

Lean Six Sigma

Rapid Cycle Improvement



Parkland

1. History of Lean and Six Sigma
2. DMAIC
3. Rapid Continuous Improvement
 - Quick Wins
 - PDSA
 - Kaizen

Lean Manufacturing (Toyota Production System)

- T.I.M.W.O.O.D
- 5S
- SMED
- TAKT TIME
- KAN BAN
- JUST IN TIME
- ANDON
- **KAIZEN**
- **VALUE STREAM MAP**



Six Sigma DMAIC

- **PROJECT CHARTER**
- FMEA
- **PDSA/PDCA**
- **SWOT**
- **ROOT CAUSE ANALYSIS**
- FMEA
- **SIPOC**
- **PROCESS MAP**
- **STATISTICAL CONTROLS**

Process Improvement

Lean Manufacturing

- Lean has been around a long time:
 - Pioneered by Ford in the early 1900's (33 hrs from iron ore to finished Model T, almost zero inventory but also zero flexibility!)
 - Perfected by Toyota post WWII (multiple models/colors/options, rapid setups, Kanban, mistake-proofing, almost zero inventory with maximum flexibility!)
- Known by many names:
 - Toyota Production System
 - Just-In-Time
 - Continuous Flow
- Outwardly focused on being flexible to meet customer demand, inwardly focused on reducing/eliminating the waste and cost in all processes

- Motorola was the first advocate in the 80's
- Six Sigma Black Belt methodology began in late 80's/early 90's
- Project implementers names includes "Black Belts", "Top Guns", "Change Agents", "Trailblazers", etc.
- Implementers are expected to deliver annual benefits between \$500,000 and \$1,000,000 through 3-5 projects per year
- Outwardly focused on Voice of the Customer, inwardly focused on using statistical tools on projects that yield high return on investment





Define

- Project Charter
- Voice of the Customer and Kano Analysis
- SIPOC Map
- Project Valuation / ROIC Analysis Tools
- RACI and Quad Charts
- Stakeholder Analysis
- Communication Plan
- Effective Meeting Tools
- Inquiry and Advocacy Skills
- Time Lines, Milestones, and Gantt Charting
- Pareto Analysis



Measure

- Value Stream Mapping
- Value of Speed (Process Cycle Efficiency/ Little's Law)
- Operational Definitions
- Data Collection Plan
- Statistical Sampling
- Measurement System Analysis (MSA)
- Gage R&R
- Kappa Studies
- Control Charts
- Histograms
- Normality Test
- Process Capability Analysis



Analyze

- Process Constraint ID and Takt Time Analysis
- Cause & Effect Analysis
- FMEA
- Hypothesis Tests/Conf. Intervals
- Simple & Multiple Regression
- ANOVA
- Components of Variation
- Conquering Product and Process Complexity
- Queuing Theory



Improve

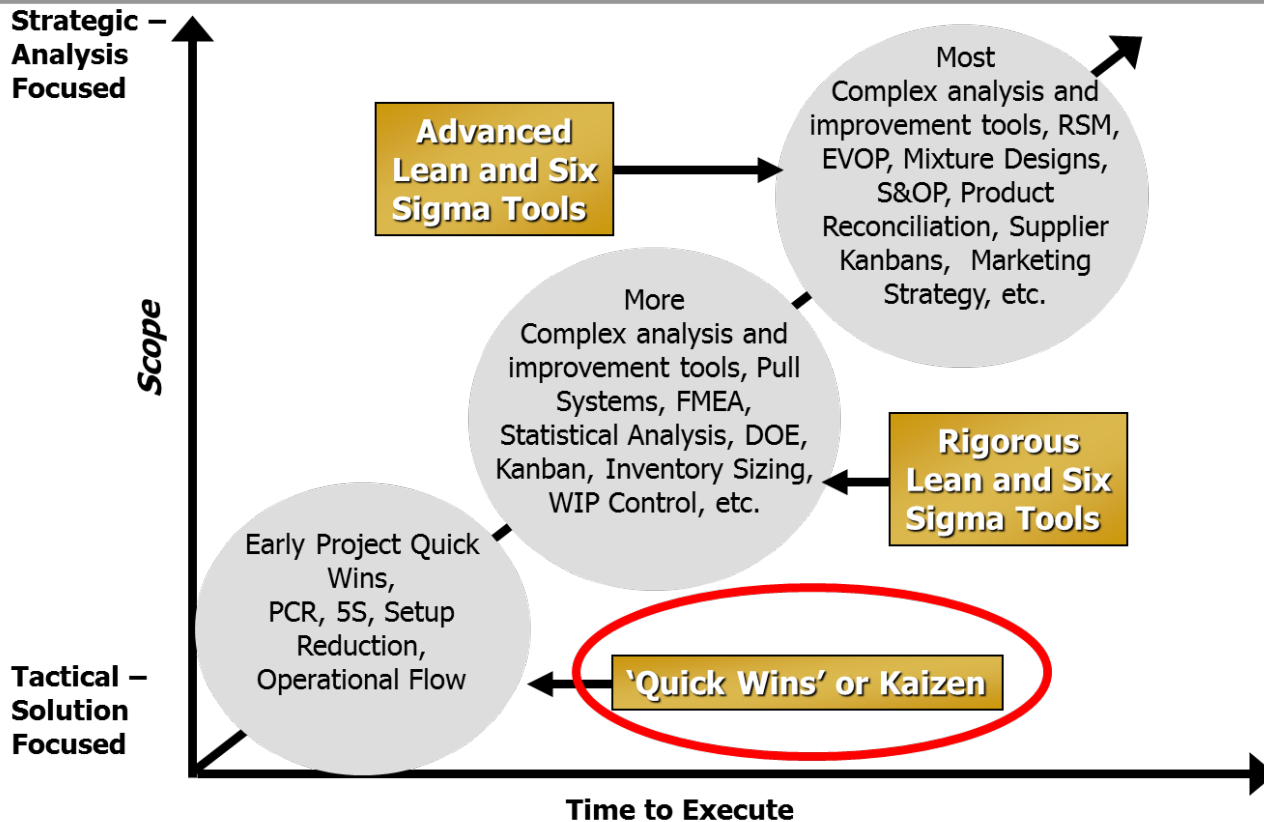
- Replenishment Pull/Kanban
- Stocking Strategy
- Process Flow Improvement
- Process Balancing
- Analytical Batch Sizing
- Total Productive Maintenance
- Design of Experiments (DOE)
- Solution Selection Matrix
- Piloting and Simulation



Control

- Mistake-Proofing/ Zero Defects
- Standard Operating Procedures (SOP's)
- Process Control Plans
- Visual Process Control Tools
- Statistical Process Controls (SPC)
- Solution Replication
- Project Transition Model
- Team Feedback Session

Quick Wins



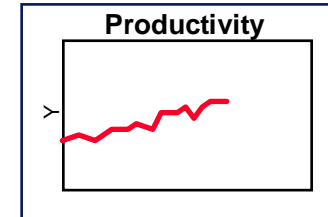
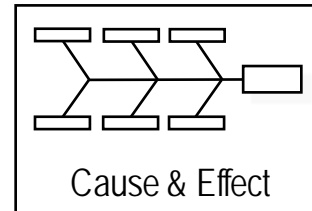
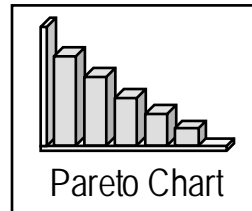
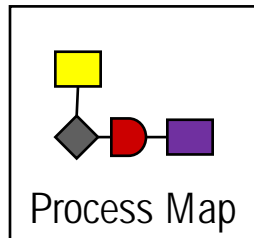
- The Lean Six Sigma training focuses on a disciplined roadmap to Process Improvement.
- The key to effect process improvement is successful completion of the Measurement and Analysis phases.
 - They set the stage for improvement
- However:
 - Opportunities may be identified early in the project that do not warrant extensive analysis.
 - ‘Quick Wins’ bypass the Analyze phase and go straight to Improve
 - Kaizen improvements still follow the DMAIC format but the Define, Measure, and Analyze portions are accelerated.

- The primary difference is in the work required to implement the idea.
 - A **‘Quick Win’** is already a developed solution idea, i.e., **it is in the Improve Phase already.**
 - The only determination left is ‘how to implement.’
 - There is still a requirement to complete Define and Measure, to clarify scope and to be able to measure a change, but there is **no need to go through Analyze Phase.**
 - A **Kaizen Event is essentially an *accelerated DMAIC.***
 - Focuses on specific improvement objective;
 - Setup Reduction, 5S, Process Improvement, Line Balancing, etc.
 - Although the Vision of the ‘Future State’ may be in place, there **is still a requirement to go through the Analyze Phase to determine HOW to make it happen** (as opposed to just ‘how to implement’ a developed idea, as in the case of the ‘Quick Win’).

What do you think might be the benefits of Quick Improvement?

- Provides momentum for the project
- Drives value (\$) early, thus improving ROI
- Provides confidence to the broader organization that Lean Six Sigma is a viable approach to process improvement
- Reduces stress on project team to 'Get Something Done!'

- Often we are able to find some opportunities for immediate improvement early in the project using our basic tools
 - Process map
 - Pareto chart
 - Fishbone Diagram
 - Metric Implementation (Hawthorne effect)



Quick Wins

- Just because we learn statistical methods does not mean we always need statistics.
- Sometimes the Answer hits us right between the eyes early in the project!
- This may be referred to as the “Inter-Ocular”* analysis.



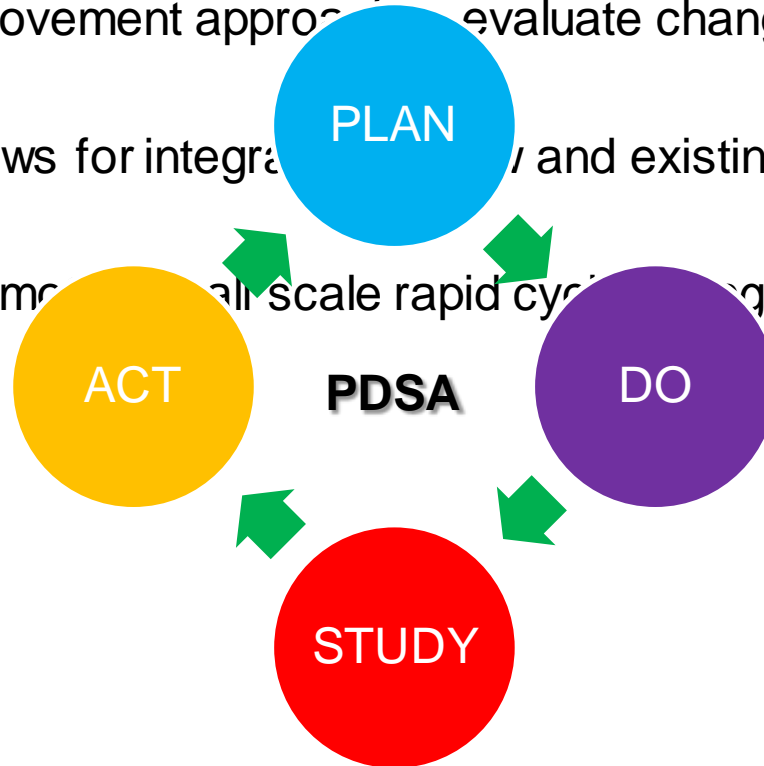
'Quick Win' Improvement Criteria

- Minimal or no Capital Expenditure
- Low Risk
 - Narrow scope
 - Buy-in to solutions by all Stakeholders
 - Certainty the change will generate a positive impact
- Improvements May be Implemented Quickly (within 1-2 weeks)
- The project team has the authority to implement the desired changes

Quick Improvement Control Plans

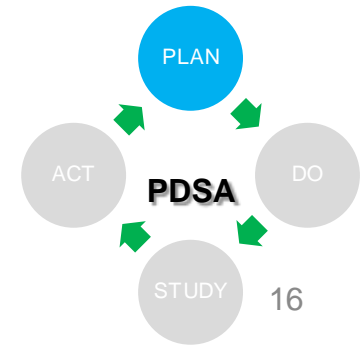
- Quick Improvements, whether ‘Quick Wins’ or Kaizen improvements, **must** have implemented Control Plans in place before being considered complete.
- It is desirable to implement improvements as soon as possible but implementation **without control can be worse than no implementation at all.**

- A process improvement approach to evaluate change
- This model allows for integration with existing systems.
- This model promotes small scale rapid cycles of change over short periods of time



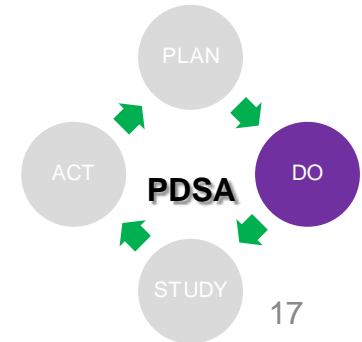
Stage 1: PLAN

- Recruit Team
- **Draft Aim Statement**
- Describe Current Context and Process (Brainstorm)
 - SWOT
 - Process Map
- Problem Statement
- Identify Causes and Alternatives
 - Root Cause Analysis



Stage 2: DO

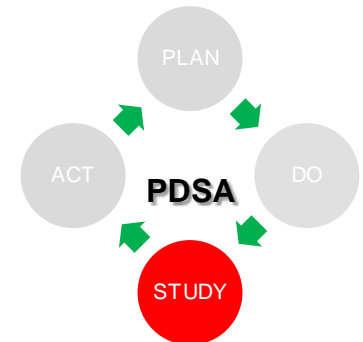
- Start to implement you action plan
- **Collect data**



Stage 3: STUDY

Using the aim statement drafted in **Stage 1: Plan**, and data gathered during **Stage 2: Do**, determine:

- Did your plan result in an improvement? By how much/little?
- Was the action worth the investment?
- Do you see trends?
- Were there unintended side effects?

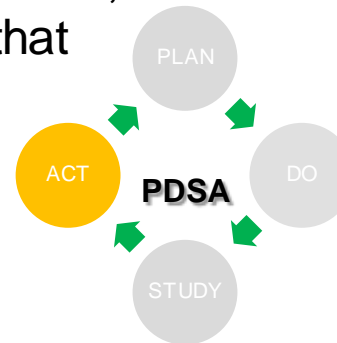


Stage 3: ACT

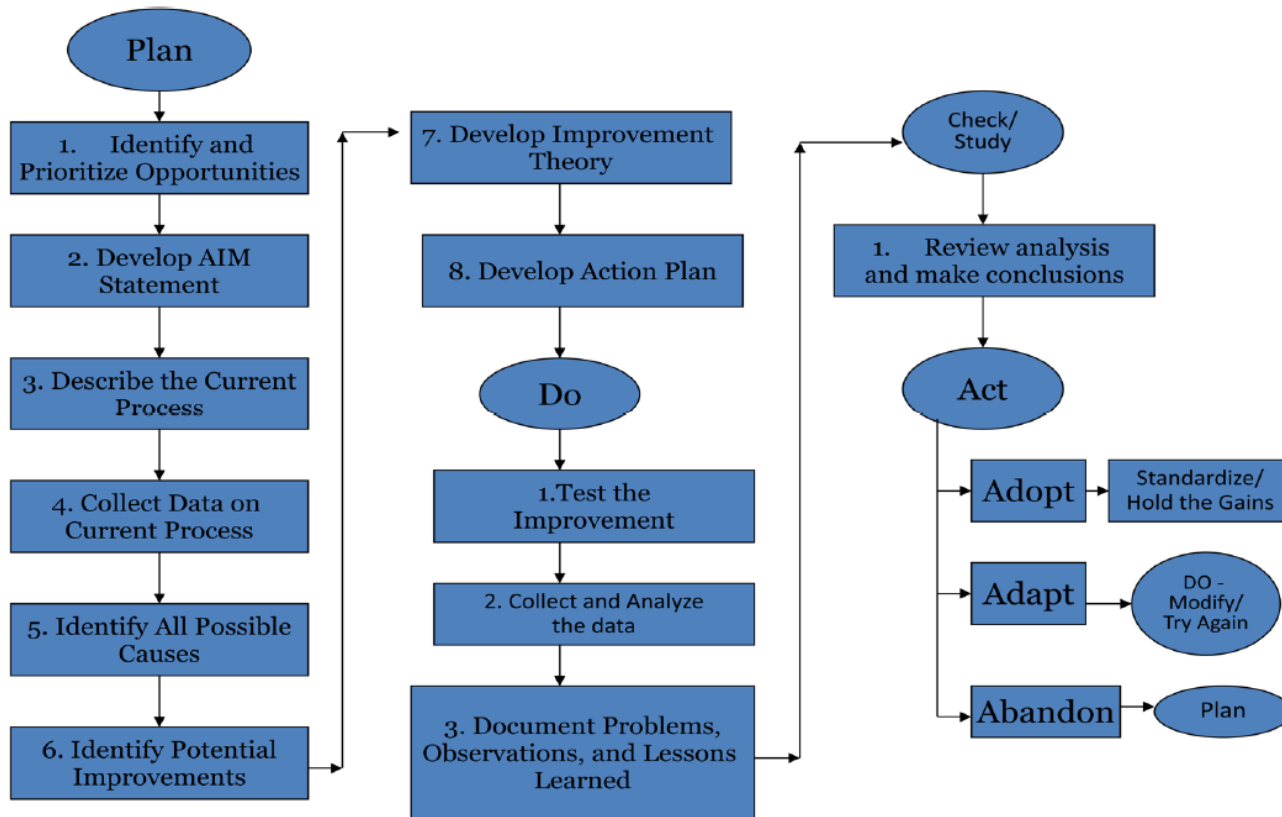
- **Reflect on Plan and Outcomes**

- If your team determined the plan resulted in success, **standardize** the improvement and begin to use it regularly.
- After some time, return to **Stage 1: Plan** and re-examine the process to learn where it can be further improved.
- If your team believes a different approach would be more successful, return to **Stage 1: Plan**, and **develop** a new and different plan that might result in success.

The PDSA cycle is ongoing, and organizations become more efficient as they intuitively adopt PDSA into their planning.



PDSA Overview



- Kaizen is the organized use of common sense to improve cost, quality, delivery, and responsiveness to customer needs.
- Kaizen assembles cross-functional teams aimed at improving a process or problem identified within a specific area.
- Kaizen is the continuous improvement vehicle utilized by the Toyota Production System.

Types of Kaizen

- Any narrowly scoped problem may use the “General” process improvement Kaizen methodology to find solutions. Some problems however require a specialized Kaizen methodology.
 - Set Up Reduction(i.e. Discharge Process)
 - Throughput
 - Product Cost Reduction
 - Infection Prevention
 - 5s

- When obvious waste sources have been identified
- When the scope and boundaries of a problem are clearly defined and understood
- When implementation risk is minimal
- When results are needed immediately – i.e., capacity constraints, setup reduction, acute quality problems, safety/ergonomic issues
- In the early stages of a project to gain momentum and build credibility

As the result of Process Mapping, work area tour, data collection, etc., obvious sources of instability and waste are identified.

Kaizen Deployment

- Kaizen is a vehicle to implement ‘Quick Improvement’
 - A. **Pre-Event Prep:** Identify and plan narrow scope events
 - B. **Kaizen Event:** Implement do-now quick hit solutions during the Kaizen event
 - C. **Follow-up Action Items:** Kaizen activity typically ends 20 days following Kaizen
- The Kaizen approach follows the DMAIC process – it is a “DMAIC Workout!”

Kaizen! Timeline

(Maximum of 30 Days from Start of Event Prep, Through Event, to Final Follow-up)



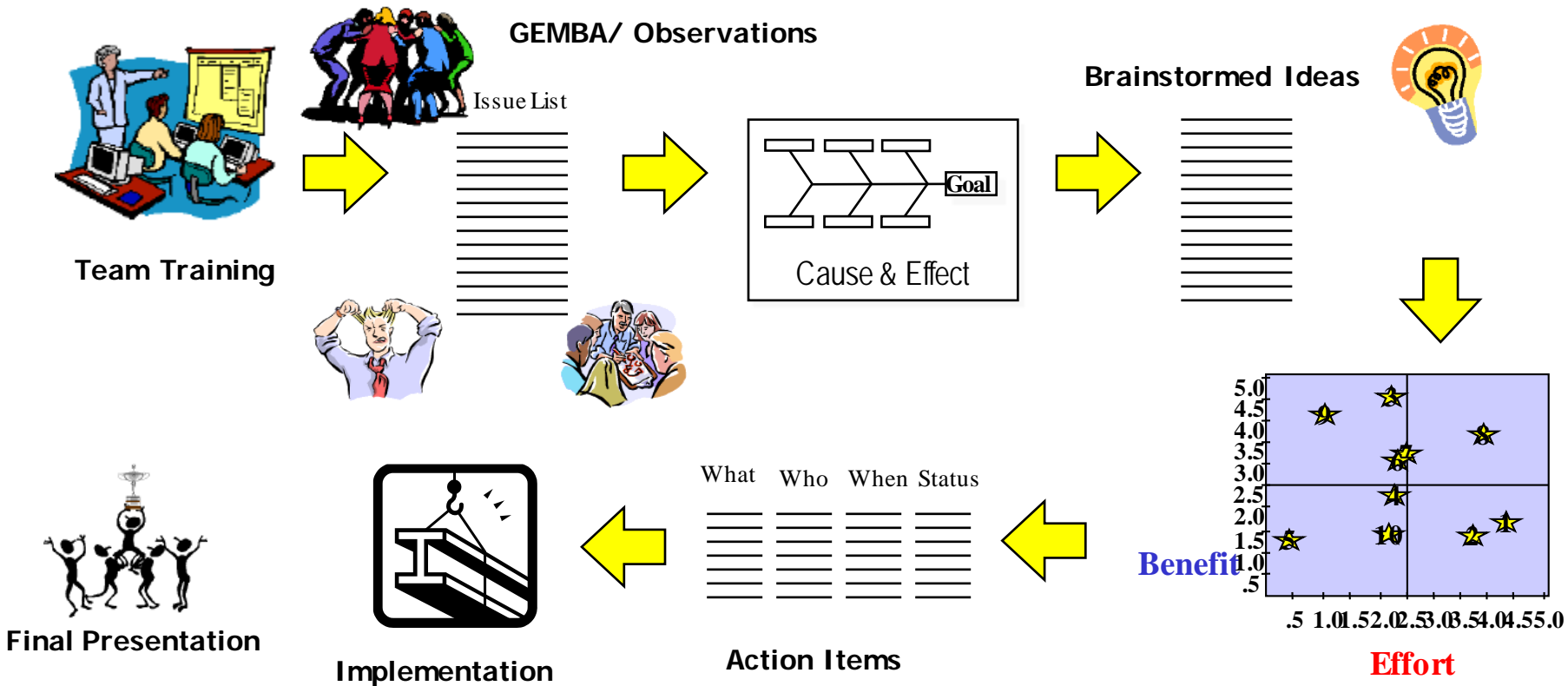
Kaizen Preparation

Preparation Phase (1-2 Weeks before start of event)

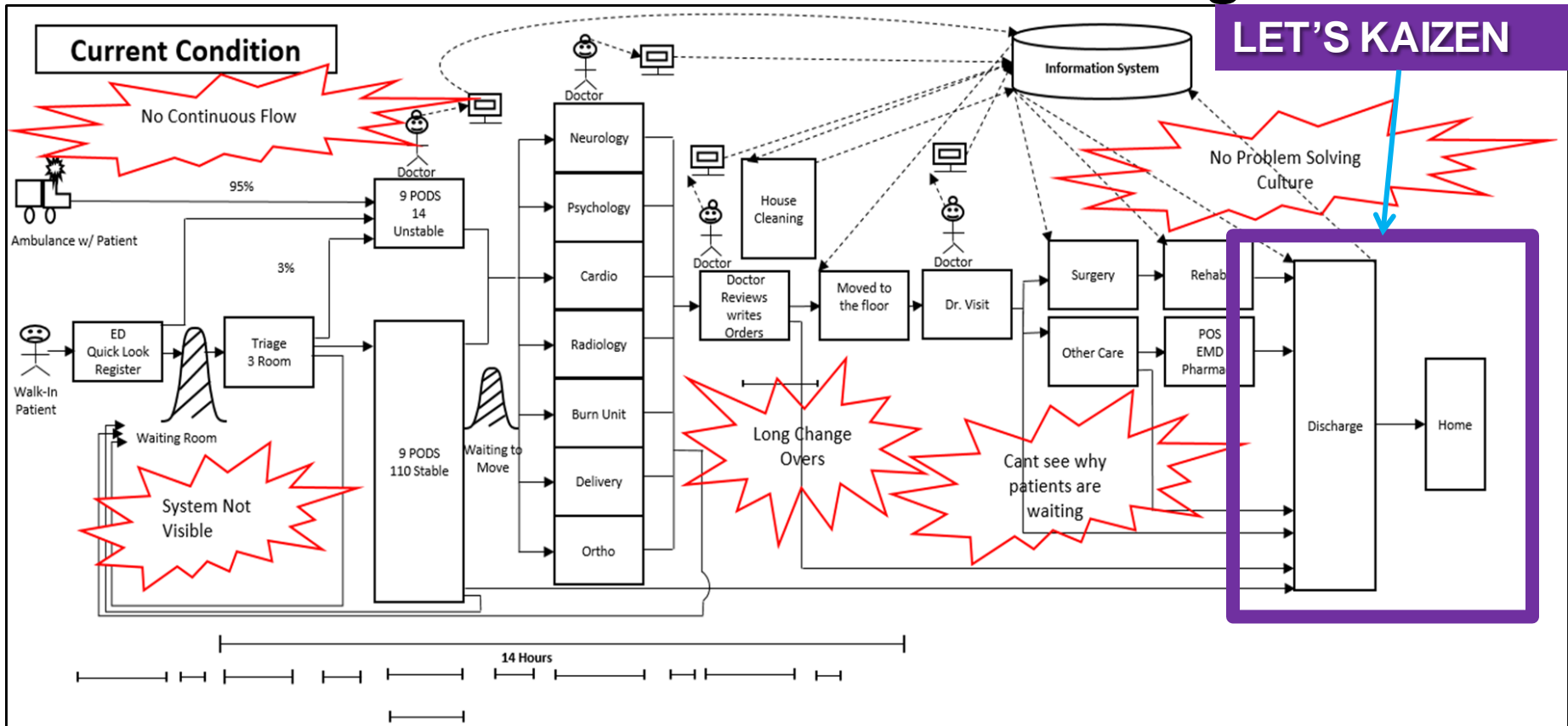
- Data Collection/Analysis
- Team Selection/Notified
- Scope Identified
- \$\$ Savings Determined
- Process Map
- Resources Alerted
- Create “Specialized” Training
- Logistics Arranged (Appendix)



Kaizen Follows the DMAIC Structure



Kaizen-Discharge Process

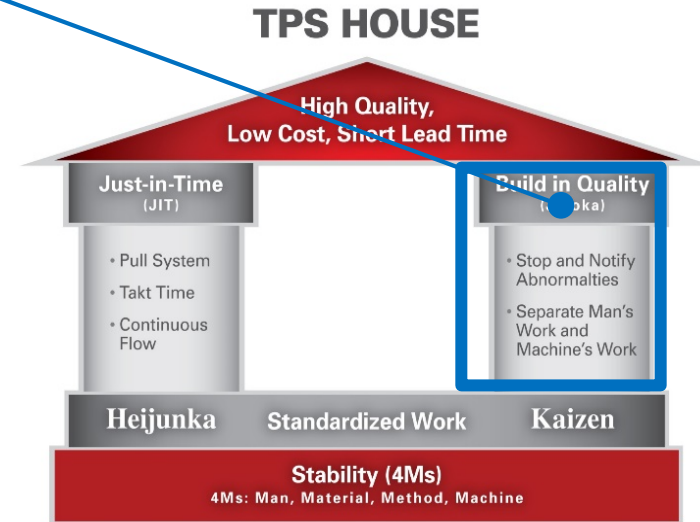


A 3-day workshop was held from 4/11/16 to 4/13/16 jointly by Toyota and Operational Excellence to analyze and improve the selected process

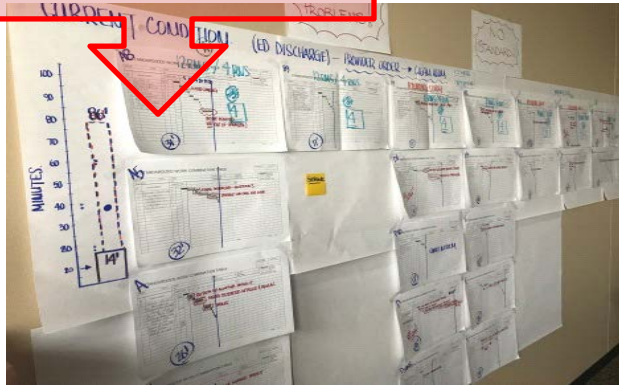
- **Workshop Facilitators: Scott Dickson and Ben Naughting (Toyota), David Garcia, Gabriel Fruge (Parkland OPEX)**
- **Team: ED Nursing, UTSW Medical Staff**

Training/Introduction to TPS

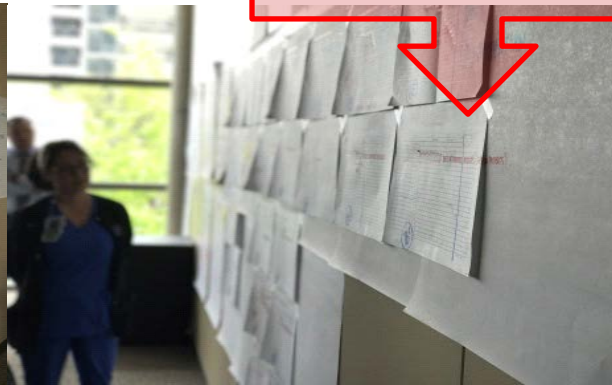
- Use and teach TPS Philosophies
 - **Customer 1st,**
 - **People Most Valuable Resource**
 - Kaizen (Continuous Improvement)
 - Shop Floor Focus)
 - Grasp current condition –Visualize problems / stagnation
 - Standardize discharge process and utilizing TPS
- Technical Tools:
- Implement Jidoka (Built-in Quality) thinking
 - Visualize abnormalities' Understand Ahead/Behind condition in 3 seconds
 - Standardized Work



Data collection & observations



Brainstorming



- The team developed a standard process for ED discharges using the Single Minute Exchange Die (SMED) methodology to identify internal and external elements.
- The methodology showed the opportunity to reduce the discharge turnaround time (order to DC) from an average of 52 minutes to 15 minutes ($\approx 70\%$)

Standardized Process

- The group performed several trials and observations before reaching to the optimal sequence.
- Early Providers Notification
 - Allows the nurse to proactively initiate the preparation (PREP) or discharge

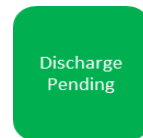
| | | Final Sequence | Owner |
|----------------------------------------------------------------------------|----|-----------------------------------------------|------------------|
| PREP <i>Before Discharge Order</i> | 1 | Pre- Discharge Notification to RN and Patient | Provider |
| | 2 | Request Patient to get Dress | Provider/RN/Tech |
| | 3 | Collect Equipment | RN/TECH |
| | 4 | Call Social Worker (If necessary) | RN |
| PRINT <i>After Discharge Order</i> | 5 | Acknowledge order | RN |
| | 6 | Request Translator (If Required) | RN |
| | 7 | Print AVS | RN/TECH |
| EXECUTE <i>After Discharge Order</i> | 8 | Obtain vitals signs & Chart | RN/TECH |
| | 9 | Remove PIV & Chart | RN |
| | 10 | Perform DC Instructions | RN |
| | 11 | Complete DC Note | RN |
| | 12 | Remove from EPIC | RN |
| | 13 | Remove from Room to: | RN/TECH |
| | | -Chair | |
| | | -Discharge Lounge -Waiting Room | |
| | 14 | Push "Red"button | RN |
| | 15 | Clean Room | TECH |
| Patient can be removed from system if waiting for ARC and/or Social Worker | | | |

➤ Andon (Signal System)

- Transition from Signal to Action
- Re-defined Light System
- Re-configured Responder 5 Configuration



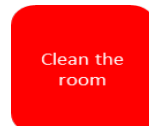
Before



Sequence

- 1 Provider determines when patient will be discharge
- 2 Provider presses "Discharge Pending button"
- 3 Nurse acknowledges green light and begins Discharge process

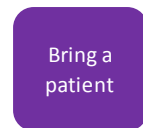
Process



Sequence

- 1 Patient is discharge
- 2 Nurse walks patient out of the room
- 3 Nurse presses "Clean the Room button"

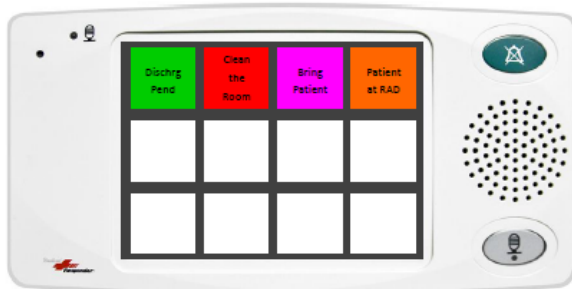
Process



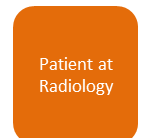
Sequence

- 1 RN/Tech cleans room
- 2 Nurse presses "Bring a patient" button
- 3 Nurse takes patient from waiting room to POD room

Process



Current



Sequence

- 1 Radiology Tech gets to the ED Pod area
- 2 Takes Patient to ED radiology
- 3 Radiology Tech presses "Patient at Radiology" button

Process



- Kaizen team met with Parkland's leadership to show and explain the story(all work done) during event.
- Great opportunity to discuss opportunities and areas for support.

Summary

- The rapid improvement work must be seen as the Work and not a separate project.
- Implementation and holding the gains requires integration into daily work and meetings
- Start work with those interested in change
- Communicate what is happening persistently
- Provide support to providers and staff who take on this new work

References

- <http://www.health.state.mn.us/divs/opi/qi/toolbox/pdsa.html>
- Kubiak, T.M. (2009). Book of Knowledge. ASQ Quality Press: 2 edition