quality improvement (QI) initiatives are defined as “changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning)” (Batalden & Davidoff, 2007, p. 2). The improvement in the delivery of patient care is a job duty that child life specialists already practice. Child life specialists can formalize these typical job duties into a QI project in order to provide supporting evidence for their interventions with patients (e.g., effectiveness of a new expressive activity).

The previous three articles in the “QI, Step by Step” series discussed the introduction to QI and problem identification (Birkett & Froh, 2018), the analysis of process failures and root causes (Cassani & Bonjour, 2018), and the development of SMART aims (Calvert, 2018). This article will address step 4 in the QI process: identifying key drivers. Laying the foundation for improvement by creating a thorough improvement plan as outlined in the previous articles is crucial for a couple of reasons, including avoiding incorrect assumptions about the cause of a problem and wasting time “fixing” things that are not actually related to your problem or goal (Luzader, 2014).

Key drivers are the factors, or project activities, needed to accomplish the SMART aim developed in the previous step. In other words, key drivers are what you need to have in place and working well in order for improvement to happen (Luzader, 2014). Key drivers are identified by brainstorming what needs to be done to accomplish the SMART aim (United States Department of Health and Human Services [US DHHS], 2013). For example, using the SMART aim created in the previous article: “Increase the number of Psychosocial Risk Assessments in Pediatrics (PRAP) completed on patients seen by child life specialists each day from 0% to 50% by 7/1/2018” (Calvert, 2018, p. 49), drivers might include: child life specialists have access to the PRAP tool, child life specialists have access to computers, and child life specialists forward their phones to a coverage partner when they are charting. The next step would be to logically group the drivers together and define each group of drivers (US DHHS, 2013). From the list of drivers, the header for the group may be “access to technology” or “protected time of child life specialist.” Typically, the headers become the key drivers and the grouped items become the secondary drivers, or interventions, which will be discussed in the next “QI, Step by Step” article. Key drivers should be evidence- or data-based, stated in the affirmative, and stated as a noun with a descriptor (Luzader, 2014). An easy way to create key drivers is by flipping your failure modes to be positive (Luzader, 2014; Cassani & Bonjour,
For example, if a failure in completing the PRAP is insufficient time, a key driver would be protected time for documentation (Cincinnati Children’s Hospital Medical Center, n.d.).

A key driver diagram demonstrates the relationship between the SMART aim, key drivers, and secondary drivers, or interventions (see Figure 1), and defines the system of change that needs to occur so that the SMART aim is achieved. The key driver organizes the improvement plan and brings all of the components together into a simple, visual roadmap (Luzader, 2014). An important part of this step is prioritizing key drivers. You will want to focus on key drivers with the highest likelihood to impact your aim, that align with the strategic plan of your department and/or organization, and that are within your control and influence (Luzader, 2014). The next step in the QI process is to identify potential interventions, design and execute Plan-Do-Study-Act (PDSA) cycles, and scale up successful interventions. Continue to follow this series as we delve into the QI process, and access past articles on our blog.

**REFERENCES & RESOURCES**


![Figure 1. Key Driver Diagram](image-url)