# WORKING WITH LIVING SYSTEMS

Applying a Systemic Approach in Advising Organizations

June 13<sup>th</sup> 2018

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SEE?



SEE?



SEE?



SEE?



SEEING SYSTEM ELEMENTS IN AN ORGANIZATION--THE INABILITY TO SEE SOMETHING IMMEDIATELY DOES MEAN THAT IT DOES NOT EXIST INDEPENDENT OF YOUR PERCEPTION

# BACKGROUND

- Personal Journey:
  - Corporate Attorney
    - ► Litigation: Case Studies in Organizational Defects
    - ► Wall Street Attorney:
      - Regulatory and Control Systems design
- ► New York City Health & Hospitals
  - ► Largest Public Health System in US.
    - ▶ 1.4 million patients yearly
    - ► 70 locations -11 acute care hospitals
    - ▶ \$6.7 Billion in annual revenue (415.4 rubles)
    - Interpretive services provided in 190 languages
  - Joined H+H to lead Regulatory Compliance and Process Redesign



# OVERVIEW

► (PART I) During this presentation we cover:

- Organizational Redesign from a Systems Perspective
  - ► 1<sup>st</sup> Philosophical Roots of Systems Thinking
    - Linear and Non-Linear Thinking
  - ► 2<sup>nd</sup> Development of Hard Systems approaches
    - Operational Research
    - ► Systems Analysis
    - ► Systems Engineering
  - ► 3<sup>rd</sup> Development of Soft Systems approaches
    - ► System Dynamics
    - ► Cybernetics
    - Complexity Theory



## OVERVIEW

- ► (PART 2) During this presentation we cover:
  - Application of systemic reengineering
    - ▶ 1<sup>st</sup> Kings County Hospital: What Went Wrong?
      - Unsustainable Operations
    - 2<sup>nd</sup> Diagnosing the Problem and Organizational Assessment
      - Personnel and Culture
      - ► Baseline Metrics Collection
      - ► Viable Systems Tool Utilized
    - ► 3<sup>rd</sup> Solutions Approach
      - System Dynamics, A3 Thinking and Problem Solving: MACRO APPLICATION
      - ► VSA
      - ► Plan of Care
      - ► Execution Model

### PHILOSOPHICAL ORIGINS OF SYSTEMS THINKING

Philosophical Roots of Systems Thinking

- Western Philosophical Tradition
  - Early Systems Thinking in the West
    - Plato's Theory of Universals (Relationships)
    - Aristotle's Recursive structure of the City State (Fractals)
    - ► Heraclitus-"No man ever steps into same river twice." (Change)
  - ► The rise of Reductionist thinking
    - Atomist, Sceptics & Hedonist Schools of thought
    - Newtonian Mechanistic and Deterministic Modeling
    - Mechanistic thinking and influence on the hard & soft sciences
    - ► Scientific Business Management, e.g. Taylorism



Plato



Isaac Newton

### PHILISOPHICAL ORIGINS OF SYSTEMS THINKING

**Philosophical Roots of Systems Thinking** 

Eastern Philosophical Tradition

► Holism

 Collectivism and Relationships: Prevailed in Russia, Eastern Europe, China along with most Asian and Latin American countries

Source: Svetlana Kirdina-Institutional Matrices Theory

Southern Philosophical Tradition

► Holism

- ► Prevails in Latin American and African countries
  - Prevalent in Hunter-Gather Era Cosmology
  - Prevalent in Agrarian Era Cosmology

# LIMITATION OF LINEAR THINKING

- Definition SYSTEMS THINKING: A method of critical thinking by which you analyze the relationships between the system's parts in order to understand how the system operates in its entirety (aka Non-linear thinking).
- Definition RUDUCTIONIST THINKING- An approach which analyzes the parts of a system in isolation and adding them up with the whole set of parts being nothing more than the sum of its individual parts (aka linear thinking).
- The reductionist approach discounts the relationship and properties of the individual parts. It is based on the Super Position Principle.
- Limits of Linear Thinking:
  - Moore's Law-Doubling of CPU processing Speed
  - Kryder's Law-Storage capacity exponential cost drop
  - Al doubling-Exponential Machine Learning
- Technological disruption in the Market Place & Increasing Complexity





### APPLICATION OF SYSTEMS THINKING



# PART I: EVOLUTION OF SYSTEMS THINKING

# Hard Systems

Development of Hard Systems Approaches-Key Characteristics:

- Systemic problem solving versus ad hoc approach
- Objective definition of problem by stakeholders
- Goal seeking
- ► Limitations:
  - Problems dealing with significant complexity
  - ► Coping with plurality of different beliefs
  - Dealing with issues of politics and power

#### History: WWII and post war development

- Operational Research
  - Lean Approach
- ► Systems Analysis
- ► Systems Engineering





# Soft Systems

#### **Development of Soft Systems Approaches**:

- ► System Dynamics
- ► Cybernetics
- ► Complexity Theory

#### Key Characteristics:

Concept of an OPEN SYSTEM



- Ability to resolve a wider range of complex problems marked by greater pace of change and diversity
- Doesn't just focus on system ; value is placed on input from participants in the system
  - Facilitation of common goals among participants in the system
  - Engagement of participants to create a learning environment
  - Personal development focused, organizational agility and sustainability

# Soft Systems Continued: System Dynamics

- Philosophy and Theory:
  - Many variables existing in complex systems become causally related in feedback loops that themselves interact.
  - > Systemic interrelationship between feedback loops constitute structure of the system.
  - ► The structure is prime determinant of system's behavior
  - Emphasis on relationship between positive and negative feedback archetypes & system behavior
- Method:
  - Problem Structure
  - Causal loop modeling
  - Dynamic Modeling (all phenomenon is in a state of becoming)
  - Scenario planning and modelling
  - Implementation and organizational learning
- ► Contributors to the Field: Jay W. Forrester, Aleksandr M. Lyapunov\* & Donella
- ► Key Characteristics:
  - Recognition of system archetypes
  - Reduction of wasted and misdirected effort
  - Targeted interventions to points of maximum leverage

# FEED BACK LOOP



# Soft Systems Continued: Cybernetics

- Philosophy and Theory:
  - > All viable systems exhibit the same organizational characteristics
  - ► Systems have recursive characteristics
- ► Method:
  - ► Logic and mathematical modeling expressing genuine interdisciplinary laws
  - Based on recursive systems modeling
  - Viable Systems Model
  - Second Order Cybernetics
    - ▶ Role of the Observer in Human Development & Impact on Environment
- Contributors to the field: Stafford Beer, Robert Von Neumann, Gregory Bateson & Norbert Wiener
- ► Key Characteristics:
  - ▶ Black box control through positive and negative feedback for homeostasis
  - ► Law of Requisite Variety through algorithms
  - Isomorphic modeling based on neurophysiology



# Soft Systems Continued: Complex Systems

- Philosophy and Theory:
  - > Parts of system can be understood through their relationship with each other and with the whole
  - ► Stable structures are temporarily born.
  - Paradigm embraces a process view (perpetual state of becoming)
  - > Systems constantly interfacing with their environment
- ► Method:
  - Information flow
  - Degree of diversity
  - ► Richness of connections
  - Level of contained anxiety
  - ► Degree of power differential
- ▶ Contributors to the field: Aleksandr M. Lyapunov, Ilya Prigogine, Boris Pavlovich Belousov & Edward Lorenz.
- ► Key Characteristics:
  - Sensitive dependence on initial conditions
  - Strange attractors
  - Self-Similarity (Fractal)
  - Self-Organization
  - ► Edge of Chaos
  - Fitness Landscape



Strange Attracto

# ► PART II: APPLICATION AND CASE STUDY

### KINGS COUNTY HOSPITAL



- The Problem: Global News Story
- Department of Justice Investigation (DOJ)
- Lawyer Charged with Compliance & Redesign: DOJ Decree
- Used Lean Performance Improvement

# CASE STUDY: WHAT WENT WRONG?

Kings County Hospital Center: Behavioral Health

- Location: Brooklyn New York
- Serves over 800,000 pop. 94% Caribbean
- 627 Beds
- Est. 1857 as Almshouse, Hospital & Lunatic Asylum

#### Funding Neglect by City Administration

- Facilities fell in disrepair
- Difficulty in recruiting talented





# CASE STUDY: WHAT WENT WRONG?

#### The Tragic Event:

Esmin Green a 49 year old Jamaican native died in Kings County Hospital's psychiatric emergency room while waiting for a bed.

She slumped over and fell on the floor for more than 24hrs before help arrived.

As she lied lifeless, which was captured on video camera, ED staff became aware of her state and left her on the floor.

Lawsuit followed by the US Department of Justice (DOJ) charging neglect by the hospital.

Department presents findings an issue consent decree

#### **DOJ Findings for Targeted Corrective Measure**

- Delayed triage times
- Poor assessment and treatment planning
- Poor documentation of patient status & process
- No uniform diagnostic algorithm
- Lack of effective care team collaboration
- Unnecessary use of physical restraints
- Outdated electronic medical record system
- Poorly trained staff to manage violent patients
- Culture of blame
- Poor management communication with staff
- Poor data collection system
- Inadequate facilities for proper treatment

### CASE STUDY: WHAT WENT WRONG?

#### U.S. EDITION 🗸 Thu, May 31, 2018

U S	World	Business	Tech & Science	Culture	Sports	Health	0
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#### CULTURE

#### THE WOMAN WHO DIED IN THE HOSPITAL WAITING ROOM

BY JENEEN INTERLANDI ON 7/11/08 AT 8:00 PM

SHARE **f** 💙 **t** in 🕞 🥌 🖾

CULTURE

**B B C** NEWS

E smin Elizabeth green fell out of her ch hospital nearly an hour before anyone and twisted between two chairs under the w be broadcast across the country, spurring a members passed through the room and glar her vital signs or help her up. The sight of pa and lying face down on the floor, was hardly County Hospital Center. Neither was the fac almost 24 hours for a bed. At that moment G been waiting just as long, if not longer.

In fact, the hospital's psychiatric unit, also kr overcrowded and indifferent to its patients. *k* charged staff members with beating and har

#### Video shows death of US patient

Newsweek

Video footage has emerged of an American woman dying on the floor of a New York City hospital as workers failed to help for more than an hour.

Esmin Green, 49, who was said to have suffered a mental breakdown, had been waiting to be seen at Kings County Hospital, Brooklyn, for some 24 hours.

She collapsed in the waiting room at 0532 (0932 GMT) on 19 June.

According to the footage, it took almost an hour for the staff to notice and check her, but she had died.

#### Lawsuit evidence

On Tuesday, the New York City Health and Hospitals Corporation, which runs the hospital, agreed to increase the monitoring of patients at the hospital's psychiatric ward as part of a lawsuit settlement.

The lawsuit was filed by the New York Civil Liberties Union and others a year ago.

"That it took somebody keeling over and dying, and it being captured on videotape, for the city to come to the table in a meaningful way is unconscionable,"



# CASE STUDY: PREREQUISITES TO TRANSFORMATION

#### **STEPS TAKEN:**

- Conducted assessments of
- Personnel and Culture
- Baseline Metrics Collection
- Viable Systems Tool Utilize
  - Isomorphic Modeling



# CASE STUDY: PERSONNEL & CULTURE FINDINGS

#### **SOME FINDINGS:**

- Management removed from front line problems
- Clinicians felt disempowered to make improvements
- Clinicians didn't feel supported in their work
- Staff felt they didn't have adequate tools for work
- Non-psychiatrists felt belittled by doctors
- Psychiatrist's and nurse's skills atrophied



# CASE STUDY: BASELINE METRICS FINDINGS

#### **SOME FINDINGS:**

- Delays in triage times exceeded 30 minutes
- Length of stays exceeded 20 days
- Delays in transferring patients to inpatient units
- Some patients missed proper vital test during triage
- High expenditures on 1:1 observations
- Disproportionate number of physical restraints ordered per patient
- Non-reimbursement for greater than 35% of hospital visits



# CASE STUDY: DIAGNOSIS WITH VSM

#### **VSM Function**

5 required systems criteria for a viable system:

- ► All Viable Systems Must Have:
- ► 1) Primary Activity
- ► 2) Coordination Function
- ► 3) Operational Control Function
- ► 4) Intelligence
- ► 5) Policy System

(Modeled after Neurophysiology)



# CASE STUDY: DIAGNOSIS WITH VSM

#### **FINDINGS:**

#### Addressing deficiencies in absence VSM elements:

- ► All Viable Systems Must Have:
- Coordination Function -> Communication: Communication and interface between sub-units with BH division of the facility. System deficiency.
- Operational Control Function 
   Regulation: Involves effective two-way communication between the three service units to effectively meet control system criteria. System deficiency
- Intelligence > Link to environment: It is the reciprocal link between the primary activity and its external changing environment. System deficiency.
- Policy System 
   Purpose: Where clarity about the overall direction, values and purpose of the organizational unity is established and maintained for organizational effectiveness. System deficiency.

**Deficiencies Identified** 

# CASE STUDY: TRANSFORMATIONAL PLAN

#### Culture Change:

- Role of Organizational Psychology
- Personal Development Plans (PDPs)

#### Process Change:

- Transformational Plan of Care (TPOC)
- Qualitative and Quantitative Measure
- From Top to Bottom within Organization
- Redesign: Emergency Room, Inpatient & Outpatient services



# CASE STUDY: WHY LEAN?

The LEAN Systemic Approach

Total Systems Resigned required

LEAN System Characteristics:

- Respect for Humanity Approach
- Recursive Characteristics
- Open Systems Modeling
- Qualitative System Wide Changes
- ► Quantitative Metrics to Monitor



#### Case Study: CULTURE CHANGE

#### Developing Transformational Leaders

#### Transactional vs Transformational Leadership

Categories	Transactional	Transformational						
Leader's source of power	Rank, position	Character, competence						
Follower reaction	Compliance	Commitment						
Time frame	Short term	Long term						
Rewards	Pay, promotion, etc.	Pride, self-esteem, etc.						
Supervision	Important	Less important						
Counseling focus	Evaluation	Development						
Where change occurs	Follower behavior	Follower attitude, values						
Where "leadership" found	Leader's behavior	Follower's heart						

#### Creating a safe and Learning Culture



# CASE STUDY: PROCESS CHANGE

#### General Lean Approach

 Description of the A3:
 Box 1: Reason for Action
 Box 2: Current State
 Box 3: Target State
 Box 4: Gap Analysis
 Box 5: Solution Approach
 Box 6: Rapid Experiment
 Box 7: Completion Plan
 Box 8: Confirm State
 Box 9: Insights/Lessons learned

	Description: \$\$\$ Spent on new Fiber-optic Endoscop	pes and repairs Value Stream ID: OR Site				Site/Lo	cation: Lincoln Hospital	Event #: 3	Revision					
	Executive Sponsor. Melissa Schori, MD	Process Owner: Arlinda Racaza, RN					Facilitator: Dona Lyttle	Sensei	Rayne Johnstun					
Culty	1: REASONS FOR ACTION	4: GAP ANALYSIS					7. COMPLETION PLAN							
ren		Gap	Gap 1 <sup>st</sup> Why 2 <sup>nd</sup> Wh		3rd Why	4 <sup>th</sup> Why	What Who	When	Status					
date: 7/ It Date: 4/	<ol> <li>Reason for Action: Fiber-optic Endoscopes (FE's) are unavailable when needed because they are frequently broken or being repaired. From June 2010 to</li> </ol>	Anesthesiolo gists waste time searching for	FE's aren't always available	FE's are broken whi slammed in drawers	They are en placed on top n of the anesthesia	There is no secure location to put them on	Buy supplies for anesthesia Joe carts	July 15	Done					
19 - 22/2010	June 2011, \$48,400 was spent repairing and replacing FE's	FE's	droppe floor, et		n cart before and after surgery	the anesthesia cart	Put tubes on carts and Joe label "Clean" Joe and "Used"	July 18	50%					
Team Le Chua, An Montecer	Scope Trigger: Need to use FE is identified Done: FE is not needed and put away	There is potential danger to patient's	There is confusion over whether	There is no designated location fo	b d ur		Post standard work on carts Nancy and train staff	July 22	25%					
RN, Hen		health	or not FE's are clean or used	and used F on the cart	'E's t									
nda Ilata	2: INITIAL STATE	5: SOLUTION APP	ROACH				8: CONFIRMED STATE							
Racaz N. B. Shah	FE's are broken don't knowledge	If We			hen We.		Metric Baseline T	arget 30 days	60 90 days days					
za, RN; Team Membe Banisdhar Chauhan, MC n, RN, Valerie Katz, MC	drawers, dropped on the floor, etc	Put two the anesthe	siologi	sts' c	Won't nee ook for go lean FE's	ed to bod and s when	\$\$\$ spent on repairs and new FE's	\$0 \$1,200	\$435 \$128					
	estering the Anesthesiologist	tube for FE's ar	resan ate one r clean nd one fo	or to	•Eliminate potential dange to the patient		Patient safety N/A incidents	0 2	1 0					
, Evelyn , Alberto	As to search for valiable FCs 533 Spent on Fulling FCs 553 Spent on NEW FCs 550 550 550 550 550 550 550 55	dirty FE Create work w process the tub carts	standar ith steril sing abo es on th	d u e n out o	Don't spe innecessa noney on or new FE	end ary repairs I's	SSS Spent on Fixing FE's	555 Spent of 2.5 2 1.5 0.5 0 Jun Aug	NEW FE's					
	3: TARGET STATE:	6: RAPID EXPERIMENTS					9: INSIGHTS							
2	FE's are always available	Experiment	Expected Outcome		ctual F utcome	Follow up	Worked well: • Able to quickly identify the gaps as a team	• Be able to more easily	ove: obtain data					
4	Con	Install 2 tubes in anesthesiolo gist cart, one for clean EE's one for	All FE's ar placed in t correct pla (clean and used) and	the pla lace co d pla d rep s ac	IFE's E aced in the a prrect g ace, and b placed F coording to b	Expand to all anesthesiolo gist carts, buy more PVC pipes, pardware	No Blaming environment     Able to find quick solutions	Learned: • Working v methodolo works well	vith A3 gy really					
7	S\$ saved on repairs and replacements S\$ spent on pew or repair FE's = \$0	Used FE's are replaced and run with properly new during standard changeover work			andard a ork during t angeover s	and install subes. Post standard work in each cart	Hindered: • Lack of materials to complete 2 carts instead of 1	Always material the store make sense the sense sensense sense	ake sure you y, it needs to					
9	Patient Safety= 0 harm to patients													
	♥ 2009 Simpler (www.simpler.com)					(www.simpler.com)								

	刻	Gimmler	Description:	RIE 18: Restri	ctive Intervention 1	am ID: Behavioral Health Services			Site / Location:		Kings County Hos	pital Center	Event Numb		t Number: 18		8	Revision:		
L	Y	Simpler	Sponsor:	Joseph Merlin	0	Process Ow	ner: Evelyn Be	ersamin /Opal	Sinclair-Chun	g Facilita	tor:	Ameer Roberts	on s	Sen	ensei:			Br	uce Smith	
O U	O III 1: REASONS FOR ACTION				4: GAP ANALYSIS		I	What	Why	Why	Mby Wby W		Why		7: COI	MPLETION	PLAN			
urrent Date: 8/20	There is a high utilization of restrictive interventions (1:1, restraints, STAT IM and Q15) and there is inconsistent documentation of these interventions. There is also a lack of preventative measures resulting in unsafe units.				Target State action plan was derived from the waste opportunities identified Defects Overproduction Waiting			Lack of competence	Lack of willingness and motivation to learn	Weak clinical and didactic support	Administrative decisions without frontline staff input	Don't trust frontline staff judgment	2	JDI X	What Molify restrictive intervention policy and procedures to reflect elimitation of elopement and assuttive/agressive as 1:1		Who Allena (	Whe C. 8/51/	9 <b>0</b> 10	
y2010 y2010					what were record for the second	Transportation	tarent (numan potential)	Inconsistent adherence to criteria for	Current system allows for	Construct for specialized	Specialized training process not	Shifted resources away from	Reactions without understandi	Ħ	X	Training on n work, 1:1 mo role integratik intervention p	Ining on new standardized in, 1:1 modification options, a integration and simplified arvention protocols		94/1	0
a					issuing v restraints v		wide variation	behavioral training not utilized	carried out	specialized training	ng the cause and effect of doing such	$\parallel$	x	X Role out and train on Qmed form simplification-modification and new restraints policy and procedures     X Standard work delivered to Related to Restrict Committee		Aliena	B. 9/81/ C. 8/81/	10		
Melli	Mono Sector				After analyzing the 8 WASTES in our direct causes and then utilized the 5	stormed for potential causes.							H	x	Investigation	of quality of food	Allena C. Works	/RI 9/31/	10	
G	2	2: INITIAL STATE			5: SOLUTION APPROACH		-					•		1	8: COI	NFIRMED S	TATE			
v	2	<ul> <li>Cited by regul</li> </ul>	ators		Gap			If We:			Then \	Ne:	Indicato	ra I	Me	trio	Baseline		Target	DUE 9/30/10
Mian Sidd Maurice, S Veronica H		✓ Deficiency of policies and procedures (unclear/confusing/inconsistent)     ✓ No standard of work			Failure to identif acknowledge tri	Institute specailized training across disciplines and bette integrate teams		d ter	Will na applica interve them	rrow var ation of r ntions a	iation in estrictive nd lower	Safety	Safety		raints 4V	IF Adult Units = 06A Units =1.00 EF (per 100 visit V = 0.205 V = 2.465 r IF units rate pe	0.667 93 ts) =1.81) er 100 pt	Adult: 0.195 Child: 20% Good - <u>0.5744</u> 40% Vary Good <u>- 0.555</u> 50% Outstanding <u>-</u> 0.5455	•	
ique, iuzett		<ul> <li>Use of restraints are inconsistent</li> <li>Inconsistent potification to femily</li> </ul>										qualit	quality		tage of Al teled 7V	All BHS: <u>229</u> (55%) 7W: <u>20</u> (100%)		100%		
e Oca				Inconsistent adherence to criteria for issuing		<ul> <li>Establish role definition and protocols in</li> </ul>		Will avoid over utilizatio of restrictive interventio			indicato	•	Metric				Target	DUE 8/30/10		
sio, Vi a Con				restraints	managing patient high risk behavior						Bafety	Reportable Incidents		rtable Al Sents 7V 4V	All BH0: <u>31</u> 7W: <u>8</u> 4W: <u>6</u>		Zero			
rier, Magdalena cibria Blumberg, stable		Purple = 21 Waste opportunities identified Yellow & Punk = tasks by who what & when			Inconsistent adh criteria for issuir restraints	Help patients better understand behavioral boundaries leading up to the different forms of restrictive interventions		r oral up to of tions	We will reduce the utilization of restricti o intervention, and in t the number of times are used as default behavior managemen		the strictive nd in turn, times they fault gement	he trictive J in turn, mes they iult ement		1218		All DHs: <u>5,141</u> 7W: <u>55</u> per month 4W: <u>55</u> per month Average Days on 1:1's: All DHS = 7 days (Nov Dec.) 7W/WW = 2.6 days (Jun Jul.) (Oost savings will be		Ordered: 20% good - <u>5,112</u> 40% very good - <u>3,054</u> 80% outstanding - <u>2,673</u> Average stay = 60% reduction (Oost savings will be		
(1)	)	Blue = Subjective varia	bles						method		_					measured by this metric)		measure by this metric)		
$\geq$	3	3: TARGET STATE:	ulator		6: RAPID EXPERIMENTS	6: RAPID EXPERIMENTS									9: INS	IGHTS	i -			
( <u>2</u> )		<ul> <li>✓ Clear and concise</li> </ul>	policies and proce	Experiment redures for BHS			Expected Results		Actual Results		Cycles		What Went Well				What Could In	nprove		
3 4 5	<ul> <li>Standard of work</li> <li>Consistent use of restraints</li> <li>Consistent notification to family</li> </ul>			Peer orientation including summ restraints and medication exp	er orientation Us luding summary of add traints and inf dication explanation pat ori		Usefulness of I additional g information in a patient's i orientation		Majority of patients surveyed said additional information is useful.		1	1			tion of the why tions I down issues i out the proces	s and hows of restr in order to move the s of restraints	ictive e team			
$\geq$				Survey psychia	trist and	Feedback	on why	The m	ajority		2				Wha	t Helped		What Hinde	ered	
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(8) (9)	8 9 Four forms of restricting patients' mobility newly mapped		newly mapped					survey approa staff: 5 rejecte	13 rejected ich. Other 4 out of 45 d approach				Experience of learn mem Open communication he problems better			mbers elped us understar	d the			

#### LEAN IMPROVEMENT SYSTEM-A3 THINKING ON RECURSIVE LEVELS



#### CASE STUDY: TARGETED QUALITATIVE IMPROVEMENTS

#### KAIZEN Transformation Process

- Division and Process Focused:
  - Weeklong event
  - Facilitated by a Lean Sensei
  - Rhythmic in pace
  - Team sequestered for full week
  - End of week tangible results



# CASE STUDY : MEASURING QUANTITATIVE



Control mechanisms supporting internal recursive processes and systems!

### THE "TRUE NORTH" METRICS

- Human Development
  - Improved Capability at all levels
- Quality/Safety
  - Zero defects, zero harm
- Timeliness/Delivery
  - Timeliness, throughput, productivity
- Financial
  - Decrease Cost, Increase Revenue
- Growth/Capacity
  - Care for more people
  - Develop and/or maintain capacity without adding resources



Transformation requires improvement in all 5 dimensions

#### Kings County Case Closed January, 2017

#### Accomplishments:

- The goals of the Transformational Plan met
- Majority of Qualitative improvements sustained
- Quantitative measure monitored and reached
- A transformation is a marathon and not a sprint.
- After 7 years of close monitoring and the Department of Justice closed the case in 2017.
- DOJ Statement, "One of the most impressive transformations witnessed."
- Oxford University Press published a book on the endeavor.

#### U.S. Attorneys » Eastern District of New York » News

Department of Justice

U.S. Attorney's Office

Eastern District of New York

FOR IMMEDIATE RELEASE

Tuesday, January 17, 2017

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#### Historic Case Involving The Civil Rights Of Psychiatric Patients At Kings County Hospital Center Comes To A Close

#### Case Ends with Transformation

Robert L. Capers, United States Attorney for the Ea closing of its case against New York City over cond + Hospitals/Kings County, also known as Kings Co ("BHS"). In a letter dated January 10, 2017 to the F requested that Judge Matsumoto close the case beca requirements of a January 2010 Consent Judgment York. The Court granted that motion today.

The Consent Judgment was entered after the United 2008 and 2009 and concluded that it was failing to 1 treat its patients. The investigation also revealed vic use of chemical and physical restraints. Hospital Po beds and radiators. In a tragic incident in 2008, a pa on the floor as clinical staff and hospital police ignc community without adequate plans for their care. A facility. In addition, the facility was dilapidated and

In January 2010, the United States and the City enter bringing about a complete overhaul of the BHS, inc and diagnostic procedures, and its treatment plannin discharge planning, and fire and life safety planning included provisions for the reform of KCHC's Hos

In the seven years since the parties signed the Conscare psychiatric facility. The BHS now addresses th population that it serves. Its treatment plans and me centered, and recovery oriented. It has also developpotential patient aggression and self-harm. As a rest significantly. Nurses are more attentive and play a s better. Medication is used only for the purpose of tr controlling their behavior. In addition, the rate of re discharge planning. And, the BHS is now housed in safe. Edited by JOSEPH P. MERLINO JOANNA OMI JILL BOWEN

> LEAN BEHAVIORAL HEALTH

The Kings County Hospital Story

# Questions?

#### Ameer Robertson, Esq. <u>ameermr@gmail.com</u>

