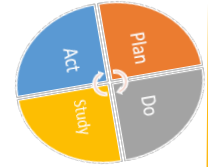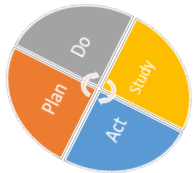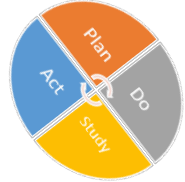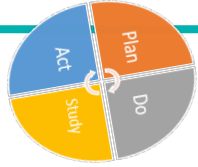
The following questions are looking to evaluate your experience with discharge planning that is completed with your primary counsellor to determine what areas worked well for you and what areas you could have received further support

Discharge planning can facilitate your return to work or school, securing new housing or returning home, basic budgeting and money management and emotional support during the transition period, etc.

Driver Diagram

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS	Process Measure(s)
100% of clients will be discharged with the updated discharge planning process by April 2022)	1. Updated discharge planning process	1.1 Lack of plan for post discharge self maintenance	1.1 Develop and implement standardized client tool to consolidate post discharge plans	1.1 How do I know its been implemented?
		1.2 Lack of external engagement/resources for clients	1.2 Environmental scan of community resources appropriate at time of discharge 1.2 Email housing	1.2 Tracking list that indicates new resources and agencies we have connected with
	2. Training	1.3 Lack of discharge checkklist for counsellors to follow	1.3 Develop and implement discharge checklist	Conduct pre and post training assessments of impact of training for a dischrge focused process
		1.4 Discharge questionnaire is too complex/timely	1.4 Replace discharge questionnaire with OPOC	Collect survey from staff regarding the discharge questionnaire
		2.1 Lack of training on standardized discharging process 2.2 Lack of training around OPOC utilization	2.1 Develop training outline and train staff on standardized processes 2.2 register and train	

Outcome Measure(s)

(similar to aim statement, what is the intended outcome-long term)
A more cohesive and resource rich discharge process for the client and an efficient user

Balancing Measure(s)

-Time demand for program manager and intake counsellor
- Increase in completion of discharge plans by counsellor/client

CHANGE IDEA:	CYCLE NUMBER:	DATE:

PLAN

WHAT IS THE PURPOSE OF THIS CYCLE? (Check one)	DEVELOP ☑	TEST ☐	IMPLEMENT ☐

WHAT IS THE OBJECTIVE OF THIS CYCLE? WHAT QUESTIONS DO YOU WANT TO ANSWER? WHAT ARE YOUR PREDICTIONS?

Train staff on how to utilize OPOC as the discharge evaluation tool to gather client experience/satisfaction with the program

LIST TASKS NECESSARY TO SET UP AND CONDUCT THE TEST (THINK 'ONENESS' AND 'DROP TWO')

What? (Specific task)	How? (Checklist, tally sheet)	Who? (Name or role)	When? (Times, dates - be specific)	Where? (Program, location site - be specific)
Register each staff with OPOC account	Follow up with OPOC representative for	Jessica	Mid April	Vitanova

OUTLINE YOUR PDSA DATA COLLECTION PLAN (WHAT, HOW, WHO WHEN AND WHERE)

What data will be collected?	How? (Checklist, tally sheet)	Who? (Name or role)	When? (Times, dates - be specific)	Where will the data be recorded?
# of staff who completed training	staff checklist	Jessica	Mid April	star report

DO

WHAT DID YOU OBSERVE DURING THE TEST? WERE THERE ANY UNEXPECTED OBSERVATIONS OR ISSUES? WHAT WENT WELL?

During the test it was determined that instead of having all counsellors administer the OPOC, it is more beneficial to have 2 desgnted staff instead. This ensures that the clients primary counsellor is not the one administering the tool, creating space for the client ot feel comfortable in provinding honest/uninfluenced feedback.

STUDY

ANALYZE YOUR DATA AND DESCRIBE THE RESULTS. HOW DO THE RESULTS COMPARE WITH YOUR PREDICTIONS? WHAT DID YOU LEARN FROM THIS CYCLE?

Due to the changes in training strategies, data no longer was based on number of staff who completed the training. The two designated staff were asked to complete a comparison rating of hte old discharge questionnaire to their experience administering the OPOC. The average score of each staff for the old discharge tool was a 5/10 where as the rating for the OPOC was an 8/10 given how easy it is to administer.

ACT

WHAT CHANGES NEED TO BE MADE? WHAT IS YOUR PLAN FOR THE NEXT CYCLE?

None

ADAPT (note changes for next cycle above)	☑	ABANDON	☐	ADOPT	☑

Lessons Learned / Ah-ha Moments

- *The biggest learning piece was recognizing the knee jerk reaction to formulate solutions from a top down process without looking at the bigger picture.*

- *This highlighted how easily QI projects can miss the mark if you do not sit in the problem long enough to fully understand its anatomy. By sitting longer and soliciting feedback from clients and staff, you begin to arrive at a higher quality response with more hands on deck to implement such improvements which ultimately results in a quicker response to improved client centered care.*

- *Our first walk along this QI path was messy and not quite complete, but the framework is one that will become permanent in our future efforts.*

- Now having implemented OPOC as a fixed entity in data collection, we will know we have reached a point of sustainability when clients results consistently reflect a satisfactory rating along with continued positive feedback from staff surrounding the new processes and their user friendliness.

Youth Habilitation Quinte INC

Organization: Youth Habilitation Quinte
Project Title: Virtual Care Best Practices

Project Status as of: May 20, 2022

THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)

COHORT 6 REPORT BACK

PRESENTATION DATE: June, 2022

e-QiP
Excellence through Quality
Improvement Project
Community-focused. Data-driven.

Project Story:

After our services pivoted from in-person to virtual care during the Covid-19 pandemic, a survey was implemented to determine how virtual services could be improved and be as effective as in-person care. During our QI learning process, our client virtual survey confirmed the same root causes that hinder care as in our 2020 findings, such as lack of screen share and lack of privacy.

In applying our QI tools, our team identified key components that would enhance virtual care. These included client access to e-learning, virtual access by partnering with a community hub for youth, and guidelines for virtual care. It is our hope that we collaborate and inspire our mental health colleagues to test these ideas while nurturing and embedding the QI culture within our team.
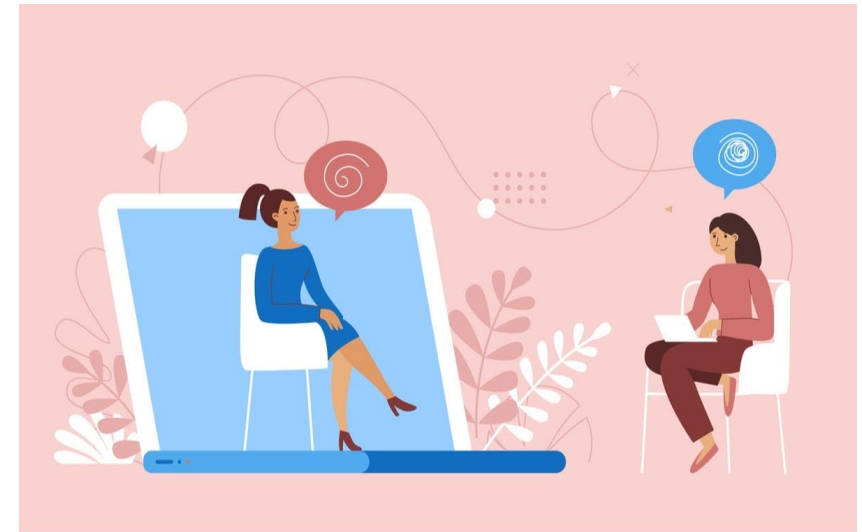
Problem/Opportunity Statement

- In our survey on virtual care, clients cited a lack of privacy at home and discomfort using technology during virtual appointments.
- At the start of our QI project, 196 mental health clients or 37% accessed services via video conference according to EMHware data.

AIM Statement

- By March 31, 2023, we will improve our client access (by 5%) in virtual mental health services and ensure the care experience is comparable to face-to-face.

Diagnostic Tools – The Vital Few.
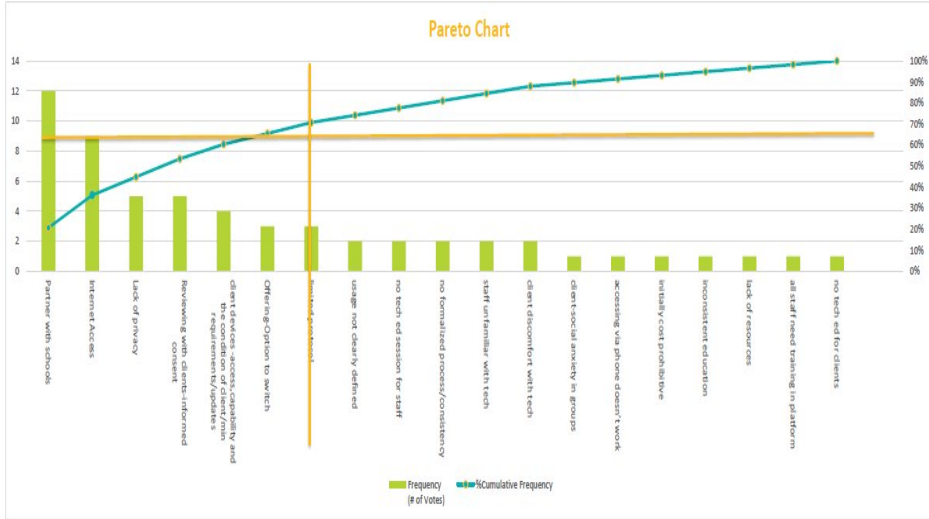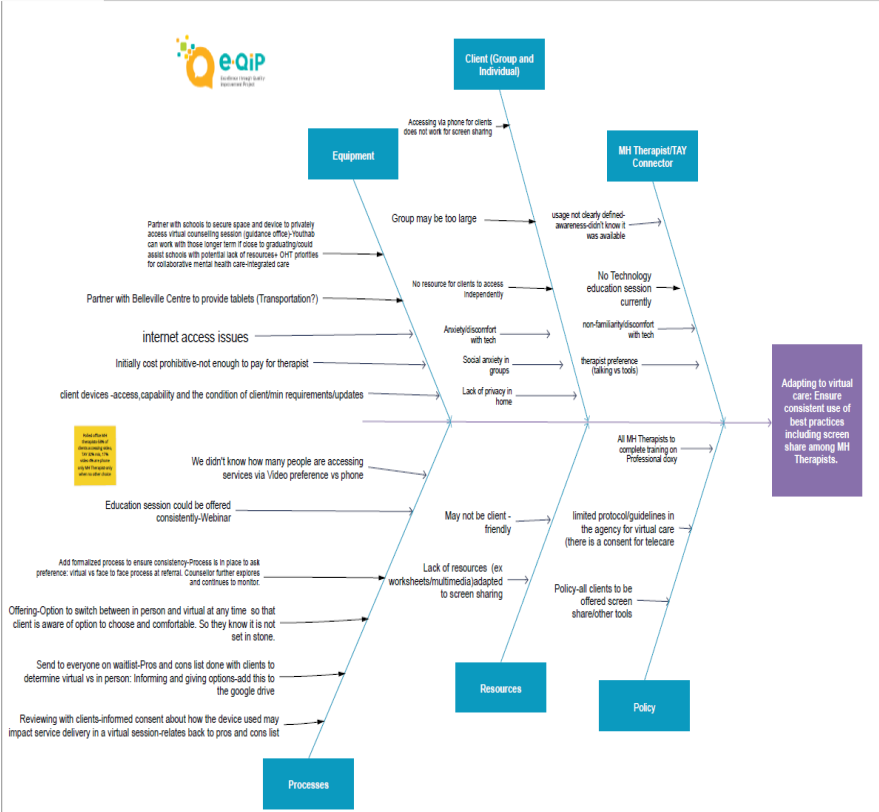
Change Ideas

TRIZ Exercise

Problem Statement or Root Cause:

Limited access to virtual care

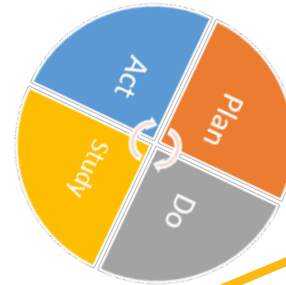| How could you and your team make the problem worse?	Reversed Ideas (Positive)
Removing the virtual care platform for everyone, removing the doxy professional from those that have it	make doxy clinic avail for everyone
Make sure your clients dont have a device capable enough-take away the devices!	Arrange for clients to have devices for their virtual care

Driver Diagram (mini)

Aim statement:	Primary Driver:	Secondary Driver:	Change Idea:	Process Measure:

By March 31, 2023 we will improve our client access in virtual MH care

Ensure Safe "spaces" are available

Reduce impact of lack of Privacy at home

Partnering with Belleville Youth Centre, Schools for space

# of sessions/#of unique individuals accessing space (school/centre) for virtual care

Outcome Measure:

Increase number of clients accessing virtual care (based on EMHware data) by 5%. Improve privacy at home and comfort with technology (improve by 5%).

Balancing Measure:

85-95% agreed overall (OPOC #30 and I believe virtual care is an effective way to receive care.)

PDSA Planning (one change idea)

Develop a plan and test a therapeutic resource with a MH Therapy client through the secondary school counselling program who may have limited privacy by April 14th.

Cycle 4: Additional testing to be done by more MH team members.

Cycle 3: Shared results. Increase in confidence among some clients. Worth the effort.

Cycle 2: Resource was tested with 19 clients via 2 Therapists by May 12th.

Cycle 1: Therapist selected a client to share the resource. Information was collected via a spreadsheet with qualitative feedback shared by April 14th.

Outcome and Balancing Measures

I felt safe (emotionally and physically) during my virtual appointment(s).

- Strongly agree
- Agree
- Disagree

21%
76%
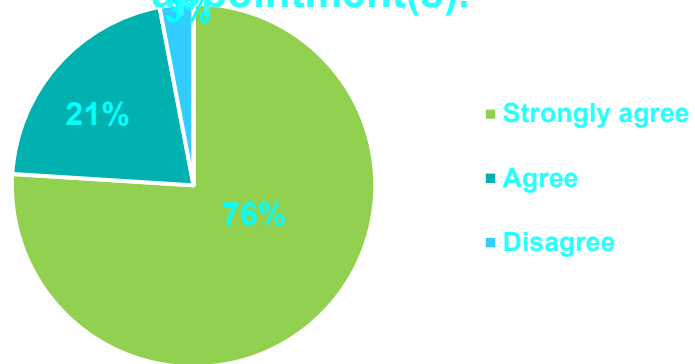
If you felt uncomfortable, please specify what contributed. Please check all that apply.

- Anxious/discomfort using tech
- Lack privacy at home
- Social anxiety - virtual group
- Social anxiety - one on one
- Other

21% 18%
7%
7% 47%
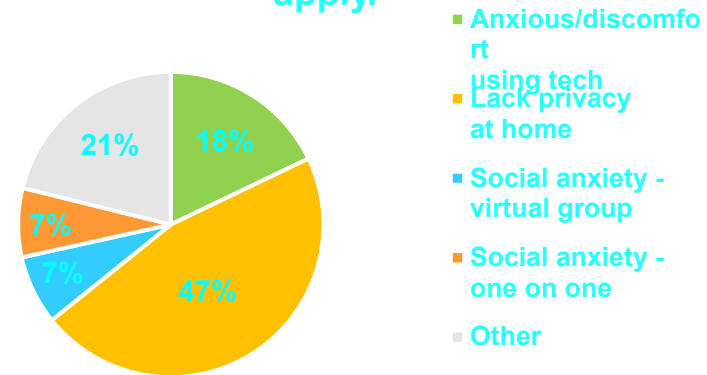
Overall, I am satisfied with my virtual appointments.
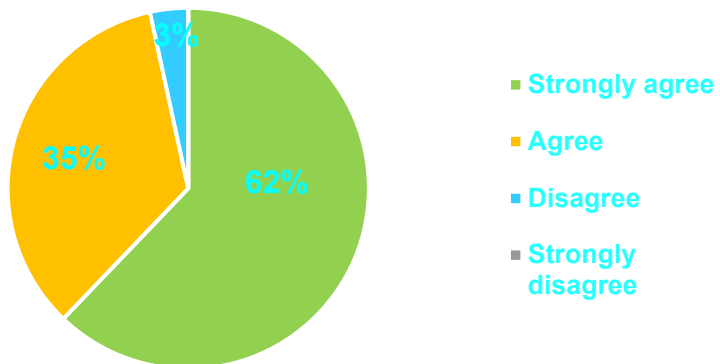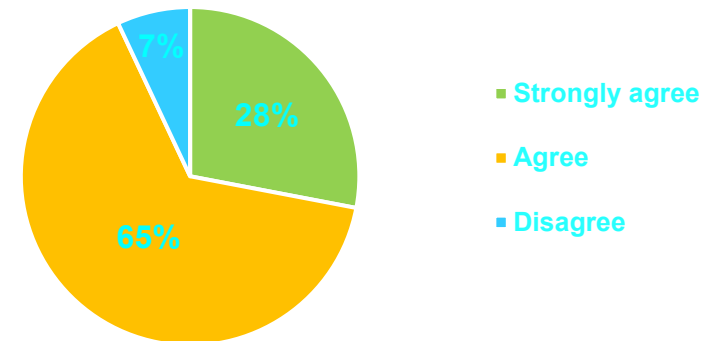
- Strongly agree
- Agree
- Disagree
- Strongly disagree

3%
35% 62%

I believe virtual care is an effective way to receive care.

- Strongly agree
- Agree
- Disagree

7%
28%
65%

Lessons Learned / Ah-ha Moments

Next Steps

Final Evaluation Survey

What is summertime all about?

- Continue to monitor your Change Ideas (collect the data now)

- Consider your threshold for Sustainability. When will you know you've reached sustained improvement?

- What will you continue to monitor past August 31st? Is this a multi-year project?

- Who else might benefit from hearing about your project?

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Applications Due June 17th!

Take your QI activities one step further…

- Is this QI project part of your Quality Improvement Plan? If not, is there an opportunity to add it?

- Consider joining E-QIP's Community of Practice.

- Do you have new board members or new senior leaders? Consider Governance and Leadership training

- Do you have others in your organization who have an interest in learning more about QI? Consider signing up for Foundations to QI (IDEAS) e-Course

Questions and Curiosities

THERE ARE MANY WAYS TO ENGAGE WITH E-QIP!

CONNECT AND IMPROVE

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- QI cycle and data literacy webinar series
- IDEAS - QI Foundations course (e-learning course)
- Agency specific governance and leadership training (customized based on need)

- Coaching consultations on quality improvement activities
- E-QIP Cohorts for QI and data coaching (6 to 7 months dedicated coaching for projects)
- Community of Practice (bi-weekly, 1-hour meetings)

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