



Redesigning Care

**REIMBURSEMENT
COSTS**

**POPULATION
MANAGEMENT**

MERGERS

**ACCOUNTABLE
CARE**

National Rural Health Resource Center

Introduction to Lean Tools

March 20, 2015

**Presented by: John L. Roberts, MA
Lean Healthcare Black Belt**

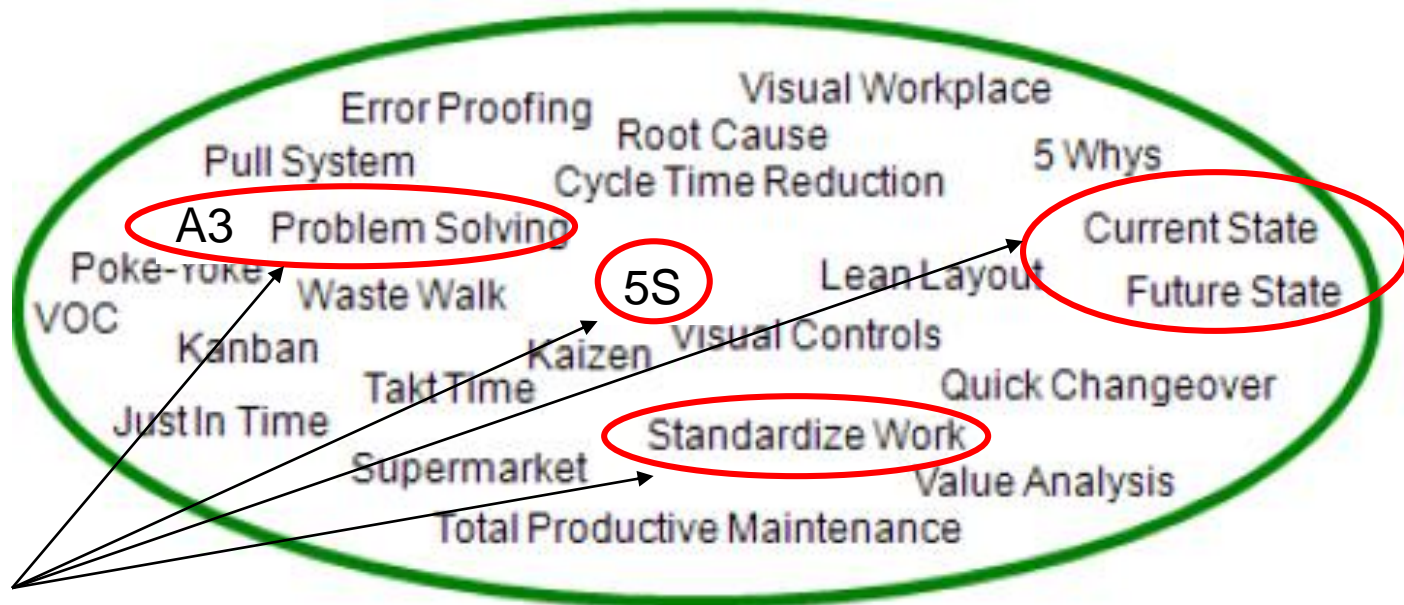
Today's Agenda

Introduction to Lean Tools

- Value Stream Mapping
- 5S: Worksite Organization
- A3 Problem Solving
- Standard Work



In the World of Lean Tools.....



**These tools can solve 95%
of your organization's
issues**



Introduction to Value Stream Mapping



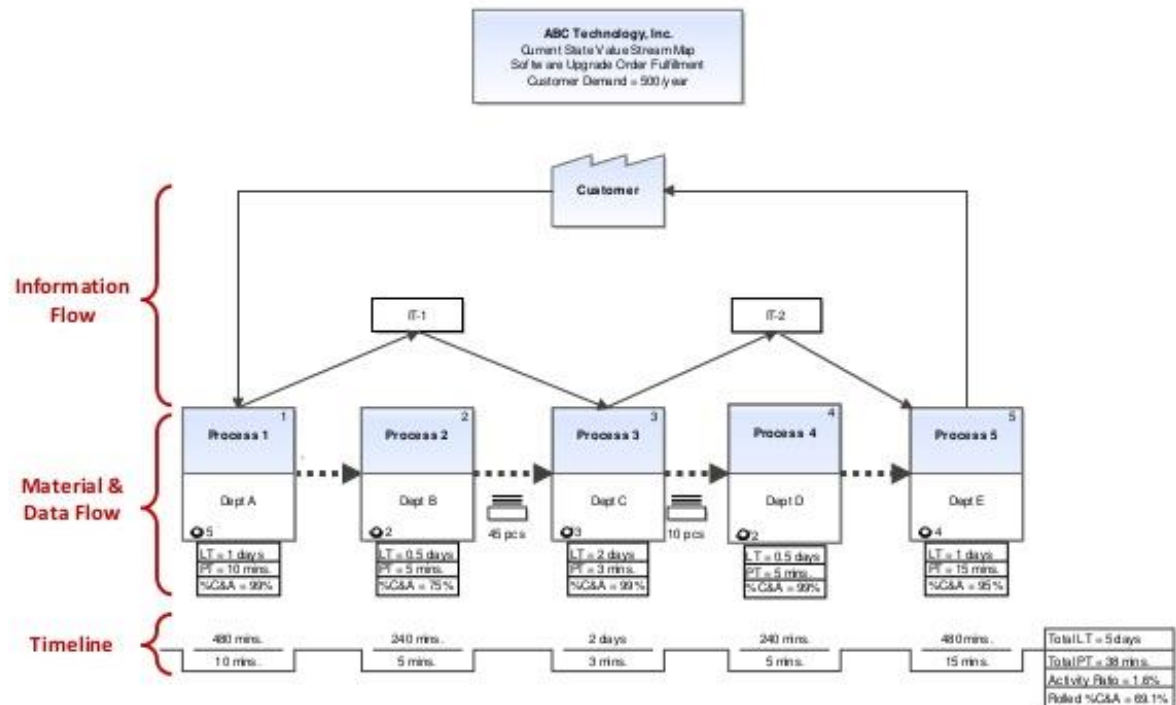
RE-THINKING HEALTHCARE
IMPROVING PATIENT CARE THROUGH DESIGN

Value Stream Mapping

Purpose: “To See the Flow”

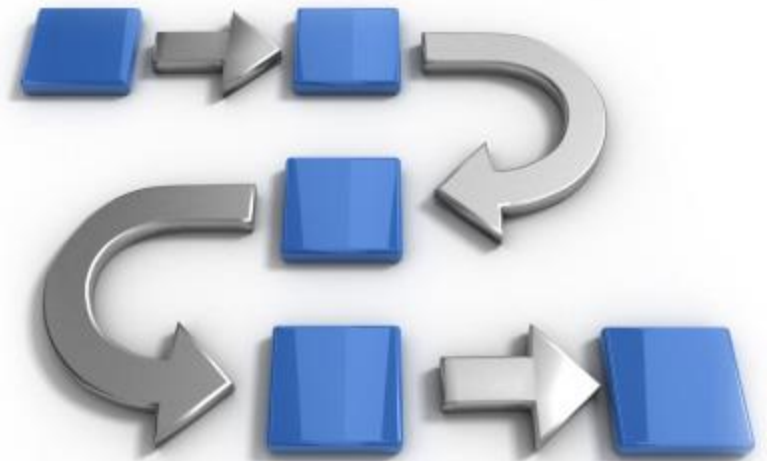
Graphical representation of **patient, material and information flow**

Basic Value Stream Map



What is a Process?

A **process** is a set of steps that transform one or more inputs into one or more outputs.



"If you can't describe what you are doing as a process, you don't know what you're doing." W. Edwards Deming

What is a Value Stream?

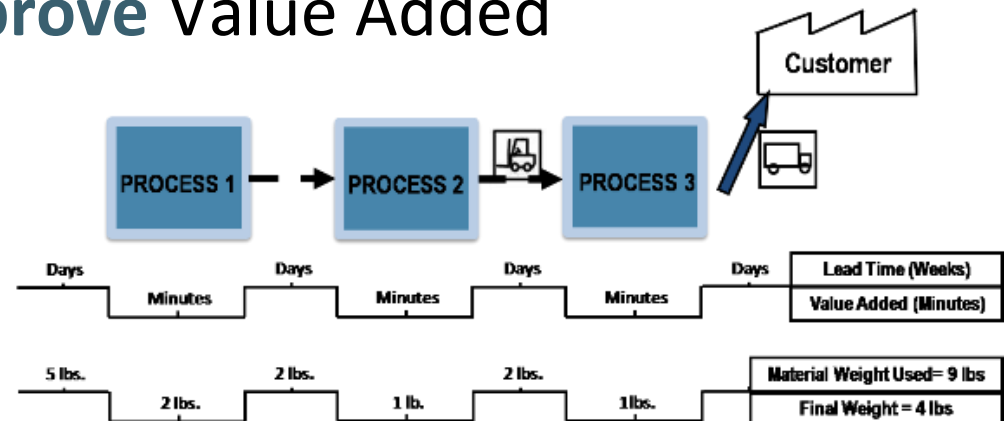
- Defines **value** from the customer's perspective
- All of the actions and tasks, both value added and non-value added, required to bring an item (an idea, information, product or service) from its inception through delivery.
- Value streams vary in scope: reach beyond the enterprise to single process size

Purpose of Value Stream Mapping & Analysis

- Develop a common understanding of the current process
 - The relationship of process steps
 - A true picture of the process
- Create a baseline to measure improvements against
- Define a vision of the future process
- Identify opportunities for improvement
- Design an implementation plan for improvements

VSM in Healthcare

- ✓ Define **value** from your customer's point of view.
- ✓ Determine which steps **add value** and which ones add waste.
- ✓ Standardize and **improve** Value Added processes.
- ✓ Eliminate **waste**.

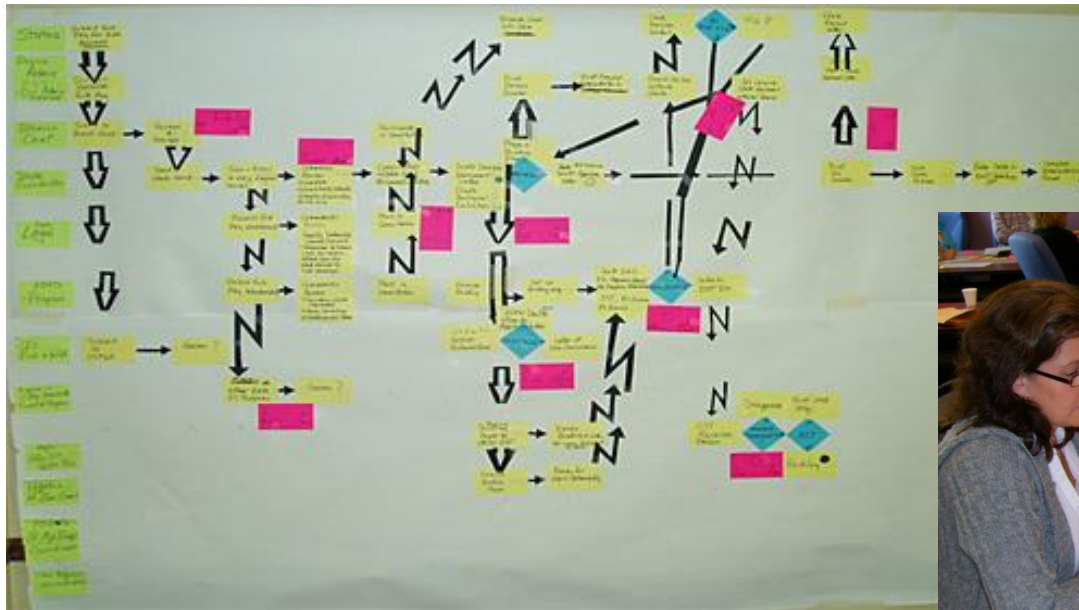


Why is VSM Helpful?

- ✓ Helps **visualize** connections, interactions and flows of patient, material and information.
- ✓ Provides a way for healthcare providers to easily **identify and eliminate** waste.
- ✓ Identifies the **constraints** – any resource whose capacity is less than customer demand.
- ✓ Helps employees **understand** the organization's entire Value Stream and not just a single function of it.

Current State Map

The way it “really” is today.....



Value Stream Mapping

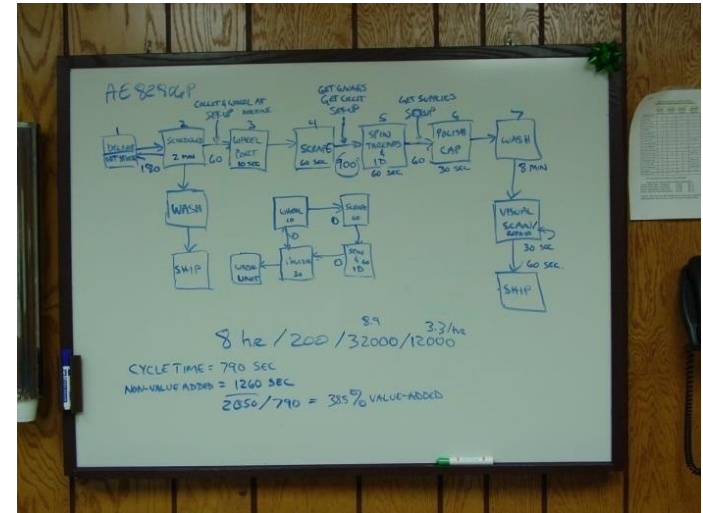
Normally a Value Stream Mapping team is comprised of three to eight participants lead by a Value Stream leader.



During the Value Stream Mapping process, team members will use additional Lean tools, methods and techniques.

Tips for creating a VSM

- ✓ The process of Value Stream Mapping should involve the **whole team**.
- ✓ Actually **walk the process**....follow the material and information through the process starting at the beginning.

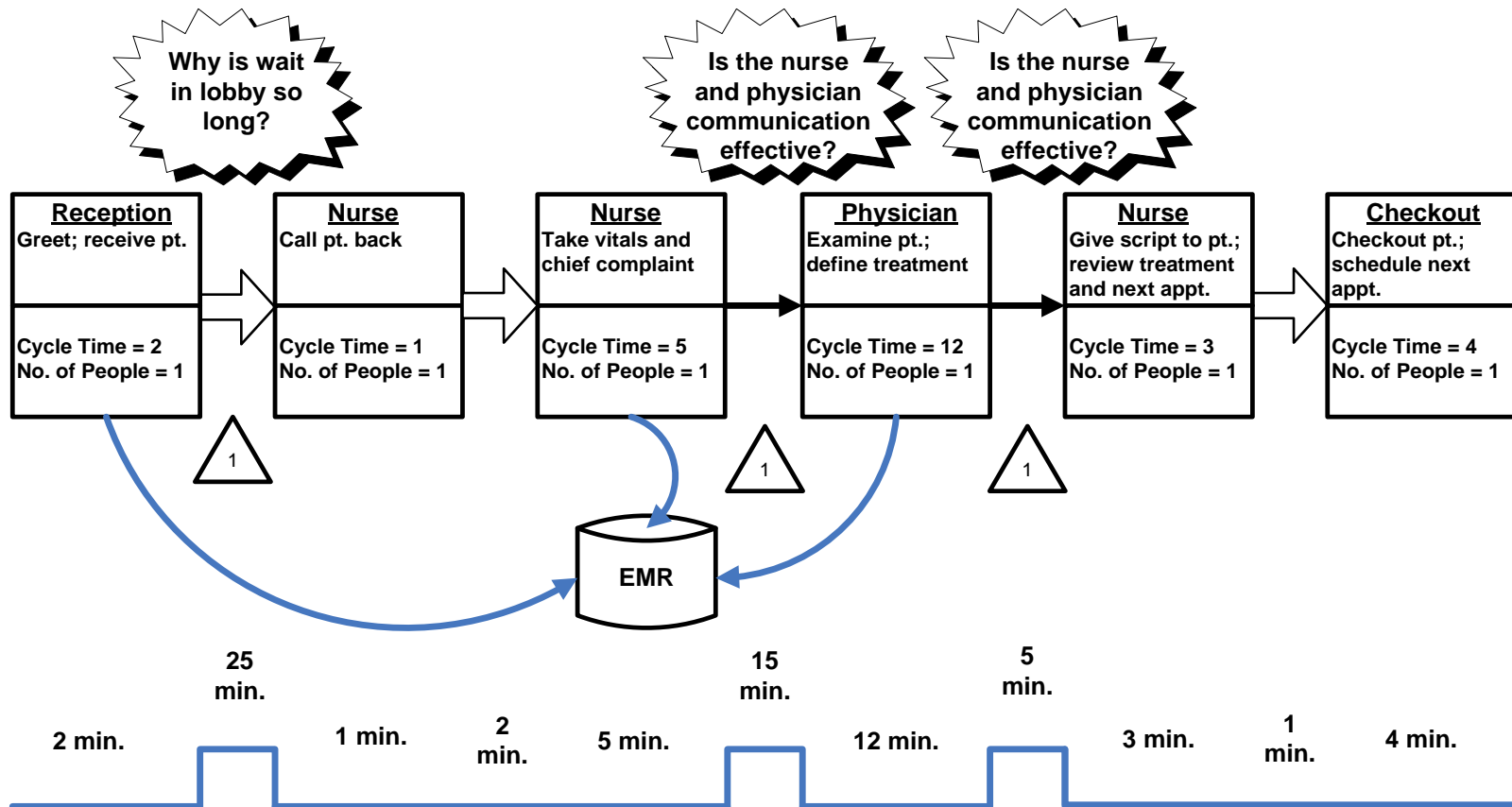


gemba
walk

Getting Started with a Value Stream Map

- ✓ Define the **boundaries**
- ✓ Define the **value**
- ✓ Identify the **tasks and flows** of patient and information between them
- ✓ Identify **resources** for each task and flow
- ✓ Create the **Current State Map**
- ✓ Visualize the “**ideal state**” and create a Future State Map
- ✓ Develop **action plans and tracking**

Current State Value Stream Map for Patient Office Visit



Seven Forms of Waste [Waste adds no value in eyes of the patient]

1. Confusion [activities that require clarification questions; looking for things]
2. Motion/conveyance [Physical movement to complete a task]
3. Waiting [Waiting for a procedure, medication to arrive, order from provider]
4. Overprocessing [doing more than is necessary]
5. Unnecessary Inventory [excess things; stored supplies that are obsolete]
6. Defects [errors, incorrect act or decision or misunderstanding]
7. Overproduction [Doing more work than is necessary; redundant paperwork]

Legend

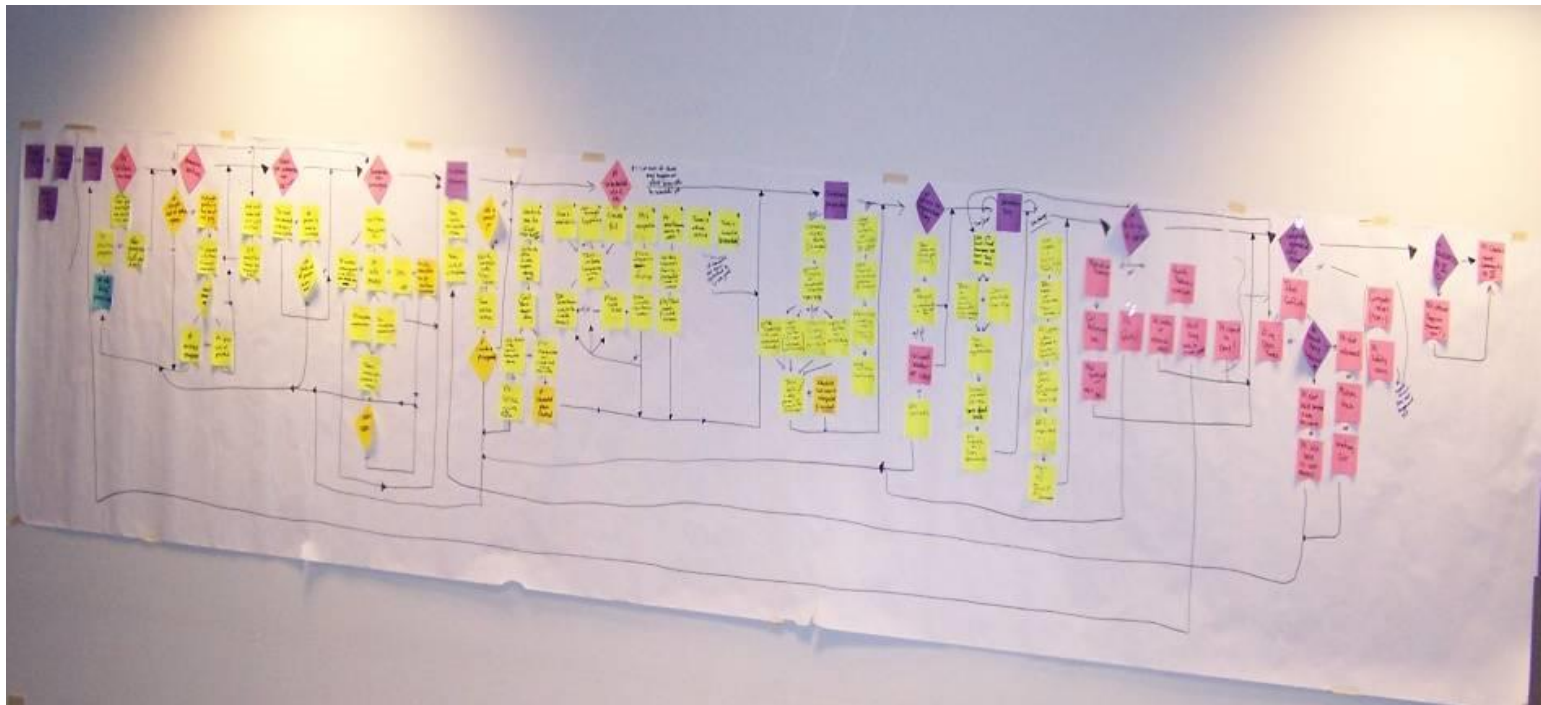
1. All times in minutes
2. Value-Added Time has value in the eyes of the patient.
[Pt. would pay for it if given option]
3. Non-Value Added Time has no value in the eyes of the patient.
[Pt. would not pay for it if given the option]

| Non-Value Added Time | Value Added Time | | |
|----------------------|------------------|------|-----|
| 45 min. | 30 min. | 60% | 40% |
| 75 min. | | 100% | |

James Shirley Management Consultants, Inc. [7/29/10]

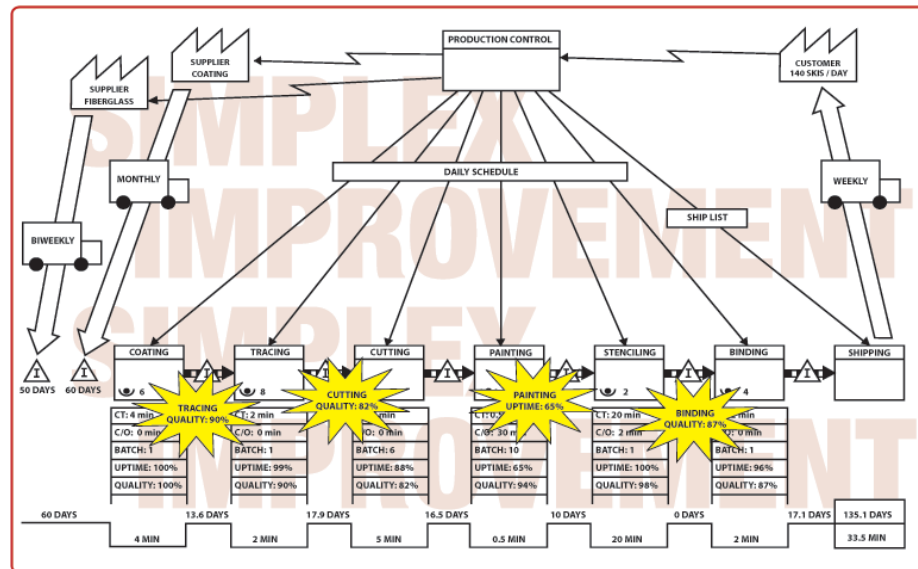
Next Step: Future State Map

Where do we want to be?



Value Stream Mapping

Using the current state map, we identify all the areas where there are significant opportunities for improvement, and mark these on the map.



Common practice is to use “**Kaizen bursts**”, where each burst represents an opportunity for change that can be addressed through a short, focused, 3 to 5 day team-based improvement activity.

Future State Map

- Any non-value added steps
- Long lead-times or queue times
- High difficulty levels
- Accurate and complete levels that are less than 95%
- Where priorities do not match
- Reliability of equipment less than 95%
- Quantities or batching work
- Long processing times

Value Stream Mapping

| DATE: 6/1/10 | | | IMPLEMENTATION PLAN | | | | | | | | | | | | DEPARTMENT SIGN OFF | | | | | |
|----------------------------|-----------|-----------------|---------------------|---|---|---|---|---|---|---|---|----|----|----|---------------------|--------------------|--------|----|----|---|
| PROJECT OWNER: Simplex | | | | | | | | | | | | | | | AK | AN | CT | BB | BF | X |
| VALUE STREAM | OBJECTIVE | MEASURABLE GOAL | WEEKLY SCHEDULE | | | | | | | | | | | | RESPONSIBLE | REVIEWED BY / DATE | STATUS | | | |
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | | | | | |
| Improve quality of Tracing | | 90% to 99% | █ | █ | █ | | | | | | | | | | Nahmias | Simplex 7/13 | ● | | | |
| Improve quality of Cutting | | 82% to 100% | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | Fernandez | Simplex 7/13 | ● | | | |
| Improve uptime of Painting | | 65% to 85% | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | Guillen | Simplex 7/13 | ● | | | |
| Improve quality of Binding | | 87% to 98% | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | █ | Shu | Simplex 7/13 | ● | | | |
| | | | | | | | | | | | | | | | | | ○ | | | |
| | | | | | | | | | | | | | | | | | ○ | | | |

Once we have developed our Future State Map, we create a build a **detailed Implementation Plan**, and use that plan to **implement the necessary changes**.

Each round creates a new Current State from which to launch the next round of changes.

Keys to Success

- Have the right people in the room
- Empower the team to make immediate changes to the process
- Full participation from all team members
- Attack process, not people
- Agree on measures and how they will be collected
- Review action plan frequently for progress

Introduction to 5S

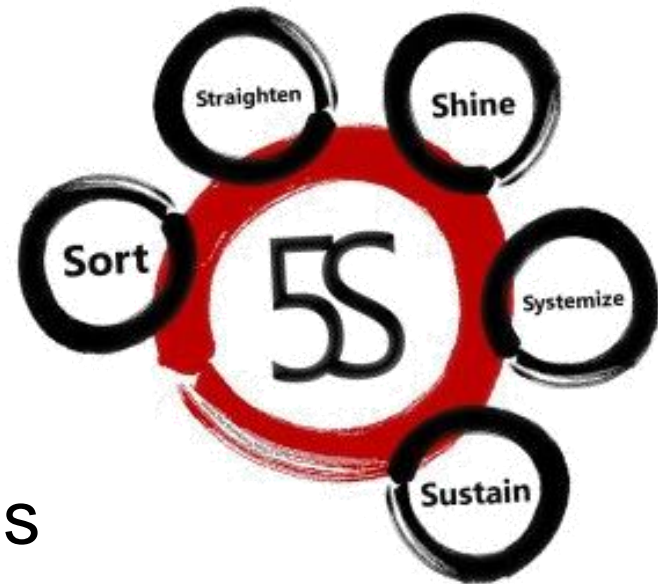


RE-THINKING HEALTHCARE
IMPROVING PATIENT CARE THROUGH DESIGN

Workplace Organization

5S is short for:

- Sort,
- Set in Order,
- Shine,
- Standardize and
- Sustain



5S represents 5 disciplines for maintaining a visual workplace (visual controls and information systems).

The 5S

1. **Sort** - All unneeded tools, parts and supplies are removed from the area
 2. **Set in Order** - A place for everything and everything is in its place
 3. **Shine** - The area is cleaned as the work is performed
 4. **Standardize** - Cleaning and identification methods are consistently applied
 5. **Sustain** - 5S is a habit and is continually improved
- 6th S - Work areas are safe and free of hazardous or dangerous conditions

Workplace Organization



Waste occurs when supplies are not properly maintained in the workplace and become either damaged over time or outdated.

An organized work environment allows us to manage and control our inventories with less waste.

Workplace Organization

Another example of waste is the time lost to searching for things in a cluttered and disorganized workplace.



You can minimize waste of motion through better location and identification of equipment and supplies.

Current Conditions



- Unorganized Workbenches
- Product Flow not Obvious
- Time wasted looking for things
- Hoarding of supplies

- Poor Utilization of Space
- General Clutter
- Supply Shortages and "Hidden" Inventories

Workplace Organization

Through the proper use of 5S methodology, you can expect to:

- Decrease waste of space
- Decrease waste of people resources
- Improve safety
- Improve the overall quality of patient care
- Improve integration of patient services (flow)
- Decrease staff motion

Step 1: Sort

Before

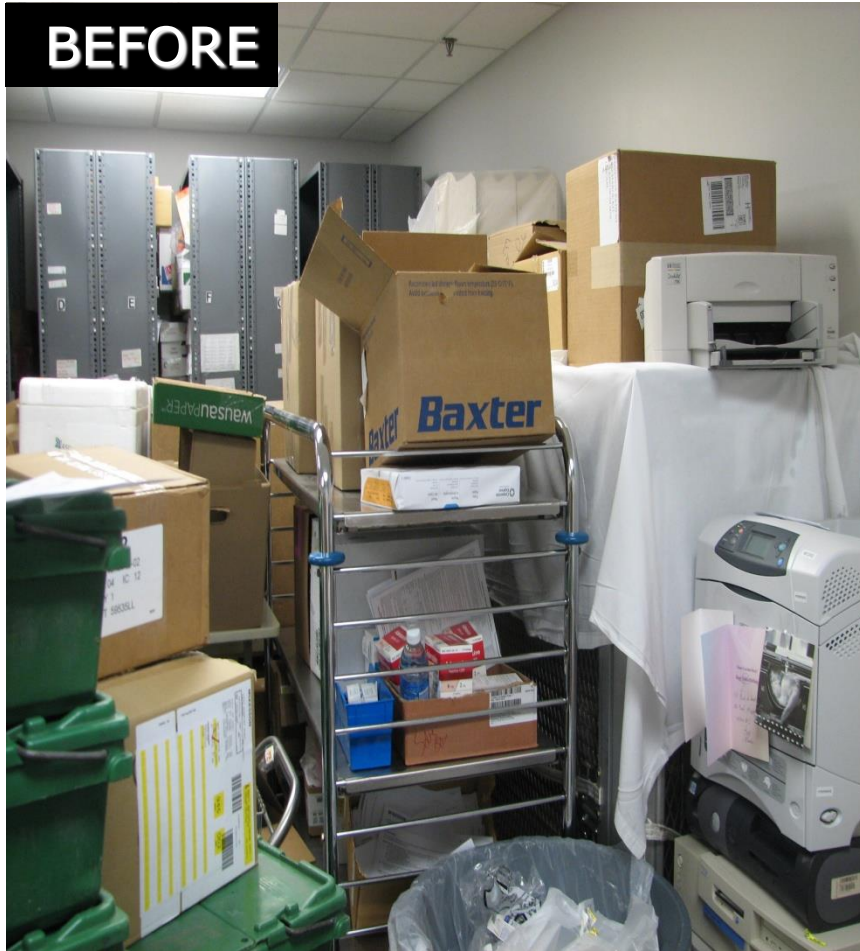


After

Separate the needed from the not needed

Step 2: Set in Order

BEFORE



AFTER

A place for everything & everything in its place!

Step 3: Shine

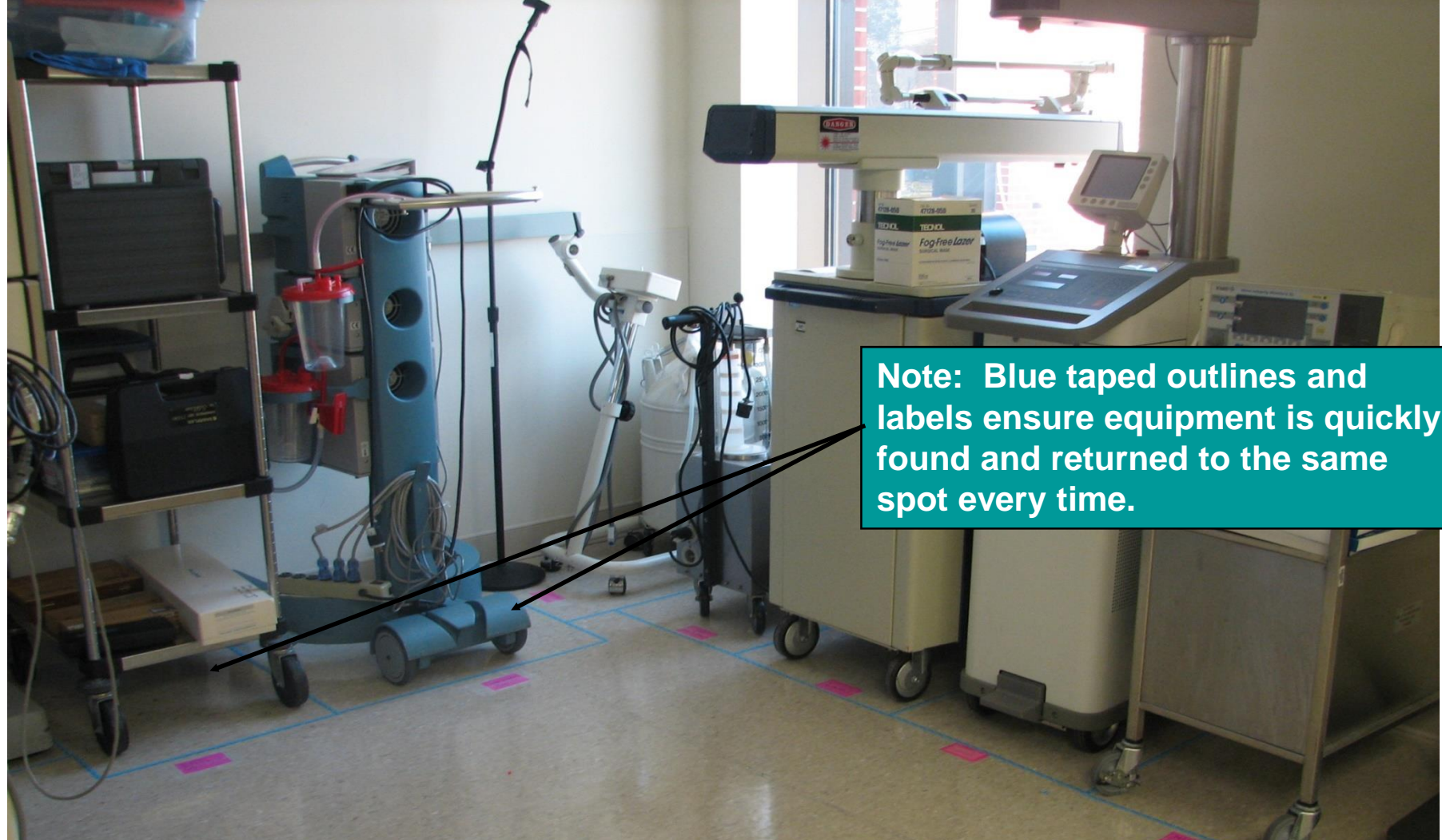


“Scrub” and inspect equipment to ensure it is in perfect working condition...

Add inspecting equipment into your work routine.

Regularly “shine” to ensure everything is in perfect working condition

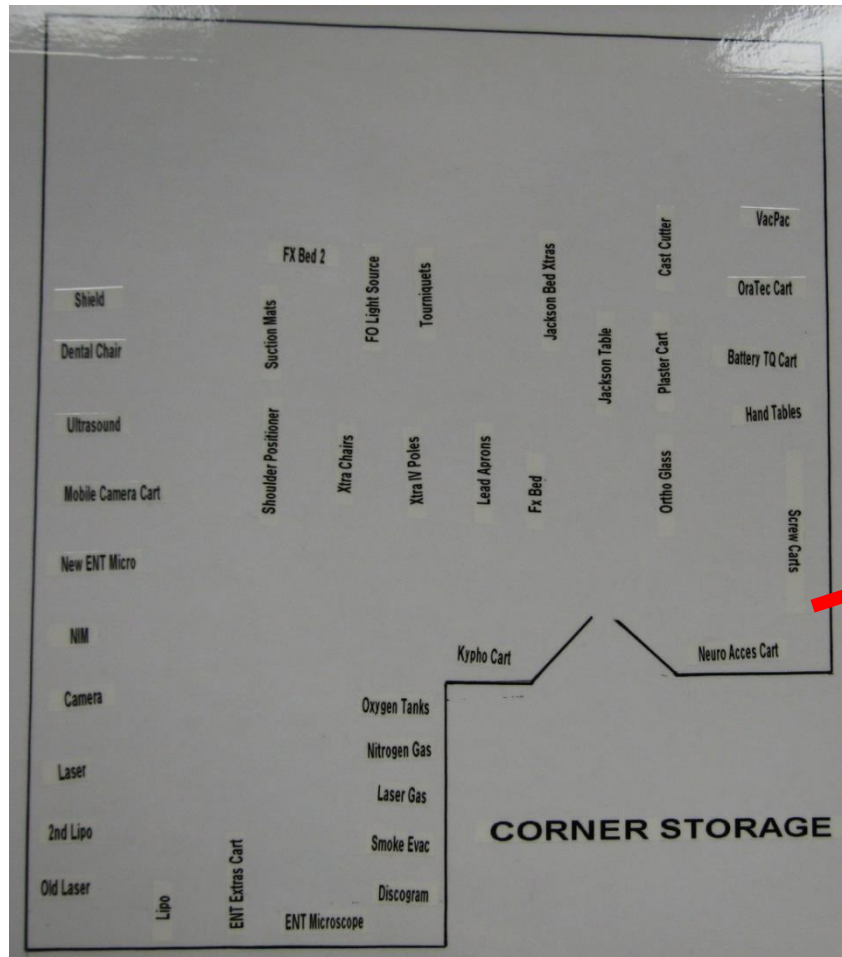
Step 4: Standardize



Note: Blue taped outlines and labels ensure equipment is quickly found and returned to the same spot every time.

Standard Work requires determining the best method then following that method every time.

Step 5: Sustain



Develop a method for sustaining your gains

Workplace Organization

There are three steps in the **Standardization** process:

- First, assign 5S responsibilities
- Next, integrate the 5S duties into regular work duties
- Now, continually check on the 5S maintenance level

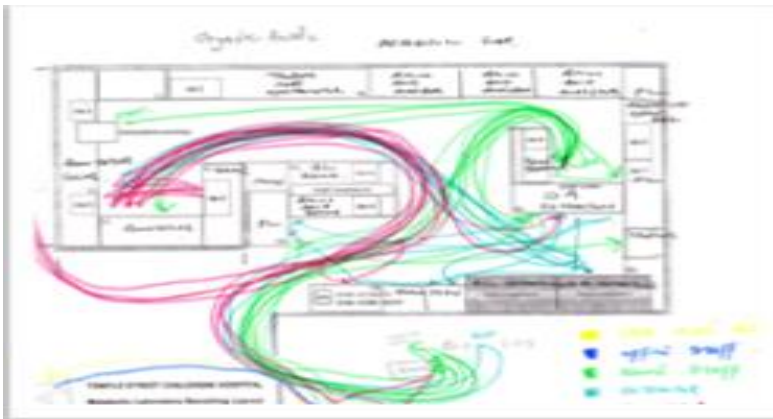
The third step is critical so that we don't wait until a significant degradation of the 5S activity occurs before taking action.



Workplace Organization

The “Set-In-Order” phase should result in reduction of wasted time and motion because equipment and supplies are close to the work area and are easy to access.

Reducing unnecessary motion is one of the key objectives.



Before



After

Workplace Organization

If better organization and labeling could save even a few seconds, when you multiply by the number of times a document is accessed, the savings can be substantial.



Introduction to A3 Problem Solving



RE-THINKING HEALTHCARE
IMPROVING PATIENT CARE THROUGH DESIGN

Problem Solving 101

What is a problem?

- Gap between what “Should Be” and “Reality”

Why are problems hard to solve?

- People treat symptoms
- No clear goals
- No consensus



What is the problem?

Most people are smart enough to solve problems. Most people don't do it right.

They don't define the problem and jump into conclusions.

Some analyze it to death without trying out anything.

Many rely too much on themselves, when multiple people typically have a better chance of solving the problem.

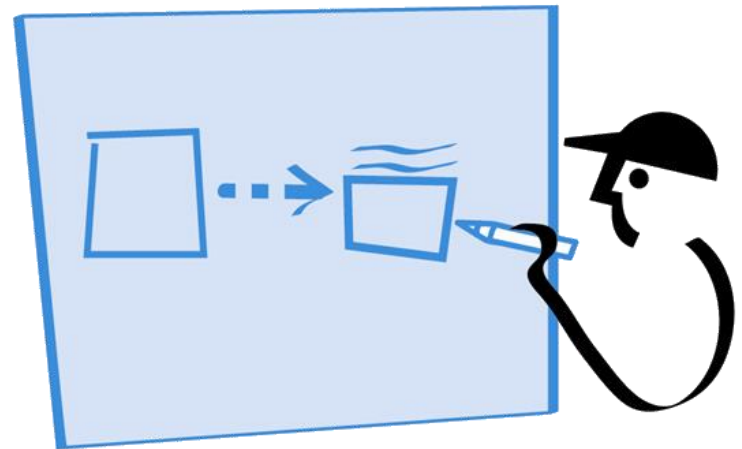
Why problems are not solved in hospitals.....

- Different departments see the problem differently
- People leap to solutions rather than identify the real issue-symptoms instead of root cause
- Solutions are adopted before their implications are fully considered
- Once the 'fire' has stopped blazing people think that the problem is solved
- The solution implementation isn't properly managed
- Nobody notices that the solution isn't actually working properly
- When the focus shifts elsewhere, things drift back to how they were

Why Add Structure to Problem Solving?

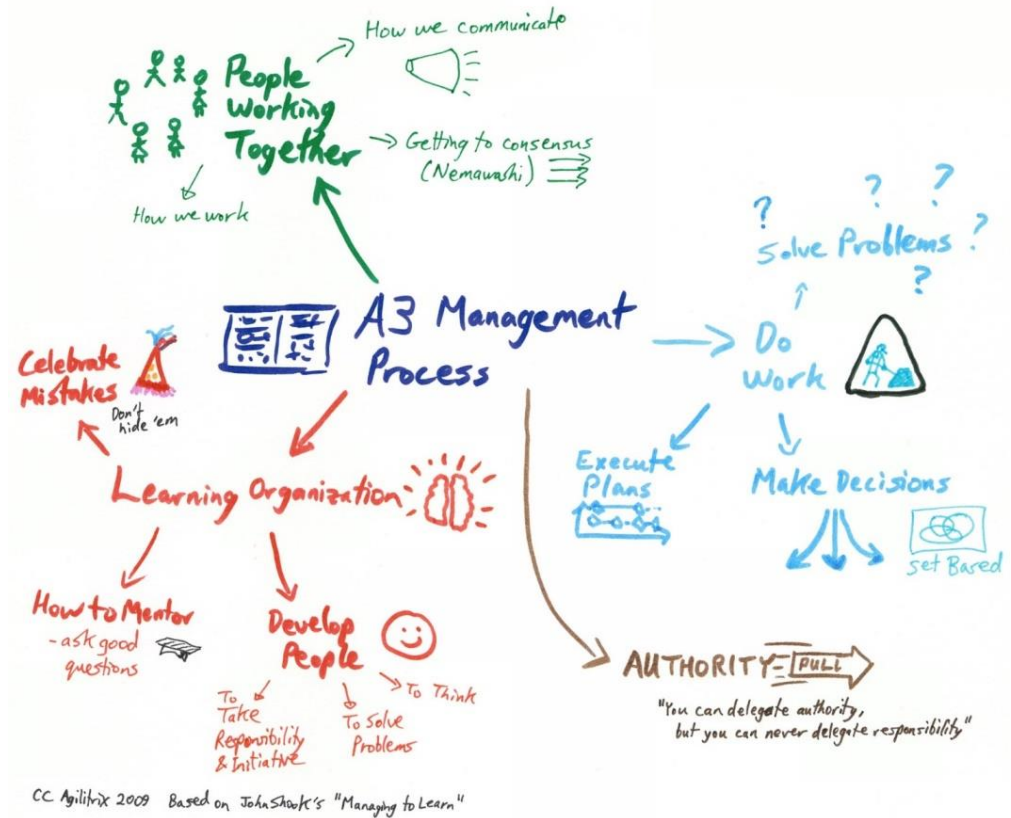
Structure promotes better...

- Thinking
- Understanding
- Communication
- Consensus



Learning by Doing

Effective learning is really what A3 thinking and problem solving is all about – learning what we can about the way work currently transpires to develop a new way to work



Advantages of team-based problem-solving:

- ✓ Those closest to the work know best how to perform and improve their jobs
- ✓ Application of a broader range of knowledge from multiple disciplines
- ✓ Broader, more creative solutions
- ✓ Greater chance of risk-taking
- ✓ Teams tend to be more successful in implementing complex plans
- ✓ Higher level of ownership of results

Team Make-Up

Typically problem solving A3 are made up of small groups (approximately 3-5 people)

Having process owners or value-adders is a must

A good cross-functional representation is recommended

This allows the people closest to the problem to make an impact

About the A3 Report

Format

- No set format
- A3 (11.7" x 16.5") size paper (Ledger in US-11 x 17)
- Some momentum to go to 8 ½ x 11 sheet
- Handwritten OK, even encouraged

Content

- Summary of a lot of work
- Should include as much graphical content as possible

Types of A3s

- Problem solving-most common
- Proposal (higher level)
- Status

What is an A3?

Theme: Enter theme name here

Background

Current Condition

Goal

Root Cause Analysis

**P
L
A
N**

To: (Approving Person)
From: (A3 Author)
Date:

Countermeasures

Suspect

DO

Effect Confirmation

CHECK

Follow-Up Actions

Action

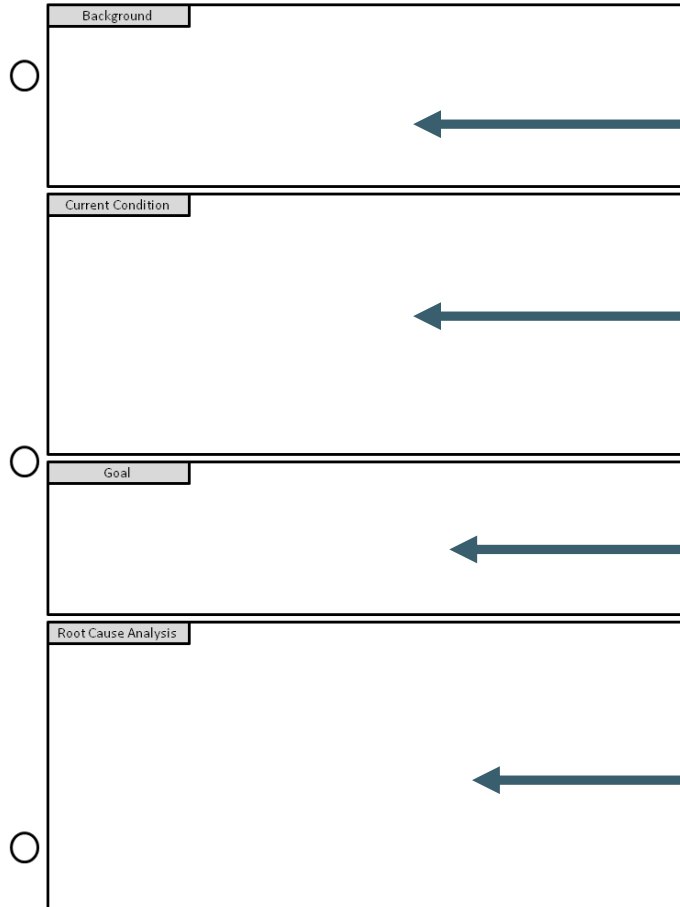
ACT

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Sections of the A3 (Plan Side)

Theme: Enter theme name here



The diagram shows a vertical stack of four rectangular sections, each with a small header box at the top left. To the left of each section is a small circle. Arrows point from descriptive text on the right to each section. The sections are: 1. Background (with a circle to its left), 2. Current Condition (with a circle to its left), 3. Goal (with a circle to its left), and 4. Root Cause Analysis (with a circle to its left).

Background

Current Condition

Goal

Root Cause Analysis

Background: Clarifies problem, adds context

Current Condition: Overview of the current process; establishes problem

Goal: Specific targets to define success

Problem Analysis: Overview of how you found the source of the problem (Root Cause)

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Sections of the A3 (Do, Check, Act)

To: (Approving Person)
From: (A3 Author)
Date:

Countermeasures: Specific actions taken to solve the problem

| Countermeasures | | | | |
|-----------------|-------------|-------------|-----|---------|
| Suspected Cause | Action Item | Responsible | Due | Finding |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Effect Confirmation: Specific proof that the CMs worked

| Effect Confirmation |
|---------------------|
| |
| |
| |
| |
| |
| |

Follow-Up Actions: Steps to provide deeper/broader improvements

| Follow-Up Actions | | | |
|-------------------|-------------|-----|--------|
| Action Item | Responsible | Due | Status |
| | | | |
| | | | |
| | | | |
| | | | |

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Example A3 Report

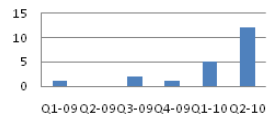
Theme: Reducing Jeff Hajek's tardiness

Background

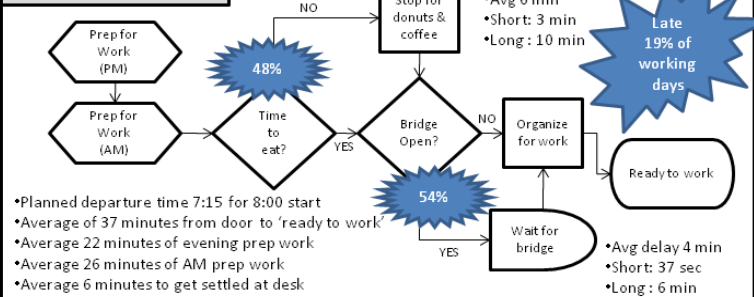
Tardiness has become a problem, jeopardizing job

- Last year, attendance was good—4 tardies all year
- This year, starting in March, averaging one per week
- I want to minimize the time spent preparing and driving
- Tardy defined as not being ready to work at 8:00

Jeff's Tardiness



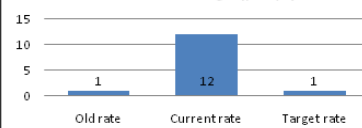
Current Condition



Goal

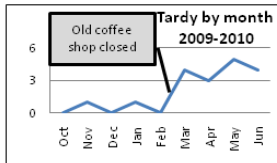
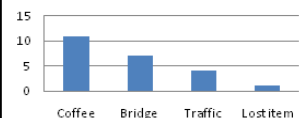
- Reduce tardiness from 12/qtr to 1/qtr
- 91.6% reduction
- Minimize time spent preparing for / travelling to work

Jeff's Tardiness Target (per qtr)



Root Cause Analysis

Contributing Factors, Q2-2010



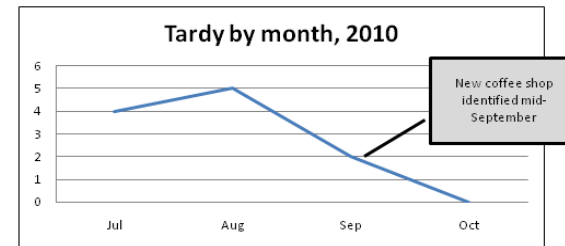
- Old coffee shop closed in March
- New shop closer to home (higher variation, less information)

To: Jeff's Boss
 From: Jeff Hajek
 Date: October 14, 2010

Countermeasures

| Suspected Cause | Action Item | Responsible | Due | Finding |
|--|--------------------------------------|-------------|---------|--|
| Stopping early for coffee eliminates option to skip. | Find new coffee shop closer to work. | Jeff H. | 9/14/10 | ID'ed and tested new shop. Decent brew, good donuts. |

Effect Confirmation



Follow-Up Actions

| Action Item | Responsible | Due | Status |
|---|-------------|---------|----------------------------|
| 1. Open donut shop on-site at office | John Doe | 3/1/11 | Scheduled start 12/1/10 |
| 2. Improve AM process to prevent skipping breakfast | Jeff H | 1/31/11 | Data collection in process |

Start with a theme....

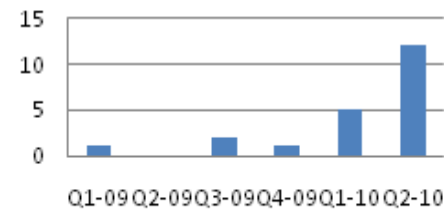
Theme: Reducing Jeff Hajek's tardiness

Background

Tardiness has become a problem, jeopardizing job

- Last year, attendance was good—4 tardies all year
- This year, starting in March, averaging one per week
- I want to minimize the time spent preparing and driving
- Tardy defined as not being ready to work at 8:00

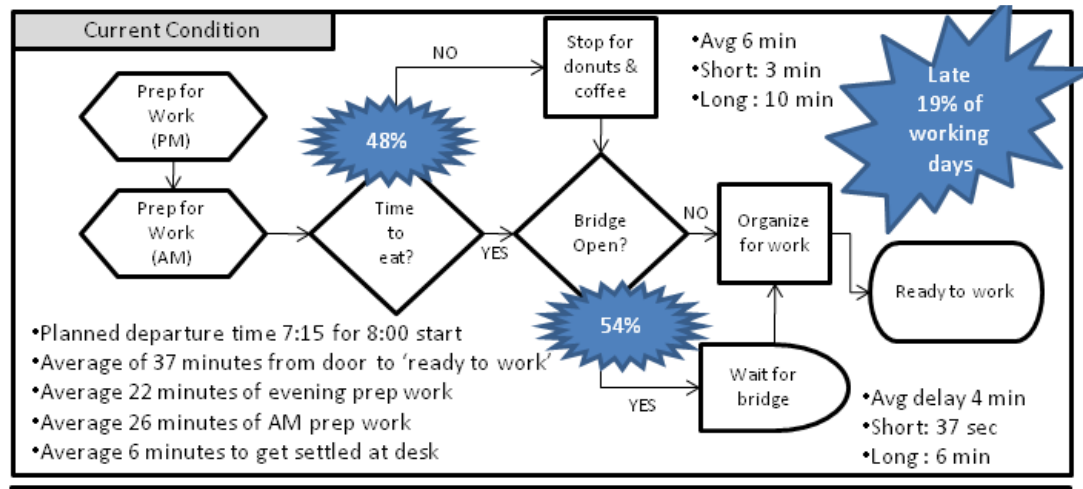
Jeff's Tardiness



Set the stage:

- What's going on? Why important?
- Match background to audience
- Link to corporate goals
- Use visuals!

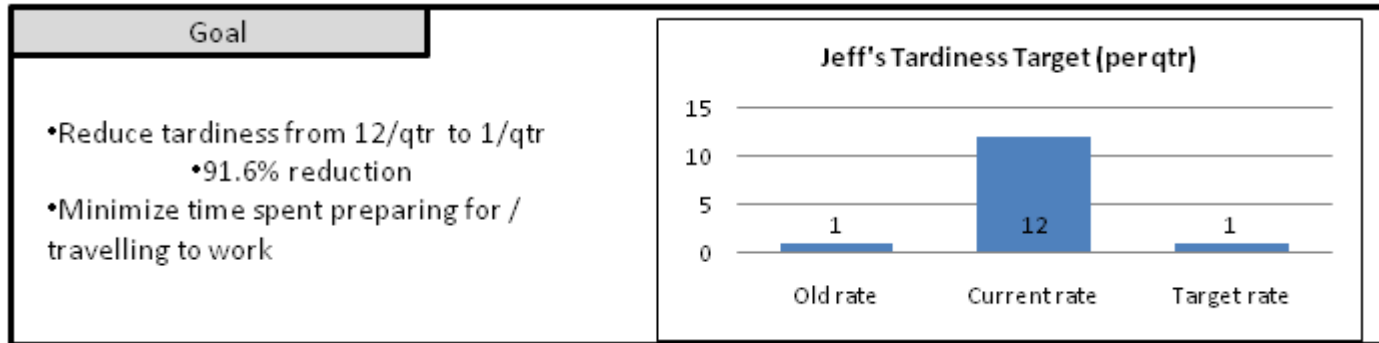
What is the Current Condition?



Lay out the facts:

- How are things done now?
- Clarify the problem (highlight specific issues; avoid assigning causes)
- Use visuals!

What is Our Goal?



Establishing targets:

- How is success defined?
- Establishes a standard
- Use visuals!

Find the Root Cause



Do the detective work:

- Find the underlying cause
- May require substantial data collection
- Confirm assumptions; talk to everyone

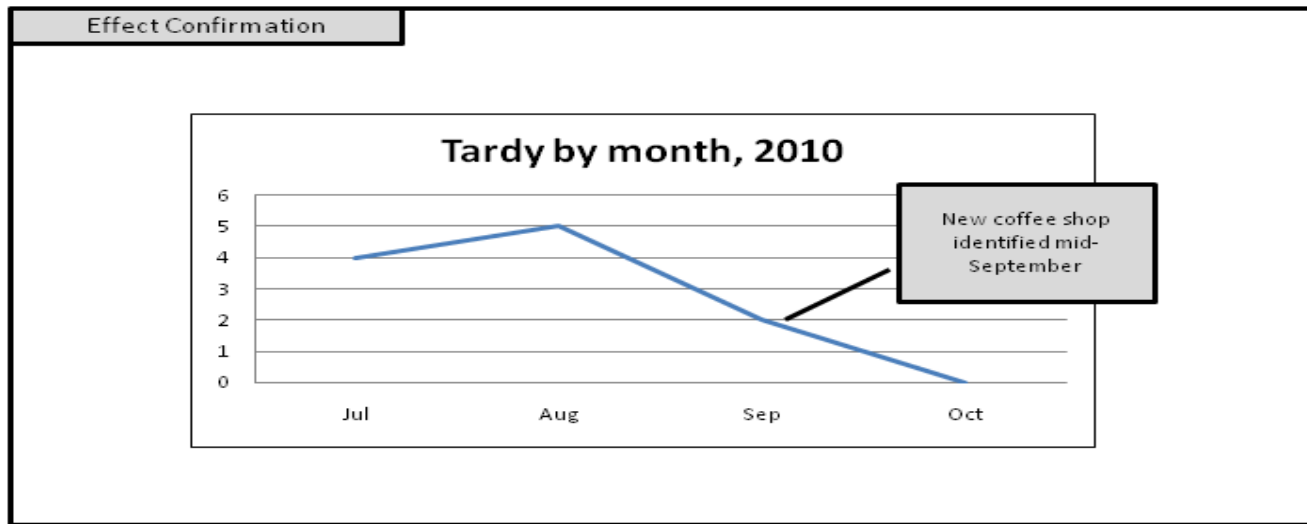
Countermeasures

| Countermeasures | | | | |
|--|--------------------------------------|-------------|---------|--|
| Suspected Cause | Action Item | Responsible | Due | Finding |
| Stopping early for coffee eliminates option to skip. | Find new coffee shop closer to work. | Jeff H. | 9/14/10 | ID'ed and tested new shop. Decent brew, good donuts. |

Improving the system:

- Decide how to remove the root cause
- May take many actions
- Probably action plans for each CM
- Clearly state why (cause), what, who, and when. Add results.

Effect Confirmation



Check your work:

- Confirm that the countermeasures work
- Should match predictions
- Use visuals!

Follow-Up Actions

| Follow-Up Actions | | | |
|---|-------------|---------|----------------------------|
| Action Item | Responsible | Due | Status |
| 1. Open donut shop on-site at office | John Doe | 3/1/11 | Scheduled start 12/1/10 |
| 2. Improve AM process to prevent skipping breakfast | Jeff H | 1/31/11 | Data collection in process |

Don't stop here...

- Decide if further improvements needed
- Decide how to spread the gains to other groups

Summary of A3 Thinking

Simple report built on sophisticated thinking:

Objectivity and Openness

Structured thinking

Clear, concise communication

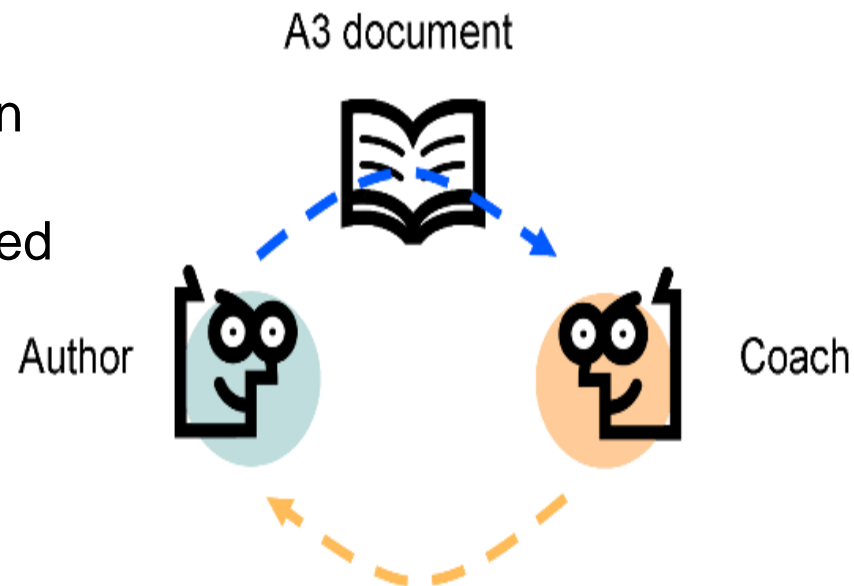
Systems thinking

Ideas reviewed and exchanged

Continuous learning

Teamwork and Alignment

Process AND Results



Problem Solving One Way



When everyone in an organization has the confidence in one consistent way to solve problems it is incredible powerful.

Standard Work



RE-THINKING HEALTHCARE
IMPROVING PATIENT CARE THROUGH DESIGN

What is Standard Work?

Standard Work is the most effective combination of activities that will **minimize** non-value added activities while **providing** high quality care.



Let me ask you a question, would you...



Add eggs to an omelet before cracking them?



Serve multiple meals to your family?

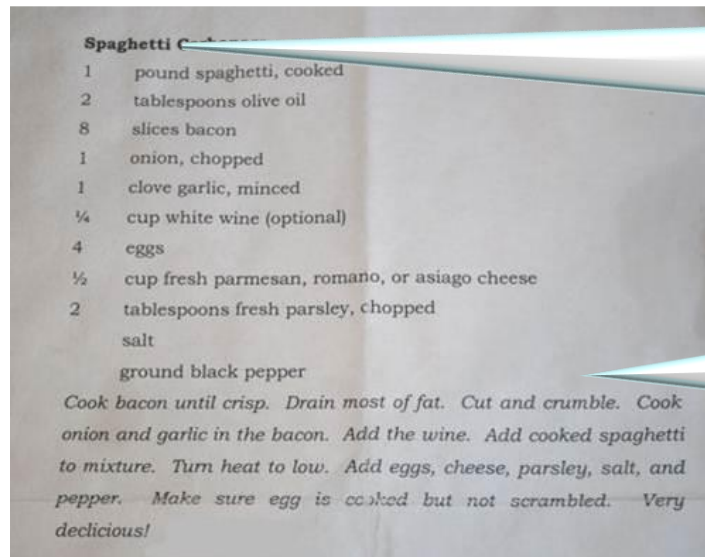


Let too many cooks spoil the soup?

What is Standard Work?

**Cooked
based on
need**

**Standard Work =
Production Recipe**



**Precisely specified
amounts of
ingredients**

**Defined sequence to
add ingredients**

Why Use Standard Work?

**We use
Standard
Work for
the same
reasons
we use
recipes.**



Consistent Output

- Identical results every time
- Everyone makes it the same



Easier Planning

- Know meal requirements
- Know time to produce



Managing Materials

- Limits workspace size
- Know material needs

Definition of Standard Work

- Simple written description of the highest quality, most efficient way known to perform a particular process or task
- It describes the only acceptable way to perform the process or task
- The standard is expected to be consistently followed
- It's about approaching similar work in a similar manner
 - formalizing the informal

Ever here this in your facility?

Standardized work doesn't always mean a long, detailed document like we have now. Do you ever here statements like these:



"We haven't followed that process for years"

"We have a bunch of binders on the shelf"

"Our policies don't reflect reality"

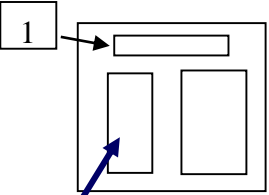
"We only update our policies when the surveyors are coming"

Standardization

When 100% adherence to reliable methods occurs, you have standardization.



Example of Standard Work Instructions

| Standard Work Instruction | | | |
|---------------------------|--|---------------|--|
| Name of Process: _____ | | | |
| Task | Key Points | Time / Timing | Visual References |
| 1. Enter Order | - Enter demographics (name, DOB, ht, wt, | 2-4 minutes |  <p>A diagram showing a rectangular box representing a form. Inside the box, there is a horizontal input field at the top and two vertical input fields below it. A small square box containing the number '1' is positioned to the left of the top input field. A blue arrow points from the bottom of the 'Visual References' column towards the diagram.</p> |
| 2. Prepare order | - Enter Rx info, enter physician/referral info | 2-4 minutes | |
| | | | |
| | | | |
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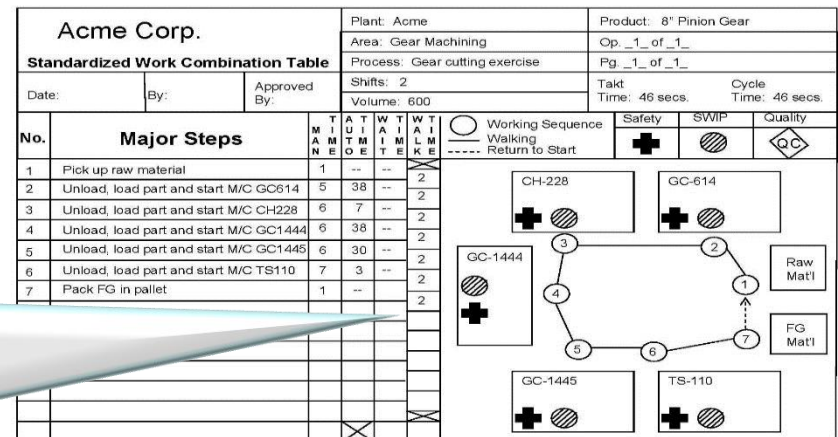
Use diagrams or screen shots here

Standard Work Instruction

The Standard Work Instruction is used to carefully record standard tasks, standard sequences, tact time, and standard work in process, together with any safety and quality checks that need to be embedded in the workflow.

**Standard Work
provides a
platform for
improvement.**

Standardized Work Chart



Slide 4-7

Standard Work – More Benefits

- Improved patient, resident, staff safety
- Enhanced process flow
- Clarifies roles
- Provides a good baseline or starting point for training new staff
- Reduces task ambiguity

Something to Think About

Without specific focus and standardization, processes tend to:

- *Degrade over time*
- *Performance decreases*
- *Increase in complexity*
- *Tasks become less coordinated*
- *Increased potential for errors*

Standard Work Drives Improvement

Standard work functions as a diagnostic tool, or baseline for, exposing problems and inspiring continuous improvement.

It supports process
standardization and
further illumination of waste
throughout the operations
process.



It is a never ending process!!!