



**Carnegie Foundation**  
for the Advancement of Teaching

# Understanding the Problem You Are Trying to Solve

**Causal System Analysis**

# Objectives

- Recognize importance of taking a systems-view when understanding complex problems
- Develop a fishbone diagram to investigate potential root-causes of a problem
- Understand that Causal System Analysis involves leveraging different perspectives and using various tools flexibly



# Faculty Introductions



**Jonathan  
Benjamin**  
Director,  
*Post-Baccalaureate  
Fellowship Program*



**Edit  
Khachatryan**  
Associate,  
*Networked  
Improvement Science*

# Participant Introductions

- Find two other people around you
- Introduce yourself, your organization, your role, and share...
  - *one thing you accomplished before the age of 18.*

# Norms

- Be present
- Listen to understand
- Share the air
- Any others to add?

Be problem-focused and user-centered



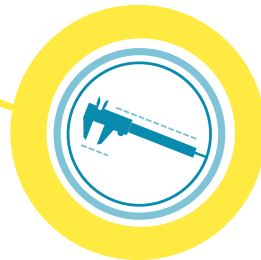
Attend to variability



See the system



Embrace measurement



Learn through disciplined inquiry



Organize as networks



# 6

CORE PRINCIPLES OF IMPROVEMENT

# Butterfly Effect Game\*



\*Adapted from "The Game Guide: Interactive Exercises for Trainers to Teach Quality Improvement in HIV Care," New York State Department of Health AIDS Institute Health Resources and Services Administration HIV/AIDS Bureau, 2006.

- Observers, what did you notice?
- Participants, how did it feel to be part of the system?
- Who was controlling the system?
- How does this activity speak to your experiences in education?





An interdependent set of **interactions among people**, the **tools and materials** they have at their disposal, and the **processes** through which they all join together to accomplish work.



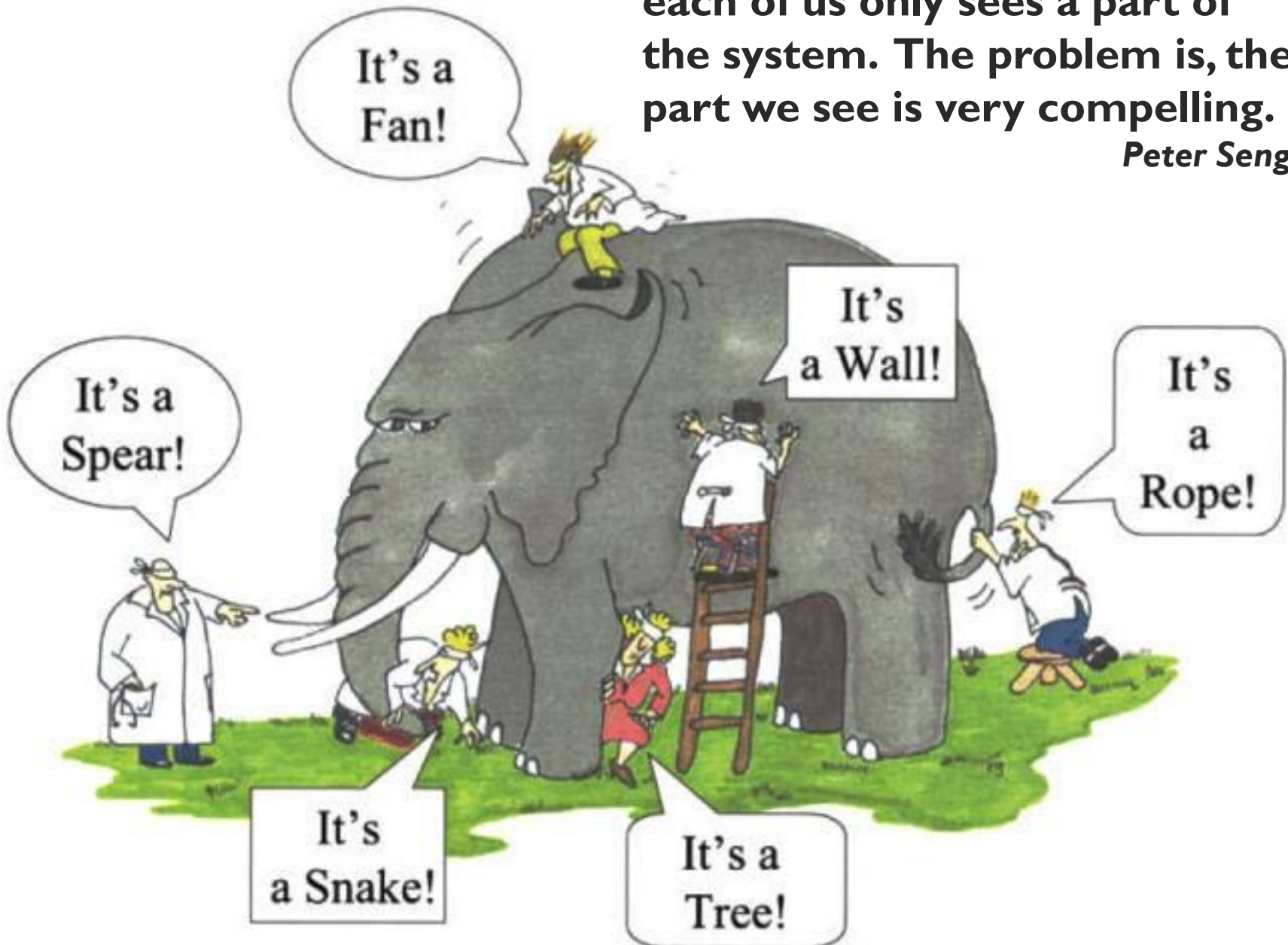
What is a  
**System?**

“Every system is perfectly designed to achieve exactly the results it gets.”

Paul Batalden

**By the very nature of systems,  
each of us only sees a part of  
the system. The problem is, the  
part we see is very compelling.**

*Peter Senge*



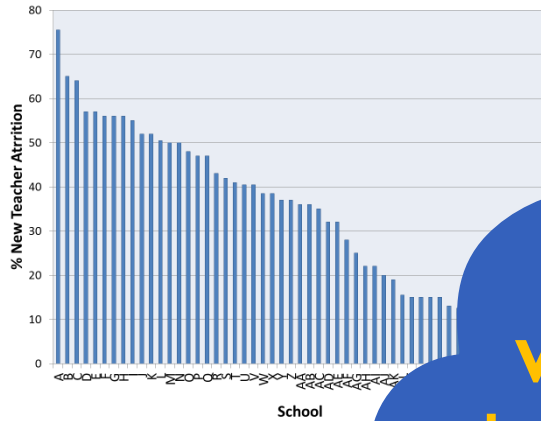
# Causal System Analysis



***Let's go investigate.***



# Tools for Undertaking Causal System Analysis

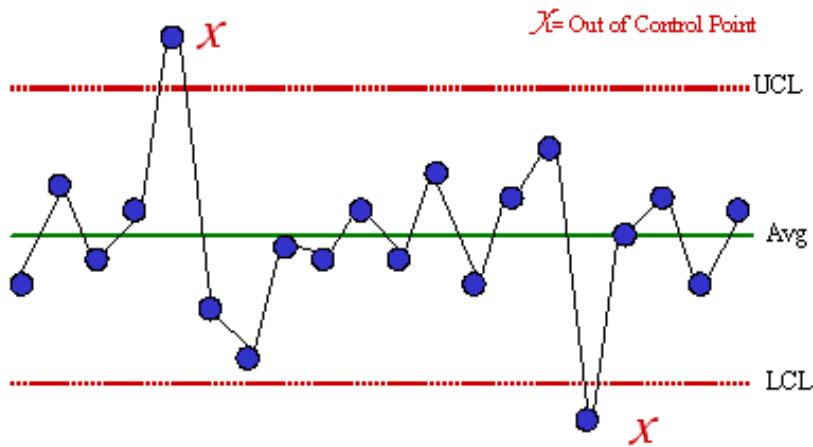


Local Data

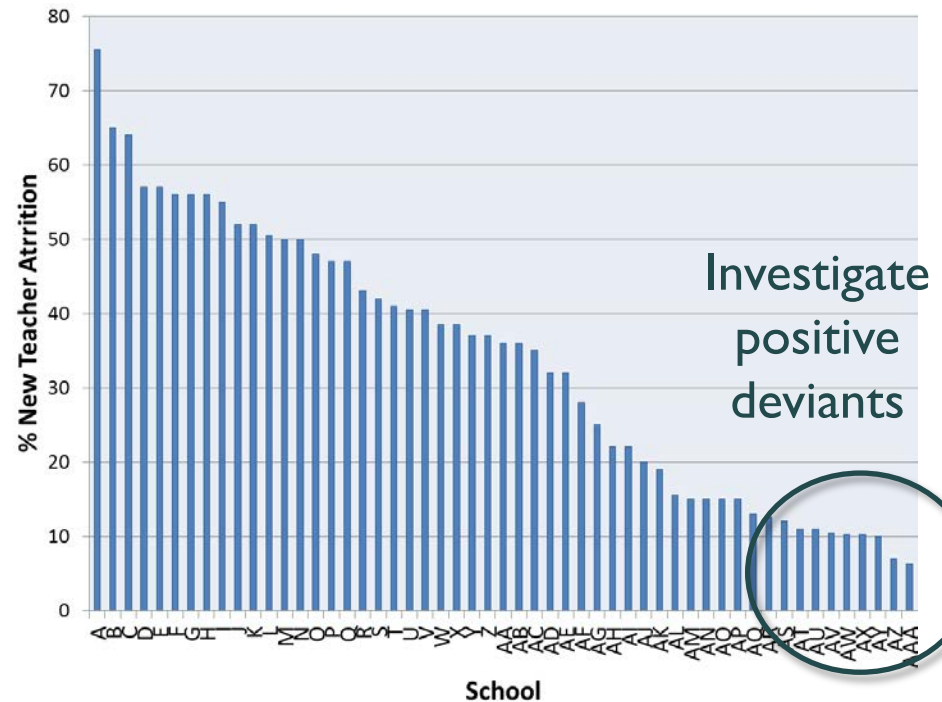
**Which tool** you use and in **what sequence** is determined by the problem, what you learn along the way, and your context.

# Dig into Local Data

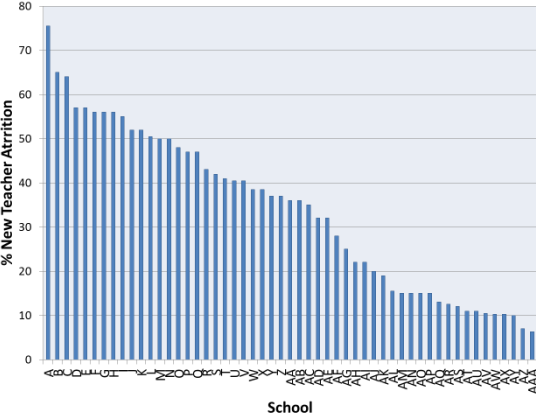
## Examine trends over time



## Examine variation across contests



# Tools for Undertaking Causal System Analysis



Local Data

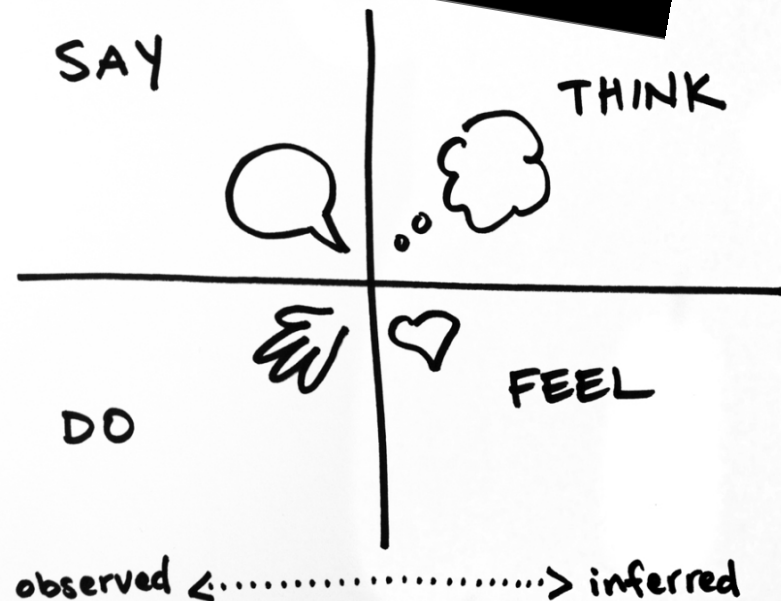


Empathy Exercises

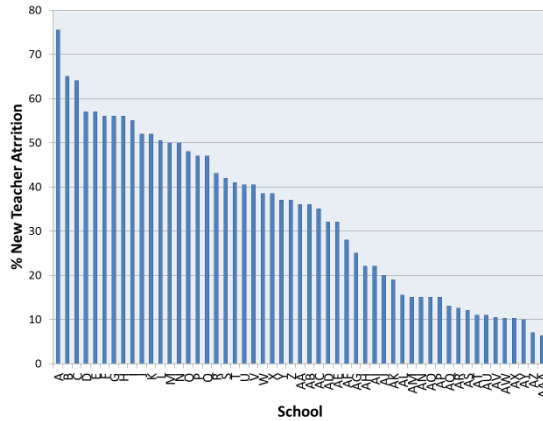


# Seeing the World as Users See it

- “Empathy” interviews
- In-context observations
- Journey maps



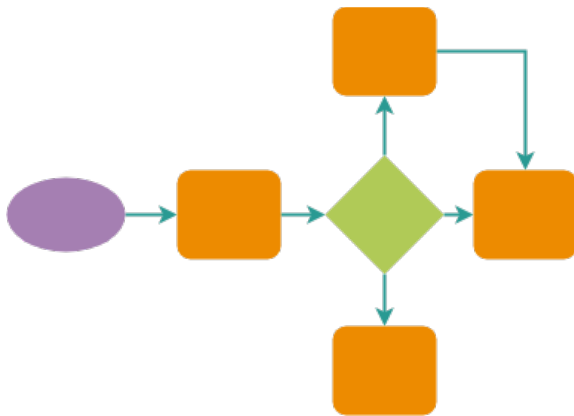
# Tools for Undertaking Causal System Analysis



Local Data



Empathy Exercises



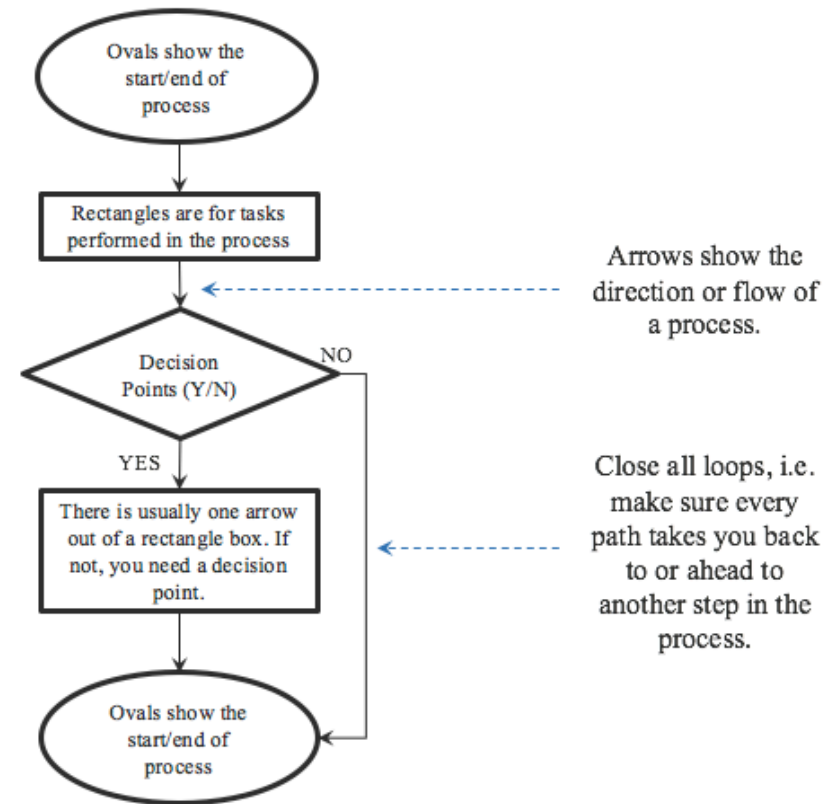
How the Work Gets Done

# Zooming In on How Work Gets Done

**Process Map:** A graphical representation of the steps that come together to produce a particular outcome.

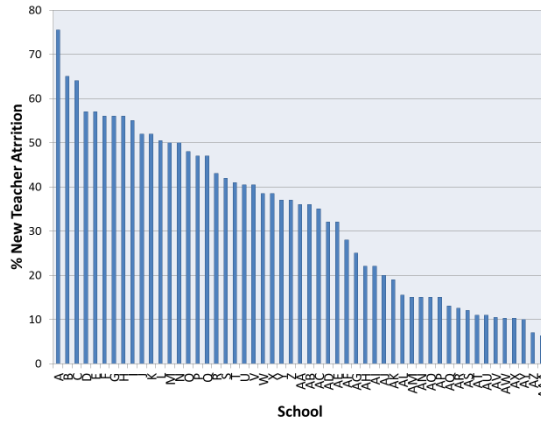
**How do you make one?** Go and see the process in action OR talk to people that are involved in enacting the process.

**Why is it useful?** Processes are a basic building block of systems. Creates a shared understanding of “what is.”

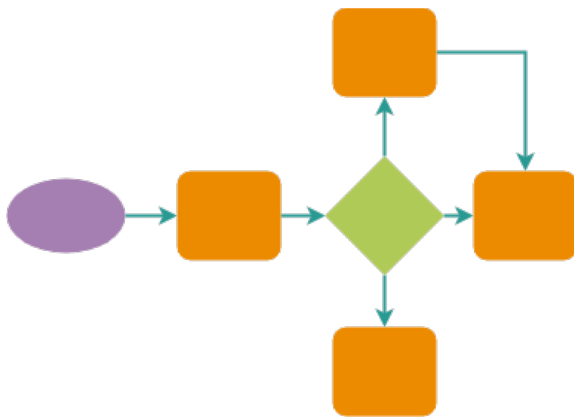


*“You cannot improve a process if you don’t understand it.”*  
-W. Edwards Deming

# Tools for Undertaking Causal System Analysis



Local Data



How the Work Gets Done



Empathy Exercises



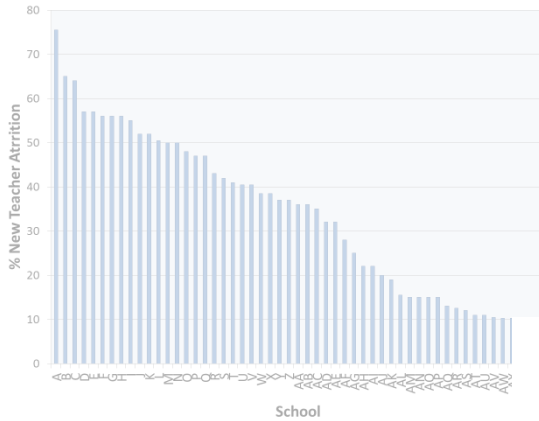
Research Scans

# Scan Existing Knowledge on the Problem

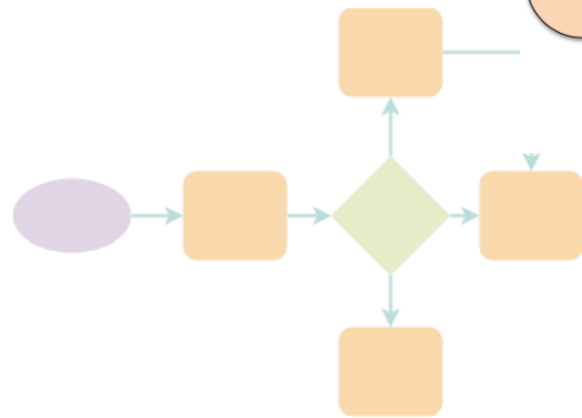


Examine research and relevant literature to find information about the problem and how it may be addressed.

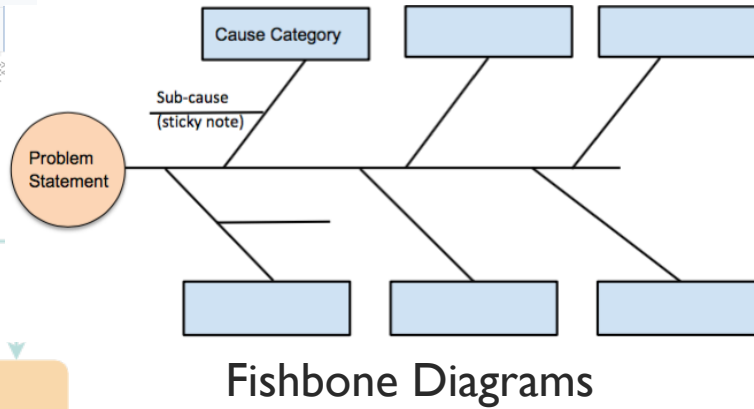
# Tools for Undertaking Causal System Analysis



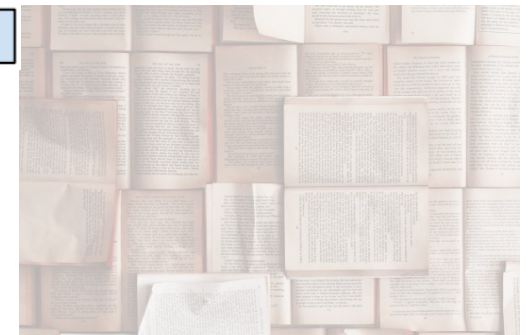
Local Data



How the Work Gets Done



Empathy Exercises



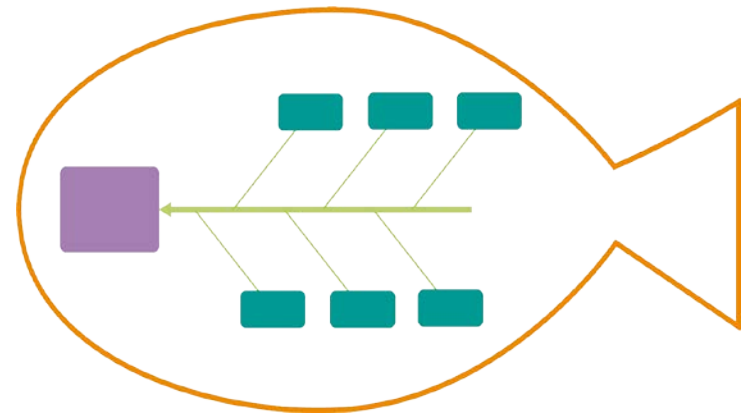
Research Scans

# Brainstorming Root Causes: Fishbone Diagram

**What is it?** A summary of a group's understanding about the causes of the current problem

## **Why is it useful?**

- Visualizes the causes of a problem at a high level.
- Helps with scoping and identifying areas to dig in deeper
- Builds consensus in the group





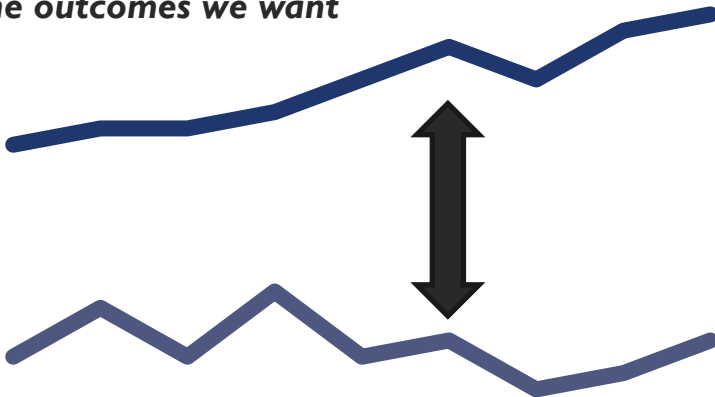
# How to Build a Fishbone Diagram

## 2) Brainstorm potential causes

1) Clear  
PROBLEM  
STATEMENT



*The outcomes we want*



*The outcomes we actually see*



## 2) Brainstorm potential causes







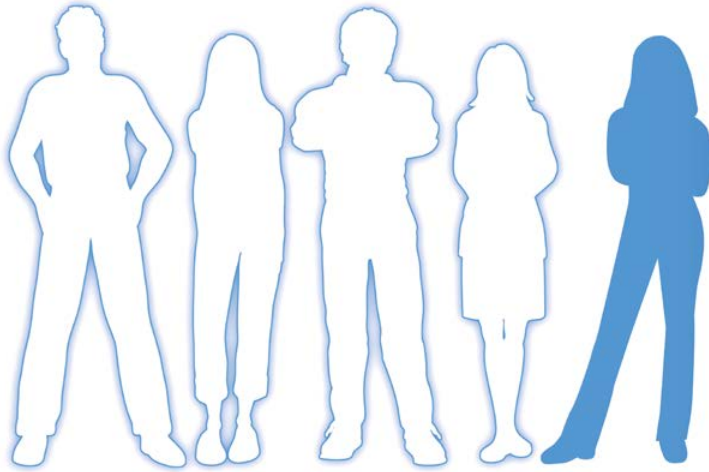
# Tips in Building a Fishbone Diagram

- Avoid SOLUTIONITIS
- Identify multiple potential causes
- Keep an open mind
- Consider a variety of perspectives
- Stay user-centered
- Use available data

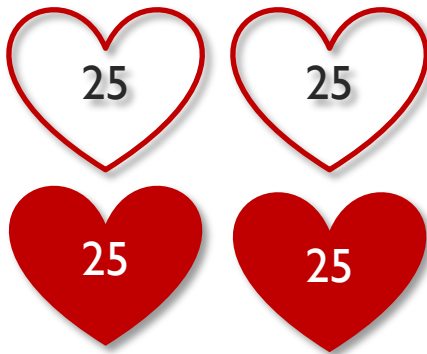
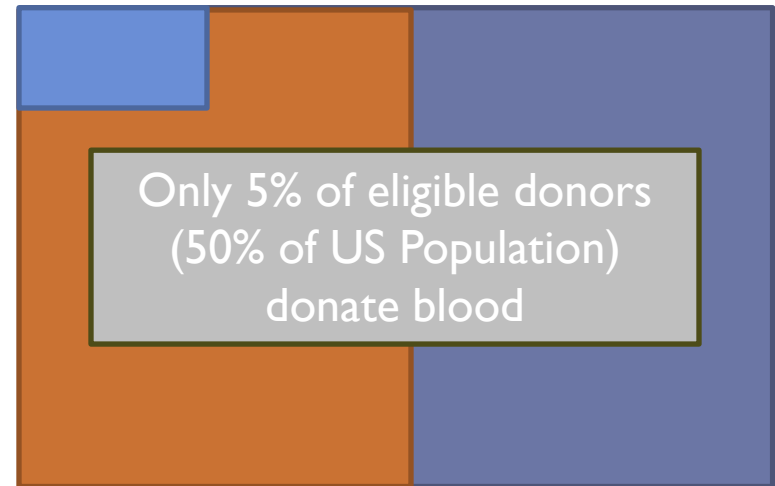
\*Remember: Definitely incomplete and possibly wrong\*



# The Blood Drive Problem: The Data



1 in 5 people admitted to hospital need blood



100 units/day requested,  
only half demand met

- Who are we?  
3 providers for 8 regional hospitals:
1. **A non-profit**
  2. **A clinic**
  3. **A university blood center**

\*Scenario adapted and improvised from local data and information

# The Blood Drive Problem: The Issue



*5% of eligible  
population donate*



**WHY NOT  
MORE  
PEOPLE?**

# Activity: Build a Fishbone Diagram

In groups of five, follow steps to identify causes of blood drive problem:

- 1) Draft problem statement (5 min)
- 2) Brainstorm causes individually (5 min)
- 3) Share causes & Cluster (15 min)
- 4) Label the clusters (5 min)
- 5) Arrange the Fishbone Diagram (5 min)
- 6) Identify next steps (5 min)

# The Blood Drive Problem: The Data

- About one in five people admitted to a hospital will need blood.
- 50% of the U.S. population is eligible to donate blood, but only 5% does so.
- The University Blood Center (UBC), a local hospital, and a non-profit community center are in a NIC and are the only three providers for 8 regional hospitals.\*
- All of the area hospitals request about 100 units of blood each day, but the blood centers can only meet half of this demand.



Not enough people give blood to meet the demand for blood from patients

Giving blood is not convenient

People are not informed

People are too busy to give blood

Giving blood often requires someone to go out of their way to the hospital

Blood drives are not held in convenient locations, such as the workplace

Wait times are often too long

People think their blood isn't the right type

People think they are ineligible when they are not

People think they will be exposed to disease by giving blood

People do not know the frequency that they can give blood

People do not know where the blood is going to

People do not understand how much blood is needed

Blood drives are not well publicized

People do not see firsthand the demand for blood

People don't have others to encourage them to give blood

People are afraid of needles or blood

People do not like the side effects of giving blood, such as a weak feeling afterwards

People think hospitals have enough blood

People do not give blood for religious reasons

People have an illness that prevents them from giving blood

People have possibly been exposed to diseases such as malaria or mad cow

Discriminatory barriers exist in the blood-drive process

People feel uncomfortable giving blood

Some people are not eligible to give blood

People are not aware of the need to give blood

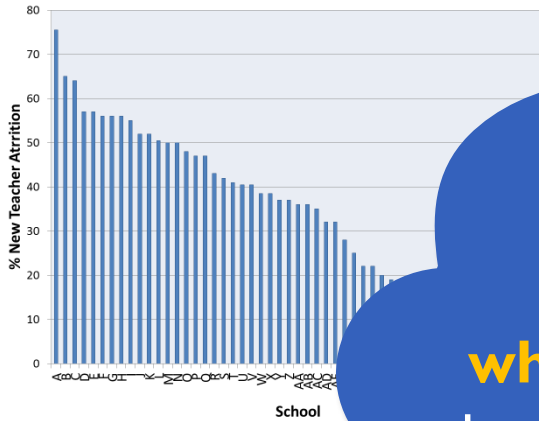
People had one bad experience

People are afraid of finding out about a disease, such as HIV

# Debrief

- Find 2 other people not in your fishbone group, discuss the following:
  1. What did you select as your problem statement?
  2. What were two of your cause categories?
  3. What are some examples of root causes your team identified for those categories?
  4. **What does your team want to learn next?**

# Tools for Undertaking Causal System Analysis

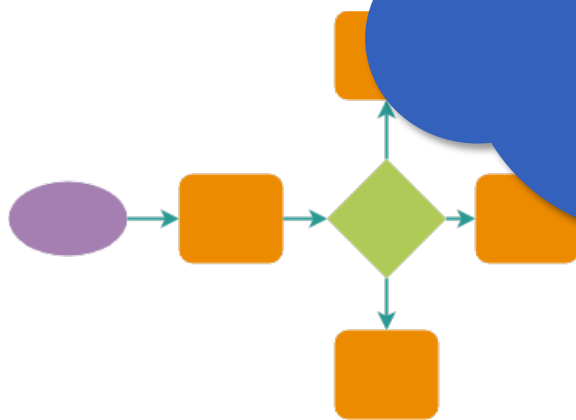


Local Data

**Which tool** you use and in **what sequence** is determined by the problem, what you learn along the way, and your context.



Exercises



How the Work Gets Done



Research Scans

# Reflection & Take it Home

- Private write:
  1. What is the problem of practice that you're tackling in your work and what do you already know about it?
  2. What one step can you commit to taking in order to understand the causes to this problem?

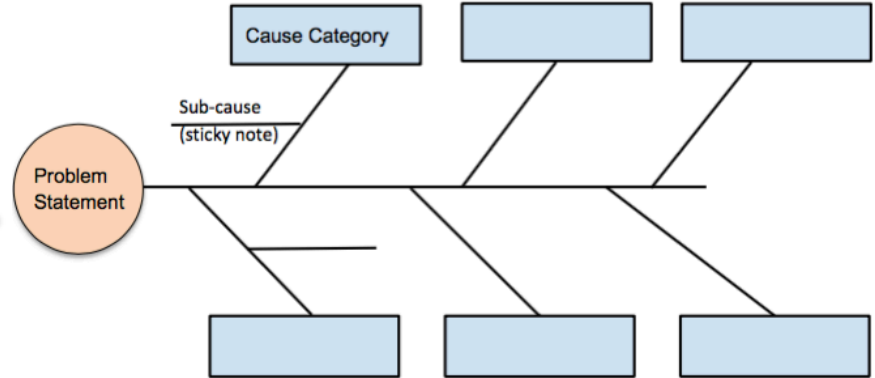
Aspirations

Current performance

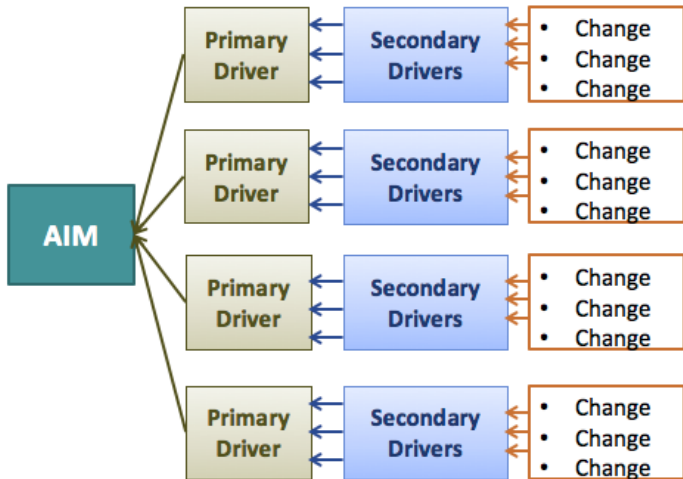
**Gap**  
 Why are we getting the outcomes we are currently getting?



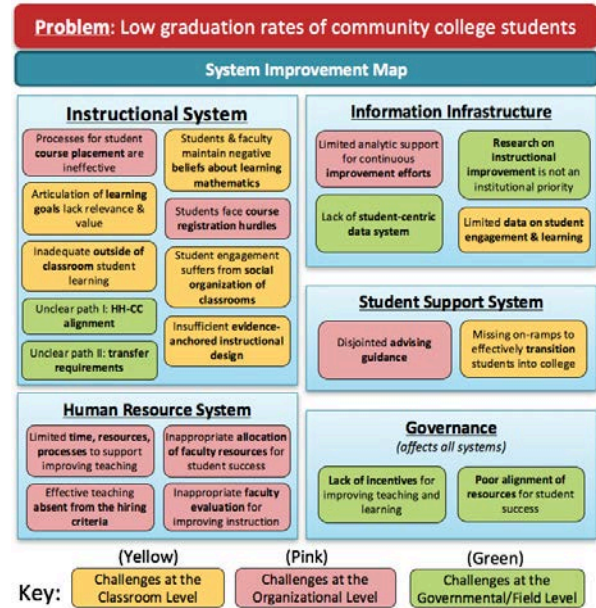
### Fishbone Diagram



### Driver Diagram



### System Map



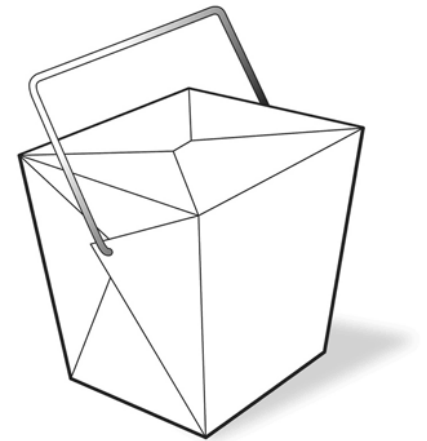
# Some Habits of a Systems Thinker

- Seeks to understand the “big picture”
- Examines different perspectives
- Resists the urge for quick fixes
- Plans to adapt and learn
- Looks for high-leverage points



# Some Takeaways

- Diagnose a problem and the system in which it occurs carefully before attempting solutions
- A variety of problem investigation tools exist; the tool you use depends on what you want to learn
- Be mindful of “analysis paralysis;” sometimes trying a change idea can yield significant understanding



# Objectives

- Recognize importance of taking a systems-view when understanding complex problems
- Develop a fishbone diagram to investigate potential root-causes of a problem
- Understand that Causal System Analysis involves leveraging different perspectives and using various tools flexibly





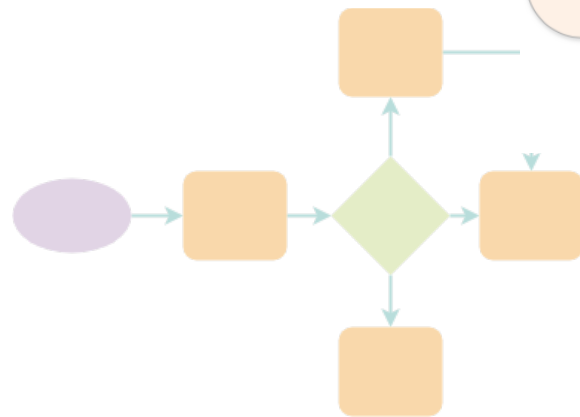
# Tools for Undertaking Causal System Analysis

Sessions:

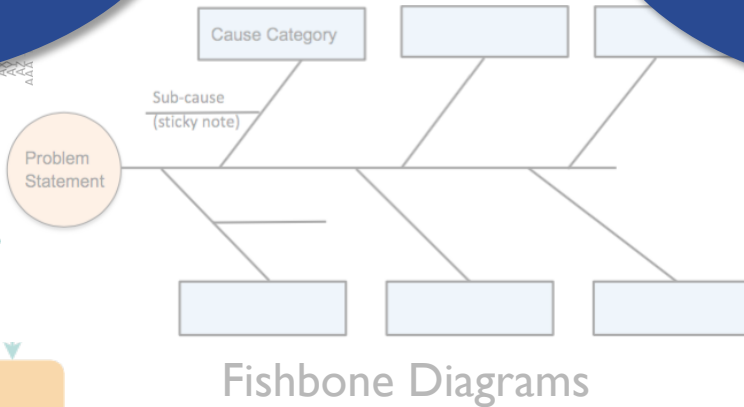
*Data-Driven Improvement*  
**Today @ 1:30**  
*Data Workshop*  
**Thurs @ 10:15**

Session: *Understanding the User Experience*  
**Today @ 1:30: Salons**  
**10-11**

Local Data

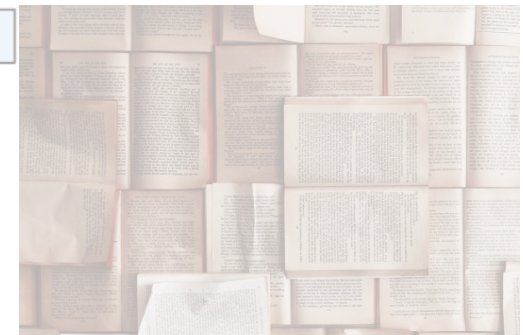


How the Work Gets Done



Fishbone Diagrams

Empathy Exercises



Research Scans



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