SUSTAINING THE TRANSFORMATION

After the Fanfare

Katie Hurckes, Lead Worker Lean Leader
Liz Rife, Lead Worker Lean Leader
WHO WE ARE

- Serving adults needing intensive psychiatric treatment for severe mental illness. Providing Hospital level of care
  - 24-hour on-site nursing and psychiatric care
  - credentialed professional and medical staff
  - treatment planning
  - pharmacy, laboratory
  - food and nutritional services
  - vocational and educational services
- Helping patients achieve a level of functioning that allows them to successfully transition back to the community
▪ Square feet – 1,550,000
▪ Employees – 2,300 (approx.)
WHERE WE WERE
THE CHALLENGE BEGINS...

- **2003** - Governor's task force recommends a "sweeping overhaul" of Oregon's mental health system
- **2004** – Senate President Peter Courtney tours hospital
- **2005** – *Oregonian* editorial series
  - Oregon State Hospital
- **2006** – USDOJ begins investigation
- **2008** – USDOJ issues findings
- **2010** – Liberty Healthcare Report
USDOJ FINDINGS (2008)

- Inadequate protection from harm
- Failure to provide adequate mental health care
- Inappropriate use of seclusion and restraint
- Inadequate nursing care
- Inadequate discharge planning and placement in most integrated setting
LIBERTY HEALTH CARE REPORT (2010)

1. Staff Compliance versus Quality Improvement
2. Need for stronger front-line engagement by Cabinet and leadership
3. Need for clear and decisive authority
4. Proliferation of committees and diffusion of leadership authority
5. Health Information Group and Quality Management is disorganized and ineffective
HOW WE MOVED FORWARD
OSH EXCELLENCE PROJECT (2010)

• Assess current cultural norms and identify strategies for culture change
• Establish objectives and measures that define success as a world class psychiatric facility
• Streamline continuous improvement projects
• Assist in developing a model organization and work structure
• Assist in developing a change management plan
• Assist in developing a communication strategy
• Identify business processes and workflow
• Assist in developing a plan for staff training
OREGON STATE HOSPITAL (OSH) PERFORMANCE SYSTEM

Foundation
Our Vision, Mission and Values

Key Goals
Helping us realize our mission and how we achieve success

Core Processes
What we do to achieve our mission and eventually vision

Process Measures
Specific accomplishments that show progress toward the goals

Outcome Measures
Defined specific accomplishments that show progress toward the goals
In July 2011, Greg Roberts, the former OSH Superintendent, created the Office of Performance Improvement (PI).

**PI Mission**

We serve as consultants who inspire and equip people to achieve a culture of Organizational Excellence.

Every Person. Every Place. Every Time.
Office of Performance Improvement

- 1 Director
- 11 FTE Lean Leaders
- 3 FTE Project Managers

All departments have mapped their core processes. Process owners are tracking metrics toward a goal. Continuous Improvement methods are applied (PDCA, problem solving) if goals are not being met. Process owners celebrate & recognize success if goals are met and continue to apply CI methods aimed at perfection. Hospital Leaders and managers are educated and coached to support the evolution of Lean culture. PI team is creating partnerships with other Lean organizations to increase our knowledge and understanding. Performance Improvement team is no longer needed (Continuous Improvement is sustained by process owners and staff).
PI SUPPORT

- Breakthrough Management
- Rapid Process Improvements
- Work Team Initiatives
- Project Management
- Lean Daily Management support
- Executive Coaching
- Value Stream Mapping
- Strategic Planning
- Team Building
- Meeting Facilitation
- Lean Training
Support System

Sponsor

- Executive level support
- Determine project parameters/scope
- Determine acceptance criteria
- Approve change requests

- Be available throughout the event and stop in to support
- Remove barriers to project implementation
- Provide project updates to Cabinet or Clinical Administration Team
**Lean Implementation – Oregon State Hospital**

**BACKGROUND**
- Oregon Department of Human Services launched the Transformation Initiative. OSH selected 2, full-time Lean Leaders that received training from Lean experts and completed work on several successful Lean events.

**CURRENT STATE**
- **PROJECTS**
  - Temporary improvement efforts that require cross-functional teams
  - Charter idea
  - Score project
  - Approval/prioritization by Cabinet
  - Walk the process
  - Event (6S/W/IFT/PVS)
  - Report out to Cabinet
- **TRAINING**
  - Hospital Staff Lean Overview (HLSO)
    - Offered bi-monthly
  - Optimization Training – Applying Lean tools to lean processes. Training teams on process thinking, standard work, measurement, 5S, value, coaching, visual controls and Leadership
- **COMMUNICATION**
  - Monthly meetings with Cabinet to present update on projects, LDMS, and prioritize emerging projects
  - Monthly Spotlight on Excellence Publication

**RESULTS**
- **PROJECTS**
  - 208 projects/consultations completed
  - 3 breakthrough initiatives in progress
  - 50 projects in progress
  - 52 consultations in progress

**OPPORTUNITIES/STRENGTHS**
- Projects that align with value streams and hospital goals are prioritized
- Process ownership and Sponsor support is solid prior to project launch to ensure success
- Lean Teams are achieving and sustaining excellent results
- Lean events are now seen as the standard method to solve problems and create positive change
- Cabinet Sponsors support project teams

**COMMUNICATION**
- Monthly Cabinet meetings provide support and direction for Performance Improvement Initiatives
  - Spotlight on Excellence is well received and provides recognition for Lean progress and timely information
  - Performance Improvement intranet provides useful information and is used by staff at all levels of the hospital

**LEON DAILY MANAGEMENT SYSTEM (LDMS)**
- Out of 90 LDMS areas (10/2018):
  - 92% have an updated PDV
  - 64% have submitted at least 1 CI Sheet/month
  - 92% huddle every day
  - 97% have an updated Metrics
  - Metrics to check process performance
  - Metrics are defined at unit level

**EXECUTION**
- **Approval/prioritization by Cabinet**
  - 30 day Report out to Cabinet
  - 60 day Report out to Cabinet
  - 90 day Report out to Cabinet
- **Execution of implementation plan**
  - Monthly meetings with Cabinet to present update on projects, LDMS, and prioritize emerging projects
  - Monthly Spotlight on Excellence Publication
  - Open dialogue with unions

**LEADERSHIP FOCUS**
- **PET**
  - Multiple PET members walking with a Lean Leader each week
  - Multiple PET members walking with Lean Leaders
  - Two Cabinet members are assigned to each Program Executive Team (PET)
- **GEMBA WALKS**
  - Cabinet members walking the process alongside Lean Leaders in different units and PETs
  - Cabinet members work with Lean Leaders to determine Leadership standard work

**COMMUNICATION**
- Monthly Cabinet meetings provide support and follow up on CI sheet completion

**LEAN DAILY MANAGEMENT SYSTEM**
- Metrics to check process performance
- Metrics are defined at unit level

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OSH Lean Implementation Results

Projects
- 292 completed
- 18 projects in progress
- 49 consultations in progress

Lean Daily Management System
- 92% of 90 LDMS areas meet all LDMS standards
- 7,107 Continuous Improvement sheets submitted

Training
- 2011-2018 Hospital Staff Lean Overview Training
  - 1525 participants

Communication
- 77 Spotlight articles
- 12 articles in Recovery Times
- Monthly Superintendent Cabinet updates
- 9 Lean Open House Events
- 15,324 visitors to OSH PI Lean Intranet Page
FOUNDATIONAL LEGACY
2018 Joint Commission Survey
READEINESS

REEVALUATION
- Reevaluate “in house” survey process
- Results of reevaluation uncover more deficiencies (19 to 147)

CORRECTIONS
- Root Cause Analysis
- Assign Sponsor
- Assign Owner
- Corrective Action Plan

SITE VISIT PREP
- Communication plan
- Survey Operation Support (SOS) Center
- Practice Mock Visit
- Response Plan
JOINT COMMISSION SURVEY QUOTES

- “Top 5% of hospitals in the nation for environment of care and life safety issues”
- “Against all hospitals, including academic medical centers, this is a very special place”
- “Lean is built into the fabric of everything you do here”
- “Leading the country in medication management”
- “Magnificent effort to replicate real life; patients are given plenty of choices”
- “We’ve never surveyed a hospital that has such a robust performance improvement and data management system in place”
- “We’re having trouble finding B tags; we’re going to have trouble explaining that to headquarters”
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<thead>
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<tbody>
<tr>
<td>1 EC.02.02.01 EP 11</td>
<td></td>
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<td>For managing hazardous materials and waste, the hospital has the permits, plans, manifests, and safety data sheets.</td>
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<td>2 EC.02.02.03 EP 03</td>
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<td>When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of false alarm signal and simulation of emergency emergency conditions. Note: 1. When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use alternative methods to notify staff instead of activating audible devices.</td>
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<td>3 EC.02.05.05 EP 02</td>
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<td>Every 6 months, the hospital tests valve type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2015, Part 4.4.5. Note 2: Mechanical water flow devices (including, but not limited to, liquid entrainment devices) must be tested no less often than required by the local authority having jurisdiction.</td>
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<td>4 EC.02.05.05 EP 19</td>
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<td>Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2015, Part 4.4.5. Note 2: Mechanical smoke detectors must be tested no less often than required by the local authority having jurisdiction.</td>
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<td>5 EC.02.05.05 EP 09</td>
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<td>The hospital tests utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit</td>
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<td>6 EC.02.05.05 EP 08</td>
<td></td>
<td></td>
<td>The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012, Chapters 6 and 9) Note: For hospitals that use Joint Commission accreditation for deemed</td>
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</table>

**FINDINGS**
- 31 Citations
  - 1 citation with required revisit in 60 days

**RESPONSE PLAN**
- Assign Sponsor
- Assign Owner
- Assign Lean Leader
- Gather team members
- Utilize lean methodology for any process changes
- Correct citations

**PDCA**
- Quality Council
HOW WE SUSTAIN AND CONTINUE
Lean Daily Management System

Primary Visual Display Boards

Routine Huddles

Continuous Improvement (CI) System
PERFORMANCE SYSTEM INFRASTRUCTURE

Superintendent’s Cabinet

Performance System Steering Committee

Quarterly Performance Review

Change Recommendations

Performance Updates

Process & Measure Owners

Program Executive Teams

Committee Structure

Clinical Executives

Performance System Team Support
**Performance System Functional Roles**

**Steering Committee**
- PS Process oversight
- PS Process recommendations
- Communication

**Superintendent’s Cabinet**
- Develop performance strategies
- Sponsor Breakthroughs/Projects
- Break through barriers
- Champion

**Program Directors**
- Define measures/processes
- Problem solve
- Ensure action
- Communication
- Champion

**Clinical Advisory Team**
- SME Clinical relevance
- Champion
- Communication

**Measure Owners**
- Problem solve
- Take action
- Accountable
- Make recommendations
- Identify risks/barriers
- Communication
QUARTERLY PERFORMANCE REVIEWS (QPRs)

“Quarterly Performance Reviews (QPRs) create the discipline to review status of the routine work (Fundamentals) and initiatives (Breakthroughs), and to drive problem solving as needed to achieve the goals of the organization”

PURPOSE:

• Frequent reminder of what is most important to us
• Performance becomes visible in a safe environment, values in action
• Enables people involved to share accomplishments
• Sets the stage for addressing problems (not solving it during the QPR)
• Keeps everyone focused on results & outcomes, not just activity
• Creates the heartbeat for “Plan – Do – Check – Act”
• Helps us assess and pursue organizational health.. “taking our vital signs”
QUARTERLY PERFORMANCE REVIEWS (QPRs)

ATTENDEES:
- Hosted by Data and Analysis
- Superintendent’s Cabinet
- Program Executive Teams
- Measure Owners
- Lean Leaders
- Performance System Team
- Treatment Mall
- Clinical Executives
- Guests
**MEASURES IN THE RED**

<table>
<thead>
<tr>
<th>Correlation to the Fundamentals</th>
<th>What we are measuring</th>
<th>How we define the measure is</th>
<th>Where the data comes from</th>
<th>Ranges of possible performance</th>
<th>Desired level of performance for the planning cycle</th>
<th>Trending Results</th>
</tr>
</thead>
</table>
MEASURE ACTION PLAN (MAP)

Measure: Patient Participation
Measure Owner: Heidi Scott/Harbors PET
Date Problem Identified: 6/22/2016
Target Date for sufficiency: 6/29/2018

Problem Statement:
Harbors is not meeting the identified goals for Patient Participation - 0% of attendees are receiving less than 5 hours of treatment. We have had steady improvements.

Root Cause:
System: the current system does not direct the treatment (treatment is not attended to directly, but rather "what we offer" directed); Process: staff aren’t regularly capturing on-unit active treatment; Culture: patient participation owned by both the medical and mental staff. Program: Continuous turnover of attenders; high acuity. When patients improve, they are transferred or discharged.

Target Goal:
All patients will receive at least 5 hours of treatment each week.

Dashboard:
- Action Plan
  - #actions: 15
  - #completed: 8
  - #on schedule: 3
  - #due soon: 0
  - #late: 4

Measure Information:
- Quarter/Year: Q1/17, Q2/17, Q3/17, Q4/17
- Target Goal: 0%, 0%, 0%, 0%
- Actual: 30%, 20%, 13%
- Indicator for trend:

Action Plan:
- Action: Aid and Assist Breakthrough - A3 developed
  - Responsible Staff: A. Cornell, H. Scott
  - Due Date: 1/1/2017
  - Action Complete: X
  - Days Remaining: 0
  - Status Comments: Finalized product awaiting project admin approval; definitions complete

- Action: Aid and Assist Breakthrough - Define Barriers
  - Responsible Staff: H. Scott
  - Due Date: 11/15/2017
  - Action Complete: X
  - Days Remaining: 0
  - Status Comments: Not started

- Action: Aid and Assist Breakthrough - Refined assessment process; Develop new processes as appropriate
  - Responsible Staff: A. Cornell
  - Due Date: 3/30/2018
  - Action Complete: X
  - Days Remaining: 15
  - Status Comments: Finalized product awaiting project admin approval; definitions complete

- Action: Aid and Assist Breakthrough - Treatment Care Plan interventions based upon assessments
  - Responsible Staff: A. Cornell, H. Scott
  - Due Date: 6/30/2018
  - Action Complete: 81
  - Days Remaining: 15
  - Status Comments: Estimated date; Not started

- Action: Bimonthly unit to PET report during PET rounds - problem solving issues around patients not participating
  - Responsible Staff: Heidi Scott
  - Due Date: 7/31/2017
  - Action Complete: X
  - Days Remaining: 0
  - Status Comments: Not started

- Action: Develop Wellness Recovery Teams
  - Responsible Staff: Stacy Castor
  - Due Date: 3/31/2017
  - Action Complete: X
  - Days Remaining: 0
  - Status Comments: Not started
Genchi Gembutsu
Engage
Muda, Mura, Muri
Be Respectful
Analyze
GEMBA PROCESS

Daily walks
- All questions are curious and phrased about the “why”

Focused walks
- Same specific questions from each member to the staff
- All questions are curious and phrased about the “why”
When leadership is out and about, it’s empowering to the people to want to do better work”
Mental Health Technician

“It makes us feel heard, like we have a voice”
Registered Nurse

“I like building relationships and letting people know who I am”
Chief Nursing Officer

“I love being able to problem solve in the moment and help someone”
Director of Treatment Services

“Great exposure to people I don’t otherwise see.”
Superintendent

“If you’re an executive leader and not out there on the front line, seeing if what you’re trying to implement is being heard, there is no way you are going to know if it’s working or not”
Deputy Superintendent

“I appreciated just a show of support. Offering guidance for collaboration as a resource.”
Psychologist
## Universal Schedule

### Standard Weekly Schedule

<table>
<thead>
<tr>
<th>Time / period</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9</td>
<td>Program/Mall Huddles &amp; Unit Morning Report</td>
<td>Program/Mall Huddles &amp; Unit Morning Report</td>
<td>Program/Mall Huddles &amp; Unit Morning Report</td>
<td>Program/Mall Huddles &amp; Unit Morning Report</td>
<td>Program/Mall Huddles &amp; Unit Morning Report</td>
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<tr>
<td>9-10</td>
<td>Clinical Work</td>
<td>Clinical Work</td>
<td>Clinical Work</td>
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<tr>
<td>10-11</td>
<td>Clinical Work</td>
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<td>Clinical Work</td>
</tr>
<tr>
<td>11-12</td>
<td>PET</td>
<td>Clinical Work</td>
<td>Clinical Work</td>
<td>Clinical Work</td>
<td>Clinical Work</td>
</tr>
<tr>
<td>12-1</td>
<td>Lunch Hour</td>
<td>Lunch Hour</td>
<td>Lunch Hour</td>
<td>Lunch Hour</td>
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</tr>
<tr>
<td>1-2</td>
<td>Clinical Work</td>
<td>PET</td>
<td>PET</td>
<td>PET</td>
<td>Open for supervision/meetings/work/disciplines</td>
</tr>
<tr>
<td>2-3</td>
<td>Open for supervision/meetings/work/disciplines</td>
<td>PET</td>
<td>PET</td>
<td>PET</td>
<td>Open for supervision/meetings/work/disciplines</td>
</tr>
<tr>
<td>3-4</td>
<td>Open for supervision/meetings/work/disciplines</td>
<td>Clinical Discipline Department Meetings</td>
<td>Open for supervision/meetings/work/disciplines</td>
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<tr>
<td>4-5</td>
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Quality Management - Office of Performance Improvement