OREGON STATE HOSPITAL

HOPE • SAFETY • RECOVERY

Office of Performance Improvement

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TRANSFORMATION AND SUSTAINMENT

"Out of the Ashes"

Kimberly Ross, Director of Performance Improvement
Dan Mussatti, Lean Leader

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Where we are now

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- 2017-19 budget – $547 million
- Square feet – 1,550,000

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- Position authority – 2,225

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- Average census – 619

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- Capacity – 33 units (756 beds)
- Operating – 28 units (653 beds)

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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

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WHO WE SERVE

Guilty except for insanity (GEI)

- People who committed a crime related to their mental illness. Depending on the nature of their crime, patients are under the jurisdiction of:
  - Psychiatric Security Review Board (PSRB, Tier 1)
  - Oregon State Hospital Review Panel (SHRP, Tier 2)

Civil commitment

- Patients civilly committed or voluntarily committed by a guardian
- Those who are imminently dangerous to themselves or others, or who are unable to provide for their own basic needs due to their mental illness

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OSH KEY GOALS

- Recruiting and engaging outstanding staff
- Ensuring safety in our care environments
- Improving our processes and performance
- Employing information technology effectively
- Excelling in recovery-oriented care and treatment for the people we serve

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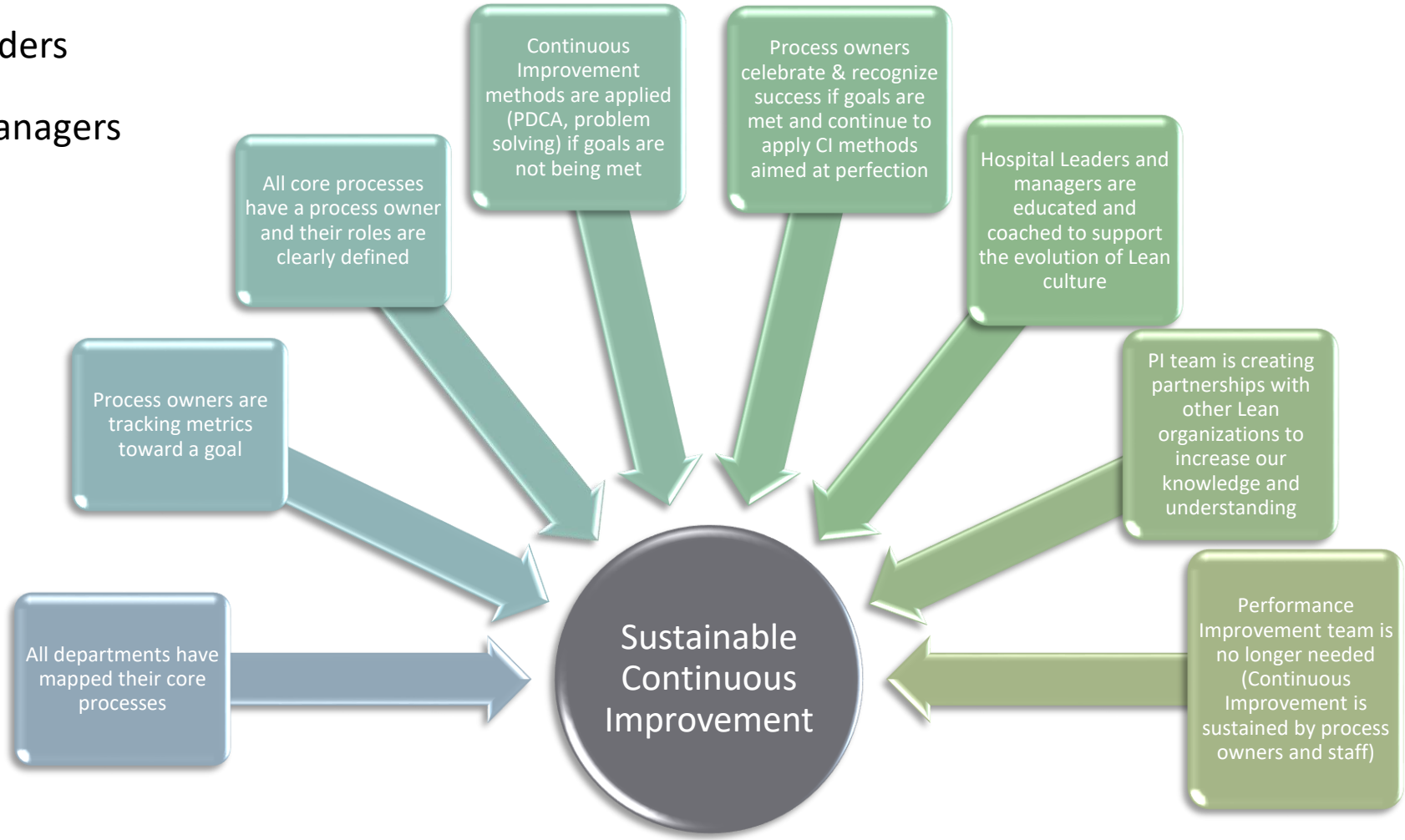
Office of Performance Improvement

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



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Lean Leader Assignments

Shaunia Scales

541-680-8438

Junction City PET: RN Leadership, Mountain 1, Mountain 2, Mountain 3, Forest 2; JC Psychology, JC Psychiatry, JC Social Work, JC Treatment Services, JC Food Services, JC Warehouse, JC Facilities, JC Operations Admin, JC Environmental Services, JC Security Team, JC Pharmacy, River Med Clinic, JC Business Services.

Dan Mussatti

503-269-4524

Bridges/Pathways PET: RN Leadership, Bridge 1, Bridge 2, Bridge 3, Bird 1, Bird 2, Bird 3; Psychology Management, Treatment Services Leadership, Treatment Malls (Crossroads, Archways, Bridges/Pathways, Springs)

Steve Unwin

503-753-0326

Operations Management, Food Services, Nutrition Services, Environmental Services, Facilities/Garage, Facilities Leadership , Safety and Emergency Management, Warehouse, Security Team

Tony Guillen

503-884-9758

Springs PET: RN Leadership, Butterfly 1, Butterfly 2, Butterfly 3; Forensic Evaluation Services, Legal Affairs, Admissions, Health Information, Consumer and Family Services, Hospital Relations

Camille Clark Wallin

503-385-7781

Data and Analysis, Standards and Compliance, Technology Services, Performance Improvement, QM Administration, EDD, Human Resources

Nate Gillard

503-884-3389

Psychology, RSD Management, Voc. Services-Client Employment, Social Work Management

Heide Knight

503-381-1914

Crossroads PET: RN Leadership, Flower 1, Flower 2, Leaf 2, Leaf 3; Pharmacy, Dental Clinic, Laboratory, Medical Clinic, Infection Control

Liz Rife

503-269-6056

Archways PET: RN Leadership, Tree 1, Tree 2, Tree 3, Leaf 1, Flowers 3

Katie Hurckes

503-269-3223

Harbors PET: RN Leadership, Lighthouse 1, Lighthouse 2, Lighthouse 3, Anchor 1, Anchor 2, Anchor 3

Bill Bahl

503-756-7612

Patient Resource Services, Accounting Office, Benefit Coordinators, Business Analysts, Central Timekeeping Office

Larry Dompierre

503-884-3441

TBD

Director

Kimberly Ross

Cell: 503-884-5850

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PI Support

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

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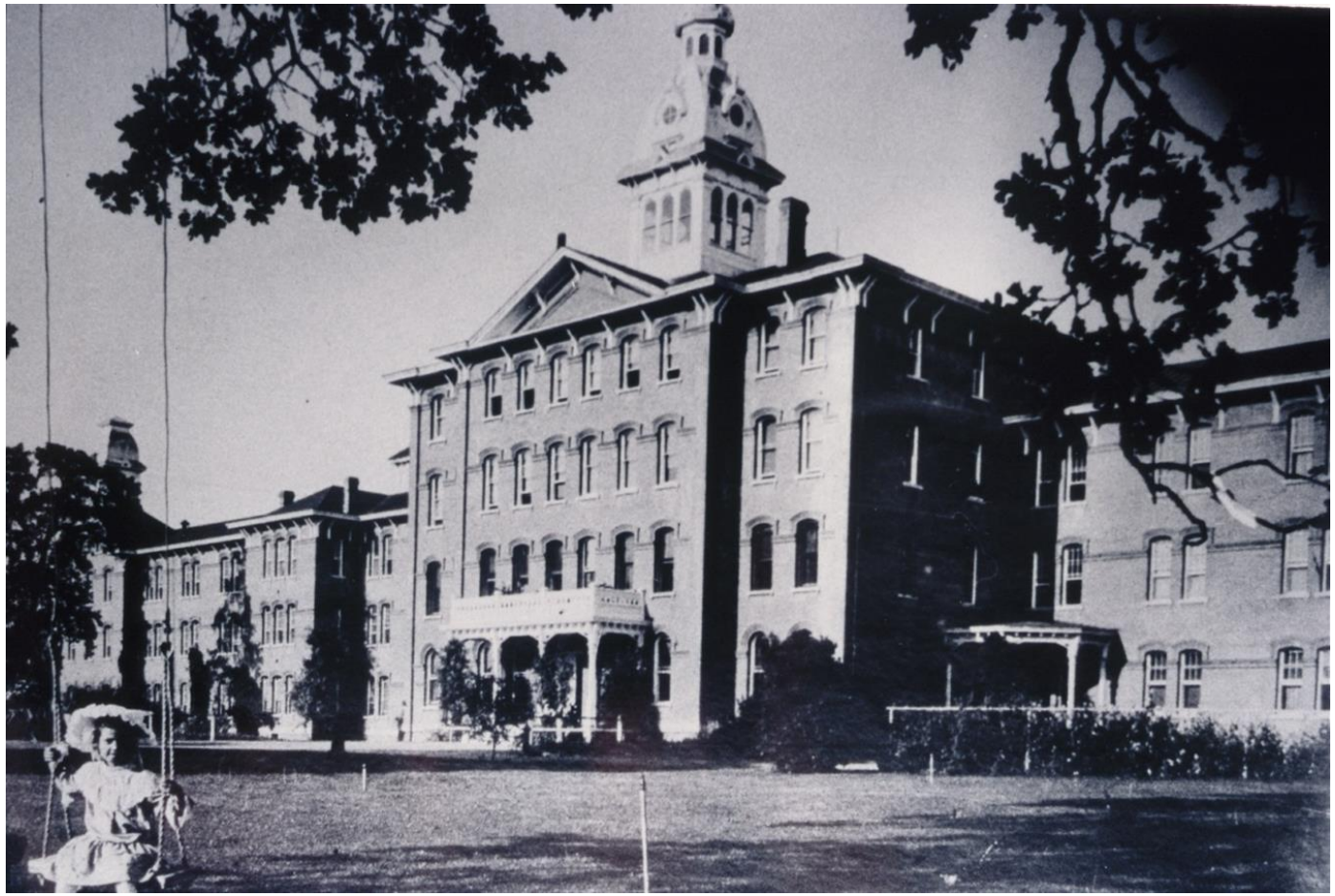
WHERE WE WERE



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THE CHALLENGE BEGINS...

- **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

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IN THE NEWS

- Lawmakers Question Agency's Efforts to Improve Safety
- State legislators Questioning Conditions at Oregon State Hospital
- "The Cuckoo's Nest Needs Rebuilding" (*Letter to Editor*)
- The Hospital That Won't Let People Go
- Neglect Comes to Roost at State hospital
- Governor hires judge to Fix Hospital
- Feds Slam State hospital Safety

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IN THE NEWS

- **December 2003**: Governor's task force recommends a "sweeping overhaul" of Oregon's mental health system --and more money.

- **January 2005**: The Oregonian exposes the storage of thousands of cremated patients' ashes in corroding canisters and the need to replace the 123-year-old J Building, likely to collapse in an earthquake

- **May 2005**: Consultants conclude the buildings are decrepit, hold too many patients and would likely collapse in an earthquake.

- **December 2005**: Class-action lawsuit alleging "dangerous conditions" at the hospital is settled after legislators agree to spend an extra $9.2 million to hire workers and improve conditions.

- **January 2008**: U.S. Department of Justice says hospital care and conditions threaten patients' safety and constitutional rights.

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USDOJ FINDINGS (2008)

A. Inadequate Protection from Harm
   1. Inadequate Incident Management
   2. Inadequate Quality Management
   3. Failure to Provide a Safe Living Environment

B. Failure to Provide Adequate Mental Health Care
   1. Inadequate Psychiatric Assessment and Diagnoses
   2. Inadequate Behavioral Management Services
   3. Inadequate Medication Management and Monitoring

C. Inappropriate Use of Seclusion and Restraint
   1. Planned Seclusion and Restraint
   2. Use of S&R as Informal Alternatives to Treatment & as Punishment
   3. Use of Ad Hoc Restrictive Measures
   4. Failure to Assess Patients in Seclusion and Restraint

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USDOJ FINDINGS (2008) CONT.

D. Inadequate Nursing Care
   1. Staffing
   2. Failure to Provide Basic Care
   3. Failure to Provide Feedback to Treatment Teams
   4. Medication Administration
   5. Infection Control

E. Inadequate Discharge Planning and Placement in Most Integrated Setting

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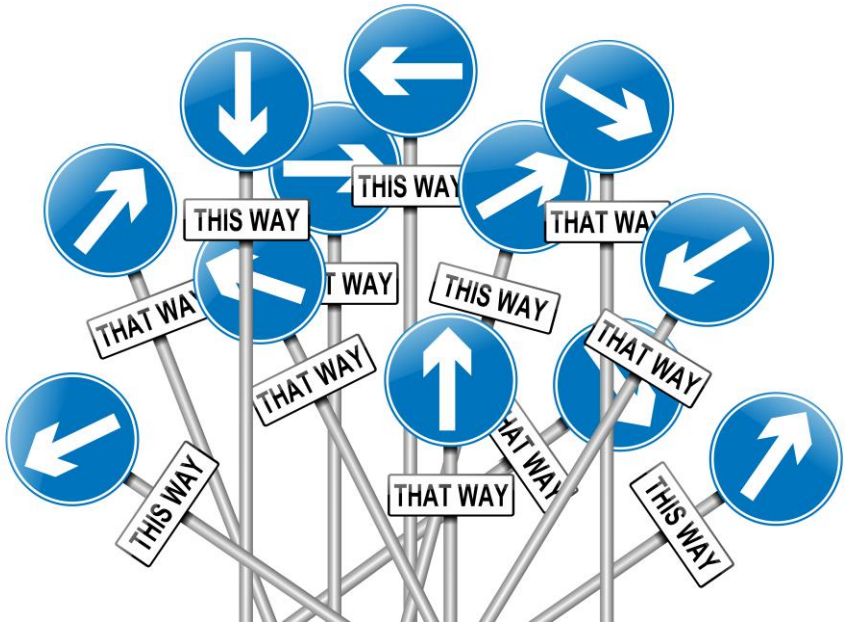
LIBERTY HEALTH CARE REPORT (2010)

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 got here

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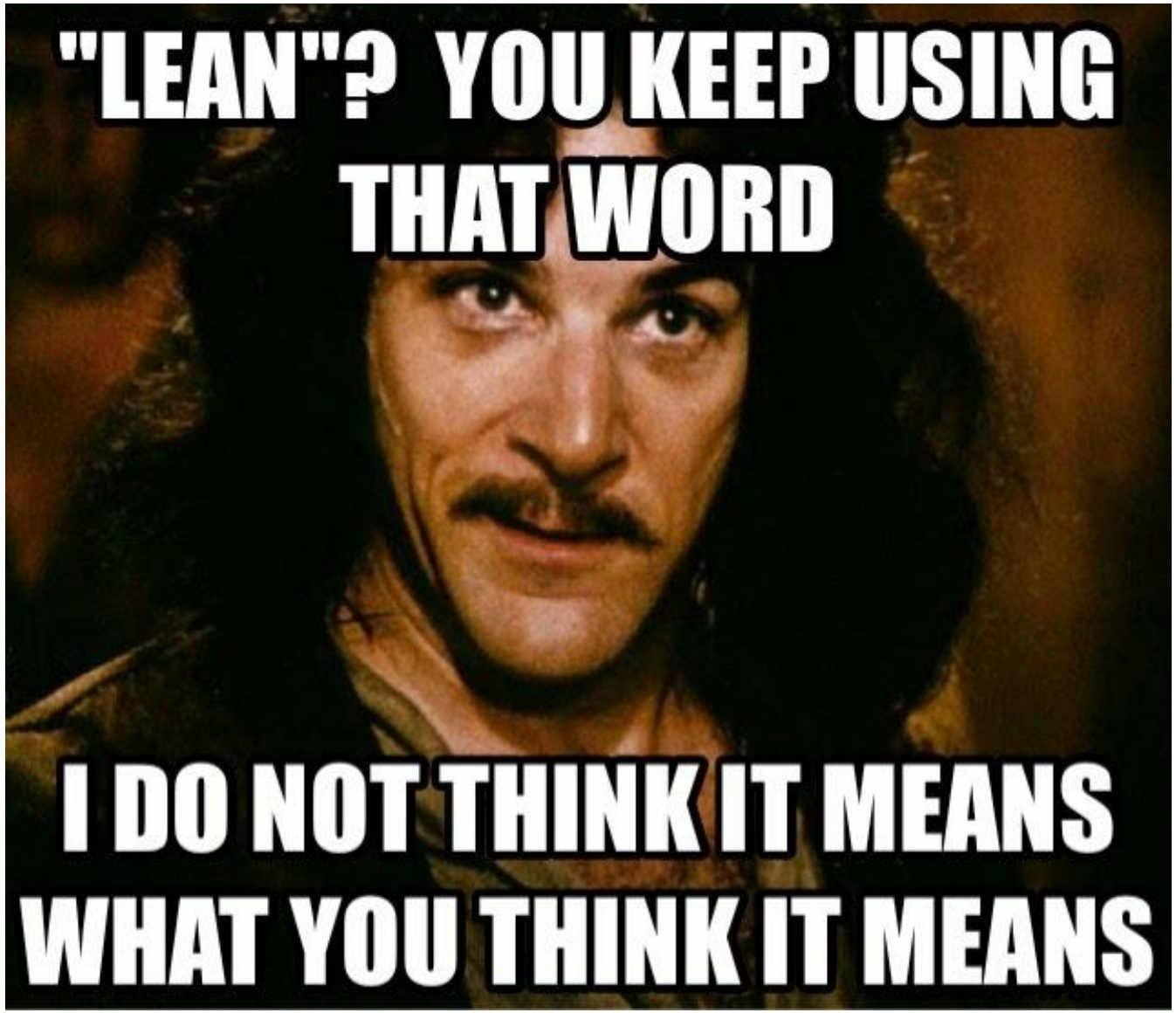

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LEAN IMPLEMENTATION

- **2008 –** Oregon DHS launched the Transformation Initiative. OSH selected 2 Lean Leaders that received training from Lean experts and completed work on several successful Lean events.
- **2010 –** Greg Roberts, hired as superintendent
- **2010 –** Kauffman Global- Launch of Excellence Project
- **2011 –** OSH created the Office of Performance Improvement- Investment of 7 FTE Lean Leaders
- **2013 –** Mass Ingenuity- Launch of Performance System
- **2013 –** Investment of 5 additional FTE Lean Leaders
- **2017 –** Investment of 3 additional FTE PI Project Managers

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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

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In July 2011, Greg Roberts, the OSH Superintendent, created the OSH 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.

VISITOR APPLICATION RPI

Before

- 67 process steps
- 17 decision points
- 20 handoffs
- Up to 43 day process

After

- 38 process steps
- 7 decision points
- 9 handoffs
- 3 day max process

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MD Recruitment RPI

Before:

- 53 Process Steps
- Recruitment Duration up to 381 Days

After

- 28 Process Steps Recruitment
- Duration no more than 25 Days

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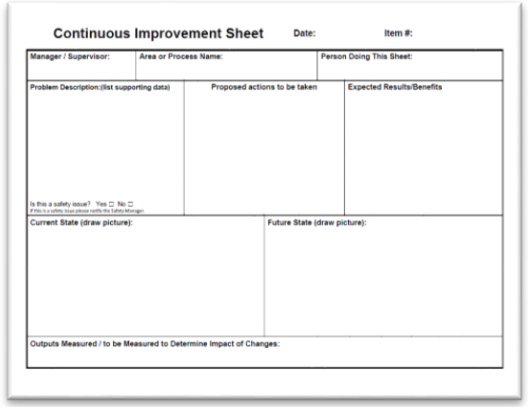
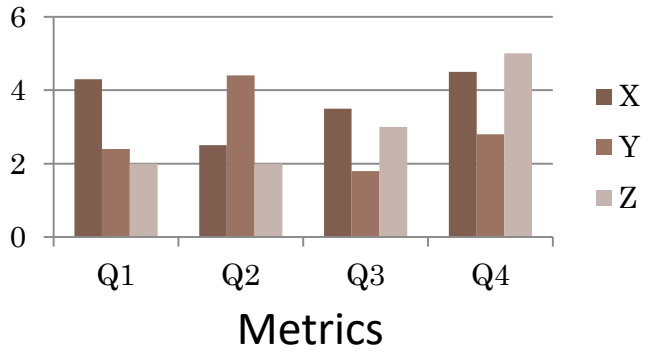
Lean Daily Management System

Routine Huddles



Continuous Improvement (CI) System



Primary Visual Display Boards

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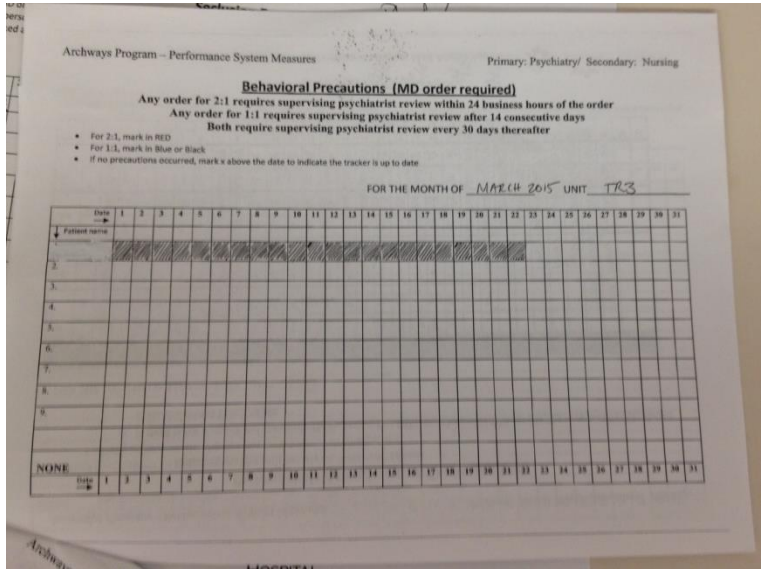
METRICS



Archways Program – Performance System Measures

Primary: Psychiatry/ Secondary: Nursing

Behavioral Precautions (MD order required)

Any order for 2:1 requires supervising psychiatrist review within 24 business hours of the order
Any order for 1:1 requires supervising psychiatrist review after 14 consecutive days
Both require supervising psychiatrist review every 30 days thereafter

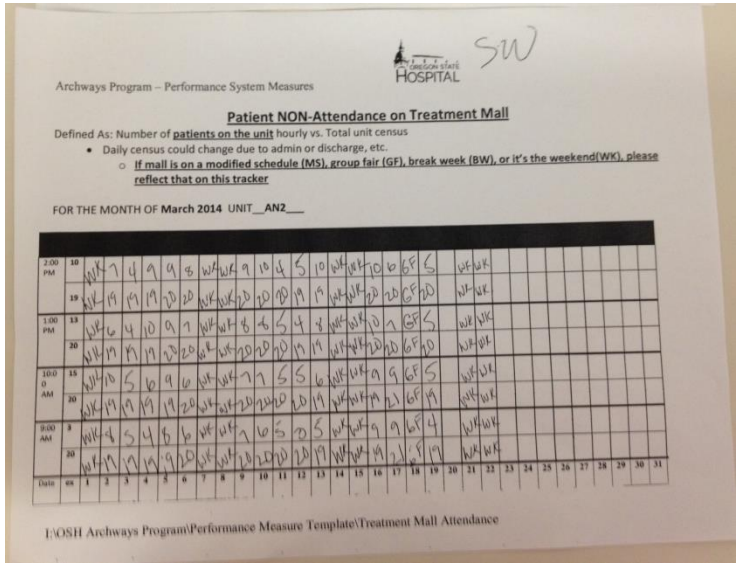
- For 2:1, mark in RED
- For 1:1, mark in Blue or Black
- If no precautions occurred, mark x above the date to indicate the tracker is up to date

FOR THE MONTH OF MARCH 2015 UNIT TR3

Date → 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Patient name ↓

NONE



Archways Program – Performance System Measures

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Patient NON-Attendance on Treatment Mall

Defined As: Number of **patients on the unit** hourly vs. Total unit census

- Daily census could change due to admin or discharge, etc.
  - **If mall is on a modified schedule (MS), group fair (GF), break week (BW), or it's the weekend(WK), please reflect that on this tracker**

FOR THE MONTH OF **March 2014** UNIT__AN2___

2:00 PM 10 19
1:00 PM 13 20
10:00 AM 15 20
9:00 AM 3 20

Date 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

I:\OSH Archways Program\Performance Measure Template\Treatment Mall Attendance

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CONTINUOUS IMPROVEMENT (CI) SYSTEM

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CI SHEET:

Continuous Improvement Sheet		Date: Item #
Person Doing the CI Sheet *Name:* *Contact Info.*	**Area or Process Name**	**Manager / Supervisor** *Name:* *Contact Info.*
Problem Description (list supporting data) Is this a safety issue? Yes ☐ No ☐ If yes, please notify the Safety Manager	**Proposed actions to be taken**	**Expected Results/Benefits**
Current State (draw picture)	**Future State (draw picture)**	
This CI sheet will be successful if:		

Quality Management – Office of Performance Improvement

'Informing the Pursuit of Excellence'

7/2017

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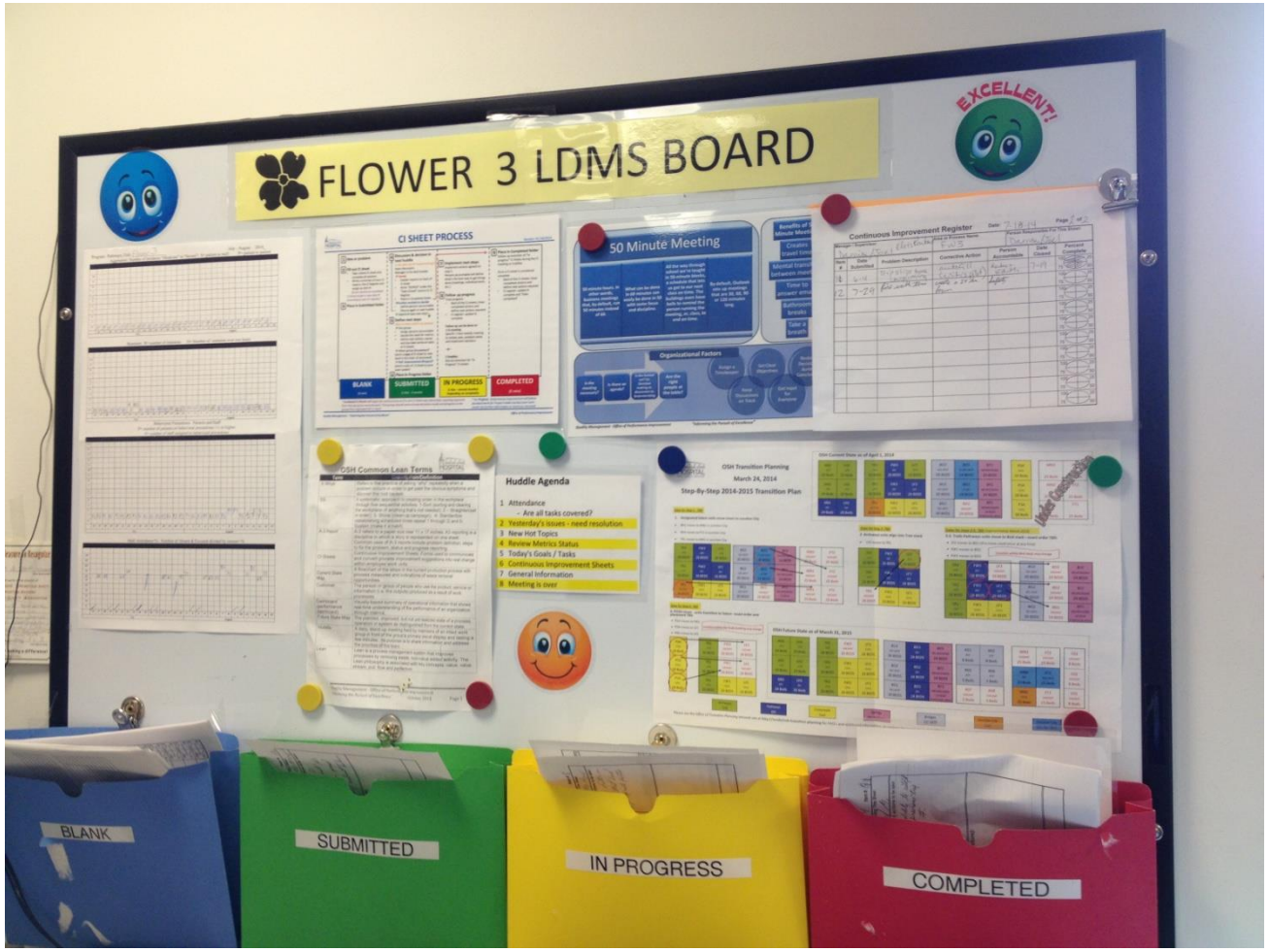
PRIMARY VISUAL DISPLAY (PVD)



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GEMBA

Lean Implementation – Oregon State Hospital

BACKGROUND

2008 - 2009
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

2010
OSH contracted with Kaufman-Global to transform the OSH culture. Contract included Lean training for managers and the completion of 5 Lean events

2011
OSH created the Office of Performance Improvement – An investment of 7 FTE Lean Leaders

2012
In 2012, multiple Lean events were launched and completed. Lean Leaders also provided support to 71 LDMS areas across OSH and delivered training

2013 - 2017
11 Lean Leaders are currently supporting Program Executive Teams (PETS), Value Stream Mapping at the program level, leading Lean projects, supporting 92 LDMS areas, delivering Lean training , and providing executive/management consultation

CURRENT STATE

PROJECTS
Temporary improvement efforts that require cross-functional teams

INITIATION & PLANNING
- Charter idea
- Score project
- Approval/prioritization by Cabinet
- Walk the process

EXECUTION
- Event (RPI/WTI/PIT)
- Report out to Cabinet
- Execution of implementation plan

MONITOR & CONTROL
- 30 day Report out to Cabinet
- 60 day Report out to Cabinet
- 90 day Report out to Cabinet

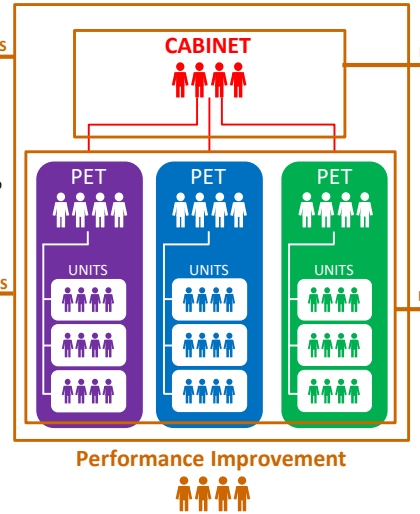
HOSPITAL –WIDE FOCUS

TRAINING
Hospital Staff Lean Overview (HSLO)
Offered bi-monthly

Optimization Training – Applying Lean tools to team processes. Training teams on process thinking, standard work, measurement, 5S, value, coaching, visual controls and Leadership

HOSPITAL –WIDE FOCUS

COMMUNICATION
- Monthly meetings with Cabinet to present update on projects, LDMS, and prioritize emerging projects
- Monthly Spotlight on Excellence Publication
- Open dialogue with unions



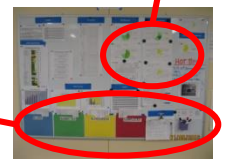
LEADERSHIP FOCUS

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

FRONT LINE FOCUS

LEAN DAILY MANAGEMENT SYSTEM (LDMS ®)
Primary visual display board is the foundation to follow Plan Do Check Act (PDCA)
Lean Leaders deployed to 88 areas (units & operational)

Metrics to check process performance
Metrics are defined at unit level



Continuous Improvement Sheets (CI sheets)
Improvement proposals to increase process performance at unit level

Huddle every day with the group to check metrics and follow up on CI sheet completion

RESULTS

PROJECTS
185 projects/consultations completed
18 projects in progress
31 projects classified as consultation in progress

TRAINING
2011-2017 Hospital Staff Lean Overview Training
- 1525 participants

2013 -2017 Module and Lean Optimization Training
- 1023 participants

COMMUNICATION
- 73 Spotlight articles
- 12 articles in Recovery Times
- PI Team meets with Cabinet monthly
- 9 Lean Open House Events
- Bi-weekly meeting with unions
- 15,324 visitors to OSH PI Lean Intranet Page

GEMBA WALKS
Cabinet members walking with a Lean Leader on average per month

Multiple PET members walking with a Lean Leader each week

LEAN DAILY MANAGEMENT SYSTEM
Out of 92 LDMS areas:
- 93% have an updated PVD
- 95% huddle every day
- 95% have updated Metrics
- 78% have submitted at least 1 CI Sheet/month

92% of LDMS areas meet all LDMS standards
5,680 Continuous Improvement Sheets submitted

OPPORTUNITIES/STRENGTHS

PROJECTS
- 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 projects 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

TRAINING
- Offer multiple web-based training opportunities
- Offer Lean training tailored to managers
- People who complete training are interested and enthusiastic
- Module training provides a tailored approach that fits unit needs
- Optimization training provides customer with standard work and control measures

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

GEMBA WALKS
- Gemba walks provide an opportunity for Leadership to build relationships with front line staff, discover improvement opportunities, provide coaching to managers and show support for Lean Leaders
- Program Executive Teams actively participate in Gemba walks each week
- Cabinet members actively sponsor Program Executive Teams

LDMS
- Unit metrics are aligned with Program Executive Teams within each Value Stream
- LDMS Primary Visual Display (PVD) boards provide the platform for cascading organizational measures
- LDMS is sustaining in the majority of the hospital with Lean Leader support
- The number of CI sheets continues to increase monthly
- LDMS and Continuous Improvement sheets are providing a real voice for front line staff

9/25/2017

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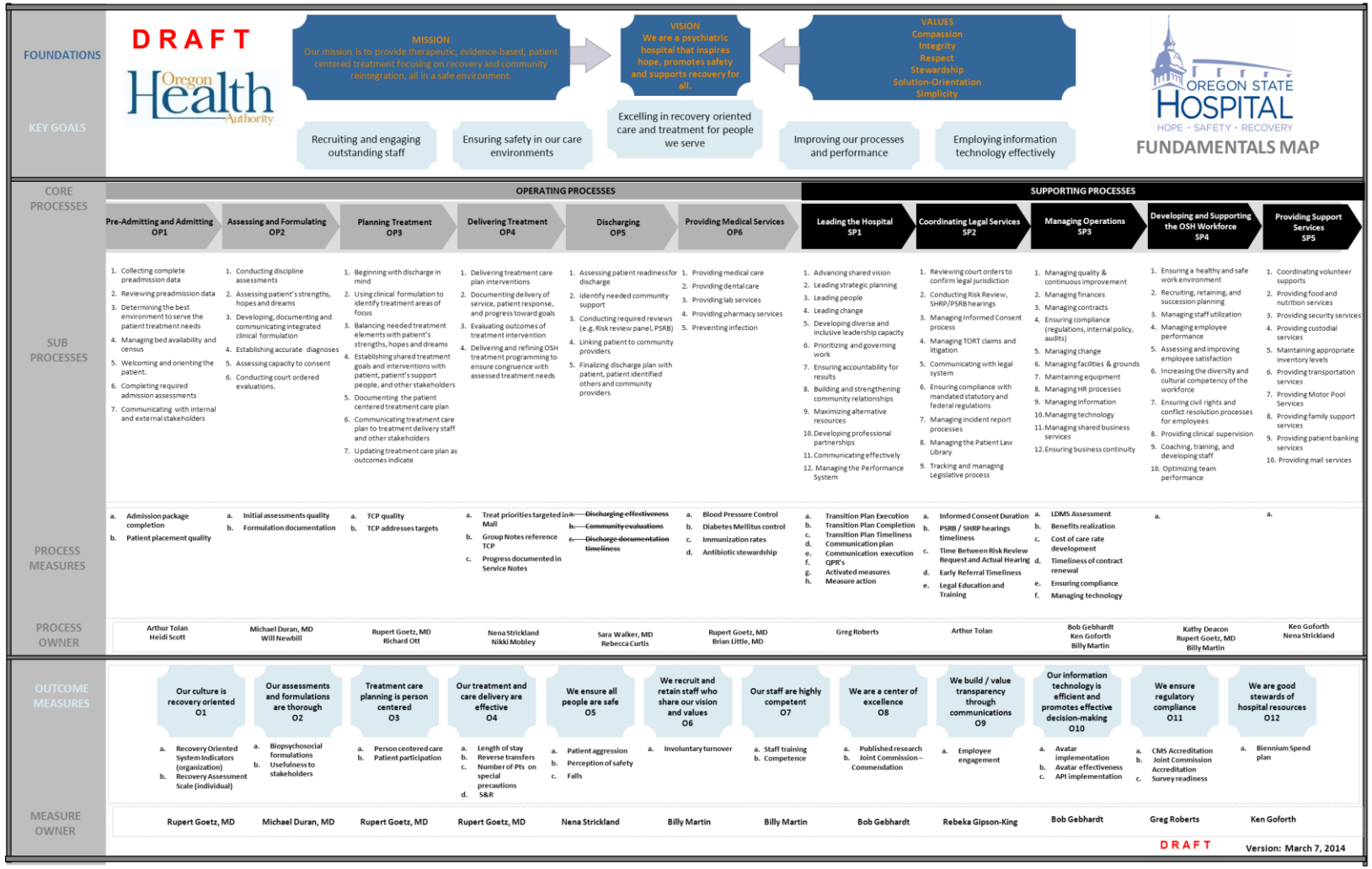
PERFORMANCE SYSTEM (2013)
FUNDAMENTALS MAP



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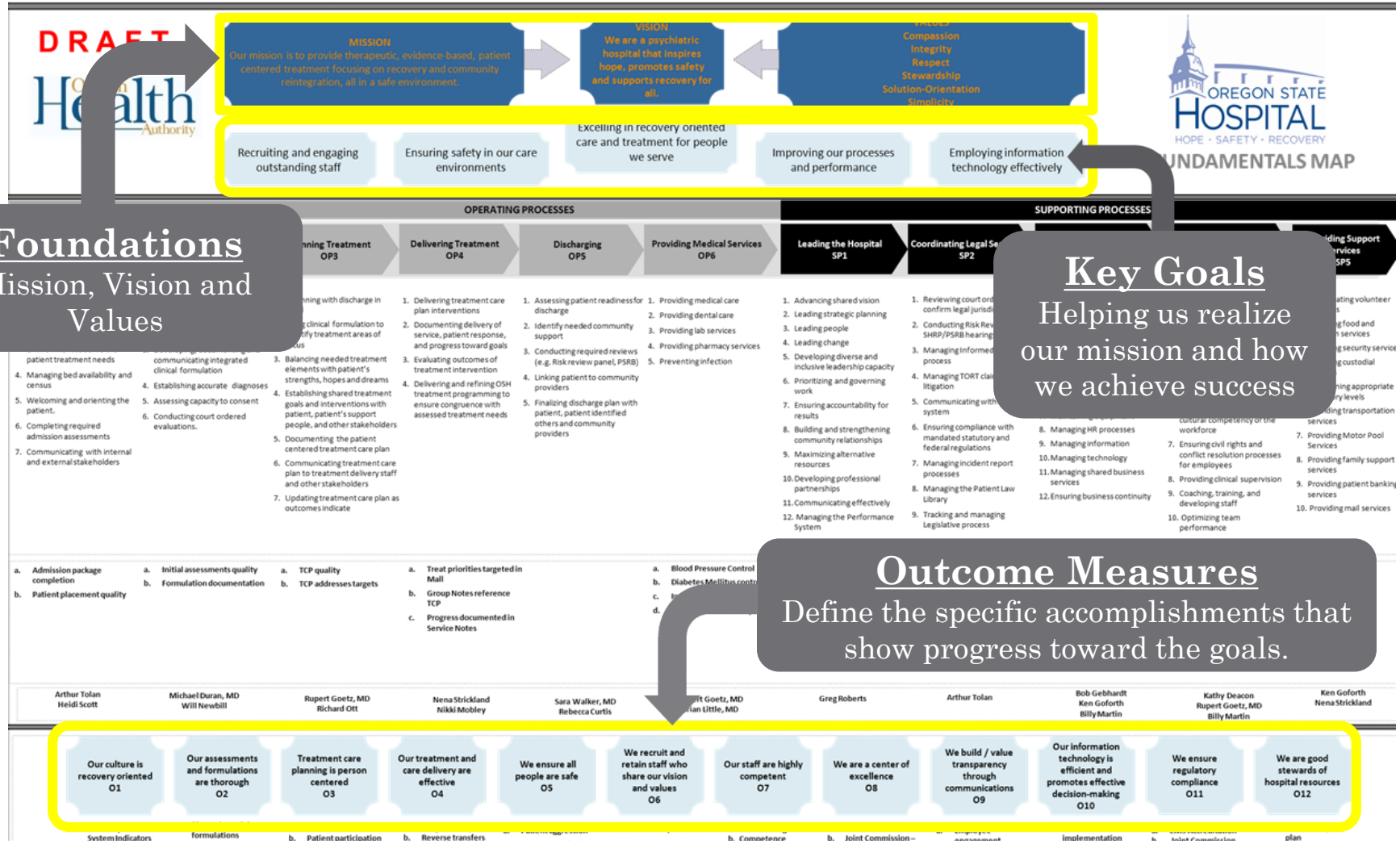


Foundations

Mission, Vision and Values

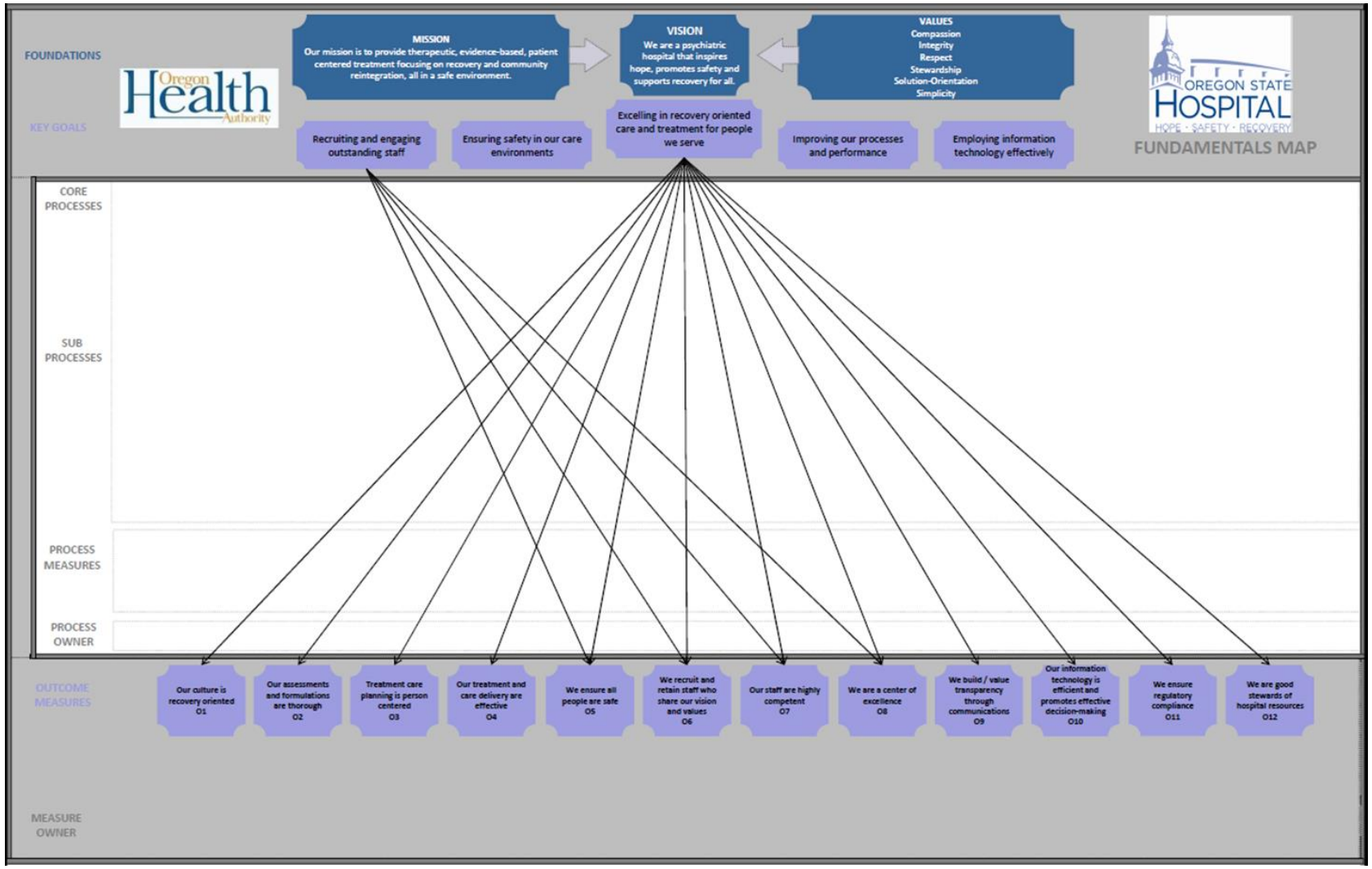
Key Goals

Helping us realize our mission and how we achieve success

Outcome Measures

Define the specific accomplishments that show progress toward the goals.

GOALS AND OUTCOMES



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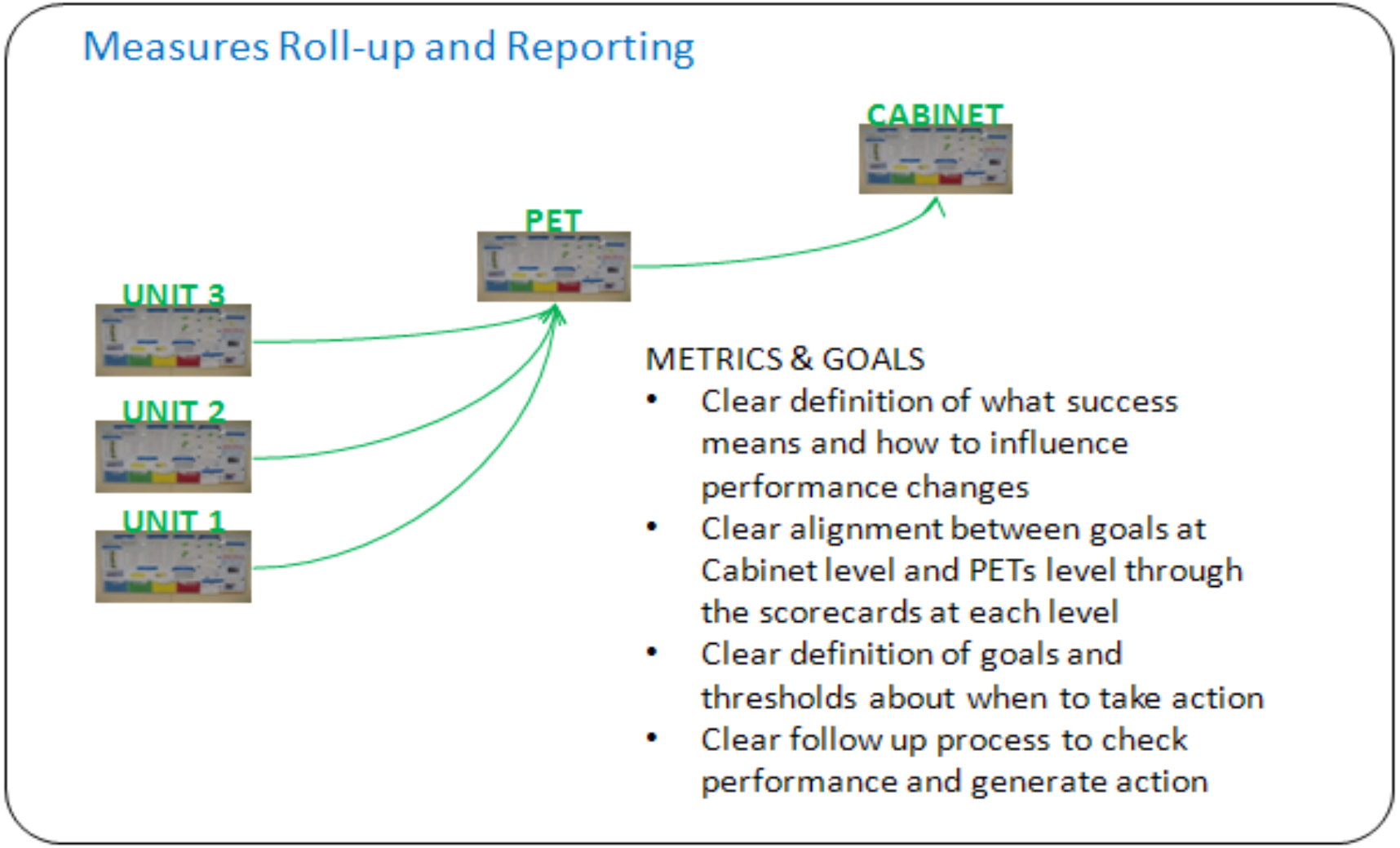
MEASURE ROLL UP



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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"

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OSH Lean Implementation Results

PROJECTS

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LEAN DAILY MANAGEMENT SYSTEM

Out of 92 LDMS areas:

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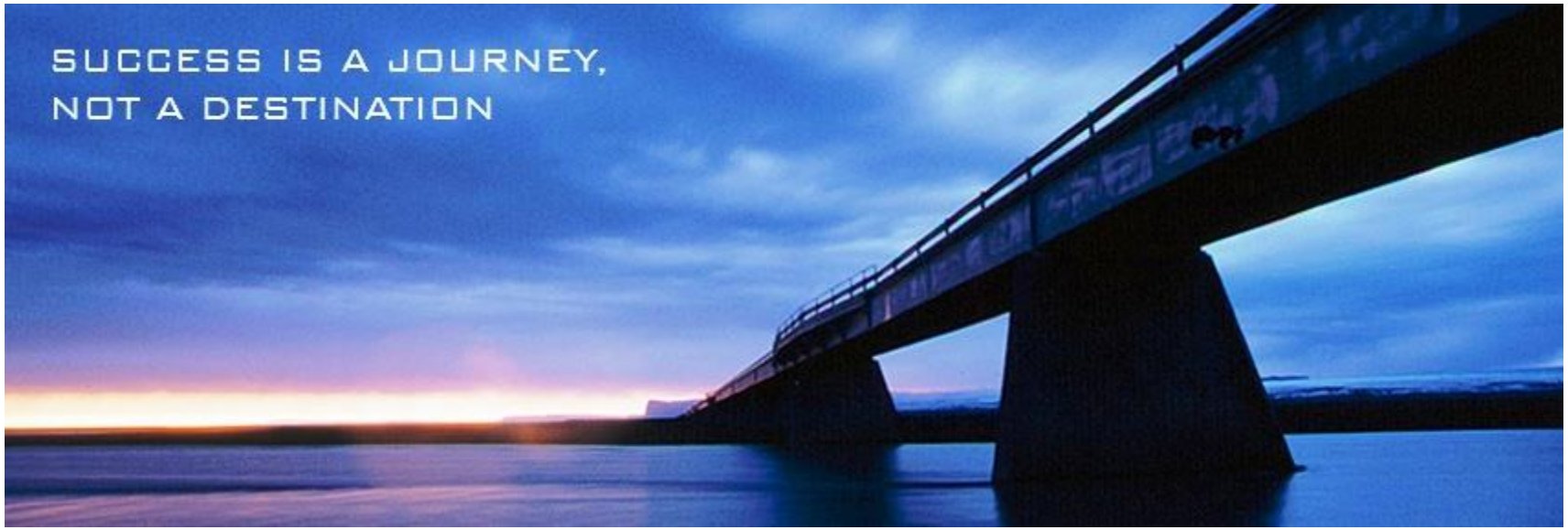
WHERE WE ARE GOING



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Quality Management – *Office of Performance Improvement*

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