



Simplify, Perfect, Innovate

# Lean Healthcare Concepts for Supervisors

15-LSUP-11A

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# CONCEPTS for SUPERVISORS

## Agenda

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START at 9:00am and STOP at 4:00pm each day

- Strategic View
  - Self-Assessment
  - Strategic Drilldown
  - Planning Model
- Lean Principles
  - Value Stream
  - 8 Wastes
  - Value Stream Mapping
  - Input-Process-Output
  - Measurements
  - Exercise (1<sup>st</sup> Statapult)
  - Variation and Process Capability
  - DMAIC Methodology
  - Process Flow
  - Exercise (2<sup>nd</sup> Statapult)
  - Tools (from Manager's viewpoint)
    - 5S
    - Standard Work

# CONCEPTS for SUPERVISORS

## Agenda

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- Tools (cont.)
  - Visual Management
  - Questions Leaders/Managers Need to Ask
  - A-3 Thinking
  - Gemba
  - Analyzing Work
  - Physical Process Map
  - Process Control
- Change Management
  - Management Styles
  - “Additional” Manager Roles
  - Lean Deployment
  - Breakout
- Summary
- Appendices
  - Appendix A - Control Chart Examples
  - Appendix B - DMAIC Tollgate Questions
  - Appendix C - Rapid Improvement Events

# SELF-ASSESSMENT

## Reality Check

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- What are you doing to enhance patient care while building a more efficient and effective healthcare system?
- What measurements are you currently tracking?
- What are your top 3 issues?



# SELF-ASSESSMENT (cont.)

## Reality Check

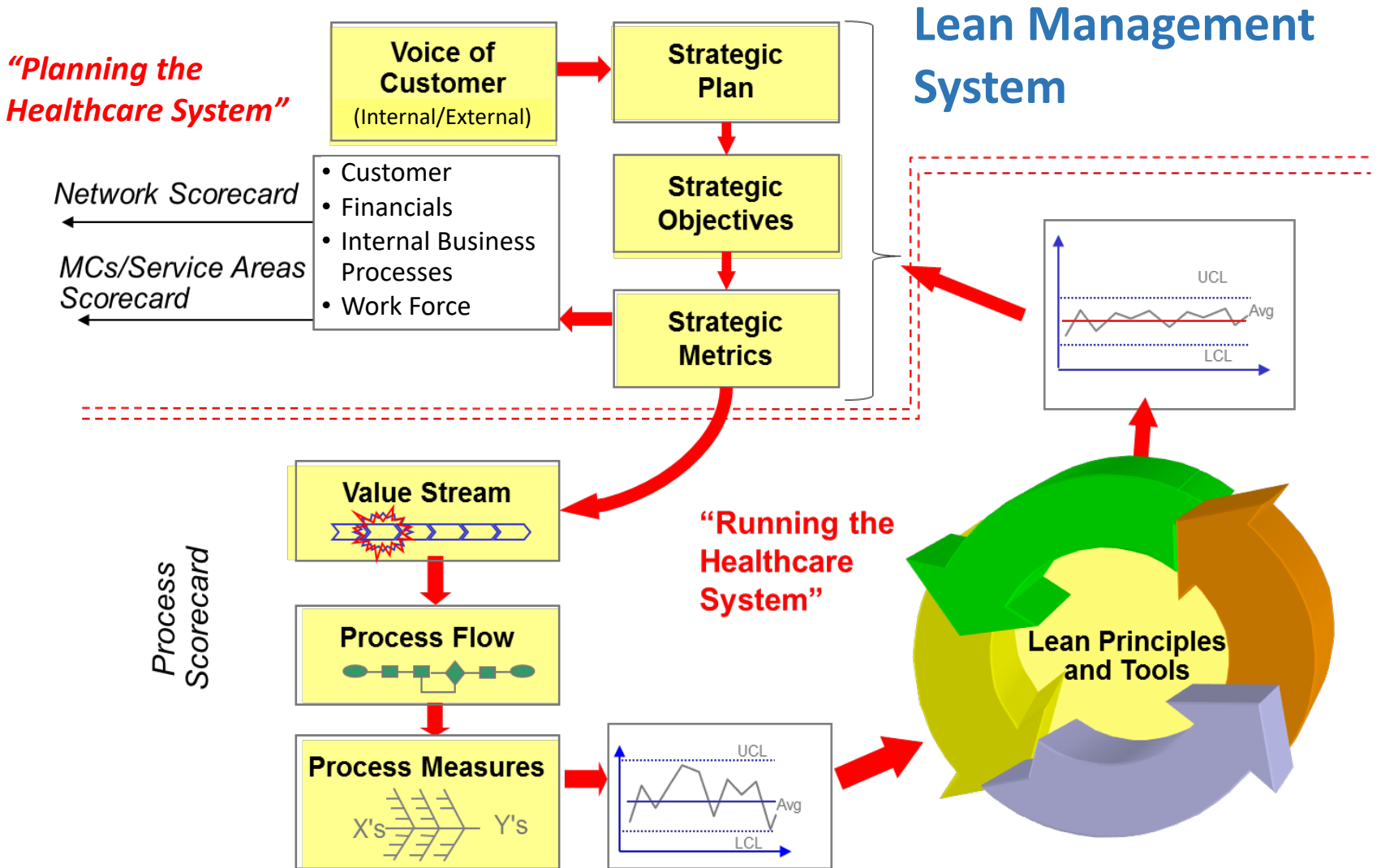
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- What have you done in the last 6 months to address the issues?
- Is there a need to improve?
- What is your vision of the future?
- What is your plan to get there?



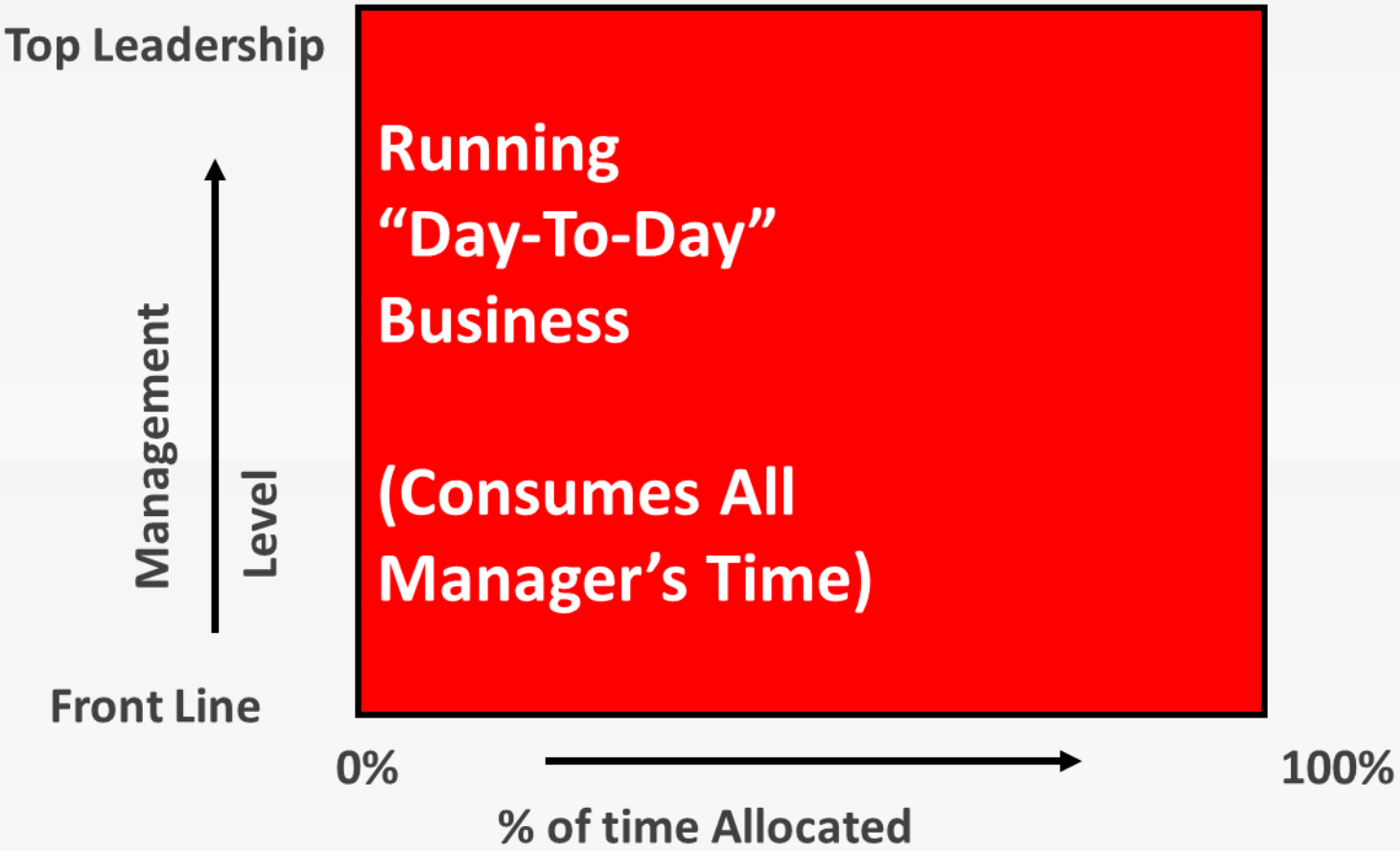
# A STRATEGIC PLANNING MODEL

Improvement Efforts Should Link



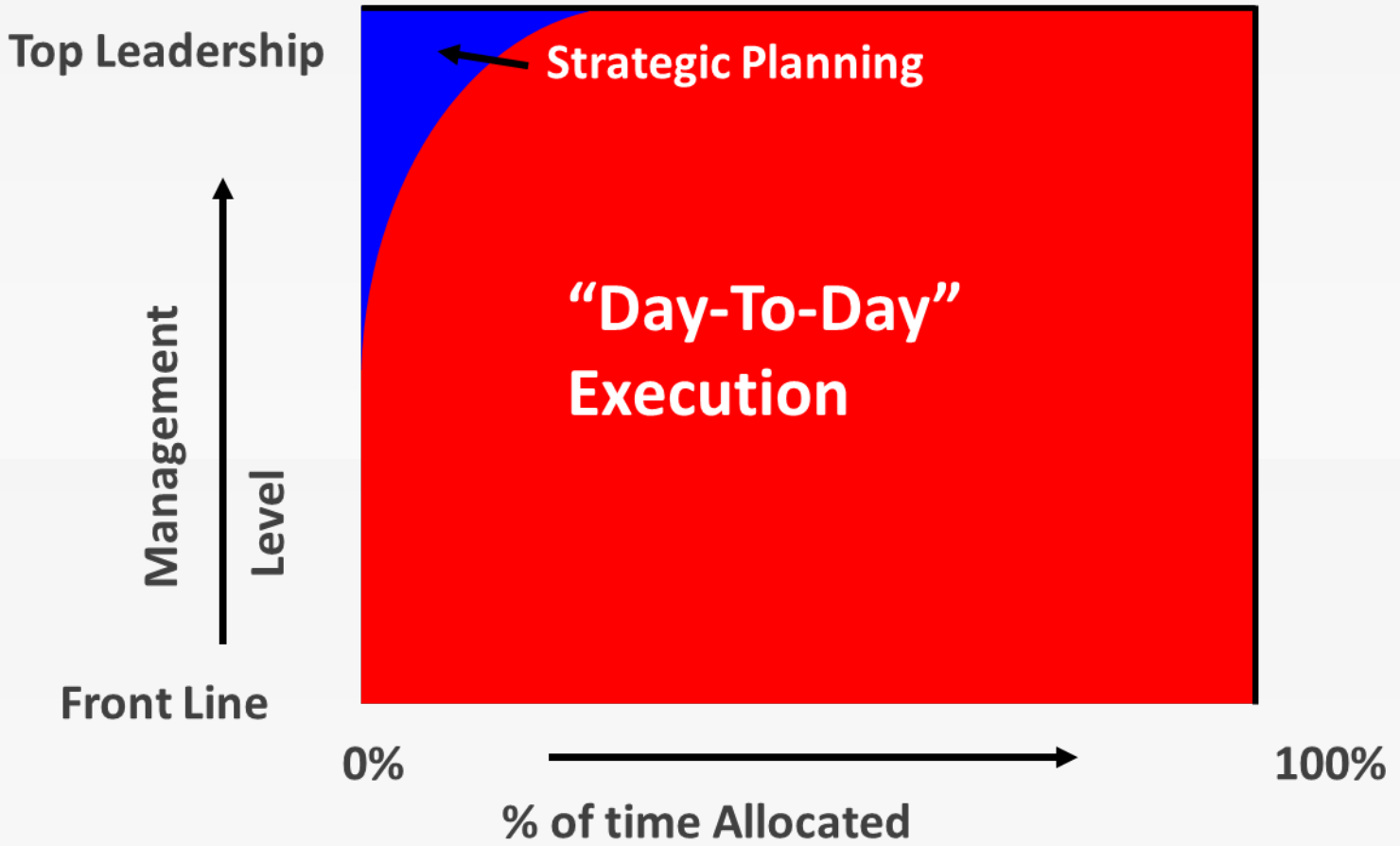
# TIME ALLOCATION

## In a “Chaotic” Organization



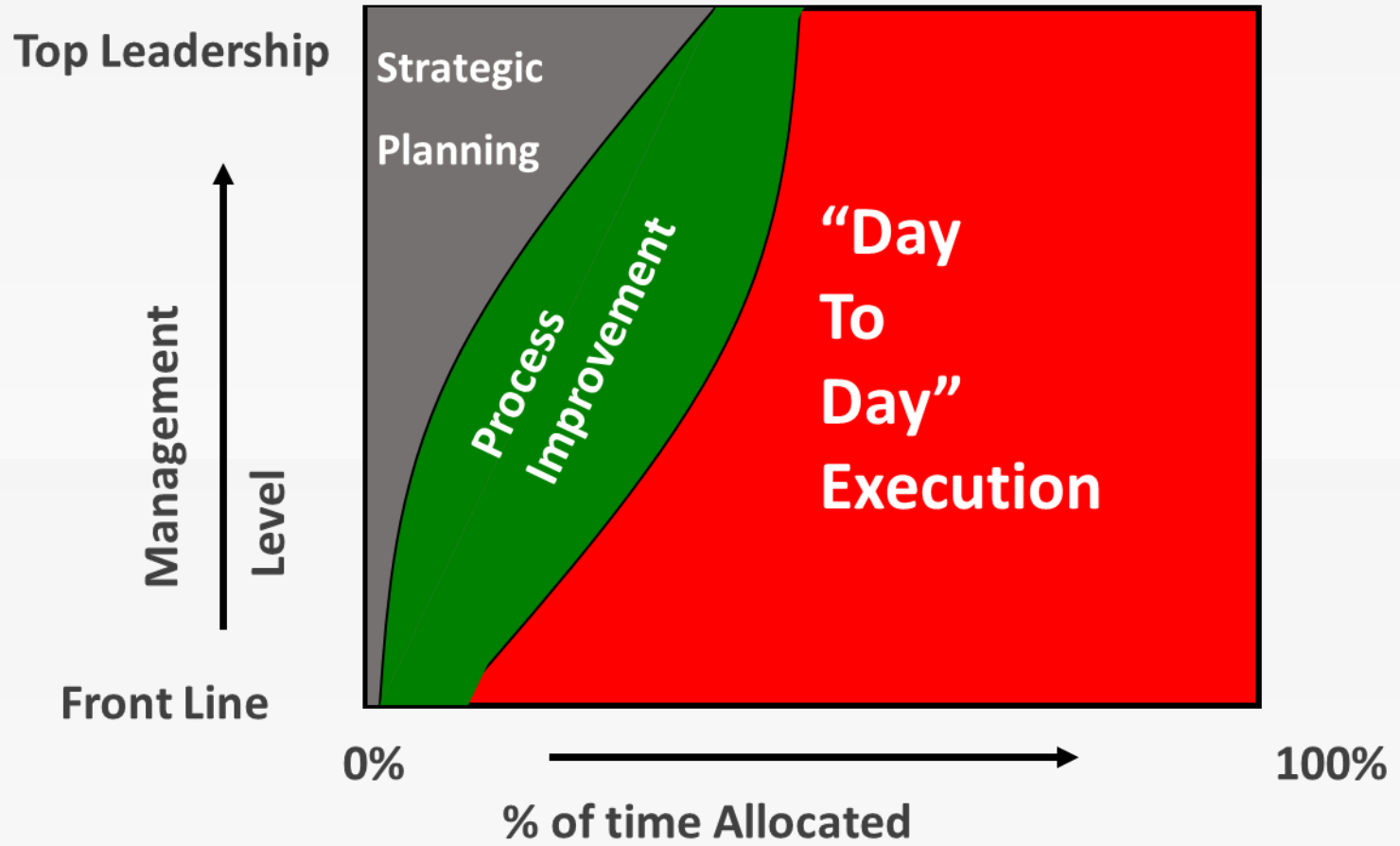
# TIME ALLOCATION (cont.)

## In a “Conventional ” Organization



# TIME ALLOCATION (cont.)

## In a “World Class” Organization





# LEAN PRINCIPLES

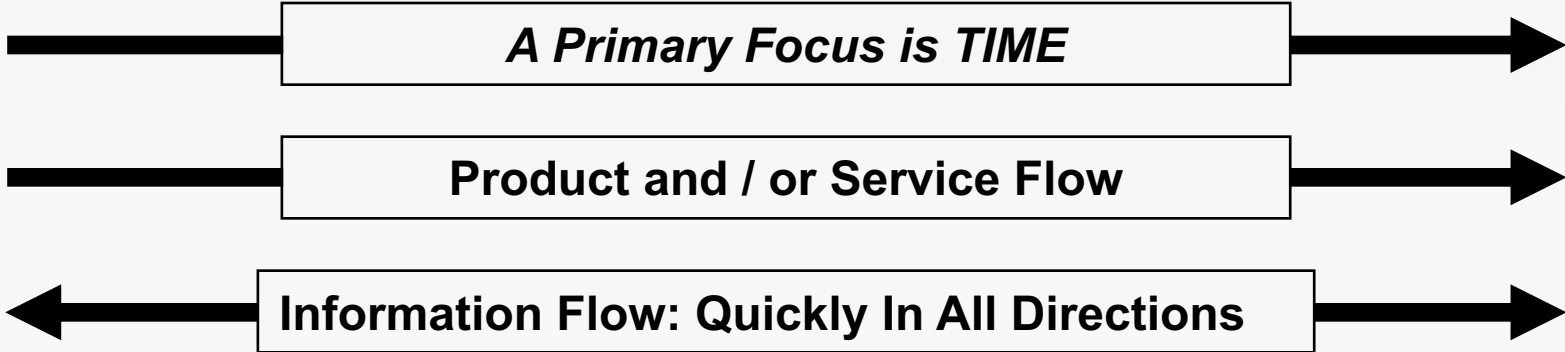
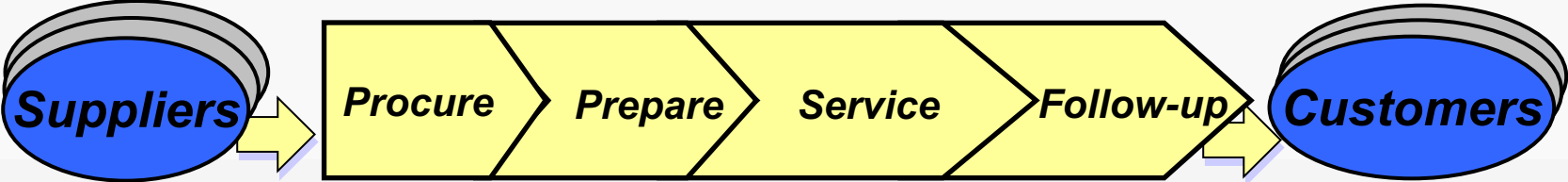
## Promote Performance Improvement

- Specify value in the eyes of the Customer
  - Learn to see your processes from the perspective of your customer
- Identify the value stream and eliminate waste/variation
  - Look at the combination of processes, not just a single process in isolation
- Make value flow at the pull of the customer
  - Wait until you know what the customer wants before you start
- Involve, align, and empower employees
  - Develop solutions using the people who are currently working in the process
- Continuously improve knowledge in pursuit of perfection
  - Constantly challenge the organization to continue removing waste from processes

# VALUE STREAM

## Adds Value to the Customer

The VALUE STREAM is the entire set of activities performed to transform the products and services into what is required by the customer.



## VALUE STREAM (cont.)

### Types of Activities

#### Value Added Activities

(VA)

- Activities where the product or service is transformed into a state required by the customer.
- Activities which, when asked, the customer is willing to pay for.

#### Non-Value Added But Required

(NVA-R)

- Activities causing no value to be created but which cannot be eliminated based on current state of technology or thinking.

#### Non-Value Added Activities

(NVA)

- Activities which consume resources but create no value in the eyes of the customer.
- **Pure Waste.**

# WHERE WASTE (MUDA) EXISTS

## D-O-W-N-T-I-M-E

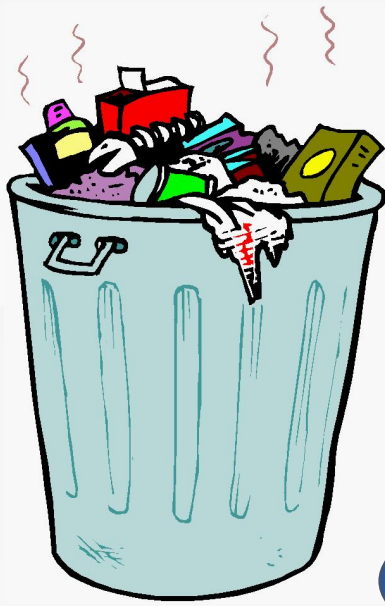
1. **D**efects

2. **O**ver-production

3. **W**aiting

4. **N**ot utilizing  
employee ideas or  
initiative

5. **T**ransportation



8. **E**xtra  
processing

7. **M**otion

6. **I**ncorrect  
inventory

# EIGHT WASTES

Type of Waste	Description	Examples
<u>D</u> efects	Processes not performed correctly resulting in defects and/or rework	Surgical cart missing an item; wrong medication; incorrect patient information
<u>O</u> ver-production	Doing more than what is needed by the customer	Unnecessary diagnostic tests; data fields larger than necessary
<u>W</u> aiting	Waiting for the next event or next work activity to occur	Waiting for equipment; waiting to move a patient to their room; waiting for approval
<u>N</u> on-productive use of people and ideas	Not utilizing employee talent or ideas “properly”	Burning high-talented workers out; putting people in “wrong” job positions; ignoring sound ideas

## EIGHT WASTES (cont.)

Type of Waste	Description	Examples
<u>T</u> ransportation	Excess movement of materials, equipment, supplies, and patients	Poor ED layout resulting in the patient being moved from room to room; nurse station far from patients
<u>I</u> ncorrect <u>I</u> nventory	Excessive inventory or inadequate inventory	Expired supplies; equipment parts obsolete; out-of-stock medications
<u>M</u> otion	Unnecessary movement and excessive walking of staff	Technicians walking miles per day due to location in facility; nurses walking miles per day looking for equipment or records
<u>E</u> xtra Processing	Required work that is not of value	Asking for information on forms that is never used; same information required on multiple forms; collecting data never used

# VALUE STREAM MAPPING

## Connection of Processes

- **Helps to visualize the entire system**
- **Links the flow of activities with the flow of information (how the system is controlled)**
- **Points out sources of waste**
- **Highlights which steps are pacemakers (holding up other activities)**
- **Allows selection and coordination of multiple improvement efforts in the same value stream**

# VALUE STREAM MAPPING (cont.)

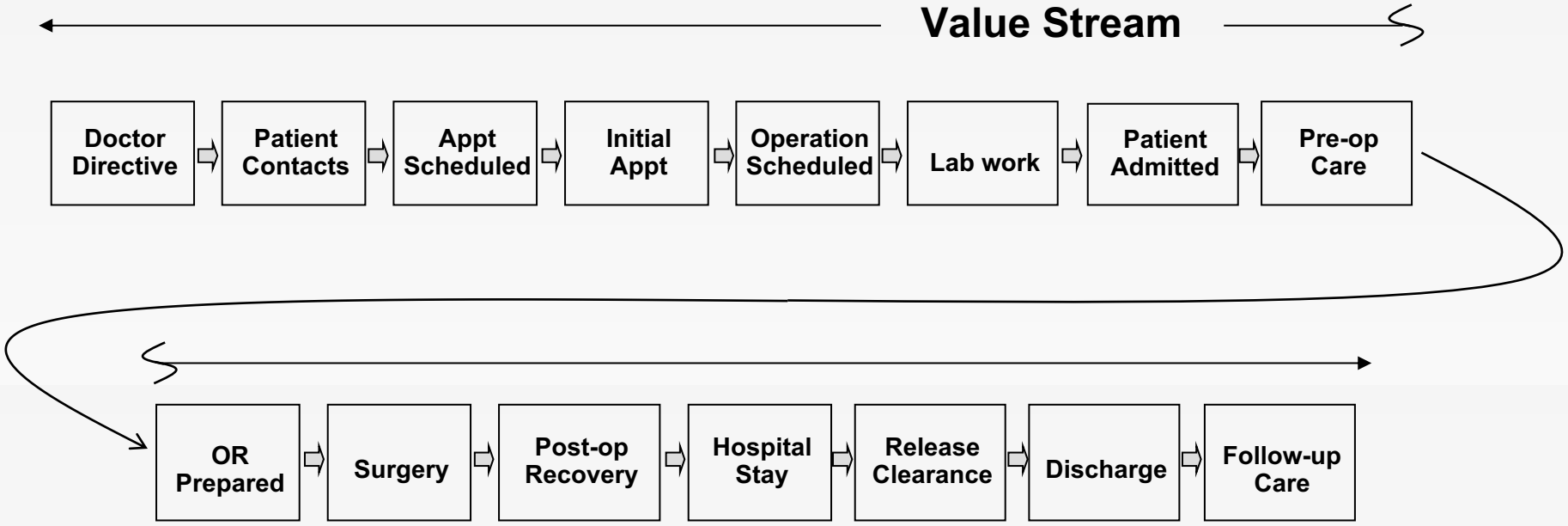
## Manual Mapping Example





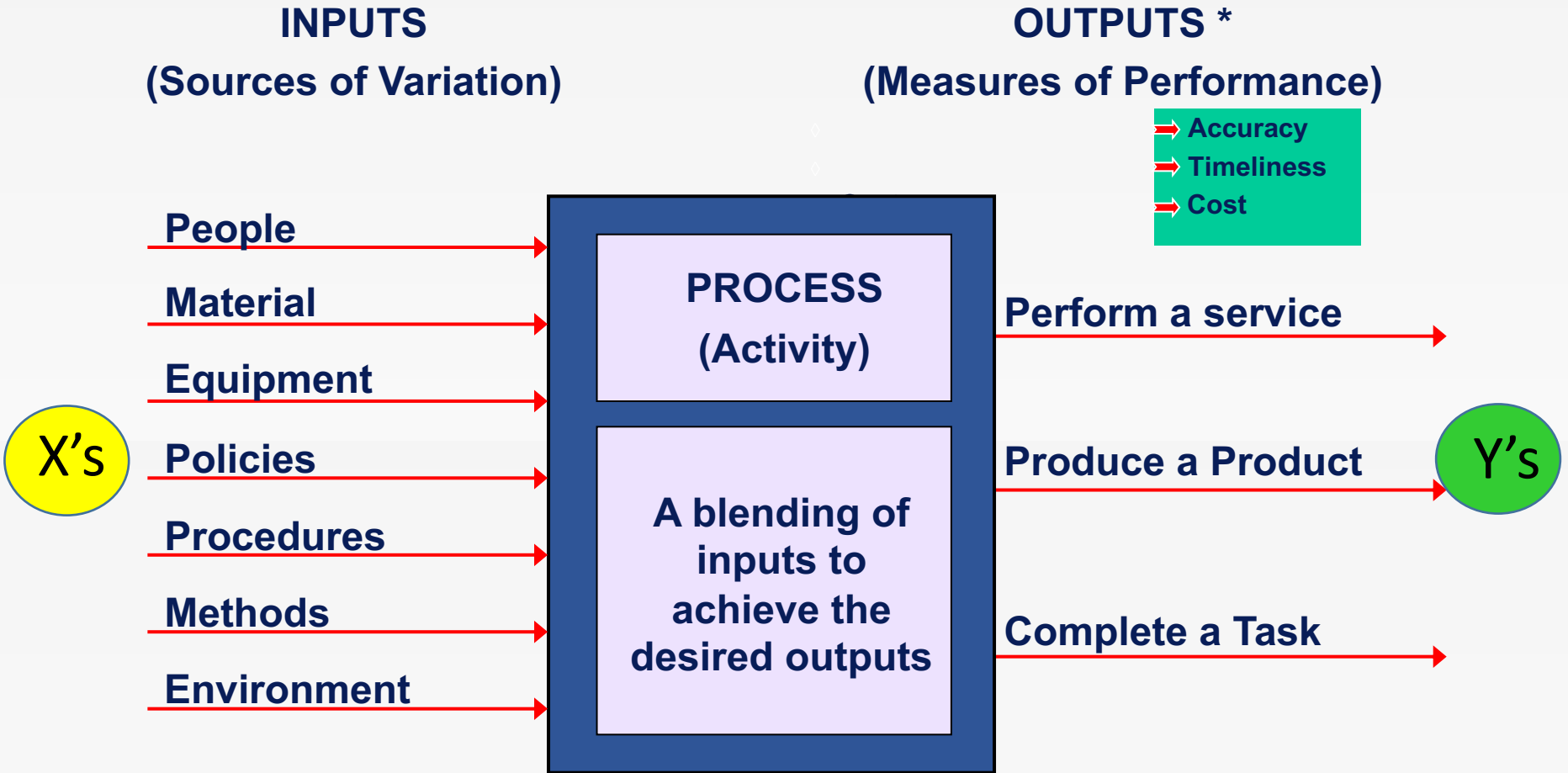
# VALUE STREAM MAPPING (cont.)

## Patient Care

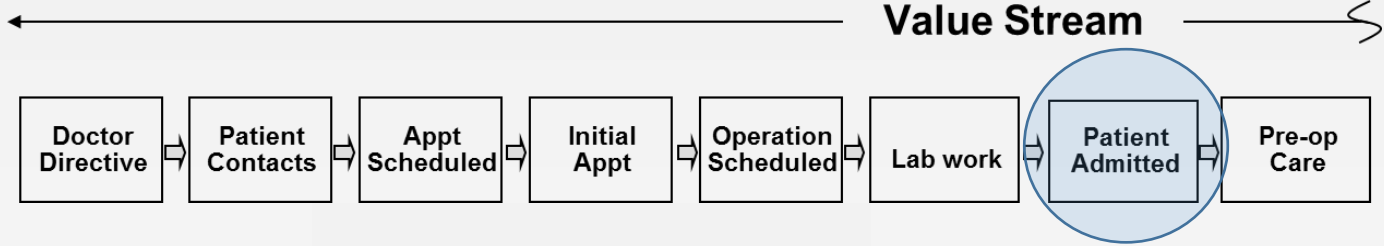


# INPUT-PROCESS-OUTPUT (IPO)

## Components of a Process



\* = Critical-to-Customer (CTC)

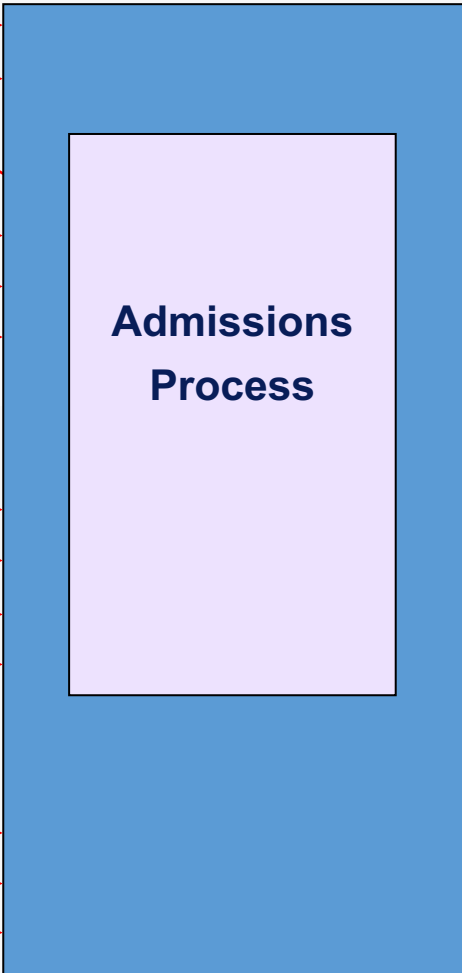


**Input**

**Process**

**Output**

- Status of Patient
- Patient Info Requirements
  - Name
  - Age
  - SSN
  - Address
  - etc.
- Healthcare Insurance (?)
- Reason for Admission
- Availability
  - Staff
  - Room
  - Bed
- Attending Physician
- Bar Coding System
- Documentation
- Staff Member
  - Time w/ Hospital
  - Training
  - Experience
- Software
- Forms
- Policies

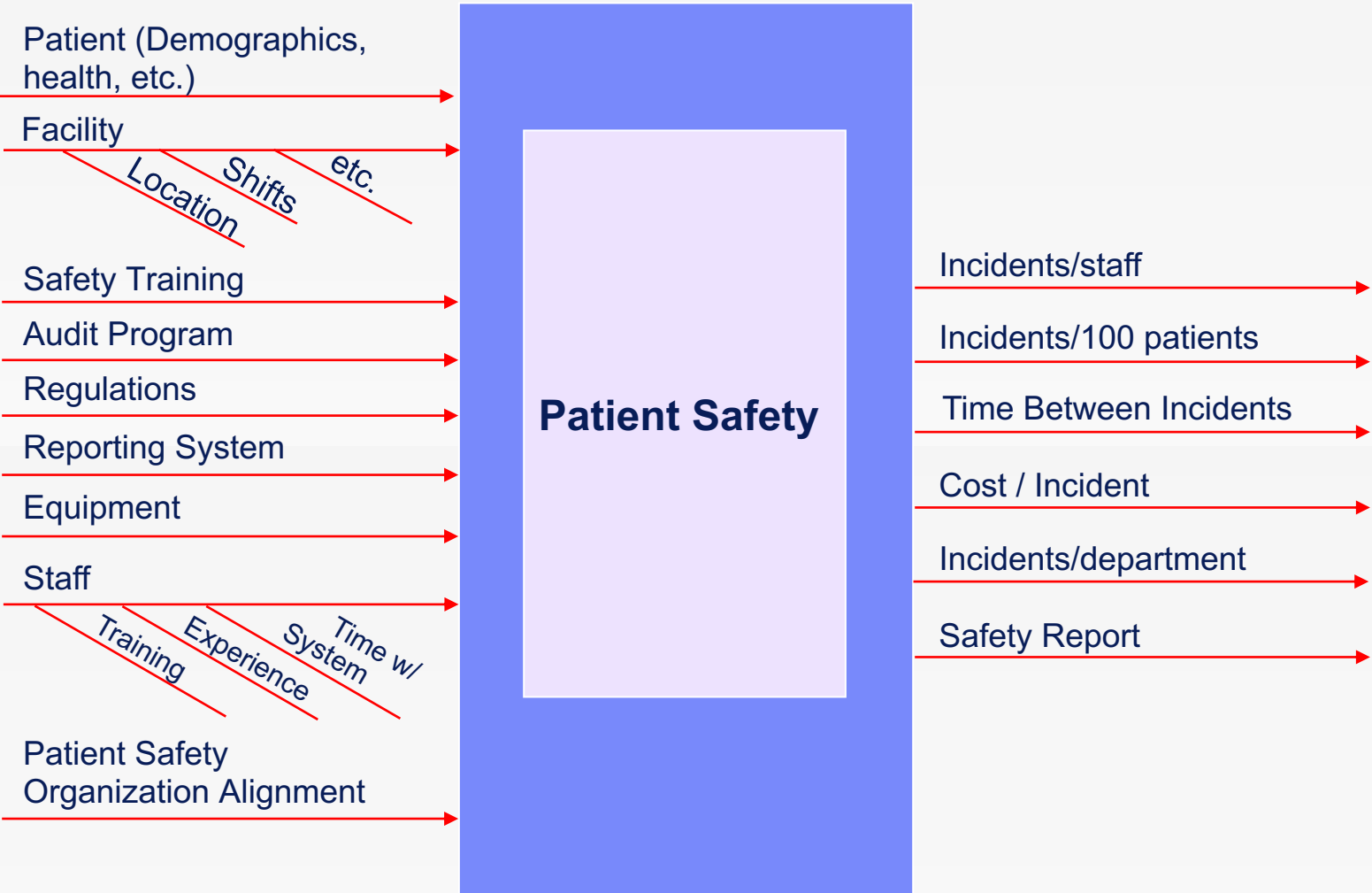


**Performance Measures (Quality, Timeliness, Cost)**

- Patient Information Errors → **Q**
- Patient Satisfied → **Q**
- Timely Patient Admission → **T**
- Admission Cost per Patient → **C**
- Bar Code Bracelet
  - Complete
  - Accurate
 → **Q, T**

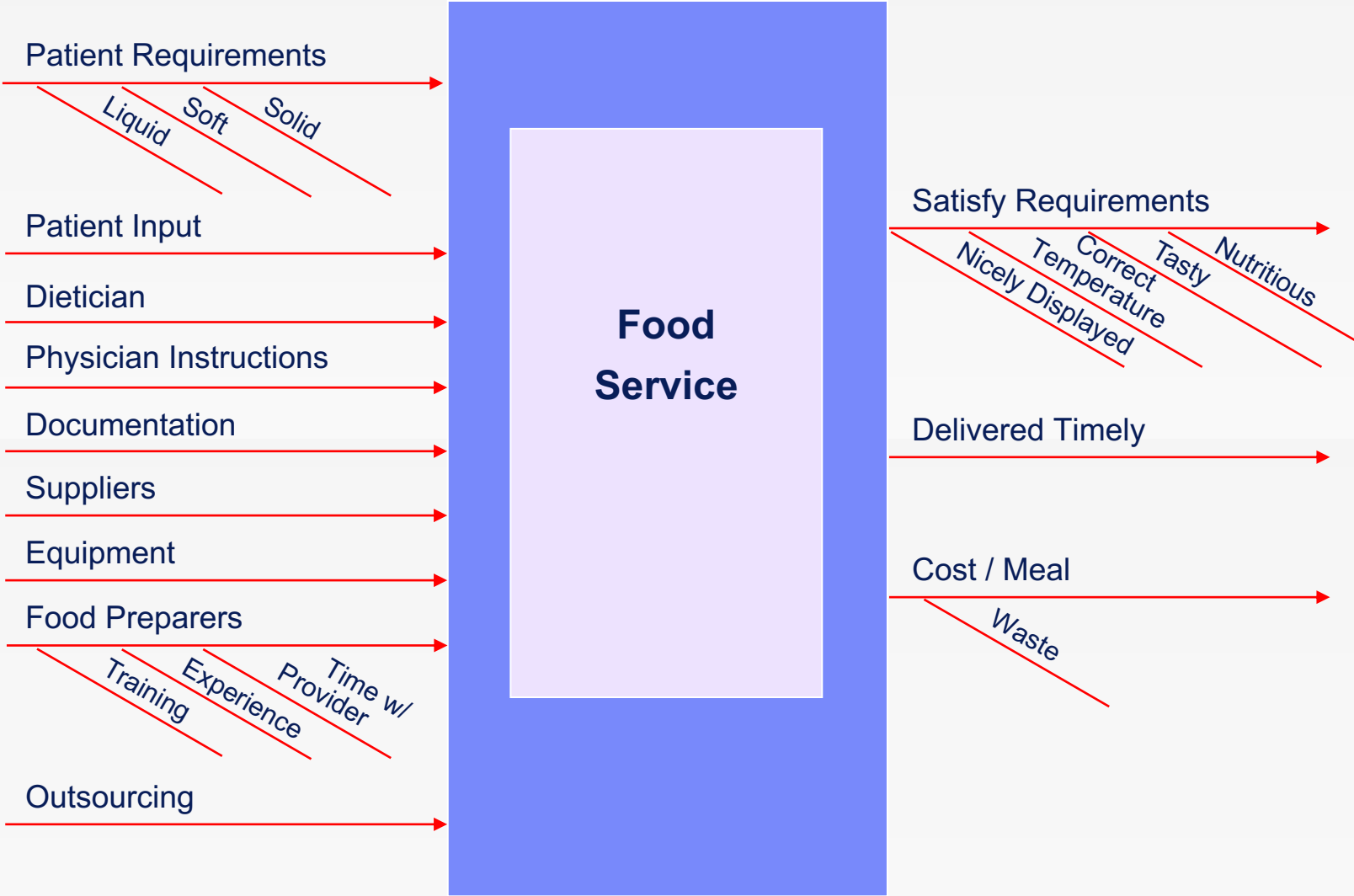
# INPUT-PROCESS-OUTPUT (IPO)

## Patient Safety Process



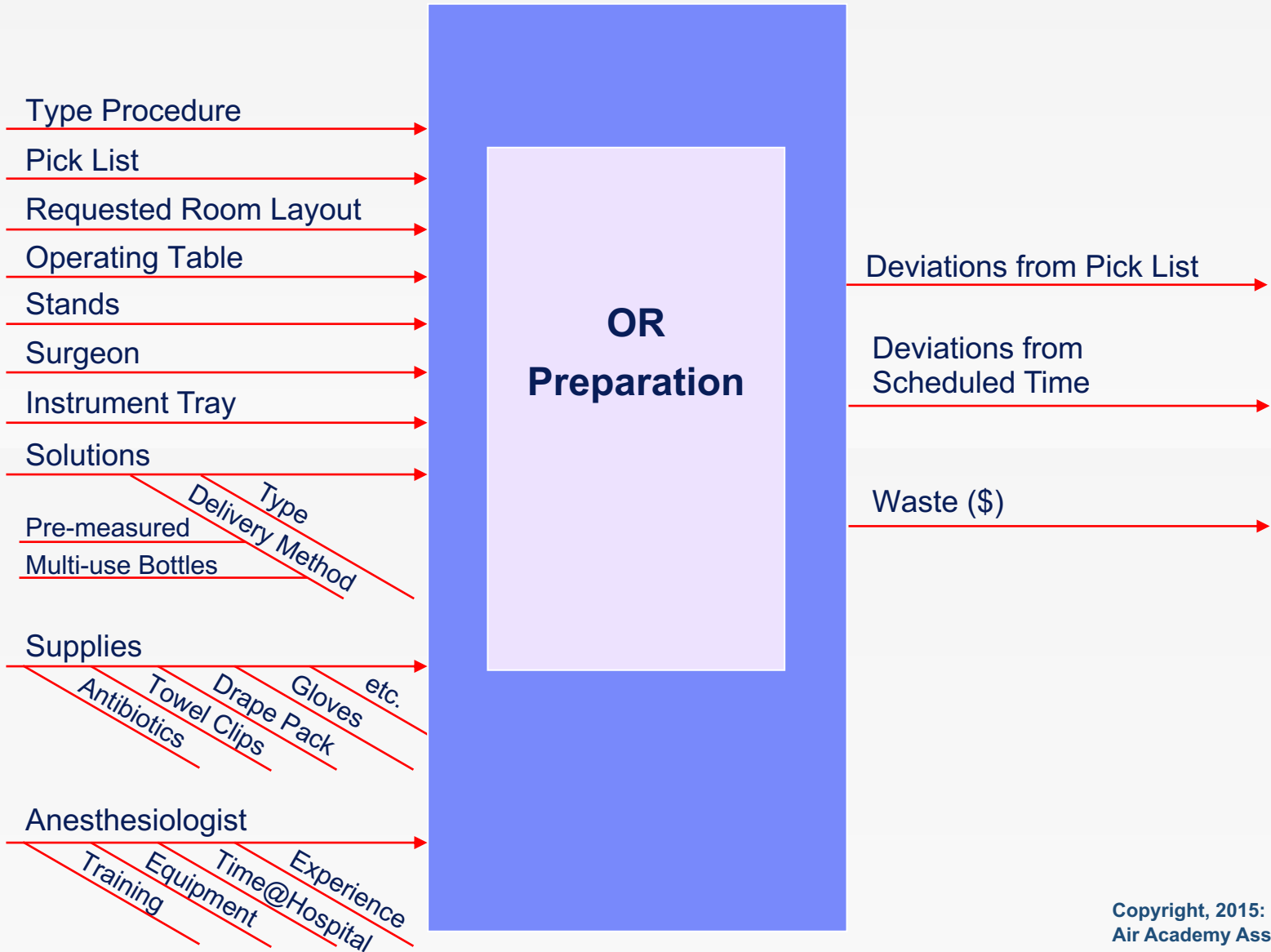
# INPUT-PROCESS-OUTPUT (IPO)

## Food Service Process



# INPUT-PROCESS-OUTPUT (IPO)

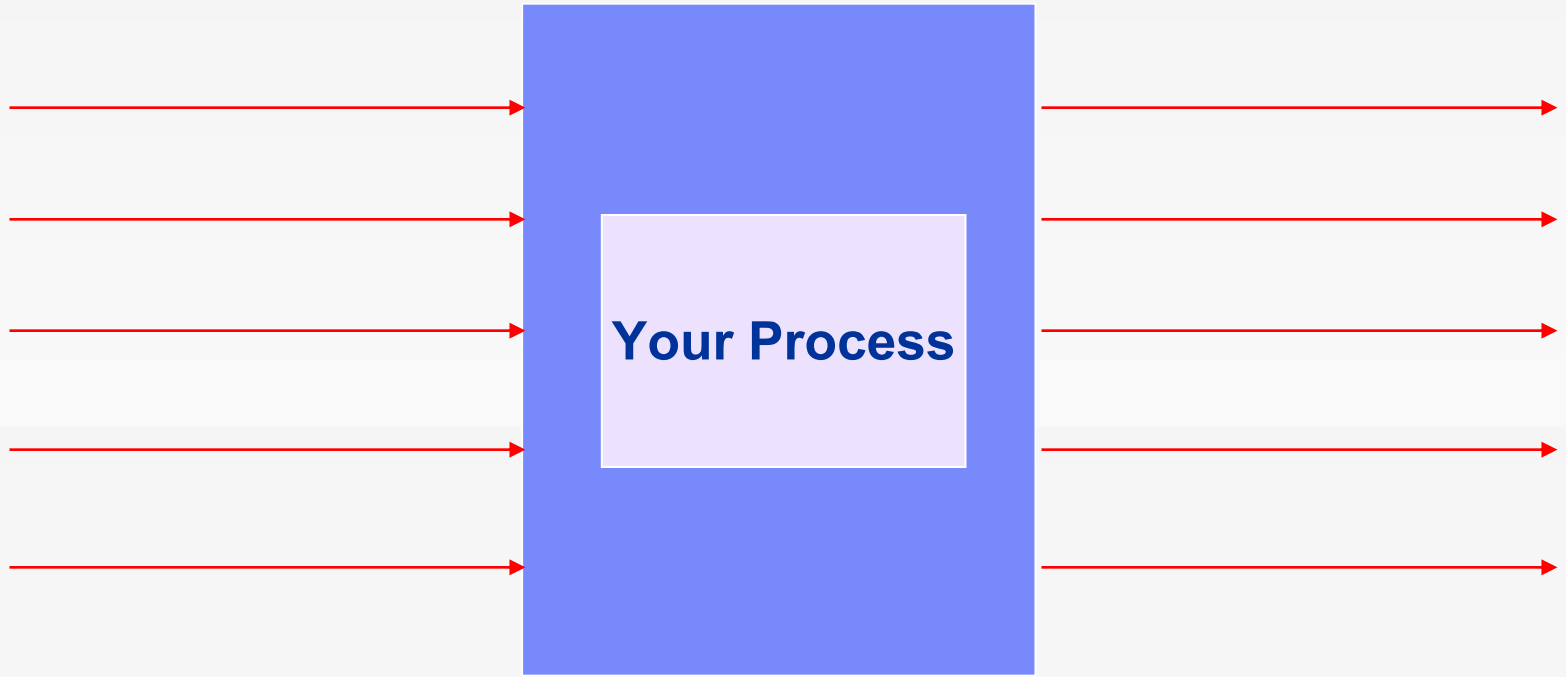
## OR Preparation Process



# INPUT-PROCESS-OUTPUT (IPO)

## Your Process

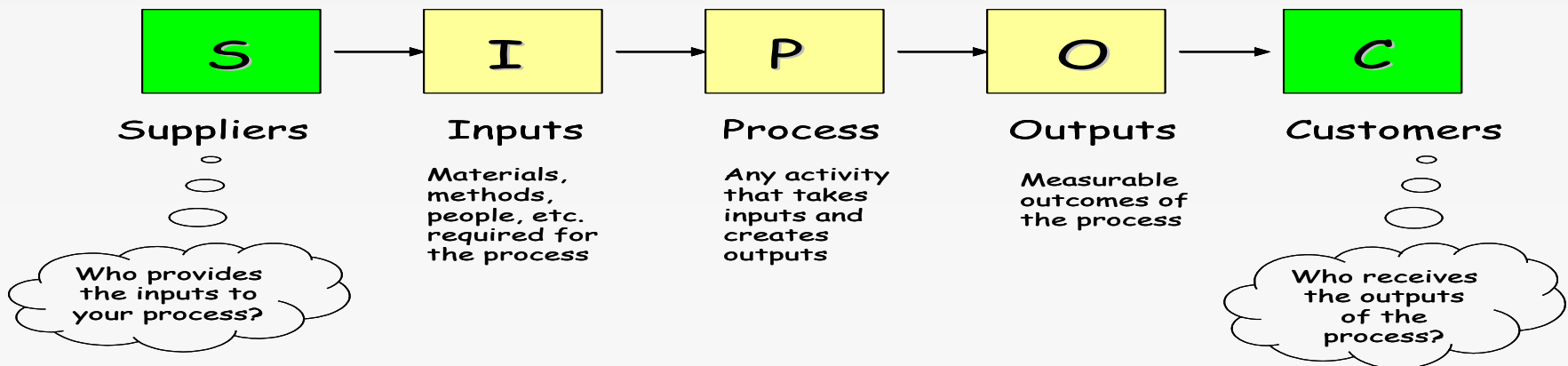
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# SIPOC

## IPO + Suppliers + Customers

- A SIPOC diagram is an extension of a simple IPO diagram
- It includes information about suppliers and customers
- To create a SIPOC diagram:
  - Name the process
  - Identify the outputs and customers
  - Identify the inputs and suppliers

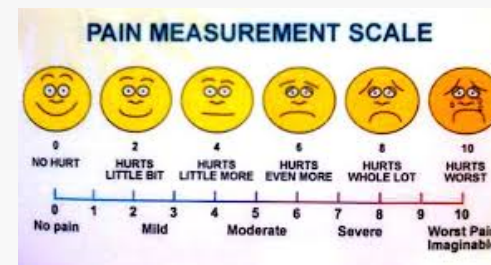




# IMPORTANCE OF MEASUREMENTS

## Beginning of Process Improvement

- To assist good decision making
- To identify/verify problem areas
- To baseline a value stream or process
- To characterize our processes (to know how inputs and outputs are related)
- To see if our value streams and processes are improving
- To determine if the patient care and improvement objectives are being realized



# IMPORTANCE OF MEASUREMENTS (cont.)

## Three Types

- 1. One-Time Measures**
  - To answer a question
  - To solve a problem
  
- 2. Measures that Track Progress Towards a Desired Outcome**
  - Customer
  - Employee
  - Financial
  - Internal Business Process
  
- 3. Measures used to Monitor a Process**
  - Baseline the process
  - Determine improvement

# IMPORTANCE OF MEASUREMENTS (cont.)

## Examples

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- % New Mental Health appointments not seen within 30 days of create date
- % billing code errors
- % medication errors
- % adverse clinical events (lab errors, needle sticks, surgery delays, etc.)
- % New Primary Care appointments not seen within 30 days of create date
- Patient complaint rate
- Average # of adverse events/ICU day
- % adverse events contributing to death
- % ICU patients with defects on ID band

# IMPORTANCE OF MEASUREMENTS (cont.)

## Examples

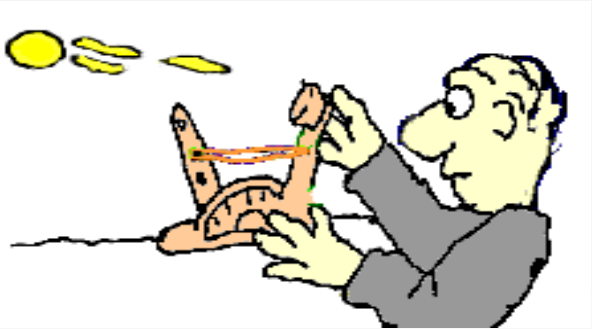
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- % CT Scan effectiveness or requiring redo
- % deviations from estimated Length of Stay (LOS)
- % incorrect surgeries
- % complications resulting from hip / knee replacement
- % depression readmission rate
- # hospital-acquired infections / 100 patient admissions
- % services performed not authorized
- # admittance errors / 100 patient admissions
- Avg time for first appointment
- % first-time appointments scheduled with wait-time exceeding one month

# BASELINING THE PROCESS

## Statapult Exercise

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- Statapult = Delivery Process
- Ball = Service Provided
- Setup = Job prep
- Measurement = Outcome of the service



# BASELINING THE PROCESS (cont.)

## Collecting Data

**Each participant must shoot Statapult® three times using the following steps:**

- (1) Insure all pins are at position #3**
- (2) Pull the arm to 177° and shoot the rubber ball**
- (3) Have someone measure your distance**
- (4) Disconnect rubber band between shots**
- (5) Your standard is no more than 15 seconds between shots**
- (6) Record distances and calculate Range (= longest – shortest)**



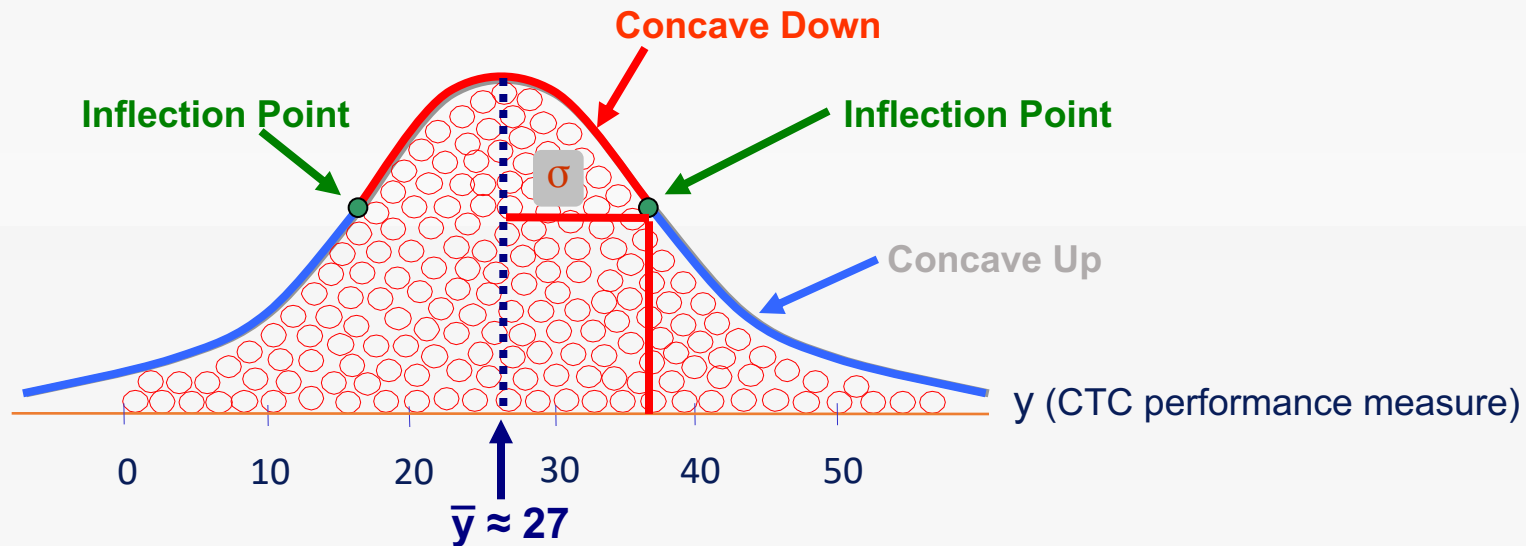
	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
Shot #1	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Shot #2	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Shot #3	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

# THE VOICE OF THE PROCESS

## Two Parameters

$\bar{y}$  = Average (mean, balance point)

$\sigma$  = Standard Deviation (variation)

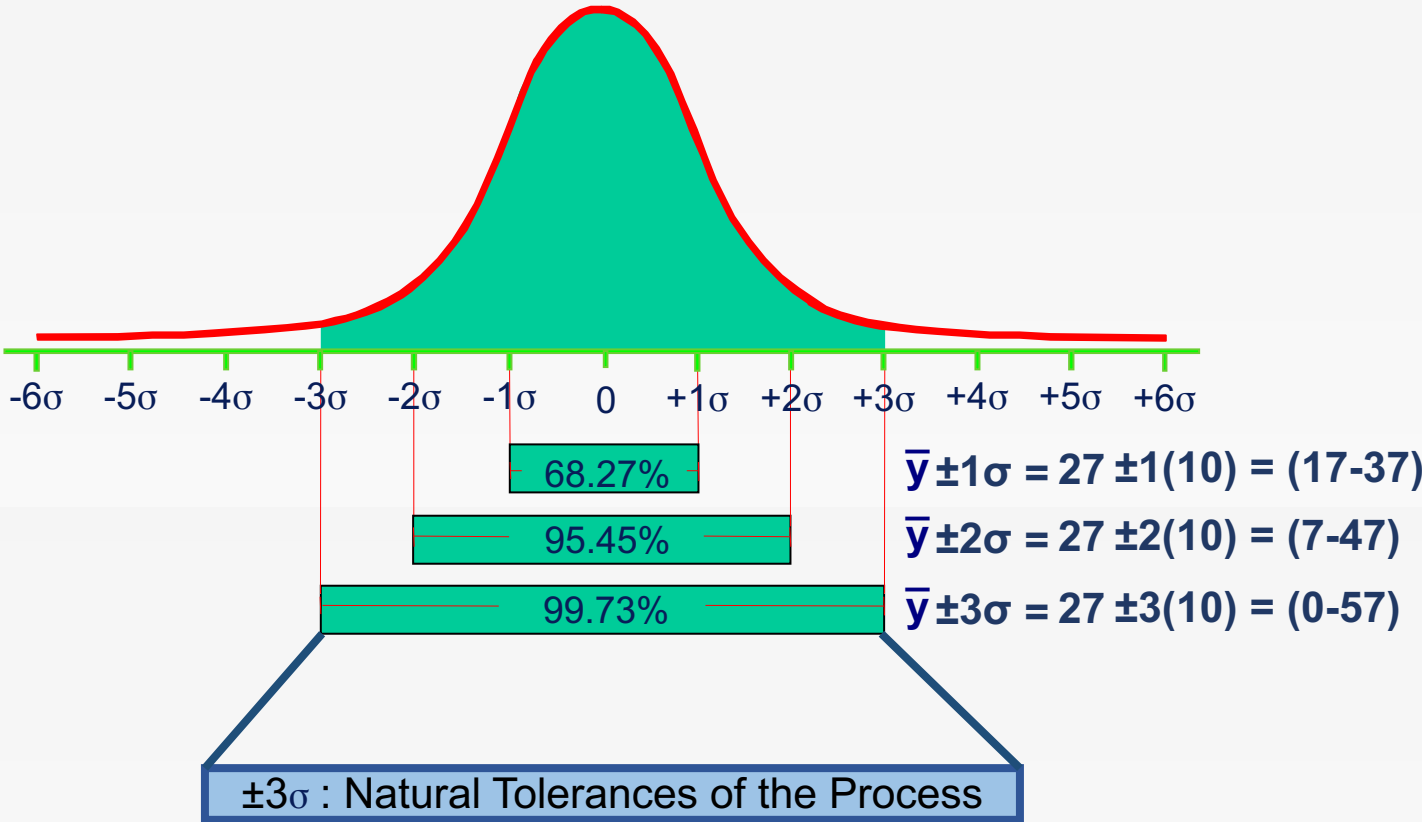


$\sigma \approx$  distance from the centerline to the inflection point

$$\sigma \approx 37 - 27 = 10$$

# AVERAGE and VARIATION

## Voice of the Process (VOP)



From example on previous page:

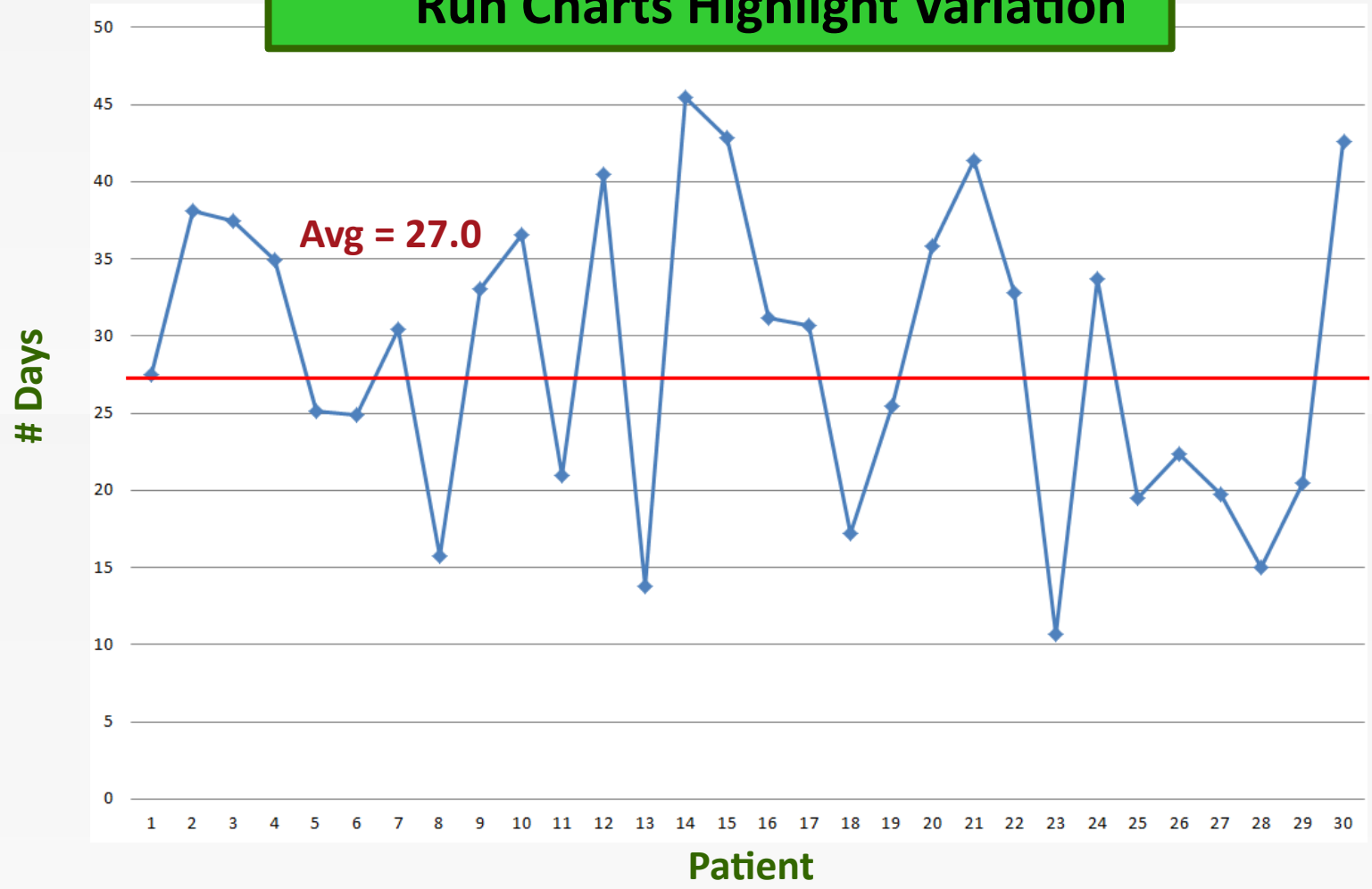
$\bar{y} = 27$     $\sigma = 10$



# RUN CHART

## Lead Time for Appointments

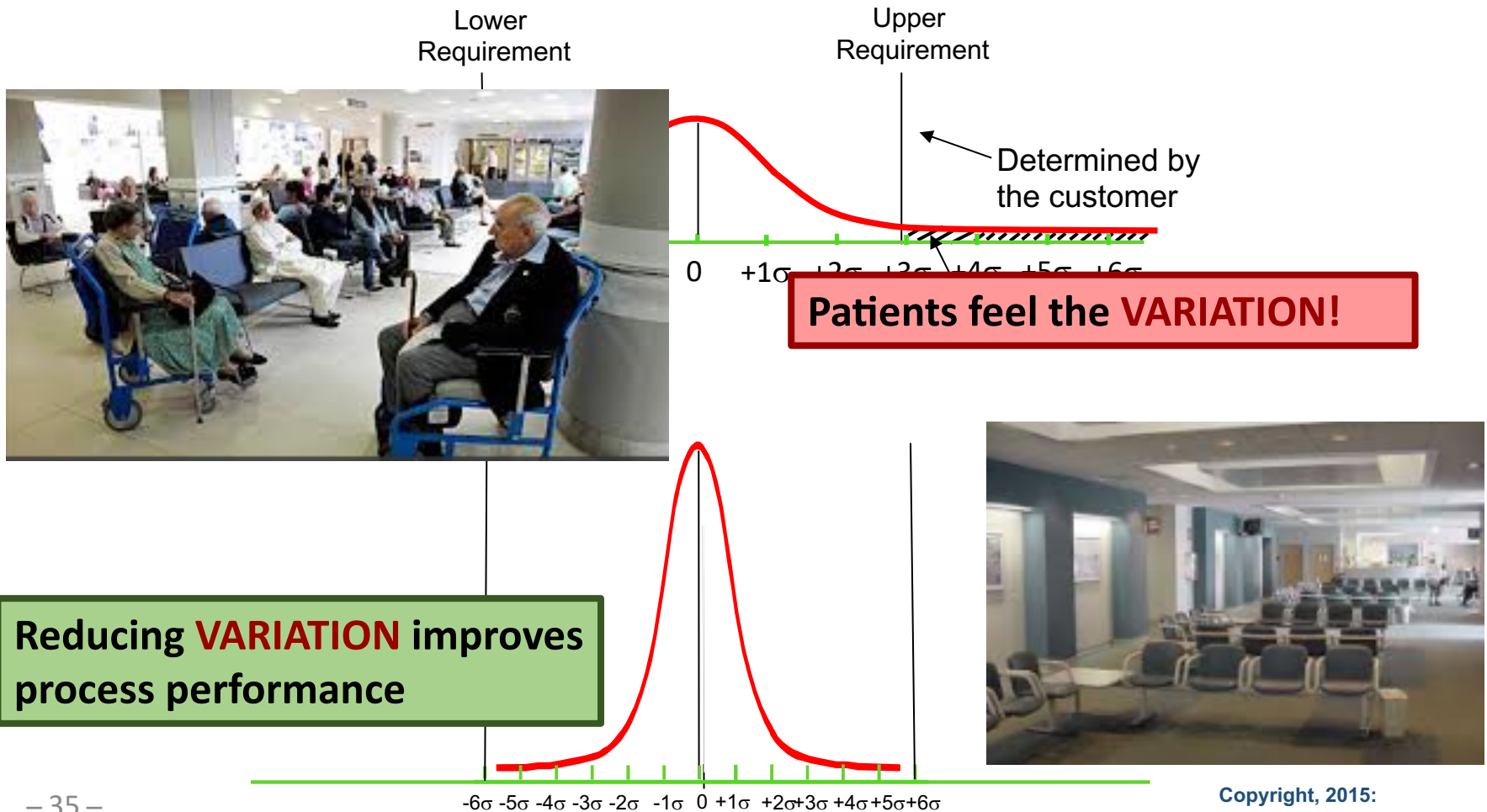
Run Charts Highlight Variation



# VARIATION IMPACTS PROCESS CAPABILITY

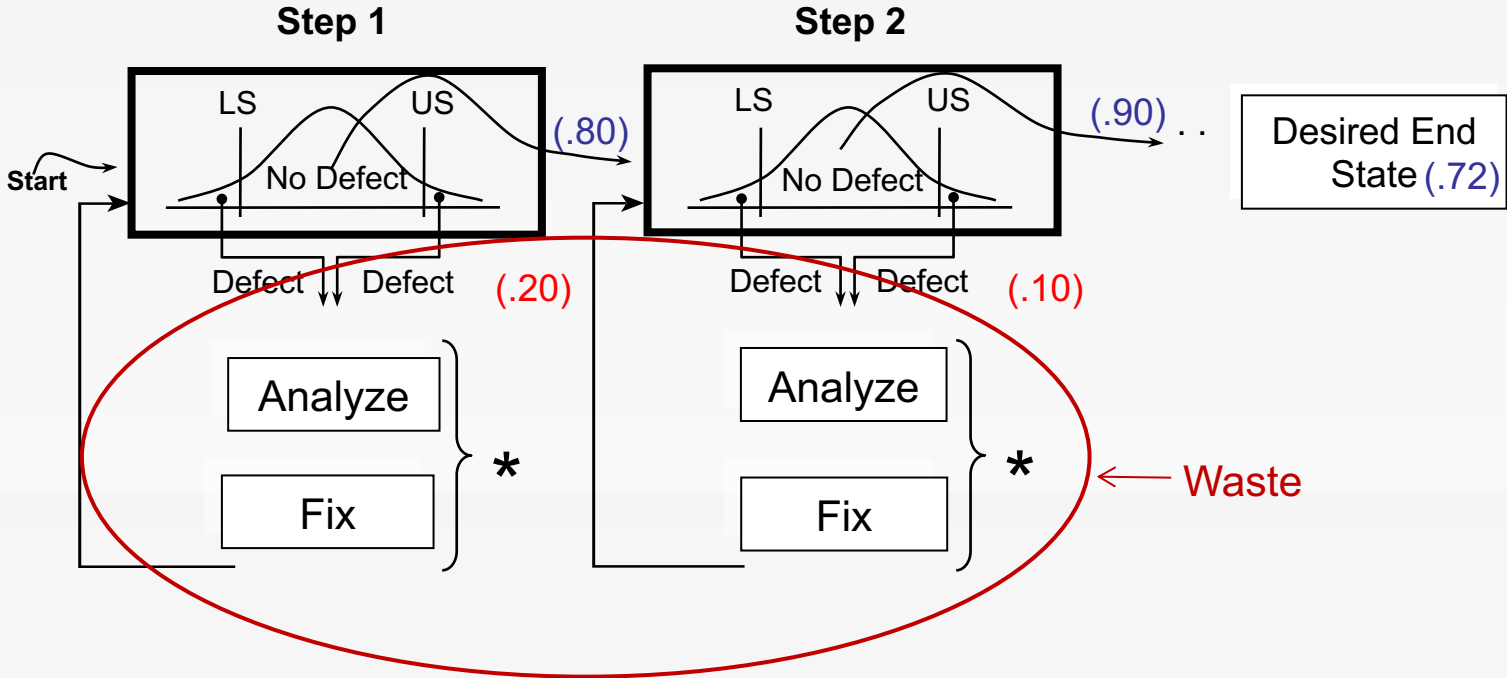
## VOC vs VOP

The capability of a process is determined by comparing **Voice of the Process (VOP)** with the **Voice of the Customer (VOC)**.



# QUALITY PERFORMANCE MEASURES

## Yield Rate

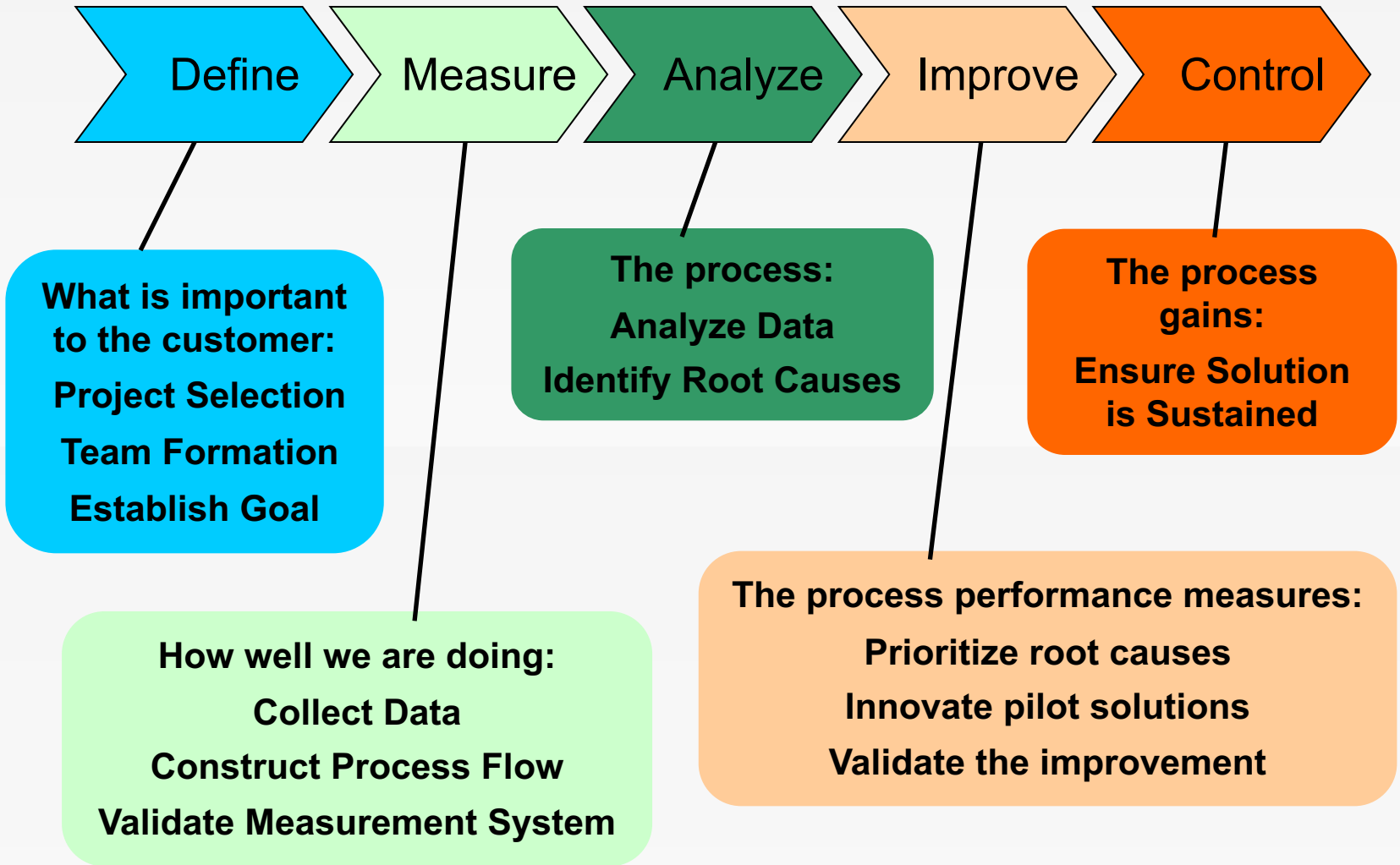


Every Time a Defect is Created During a Process (Step), it Takes Additional Cycle Time to analyze and fix.

\* These Non-Value Added Activities Typically Require Additional Floor Space, Capital Equipment, Material, and People.

# LEAN METHODOLOGY

## Systematic Approach to Improvement



# LEAN METHODOLOGY (cont.)

## Potential Tools



- Voice of Customer
- Project Charter
- Project Scope
- SIPOC
- Waste

- Physical Process Flow
- Process Flow Diagram
- Process Observation
- Value Stream Mapping
- Waste Analysis

- Brainstorming
- Cause & Effect Diagram
- Pareto Chart
- Root Cause Analysis
- 5 Whys

- Rapid Improvement Event (Kaizen)
- Mistake Proofing
- PF/IPO/SOP
- Standard Work
- Visual Management
- 5S

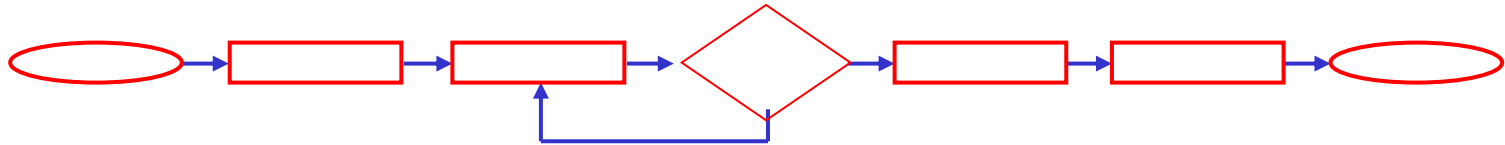
- Control Charts
- Control Plan
- Run Charts
- SOPs

# IMPROVEMENT TOOLS

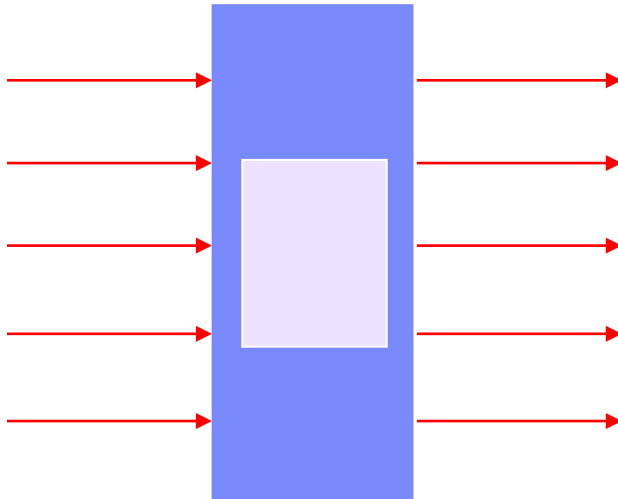
Reduce Variation, Defects, and Times



## PROCESS FLOW (PF) OR PROCESS MAP



## INPUT - PROCESS - OUTPUT



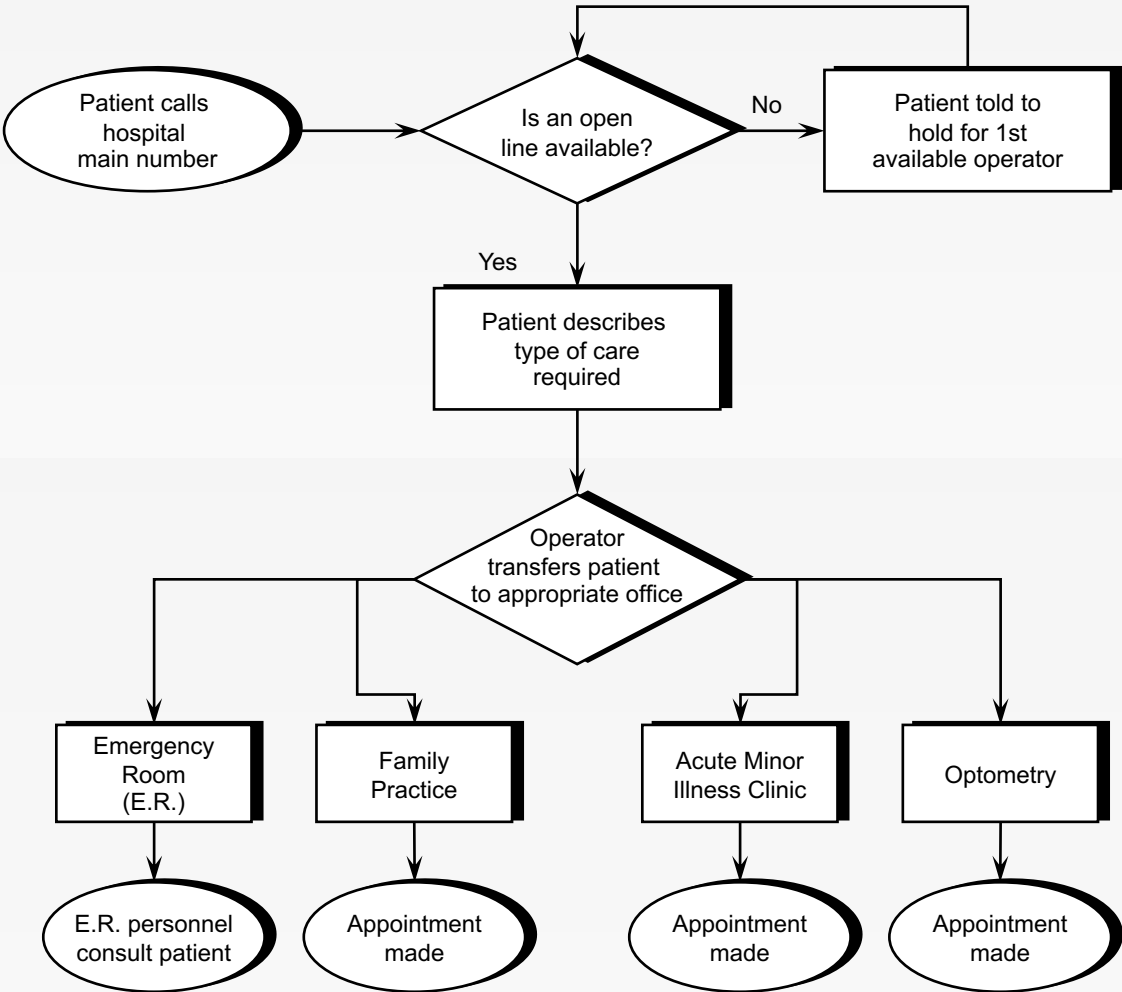
## STANDARD OPERATING PROCEDURES (SOP)

<u>How</u>	<u>What</u>	<u>Who</u>
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

# PROCESS FLOW

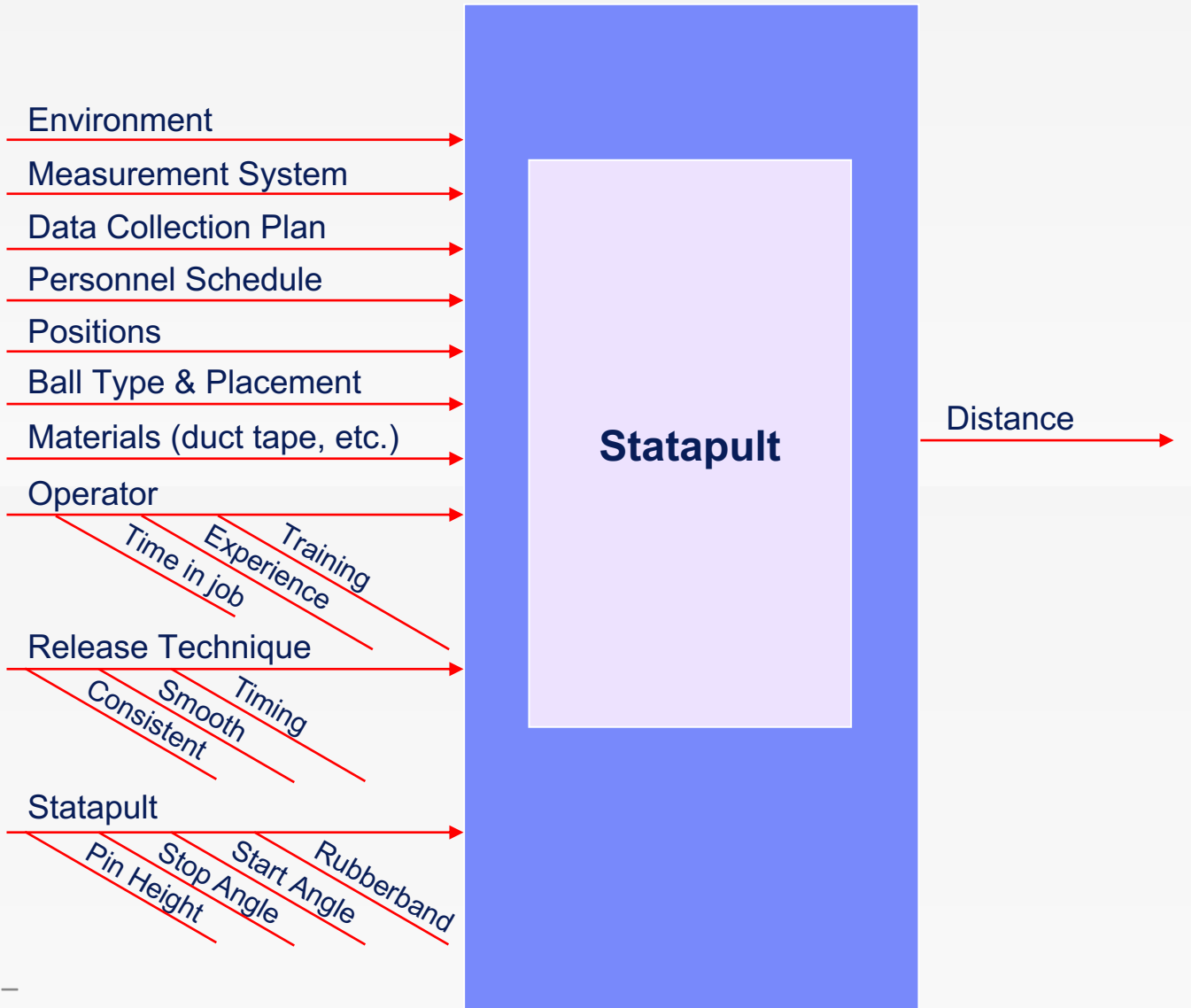
## Improves Performance

### Hospital Appointment Process



# INPUT – PROCESS - OUTPUT

## Improves Performance





# STANDARD OPERATING PROCEDURES (SOPs)

## Improve Performance

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- Define the interaction of people and their environment when performing a service
- Detail the action and work sequence of the worker
- Provide a routine to achieve consistency within the process
- Specify the best process we currently know and understand for controlling variation
- Provide a basis for future improvements
- Validate mistake proofing in the process



# IMPROVE THE PROCESS WITH PF/IPO/SOP

## Second Statapult Exercise

- (1) Process flow "Shooting the Statapult®"
- (2) Complete Cause-and-Effect Diagram
- (3) Label inputs as C or N
- (4) Write simple SOPs for all C's
- (5) Re-shoot Statapult® using the first example instructions (all pins at #3; pull angle = 177°; 15 sec. between shots; etc.)
- (6) Record data taken after PF/CE/CN/SOPs
- (7) Evaluate current process variability



	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
Shot #1	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Shot #2	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Shot #3	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Range = Longest - Shortest = \_\_\_\_\_

# 5S

## From Shop Floor to Office

- 整理 1) SEIRI = Sort
- 整頓 2) SEITON = Set
- 清潔 3) SEISOU = Shine
- 清掃 4) SEIKETSU = Standardise
- 躰 5) SHITSUKE = Sustain

### Organize the workplace ...5S

S  
A  
F  
E  
T  
Y



1. **Sort** - Identify what forms, equipment, parts, etc. are needed (keep) and what is not (remove)
2. **Set in Order** - Determine a place for needed items ... identify the storage place with clear markings
3. **Shine** - “Clean” the office/room/station and maintain the equipment
4. **Standardize** - Work procedures, systems, and policies
5. **Sustain** - Review regularly the SOPs, processes, regulations, etc. and ensure compliance

Leaders and Managers Make It Happen!

**Provide documentation so that the work environment is clearly defined, self-regulating, and self-improving**

# 5S

## Sort



How often is it used?	Storage Location
Hourly	Within arm's reach
Every Shift	Within a short walk
Daily	Further away (but convenient)
Monthly	Department storage
Annually	Facility storage
Never	Get rid of it

## 5S

### Set in Order

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- Physically reconfigure the area for optimization
- Mark locations for carts, big equipment, unit storage, etc.
- Designate location for paperwork, medications, materials, and supplies
- Build racks, containers or shadow boards for frequently used items
- Place frequently used items near primary work locations



## 5S

### Shine

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- Clean floors, walls, tools, and equipment
- Repair/replace items that could cause future cleanliness problems
- Repair faulty electrical outlets, cracks, items with excessive wear, etc.
- Paint areas if necessary
- Provide proper cleaning tools and procedures to maintain the improved condition
- Ensure that proper collection methods exist for debris and trash



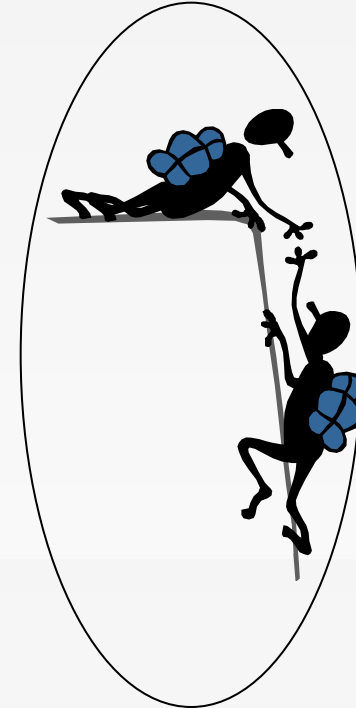


## 5S

### Standardize

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- Document the process and procedures with checklists, guidelines, flowcharts, diagrams, photographs, etc.
- Implement visual management ...color coding, checklists, labeling, etc.
- Ensure that everyone is properly trained on the current process and standard operating procedures
- Determine and document responsibility towards achieving this step
- Communicate the necessity to embrace 5S and provide any necessary 5S training



# 5S

## Sustain

- Develop a 5S audit capability
- Identify roles and responsibilities
- Review regularly the SOPs, processes, regulations, etc. for currency and compliance
- Develop a process to ensure compliance (audit, frequency, etc.)
- Utilize standard written procedures and check sheets
- Reward and recognize success

5S AUDIT CHECKLIST						
AUDIT# <input type="text"/>						
DATE <input type="text"/>		AREA <input type="text"/>		AUDIT BY <input type="text"/>		
LAST AUDIT DATE <input type="text"/>		LAST AUDIT SCORE <input type="text"/>		NEXT AUDIT DATE <input type="text"/>		
<small>www.airacademy.com/5saudit.htm</small>						
0	1	2	3	4	5	
NO DEFECT	SLIGHT DEFECT	MODERATE DEFECT	AVERAGE RESULTS <small>*Minimum Acceptable</small>	AREAS AVERAGE RESULTS	OUTSTANDING RESULTS	
<b>AUDIT SCORE</b>						
TOTAL SCORE		SORT		SET IN ORDER		SHINE
No. of QUESTIONS		STANDARDIZE		SUSTAIN		TOTAL
AVERAGE SCORE						
<b>QUESTIONS</b>						
		<b>SORT</b>			<b>SCORE</b>	
1.		Only the required <b>EQUIPMENT</b> is present in the area. All obsolete, broken or unnecessary equipment not required for current projects are removed from the area or red tagged for removal.				
2.		Only the required <b>TOOLS</b> are present in the area. Tools not required for current projects are removed from the area or red tagged for removal.				
3.		Only the required <b>FURNITURE</b> is present in the area. All obsolete, broken or unnecessary work benches, shelves, chairs, lockers, etc. not required for current projects are removed from the area or red tagged for removal.				
4.		Only the required <b>SHRUB PARTS</b> and <b>MATERIALS</b> are present in the area. Items not required for current projects are removed from the area or red tagged for removal.				
5.		Only the required <b>PAPERWORK</b> is present in the area. Outdated or unnecessary memos, instructions, reports, notices, etc. are removed from the area.				
6.		All <b>TRIPPING HAZARDS</b> such as electrical wires and equipment cables are removed from all working, standing, and walking areas.				
		<b>*SORT TOTAL SCORE:</b>				
		<b>SET IN ORDER</b>			<b>SCORE</b>	
1.		EQUIPMENT/MACHINERY is clearly identified (lump, serial, name, color code, etc.) and placed in a properly identified location. Critical maintenance points are clearly marked.				
2.		TOOLS have a designated storage area that is within reach of the user/operator. The location is properly labeled and a system is in place to identify tools that are absent (shadowboard, etc.).				
3.		When applicable, FURNITURE is clearly identified (numbered, named, color coded, etc.) and placed in a properly identified location.				
4.		Locations for CONTAINERS, WIPs, BOXES, BINS, etc. are clearly defined via signs or marked/taped lines and properly labeled.				
<small>CONTINUED ON NEXT PAGE →</small>						

5S SUSTAIN CAMPAIGN		
AREA	WEEK OF	
5S	TASK	TEAM
SORT		
SET-IN-ORDER		
SHINE		
STANDARDIZE		
SUSTAIN		



# STANDARD WORK

## Improves Efficiency

- Method for improving work efficiency by:
  - Designing the best method to complete a work task
  - Documenting the method
  - Training operators, technicians, nurses, etc. to do the same work task using the same method
- Steps to develop standard work routines:
  - ❑ Step 1: Involve those performing the process to analyze the work task by breaking it down into work components ... understand the current process
  - ❑ Step 2: Sequence the steps in a logical and efficient order ... use good ergonomic principles of human motion

## STANDARD WORK (cont.)

### Improves Efficiency

- Steps to develop standard work routines (cont.):
  - ❑ Step 3: Capture appropriate times for the completion of the steps
  - ❑ Step 4: Document with procedures, diagrams, and layouts
    - Use visual methods such as photographs, Powerpoint, and schematics whenever possible
    - Keep task descriptions clear and simple
    - Present the work steps in the sequential order in which they must be performed
    - Develop using a team approach combining the best practices in a safe and efficient way to complete the task at a sustainable pace

## STANDARD WORK (cont.)

### Improves Efficiency

- Steps to develop standard work routines (cont.):
  - ❑ Step 5: Review the procedures with all who perform the process and revise as necessary
    - Standard Work is not permanent and should be reviewed regularly for improvement
  - ❑ Step 6: Train those who work the process by demonstration with the documents as aids
    - Follow up with “hands-on” training and a review for competency
  - ❑ Step 7: “Audit” at all levels regularly and ensure standard work is current



# STANDARD WORK (cont.)

## Benefits

---

- Standard Work:
  - Predictable quality and predictable cycle time for the task
  - Efficiency gains with reduction in variability
  - Standardizes the method with standard operating procedures (SOPs)
  - Enhances competencies
  - Enhances problem solving
  - Strengthens multi-skilling
  - Details the interactions between the people (nurses, technicians, etc.) and the equipment/computers used for the process

# STANDARD WORK (cont.)

## Exercise

---

- Work as individuals or on a team (4-6 people)
- Pick a process
  - Making coffee
  - Shopping for groceries
  - A process from within a MC value stream
- Complete the Standard Work Template (next page)
- Prepare a debrief

# STANDARD WORK (cont.)

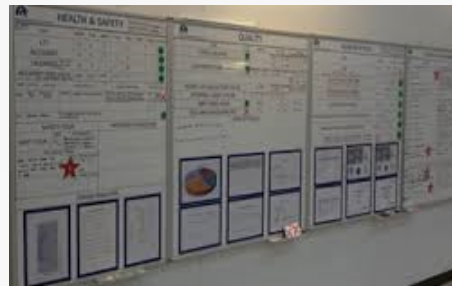
## Standard Work Template

Process:										Date:			
Step No.	Description	1	2	3	4	5	6	7	8	Max	Min.	Avg. Time	Comments
1													
2													
3													
4													
<b>TOTAL</b>													

# VISUAL MANAGEMENT

## Benefits

- Used to:
  - Support Leadership and Management
    - Displays work priorities
    - Daily process performance
    - Enhances communication
  - Provide current status/information
  - Standardize
  - Error Proof
    - Prevents process omissions
    - Supports correct process step completion

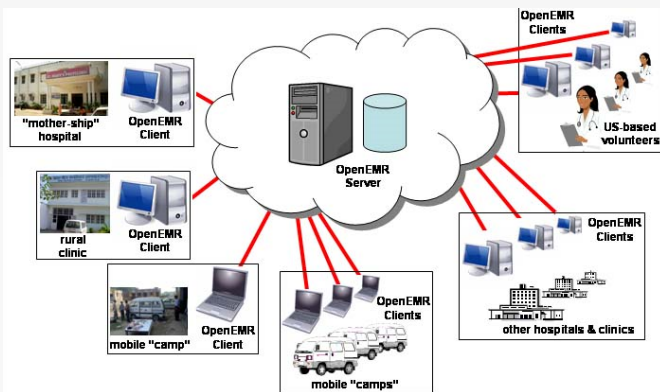




# VISUAL MANAGEMENT (cont.)

## Benefits

- Promotes:
  - Better patient outcomes
  - Safety
  - Training and standards
  - Better job performance
  - Good process control (less variation)



**HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)**  
**EXAMPLE 1**

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. Remove all PPE before exiting the patient room except a respirator if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

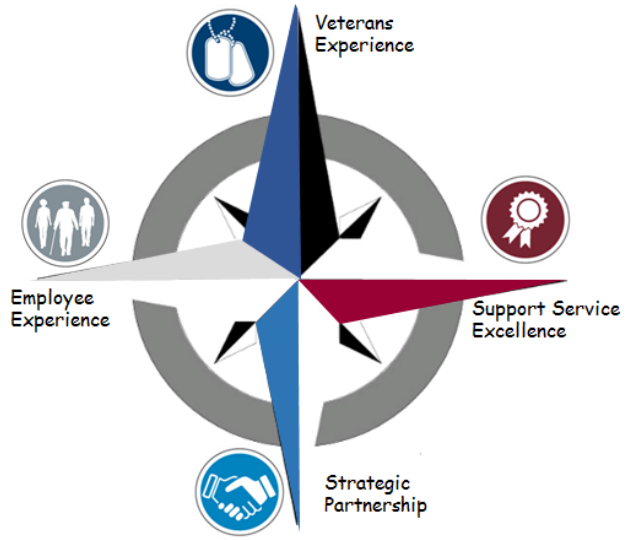
- 1. GLOVES**
  - Outside of gloves are contaminated!
  - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer.
  - Using a grabber, grasp the palm area of the other gloved hand and peel off that glove.
  - Hold removed gloves in gloved hand.
  - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
  - Discard gloves in an infectious waste container.
- 2. GOGGLES OR FACE SHIELD**
  - Outside of goggles or face shield are contaminated!
  - If your hands get contaminated during goggles or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer.
  - Remove goggles or face shield from the back by lifting head band or ear pieces.
  - If this item is reusable, clean or disinfect it separately for reprocessing. Otherwise, discard in an infectious waste container.
- 3. GOWN**
  - Sleeve front and sleeves are contaminated!
  - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer.
  - Unfasten gown by pulling one that sleeves don't contact your body when reaching for fast.
  - Pull gown away from neck and shoulders, touching inside of gown only.
  - Turn gown inside out.
  - Roll or roll into a bundle and discard in an infectious waste container.
- 4. MASK OR RESPIRATOR**
  - Front of mask/respirator is contaminated! — DO NOT TOUCH!
  - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer.
  - Grasp substrate or ribbons of the mask/respirator. Place the area of the top, and remove without touching the front.
  - Discard in an infectious waste container.
- 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE**
  - An infectious waste container is used to dispose of PPE that is potentially contaminated with blood or any.

**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE**



# VISUAL MANAGEMENT (cont.)

## Examples



True North Metrics

### Strategic View



# WHAT'S HAPPENING HERE?

## List Common Characteristics



# HUDDLE BOARD MEETINGS

## A Powerful Tool for Leaders/Managers

---

- Attended by:
  - Leaders/managers (typically, leads the meeting)
  - Team members/staff/process workers (responsibility for leading or facilitating the huddle can be rotated)
- Promotes:
  - Efficient use of meeting time (normally limited to 15 minutes)
- Provides:
  - Current status
  - Daily direction
  - Strategic alignment
- Facilitates:
  - Quick and accurate communication
  - Performance and process improvement

# HUDDLE BOARD MEETINGS

## A Powerful Tool for Leaders/Managers

---

- Facilitates (cont.):
  - Prioritization of effort
  - Self-management
  - Making adjustments and improvements to daily work practices
- Topics discussed:
  - Selected by leaders/managers
  - Related to organizational strategy and priorities
- Candidate topics include:
  - Hot issues
  - Metrics and goals
  - Current plan to meet goals
  - Day's top priorities

# HUDDLE BOARD MEETINGS (cont.)

## A Powerful Tool for Leaders/Managers

---

- Candidate topics include (cont.):
  - Problems faced
  - Help needed
  - Safety issues
  - Performance issues
  - Potential improvement efforts/events
  - Training on updated/new processes
  
- Fosters:
  - Recognition
  - Communication
  - Efficiency
  - Culture of unity
  - Trust and respect

# HUDDLE BOARD MEETINGS (cont.)

## A Powerful Tool for Leaders/Managers

---

- Success enhanced by:
  - Starting on time
  - Ending on time
  - Holding regularly (even if it's a busy day)
  - Sticking to the agenda or format
  - Not turning the huddle into just a “status report”
  - Leadership/management direction

# PROCESS IMPROVEMENT QUESTIONS

## Questions Leaders/Managers Need to Answer

---

- 1) How do you know that waste and quality issues are important to your organization? Which ones are a priority and why are they so important?
- 2) How do you know your organization's current level of quality and performance? How do you know that improvement efforts can assist you in increasing quality, improving performance, and reducing waste?
- 3) How are you actively pursuing breakthrough as well as continuous improvement in your areas of responsibility that link to customer value?
- 4) What portion of your time do you spend devoted strictly to the removal of waste and variation?
- 5) What are your products and services and who are your customers? How do you learn the value created for each customer? What is your process for soliciting feedback from your customers? What do you do with the feedback?



# PROCESS IMPROVEMENT QUESTIONS (cont.)

## Questions Leaders/Managers Need to Answer

---

- 6) What is your process for soliciting feedback from the people you manage? What kind of feedback do you solicit? What do you do with the feedback?
- 7) How do you measure, analyze, review, and improve performance by using data and information?
- 8) What are the right knowledge-generating and improvement-oriented questions you need to ask the people who work for/with you? What methods or tools can be used to answer them?
- 9) To what extent have you deployed and implemented an improvement strategy with a disciplined methodology and toolset and associated infrastructure to predictably generate higher levels of efficiency and effectiveness?

# PROCESS IMPROVEMENT QUESTIONS (cont.)

## Questions Leaders/Managers Need to Answer

---

- 10) How do you assure that your workforce is properly trained to successfully use the latest and best improvement methodologies and tools?
- 11) How would you describe the Cost of Poor Quality in your area of responsibility? How is it calculated? How are efforts to eliminate it identified and prioritized? How do you calculate the Return on Investment (ROI) from your improvement efforts (including eliminating the Cost of Poor Quality, project resources deployed, and training?)
- 12) Do you have a standard procedure for documenting the improvement efforts and results? What is it?
- 13) What barriers does your workforce face when trying to improve the way your organization does business? What are you doing to remove these barriers?

# PROCESS IMPROVEMENT QUESTIONS

## Questions Leaders/Managers Need to Answer

---

- 14) On what measures of performance, related to these issues, are you evaluated? How are you held accountable for the measures of performance? What are the specific improvement goals for them? How do you hold your workforce accountable?
- 15) What kind of plan do you have that will, one year from now, show evidence that you made a difference? What do you predict that evidence will show?

# ANALYZING WORK

## Enhances Performance

---

- In our processes, we must challenge ourselves to:
  - Analyze the work being done
  - Understand the types of activities being performed (VA, NVA, NVA-R)
  - Strive to eliminate or reduce the non-value added work
- Where's the gap? What's the problem?
  - Cycle times too long
  - Changeover times too long
  - Excessive variation
  - High defect rates
  - Excessive waiting

# ANALYZING WORK (cont.)

## Enhances Performance

- Identify the potential causes of the problem
- Tools for analyzing work include:
  - Process map (previously addressed)
  - Observation (Gemba Walk)
  - Brainstorming
  - 5 Whys
  - Pareto Chart
  - Physical Process Map

# GEMBA WALK

## Observation

---

- *Gemba* is a Japanese term for “the real place”
  - Where work is being done and value is created
- Why perform *Gemba Walks*?
  - Required by top leadership?
    - Frequency, coverage, goals, etc.
  - Enhances leaders/managers capability
  - Helps problem-solve
  - Provides first-hand view/knowledge ... get away from the office/desk
  - Fosters conversations with “your” people who work the processes
- On a *Gemba Walk* leaders need to answer:
  - What is the process?
  - How do I know it is working?
  - What can I do to help improve the process?

# GEMBA WALK

## A Leadership/Management Tool

---

- Things to observe and to discover on the *Gemba Walk*
  - How processes are accomplished (enables completion of a process map)
  - What activity is Value Added and what is Non-value Added
  - How upstream and downstream processes are performing
  - Safety
  - Ergonomics
  - Layout
  - Equipment status (maintenance and performance)
  - Consistency of work accomplishment (does variation exist?)
  - Validity of measurements (are they tracked real-time?)
  - Patient activity and wait time

# GEMBA WALK (cont.)

## A Leadership/Management Tool

---

- Chokepoints
- Compliance with Standard Work/Standard Operating Procedures
- 5S
- Waste
- Visual Management
- Problems with the process
  - Cycle times too long
  - High defect rates



# GEMBA WALK

## Points To Remember

---

- Start with a purpose in mind (see previous slides)
  - Know what you want to observe
  - Know what you want to learn
  - Know if there are any problems
- Know the people who are involved in the process
- Observe intently ... the facility, the process, the equipment, the people, etc.
- If problem solving, drill for Root Cause (use 5 Whys)
- Validate and verify ... ask yourself, “is the observation what I would normally see?”
- Listen, listen, listen

**Perform Gemba Walks**

# BRAINSTORMING

## Helps in Decision Making

---

- What is it?
  - Brainstorming is used for generating many ideas that team members can build upon in a non-critical environment
- Why use it?
  - Brainstorming engages all members of the team by treating each idea equally
  - Team members are able to pool their knowledge
  - Creative ideas are formed by building off of other's ideas
- When should it be used?
  - Brainstorming should be used when the problem can be solved using existing knowledge
  - Brainstorming can also be used as an opening step for other methods of creativity

# BRAINSTORMING (cont.)

## Helps in Decision Making

---

- Assemble a team
  - Team members should include experts in the fields that are likely to be useful in solving the problem.
  - Team size should be limited to 8 (approx.)
- Clearly state the problem to be solved
- Explain the rules for Classic Brainstorming

# BRAINSTORMING (cont.)

## Rules

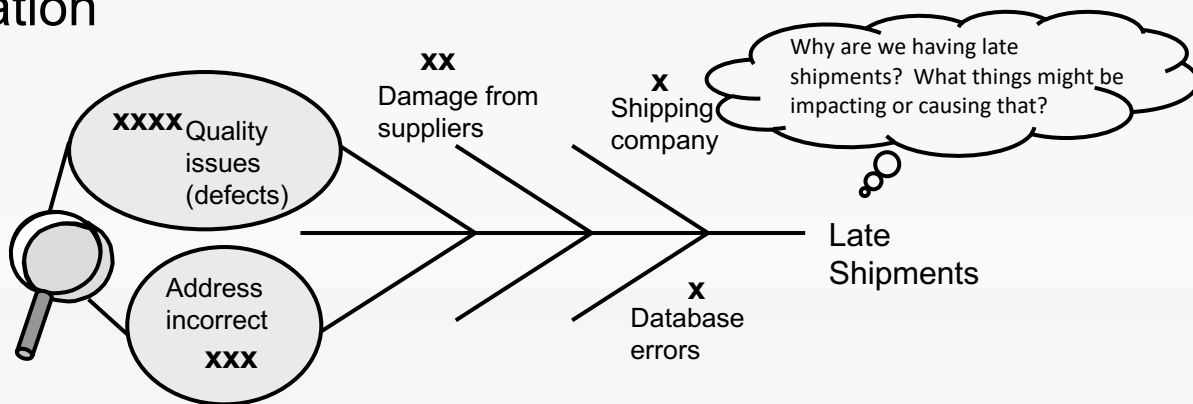
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- All ideas are recorded
- No criticism, all ideas are valid
- Quantity is important, not quality
- Be imaginative
- Build off each other's ideas
- Get to the point

# TEAM VOTING

## Tool Used to Prioritize

- Use after the “right” level of discussion has occurred
- Use a CE diagram, sticky notes, or easel paper
- Give all team members a certain number of votes
- Provides documentation



Prioritize according to number of votes

Quality Issues	XXXX
Supplier Damage	XX
Shipping Company	X
Database Errors	X
Address Incorrect	XXX

# BRAINSTORMING/CE

## Exercise

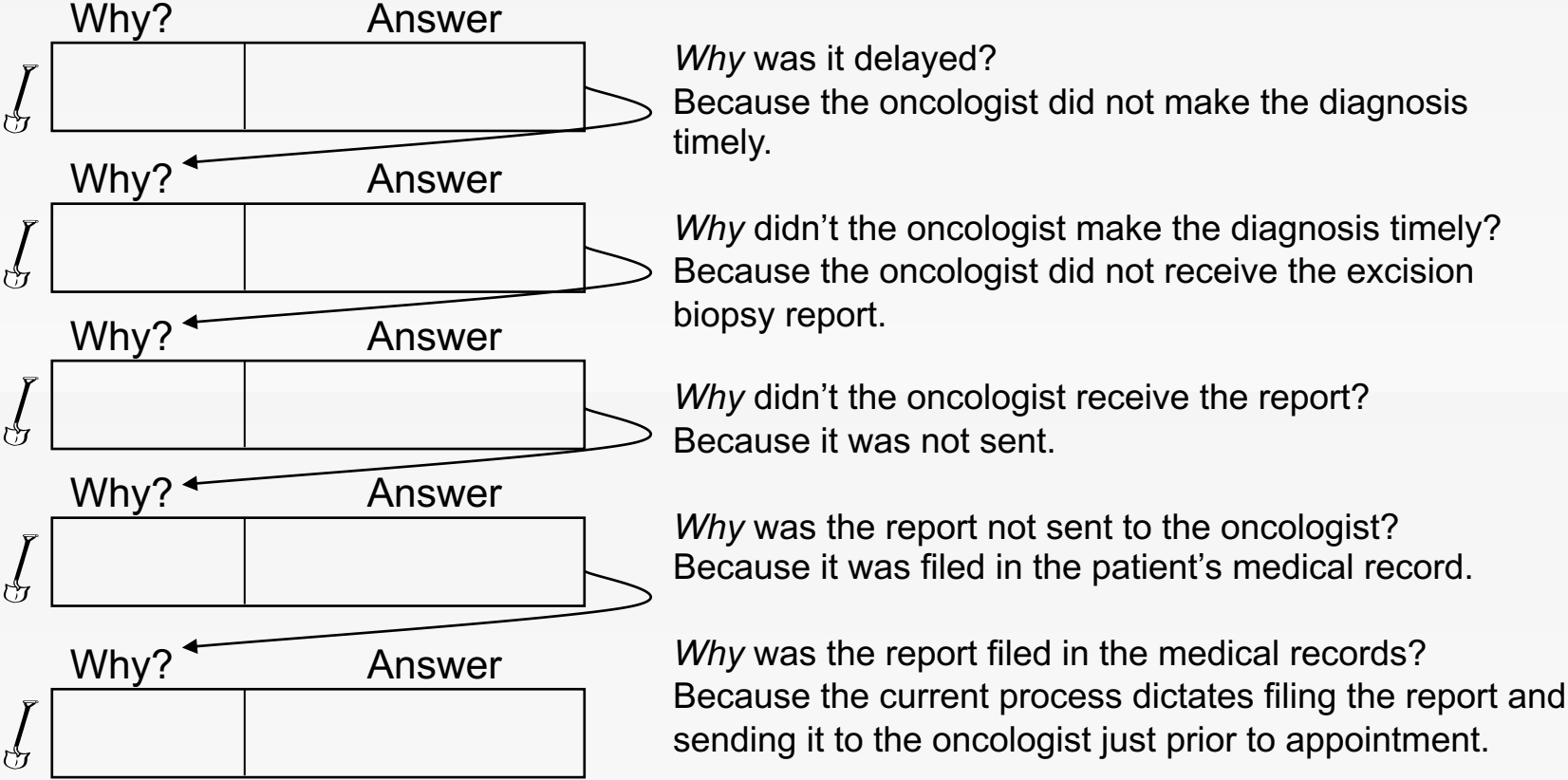
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- Break into teams of 6-8 people
- Pick a real problem (scheduling, admission, patient complaints, staffing, process thinking, etc.) and state it
- Brainstorm for 15 minutes the potential causes
- Record potential causes
- Use a team tool such as team voting to prioritize the top three potential causes
- Have a spokesperson from your group discuss:
  - The process (pros and cons)
  - The prioritization
  - The plan

# 5 WHYS

## Root Cause Analysis

**Problem:** The patient's diagnosis of skin cancer was delayed.

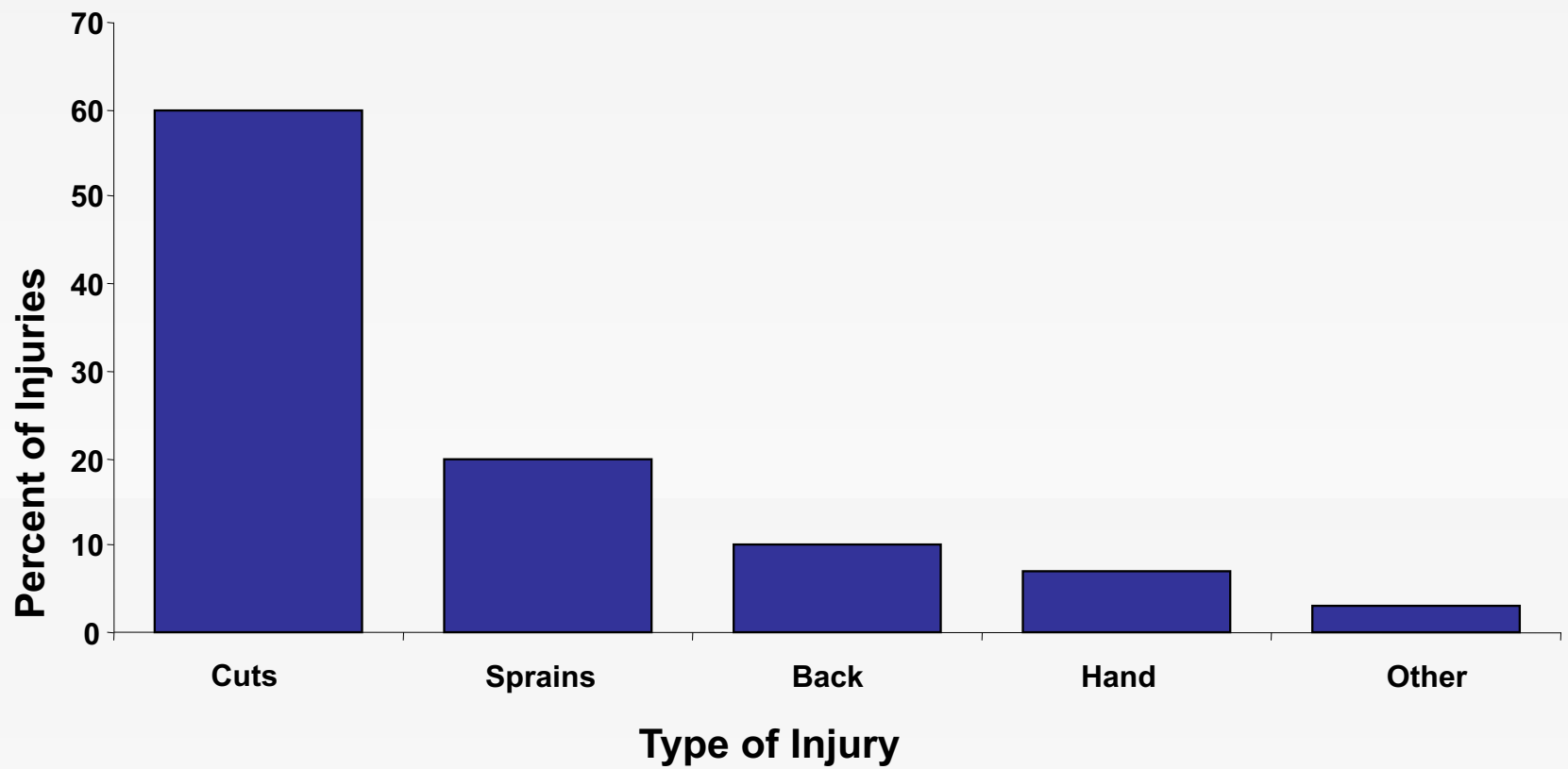


**Solution:** Revise process so that oncologist "pulls" report from pathology.

# PARETO CHART

## Stratifies Data

---



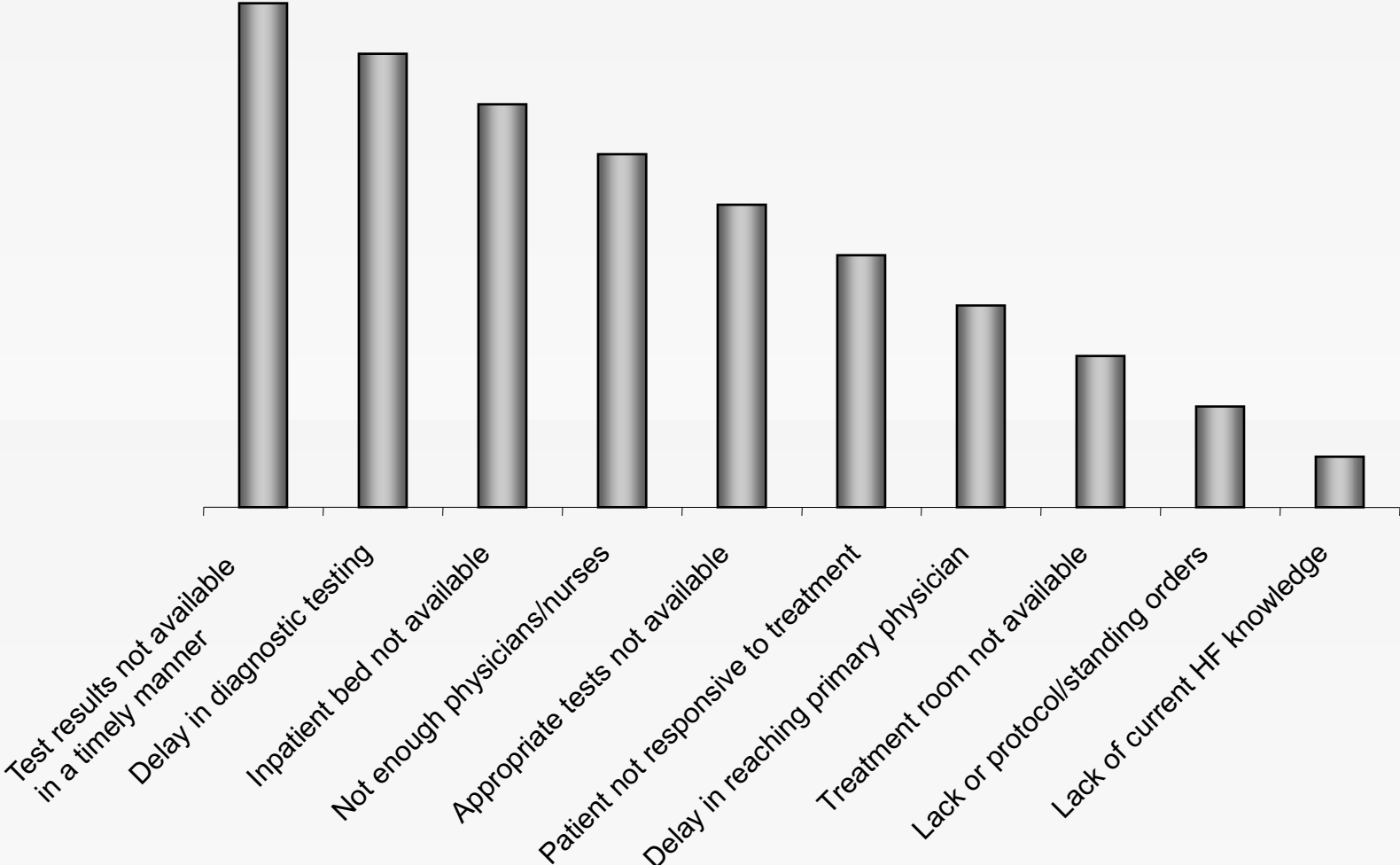
- A bar chart for non-numerical categorical descriptors whose bars are in descending order
- Used to identify and separate the “vital few” categories from the “trivial many”
- May be used in a stratified or nested fashion to zero in on precise problem area



# PARETO CHART (cont.)

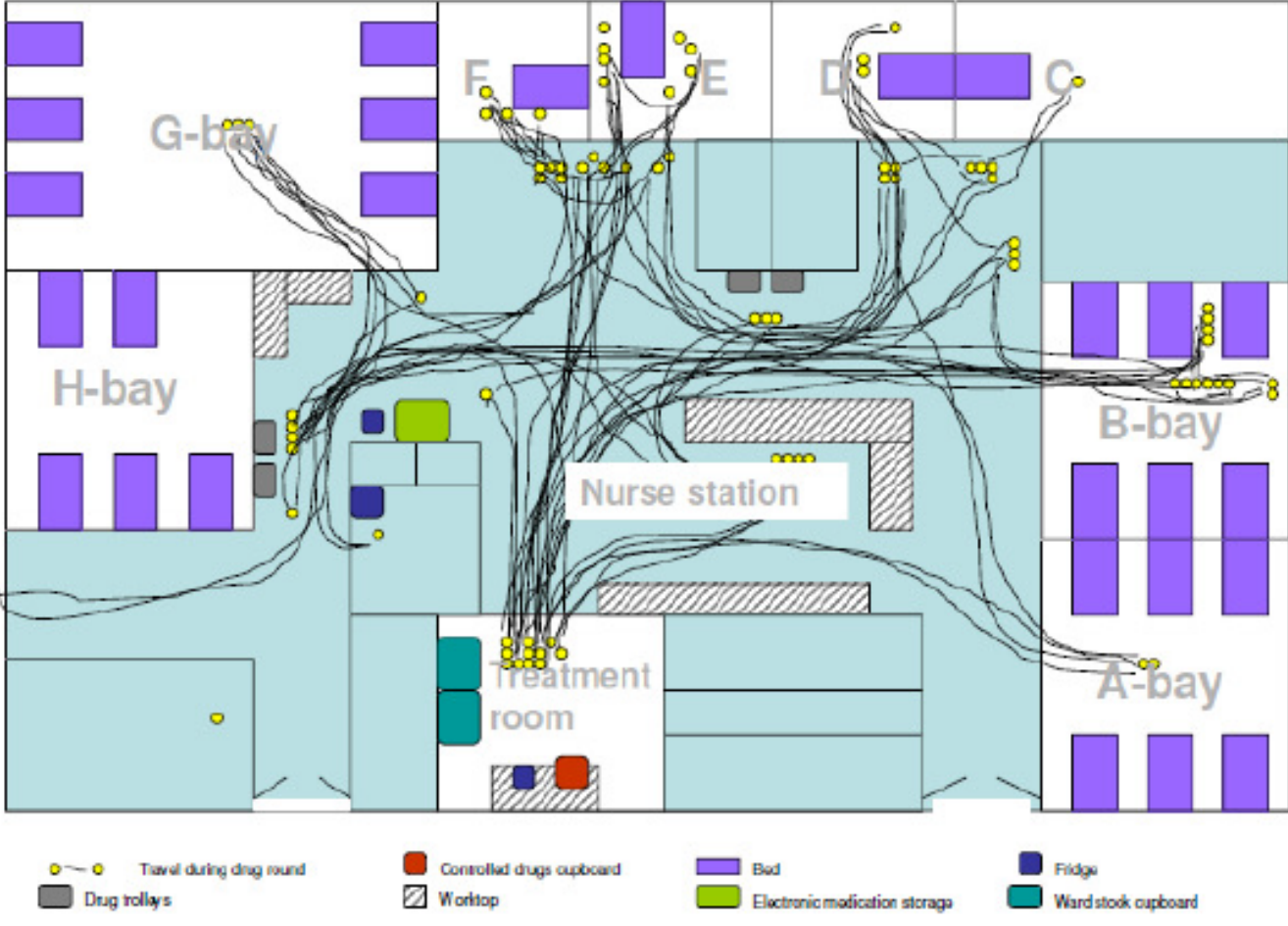
## Stratifies Data

### Barriers to Heart Failure Management



# PHYSICAL PROCESS MAP

## Spaghetti Diagram



- Plot the path on a layout
- Identify each step on the layout
- Connect the steps
- Measure / estimate the distance

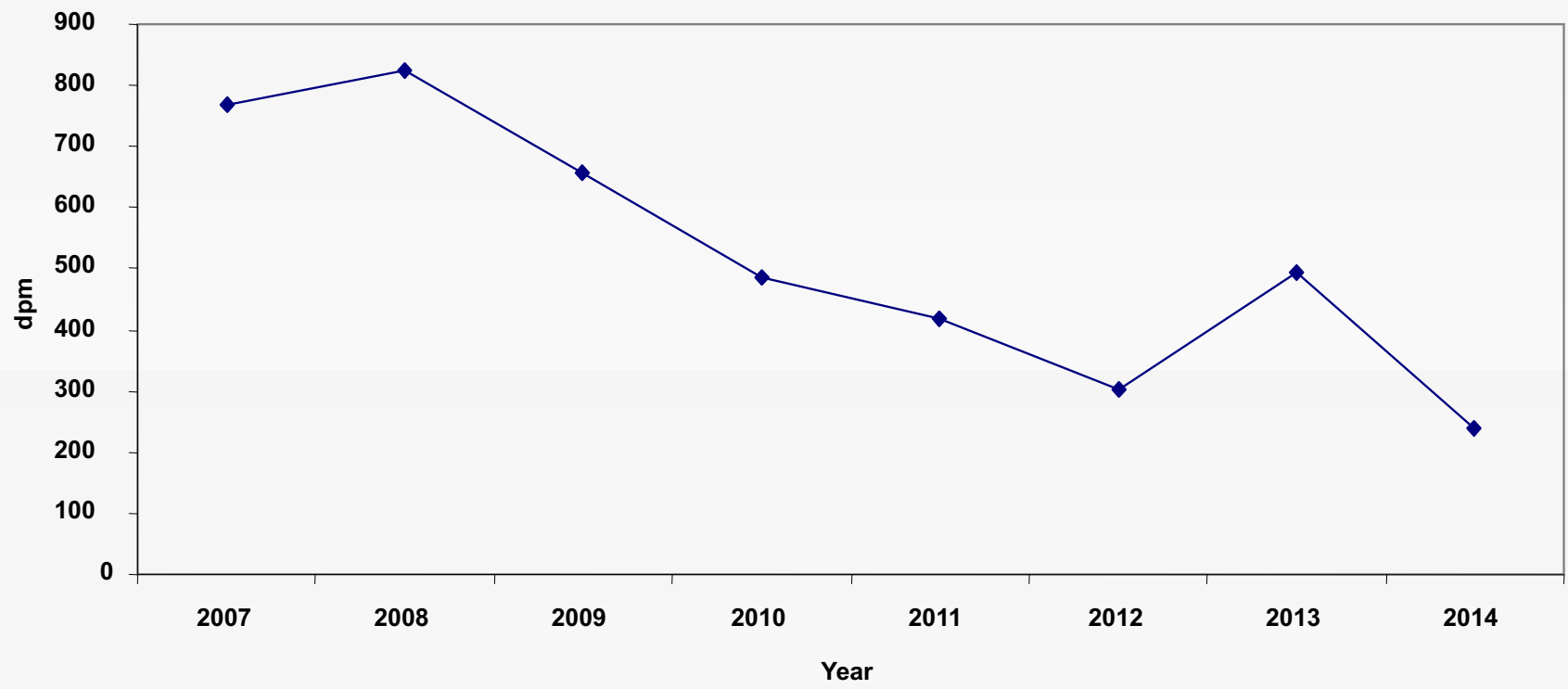
Travel distance by one nurse during a drug administration round

# RUN CHART

## Trend Chart

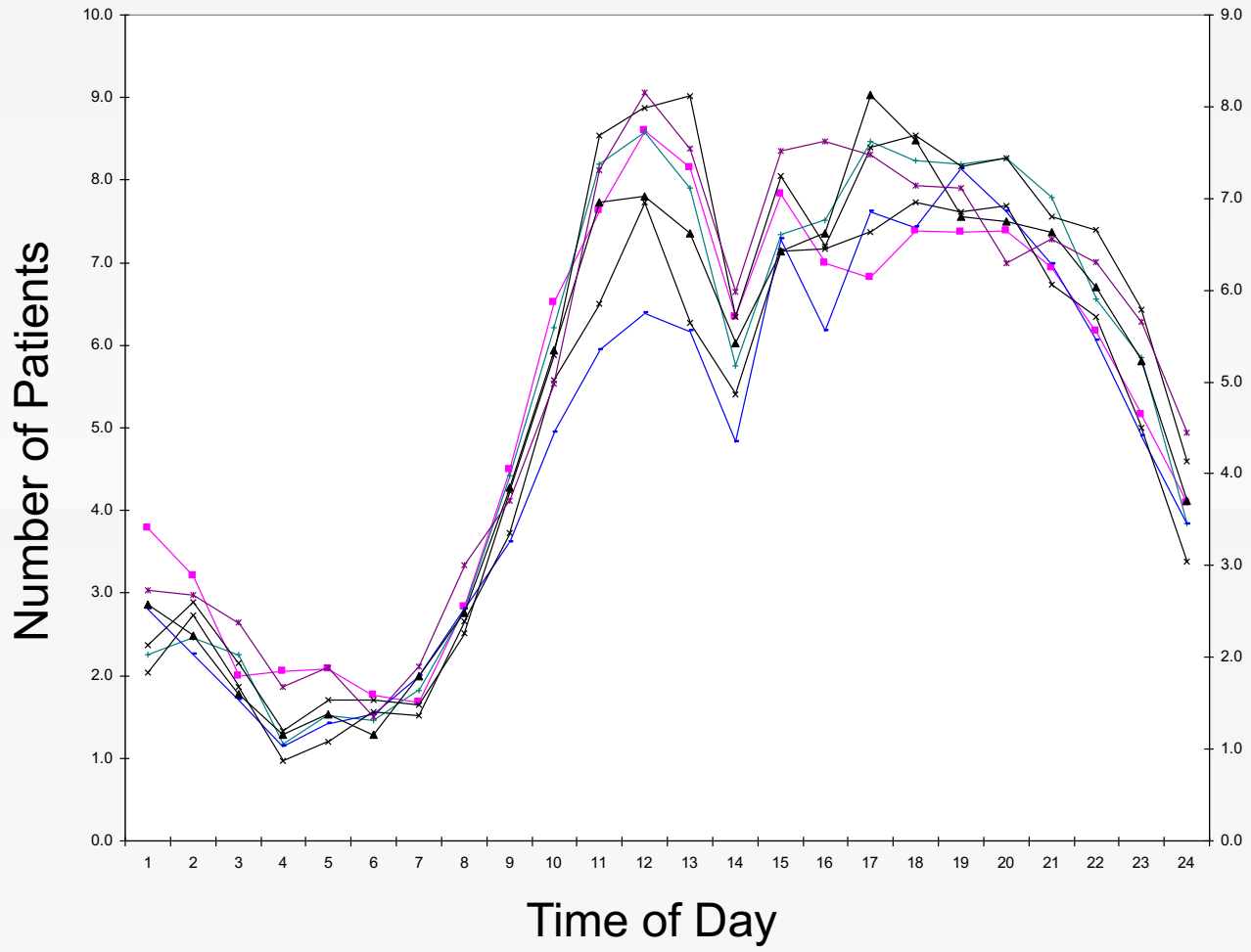
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Medication Errors



# RUN CHART (cont.)

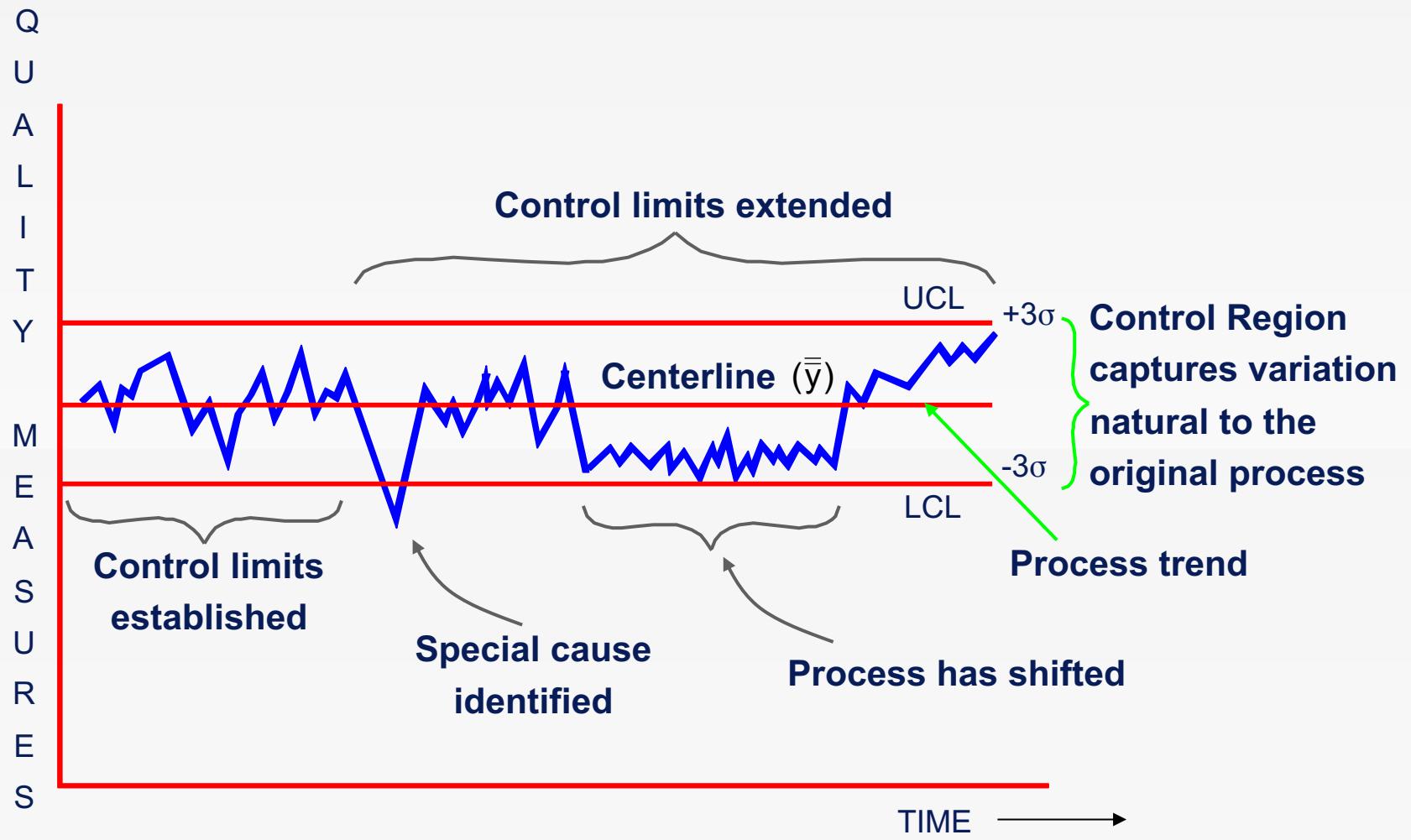
## ED Traffic Example



Note: Each line is a different day of the week

# CONTROL CHARTS

## Voice of the Process (VOP)



# CONTROL CHARTS

## Another Way to Look at Data

- A management tool that monitors “health” of process
- Data plotted in time sequence
- Provide a systematic and efficient method for gathering data and transforming it into INFORMATION
- Allow managers to make decisions based on FACTS
- Highlight average, variation, outliers, shifts, and trends
- Warn of system degradations giving managers time to prevent defects
- Allow managers to be “predictive”
- Show evidence of process improvements and helps sustain the gains
- Signal problems but not their causes

See Appendix A

# PROJECTS

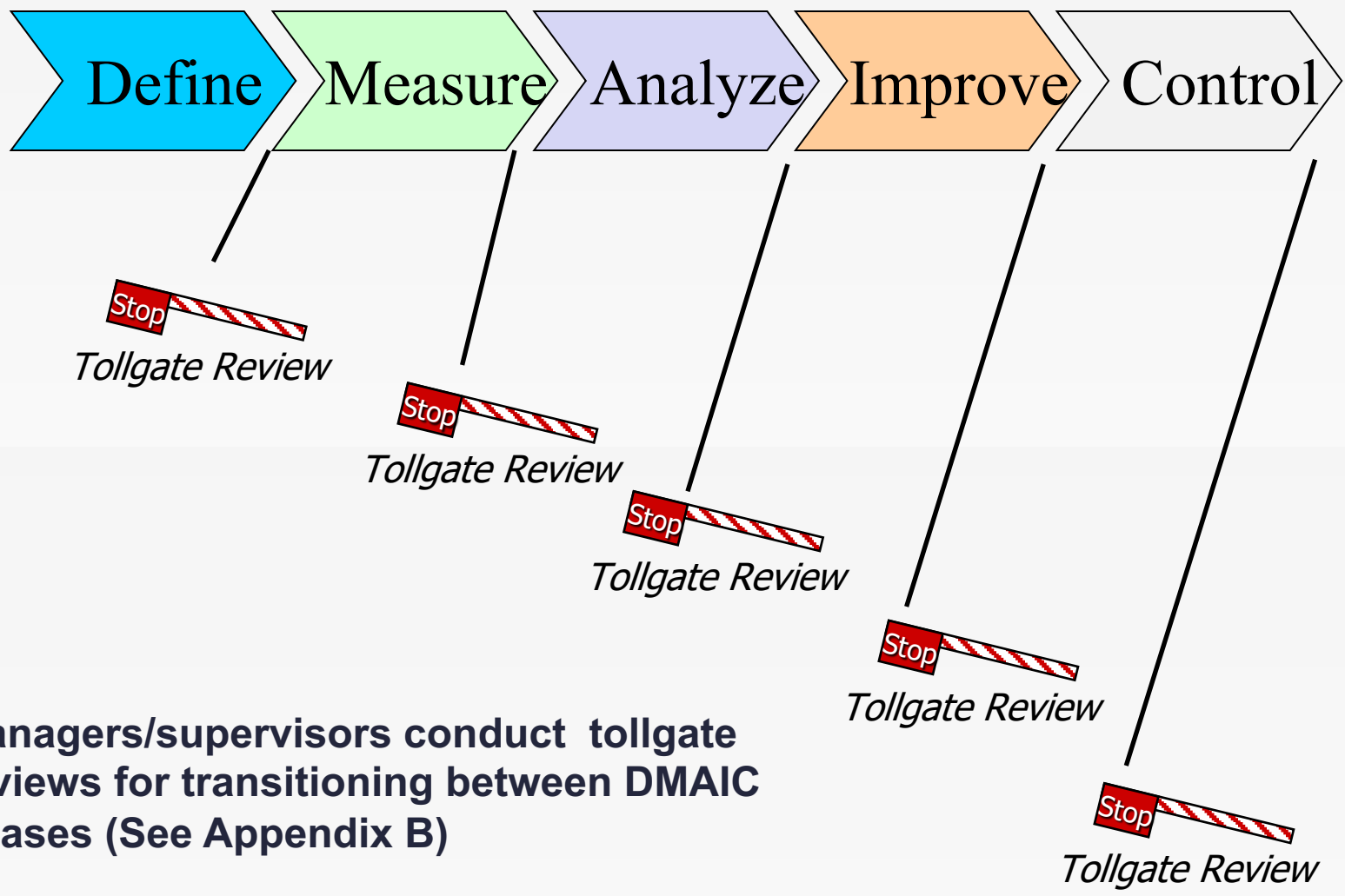
## Manager's Responsibilities

---

- Identify a key project that will benefit work flow/process, etc.
- Determine magnitude of project
  - Time, resources, depth, potential cost, etc.
- Align a belt (team leader) with the project and determine team members
- Set goals for the project
- Create and maintain project momentum
- Meet with the belt regularly to ensure project completion
- Conduct a tollgate for transitioning between each phase

# PROJECT TOLLGATES

## Keep Projects on Track



**Managers/supervisors conduct tollgate reviews for transitioning between DMAIC phases (See Appendix B)**



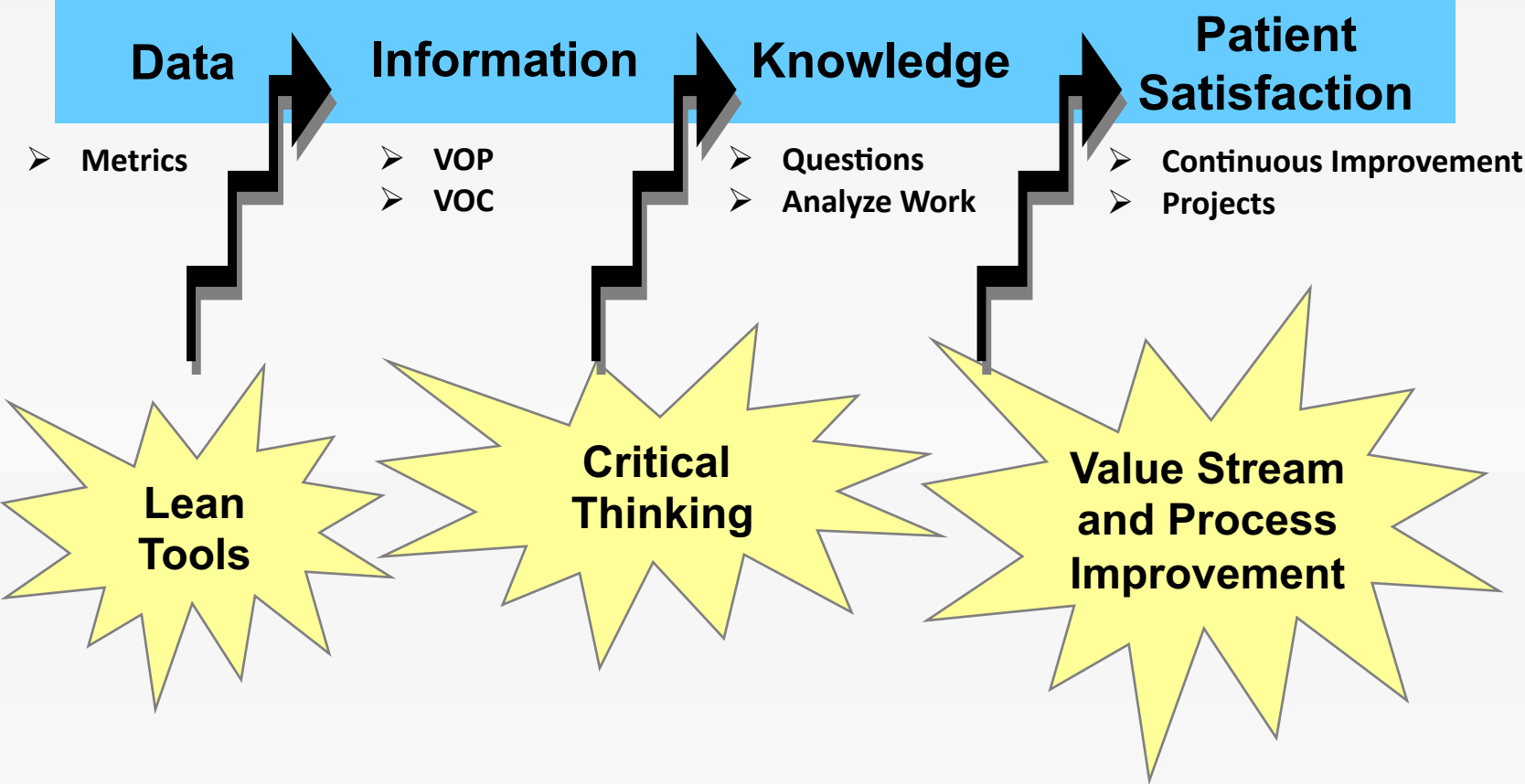
## PROJECTS (cont.)

### Manager's Responsibilities

- Assist in identification and capture of “Return on Investment”
- Break down barriers to project completion and push the project over the finish line
- Recognize and reward success
- Propagate success stories to generate cultural change

# ACHIEVING THE GOAL

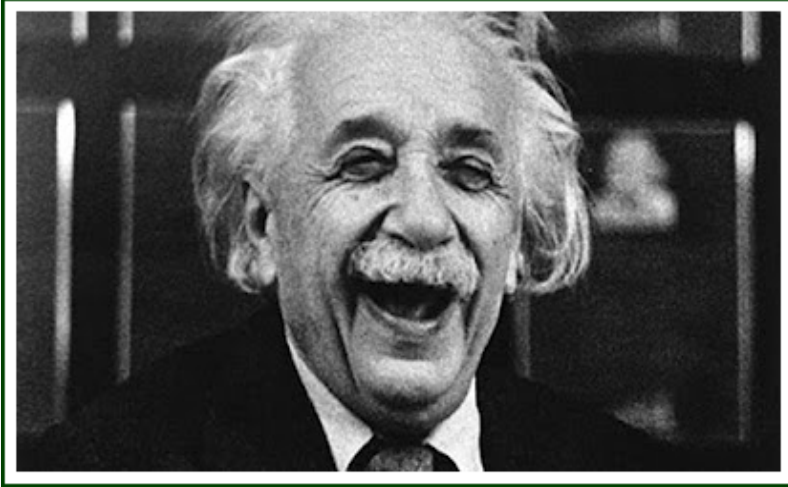
## Putting It Together



# TIME TO DO THINGS DIFFERENTLY

## Are You Hitting the Improvement Barrier?

---



*Albert Einstein  
(1879-1955)*

## Insanity:

“doing the same thing over and over again and expecting different results”

# READINESS FOR CHANGE

## A Normal Distribution

### CAVE People:

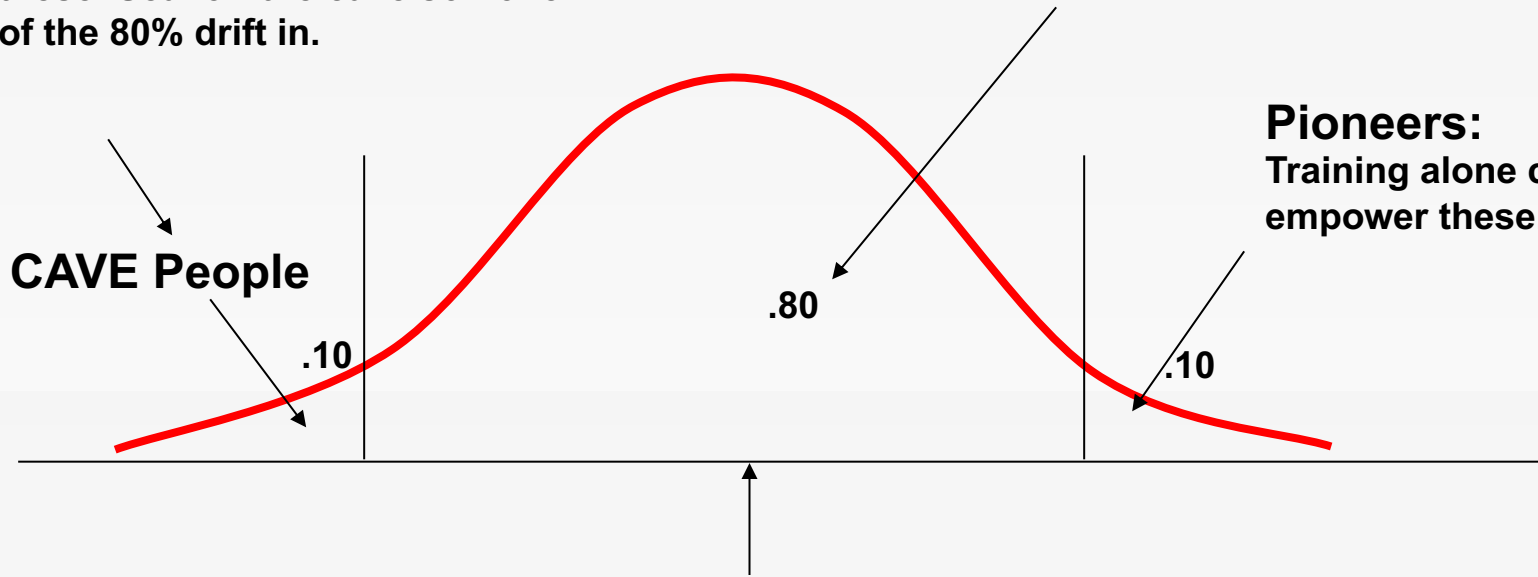
Nothing in the world will empower these. Seal off the cave so none of the 80% drift in.

### Settlers:

Training alone will not empower these.

### Pioneers:

Training alone can empower these.



To move an organization forward, management must act on these, setting/declaring expectations and aligning the rewards and recognition strategy with accountability and expectations.

# SUCCESSFUL CHANGE

## Key Ingredients

---

$$DD + VF + FS > R^*$$

**DD = Degree of Dissatisfaction (Need)**

**VF = Vision for the Future (Vision)**

**FS = First Step (Plan)**

**R = Resistance to Change**

\* *Change Model used with permission from Kelly and Frank Petrock.*

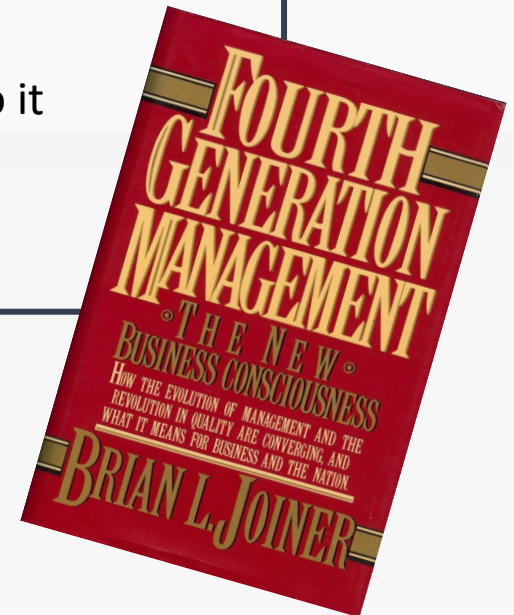
# MANAGEMENT STYLES

## Which is Yours?

---

- Management by Doing - (1<sup>st</sup> Generation)
  - Simplest, most primitive approach
  - Managers do the work themselves
  - Effective way to get things done; limited in capacity

- Management by Directing – (2<sup>nd</sup> Generation)
  - Managers tell workers what to do and how to do it
  - Work performed by employees
  - Maintains strict compliance to standards
  - Close supervision and detailed directions



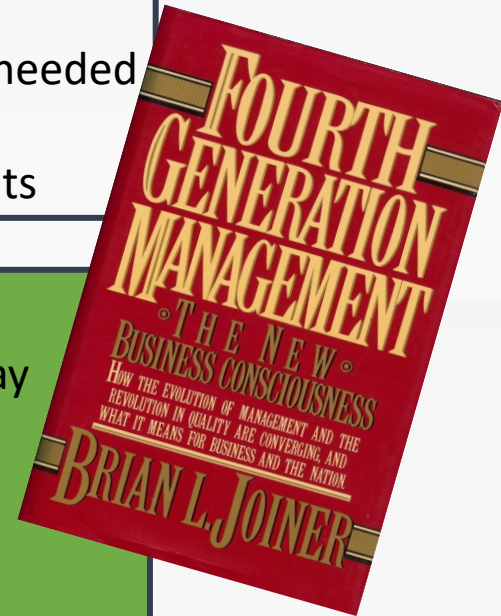
## MANAGEMENT STYLES (cont.)

### Which is Yours?

---

- Management by Results - (3<sup>rd</sup> Generation)
  - Managers tell employees what needs to be accomplished
  - Employees determine how to accomplish the work
  - Focus is on judging and rewarding people on outcomes
  - Workers seldom provided with the knowledge or skills needed to improve the system
  - Expected results achieved at the expense of other results

- 4<sup>th</sup> Generation Management
  - Managers care about results and know that the best way to achieve them is through fundamental improvement
  - Managers become the champions of customer needs
  - Managers become the drivers of real improvement
  - Managers work with process workers as “partners” to develop better methods to achieve better results



# “ADDITIONAL” MANAGER ROLES

## Drive Continuous Improvement

---

- Problem Solver
  - Enlist the “right” people
  - Determine the data to collect
  - Organize for data collection
  - Collect the data
  - Use the appropriate tools to solve the problem
- Motivator
  - By word and example
  - Out of the office and on the floor
  - Give credit where it’s due
  - Talk the language of the process workers



# “ADDITIONAL” MANAGER ROLES (cont.)

## Drive Continuous Improvement

---

- Chief “Change Agent”
  - Perform self-assessment
  - Encourage questions
  - Communicate need, vision, and plan
  - Deploy necessary resources
  - Support change
  - Take time to coach (individuals and teams)
  - Teach Lean principles and methods
  - Be engaged!

# ROADMAP

## Managers Create and Implement

---

- What is the need for Lean?
  - What is the vision for the future?
    - Short-term (1 year)
    - Long-term (1-3 year)
  - What is the plan to achieve the vision?
  - How can our Lean deployment/efforts fail?
  - What can we do to be successful?
- VSM
  - Process Flow
  - Kaizen/RIE
  - Gemba
  - Metrics
  - Prioritization
  - 5S

# IMPROVEMENT REQUIRES BEHAVIORAL CHANGE

## Lean Transforms

---

- Lean Challenges Us To:
  - Think Differently
  - Work Differently
  - Ask Questions and Challenge the Status Quo
  - Make Decisions With Facts and Data
  - Use New Principles, Tools and Methodologies

**When Culture and Need for Change Compete ...  
Real Leaders and Managers are Needed**

## Thank You – For More Information, Please Contact:

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Colorado Springs, CO 80920 USA

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