

# Using the DMAIC Process to Direct the Sequencing of Lean/Six Sigma Tools for Successful Project Outcomes

Jim Ellis

Certified Master Black Belt J&J Process Excellence

Director – US Sales Strategic Accounts

[jellis@its.jnj.com](mailto:jellis@its.jnj.com)

Ortho Clinical Diagnostics  
a *Johnson & Johnson* company



# Intent:

---

## **Using the DMAIC Process to Direct the Sequencing of Lean/Six Sigma Tools for Successful Project Outcomes**

**The purpose** of this presentation is to share with the attendees my experience over the past 5 years using the DMAIC Process how to determine what Lean and/or 6 Sigma tools is the best to use when for assuring successful outcomes of your projects.

### **Learning Objectives:**

- 1.) Clear understanding of DAMIC Process
- 2.) Clear understanding of which common Lean and 6 Sigma Tools are best used in what stage of DMAIC
- 3.) Clear understanding of how to assess success for a project and know if you have achieved it.

### **After Attending the attendees will:**

- 1.) Know what the DMAIC process is and how it is applied in project planning
- 2.) Understand which Lean and 6 Sigma tools are used in what sequence to assure successful project outcomes

# The Driving Forces of Change

Ortho Clinical Diagnostics  
a *Johnson & Johnson* company



# Today's Healthcare Delivery Challenges...

## Declining Resources

\$29.9  
billion

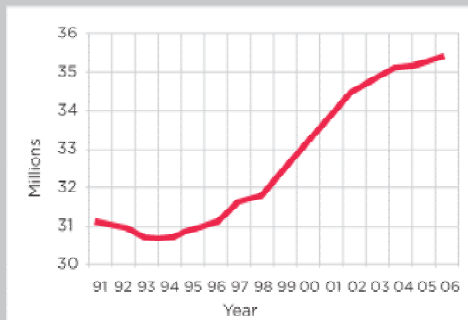
Medicare/Medicaid  
Shortfall

Space  
Capital Funds  
Skilled Labor  
Reimbursement

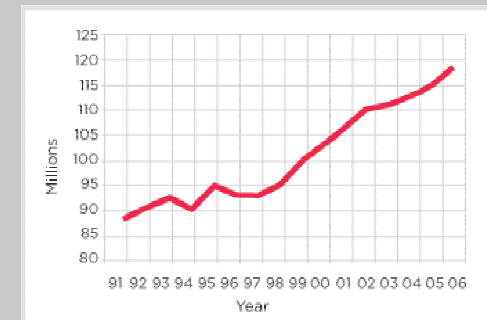
Vacancy  
Rates

Laboratory Techs 5.9%  
Imaging Techs 5.9%  
Pharmacists 8.1%  
RNs 8.1%

Inpatient Admissions<sup>2</sup>



ED Visits<sup>2</sup>



Volume  
New Technology  
Market Pressures

Increasing Pressures

# Why are labs changing?

---

**“I need to transform my lab!”**

**Why?**

- **2X Volume**
- **½ the Labor**
- **½ the Skill**
- **½ the Reimbursement**
- **New Medical Content**

**“Help Me!”**

# Where do I start?

Ortho Clinical Diagnostics  
a *Johnson & Johnson* company



# Why Should I Even Do This?

---

- Testing thru-put (TAT) reduced by 50%
- Productivity improvement >40% (Billables per FTE)
- Labor hrs per 24 hrs reduced by >40%
- Cost reduction at 28%
- Space savings of >30%
- Standardized work practices
- Reduction in Errors and Error Potential
- Improved Customer Satisfaction
- Elimination of excess unused inventory
- Elimination of visual noise
- 100% cross-training of staff
- Improved Employee Job Satisfaction

# I am Confused!

---

- Value Stream
- DMAIC
- Stakeholders
- Future State
- DMAIC
- Regression
- Mistake Proofing
- Gauge R&R
- Current State
- Muda
- FMEA
- Affinity
- Flow
- Y=f(x)
- Kaizen
- DOE
- DMADV
- DESIGN EXCELLENCE
- Fishbone
- LEAN
- Pareto
- Charter
- SIPOC
- 5 S
- Kano
- Null
- CTQ
- Push/Pull
- 6 SIGMA
- VOC



# Bringing Order to Chaos:

---

**Improve an Existing Process**

**Create a New Process**

**Create a New Product**

• **DMAIIC**

• **DMADV**

• **DESIGN EXCELLENCE**

**Define**

**Measure**

**Analyze**

**Innovative Improvement**

**Control**

**I See**

**What I will do & How it compares**

**How I will make it last**



**Reduce Waste (Muda)**

**Reduce Variation**

# DMAIIC – Define (the hardest to do right!)

---

- Charter Document
- Business Case
- Gathering the Voice of the Customer (VOC)
- Defining Success – measureable and time bound
- Stakeholder commitment
- High level Current Process map – the SIPOC

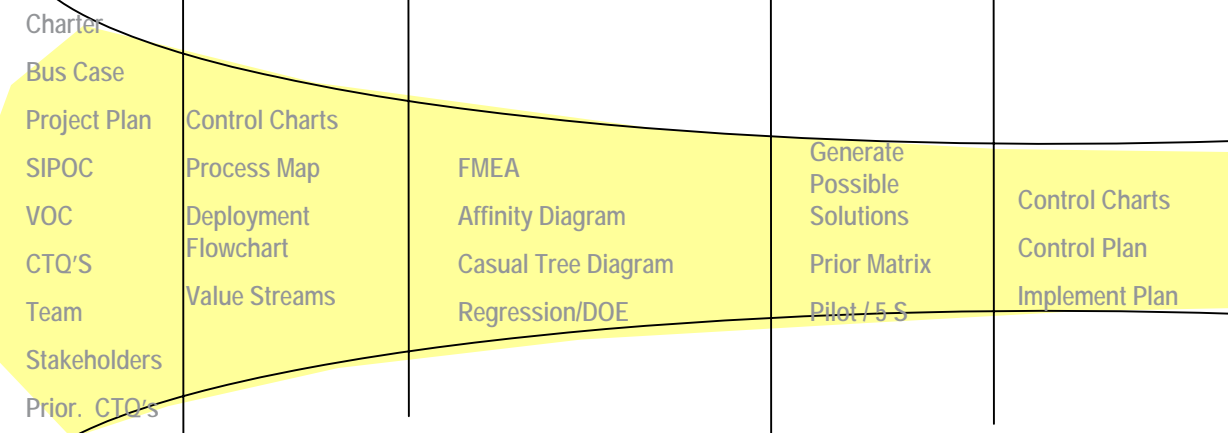
# Define Phase - Charter

<b>Title:</b>	<b>Process Improvement Opportunity for XYZ Distribution Center resulting in reduced labor costs, reduced packing costs, reduced customer defects, and reduced square footage.</b>
<b>Problem Statement:</b>	Today XYZ is spending too much on labor, packaging and storage for its products at its main distribution center. Also, end user customer defects are too high. Improvements must be made within the next 12 months.
<b>Rev:</b>	09/02/08 Stakeholder approval 9/02/08
<b>Scope:</b>	XYZ Products, from order entry to unpacked and receipted into customer's inventory. Includes up stream into Marketing and Product specifications.
<b>Duration:</b>	Immediate through next 12 months
<b>Key Stakeholders:</b>	VP's, CFO's, Line Managers, HR
<b>Steering Team:</b>	To Be Named and type and frequency of communications to be determined following first month of work.
<b>Project Teams:</b>	List all functioning teams
<b>Goals:</b>	<ol style="list-style-type: none"><li>1.) Reduce labor hours needed in picking and packing process from Current State for both domestic &amp; international.</li><li>2.) Reduce packaging total costs (cartons, corrugate, gel card staging &amp; obsolescence) from Current State.</li><li>3.) Reduce end-user customer defects from Current State.</li><li>4.) Reduce square footage (footprint).</li></ol>
<b>Resources Needed:</b>	Work this out for all resources needed
<b>Expense Funds:</b>	Detail out and get approval
<b>Methodology:</b>	PE – Lean primarily following a DMA IIC roadmap with use of Value Streams for documenting Current and Future States.
<b>Success Defined:</b>	At the end of the 12 months time, XYZ Corp. is delighted with the transferable, replicable process improvements from the project that have substantially reduced the amount of labor hours needed to perform the process, substantially reduced the cost of the packaging used in the process, substantially reduced the number of end user defects produced by the improved process and substantially reduced the square footage to store products. Magnitude of improvement for each of the 4 Goals is expected to be at least 20% .
<b>Environmental Impact:</b>	Improvements consistent with movement towards “Green”

# DMAIIC

# High Level Project Plan

8/1/08      9/1/08      10/1/08      1/1/09      4/1/09      6/1/09



VOC      Process Capability      Pred. Equation      Implement Solution      Sustain the Gain

NEED ----- DRIVERS ----- CTQ'S

1 of 4 Goals

**Reduce Sq. Footage of Products in Warehouse by at least 20%**

Demand

Units Shipped per 24 hrs

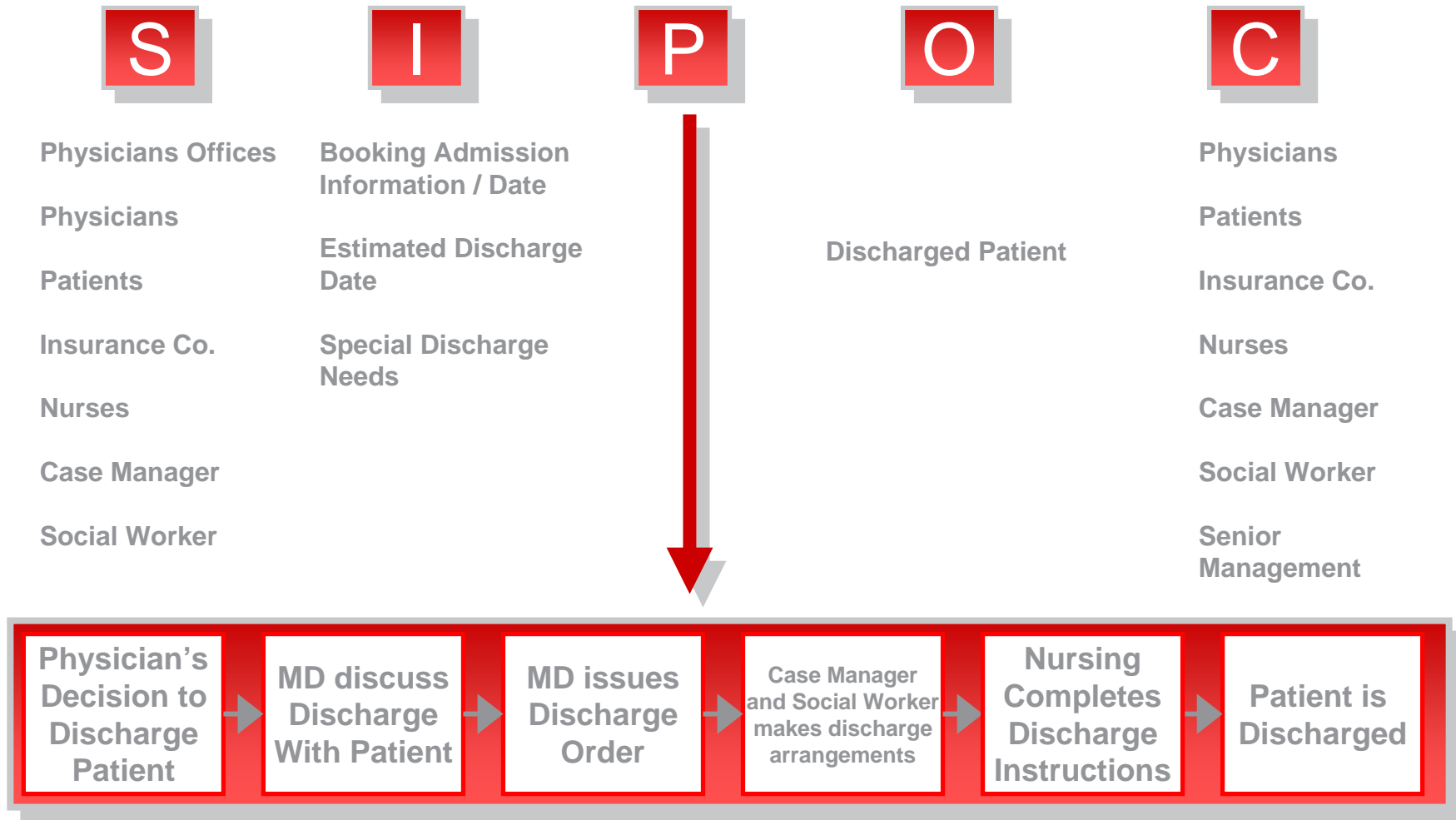
Inventory Req.

Total Units Required including safety stock/24 hrs

Footprint of Product

Cubic ft/SKU

# Define: SIPOC Analysis



# DMAIIC – Define (the hardest to do right!)

---

- Charter Document
- Business Case
- Gathering the Voice of the Customer (VOC)
- Defining Success – measureable and time bound
- Stakeholder commitment
- High level Current Process map – the SIPOC

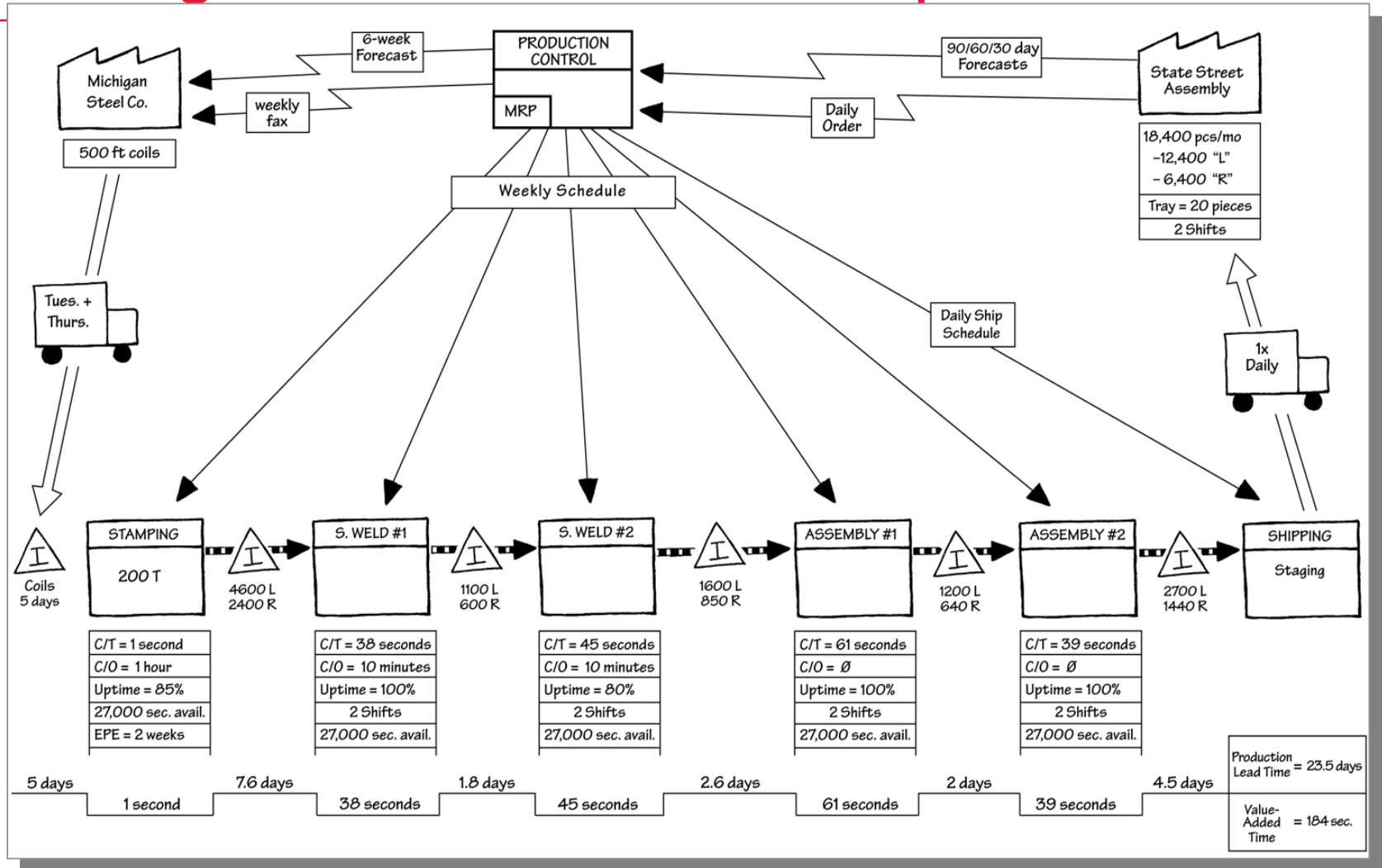


# DMAIIC – Measure (its all about the Current State – is it Capable?)

- Value Stream
- Process Map
- Data Collection Plan – how much is enough?
- Is Current State in Control? – Control Charts
- Is Current State Capable? – Specs (VOC) vs. Control Limits
- Funneling – the trivial many X's – FMEA

Measure: Value Stream Map (understanding improvement opportunities of the Current State)

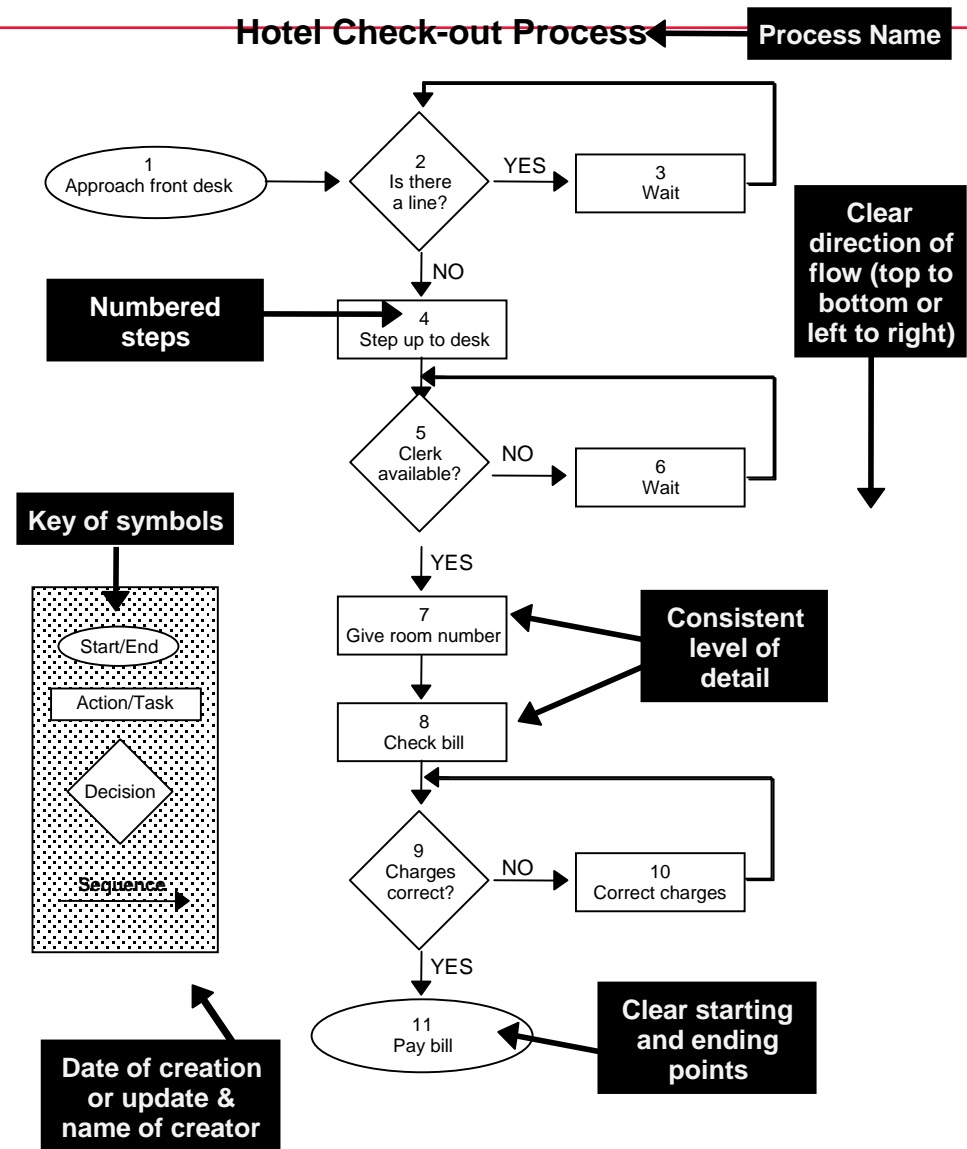
# Creating the Current-State Map



Ref "Learning to See" Rother & Shook

# Measure: Process Maps - Activity Flowchart Example

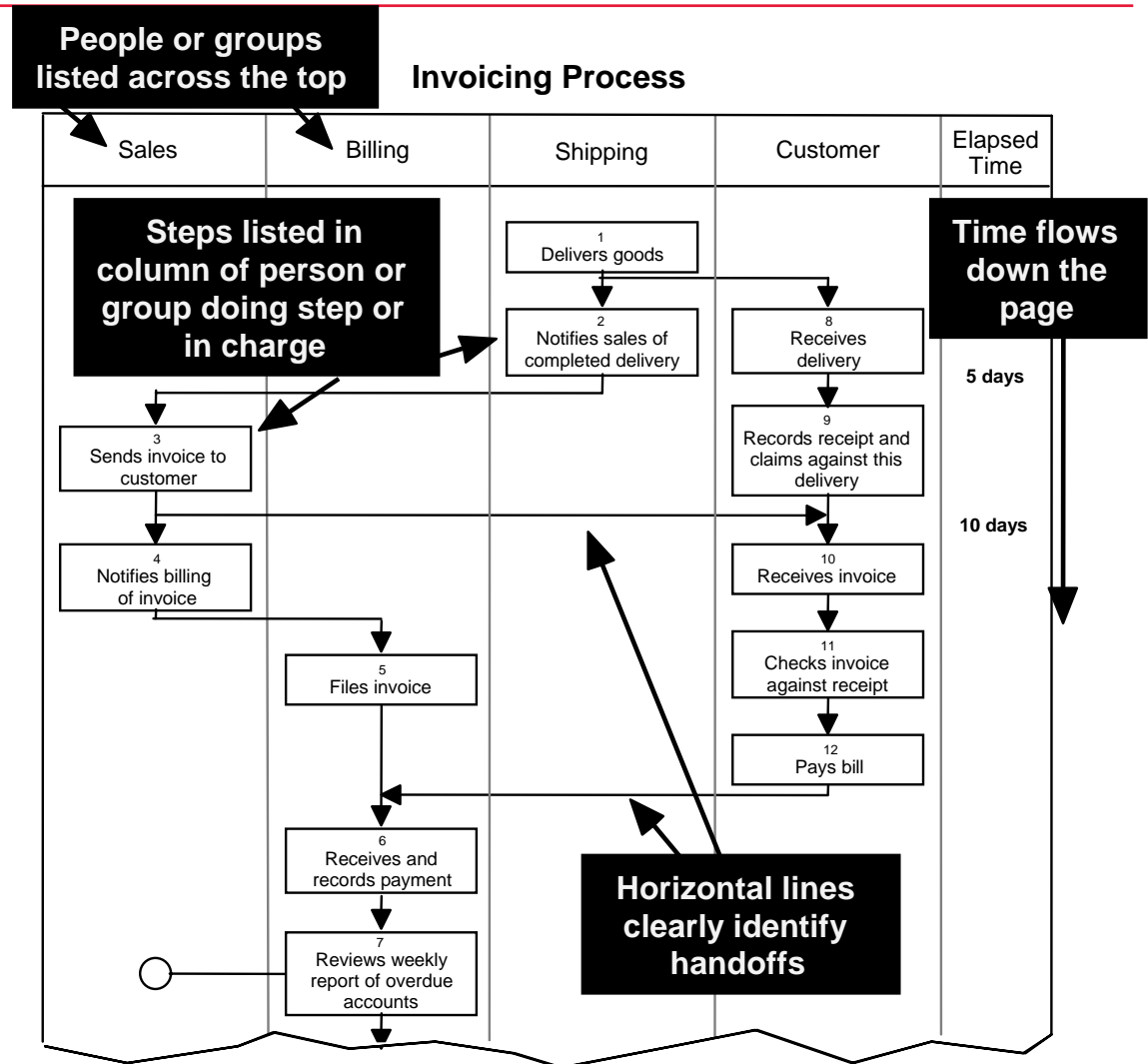
- **Activity flowcharts** are specific about what happens in a process. They often capture decision points, rework loops, complexity, etc.



# Measure: Process Maps - Deployment Flowchart Example

- **Deployment flowcharts** show the detailed steps in a process and which people or groups are involved in each step.

- They are particularly useful in processes that involve the flow of information between people or functions, as they help highlight handoff areas.



# Measure: Data Collection Plan Features

**Data Collection Plan**

**Project** \_\_\_\_\_

What questions do you want to answer?

**Being clear about your question will help you make sure you collect the right data.**

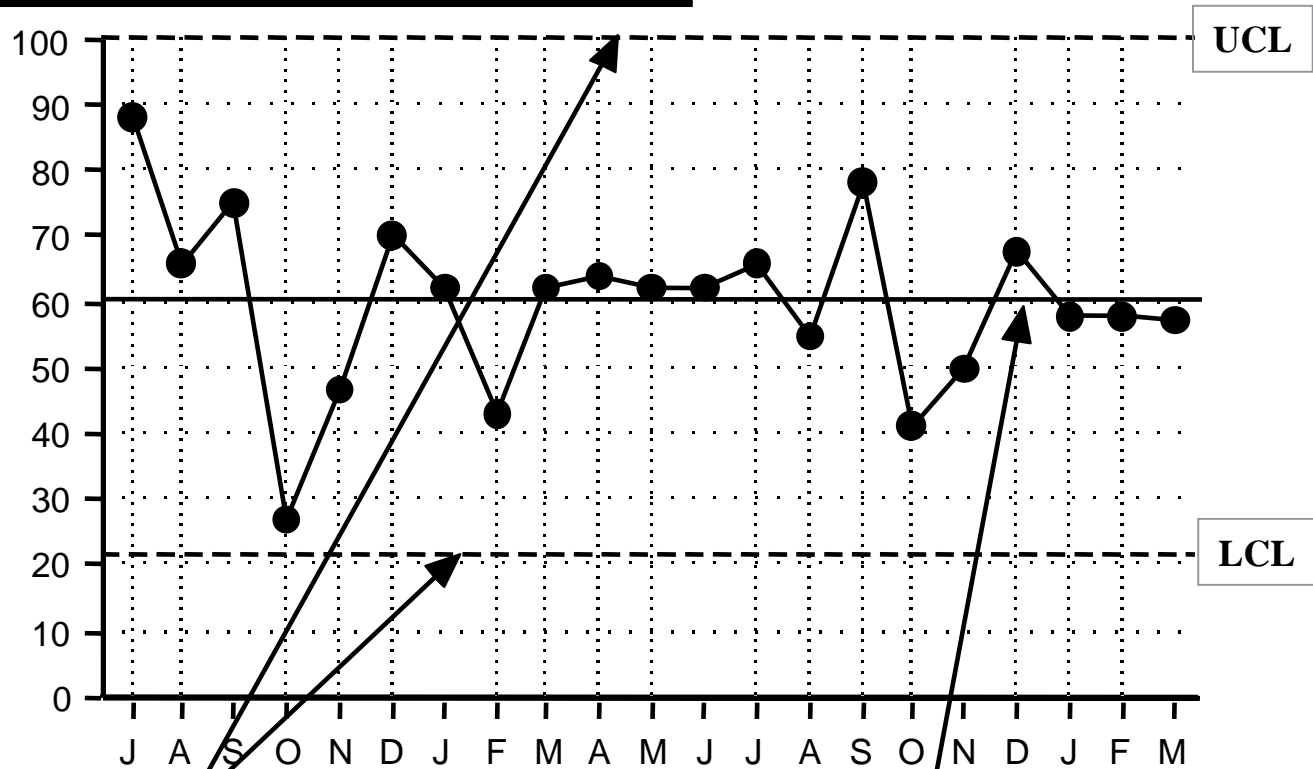
Data		Operational Definition and Procedures			
What	Measure type/ Data type	How measured <sup>1</sup>	Related conditions to record <sup>2</sup>	Sampling notes	How/where recorded (attach form)

**Recording what data you are going to collect reminds you what you want to accomplish. Noting the type of data helps you decide how you should analyze the data.**

**An operational definition defines exactly how you will go about collecting and recording the data.**

# Measure: Control Chart Features (In Control?)

**Basic features same as a time plot**

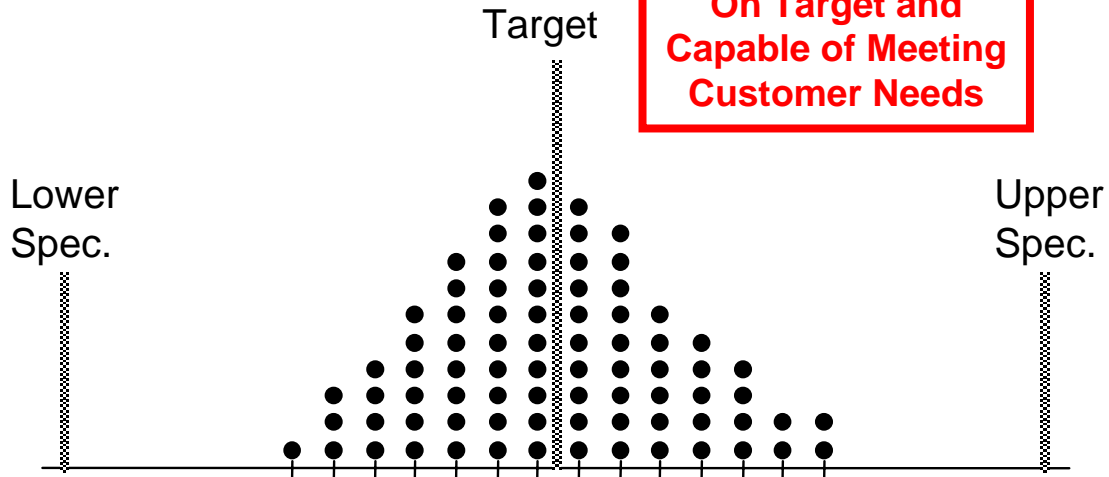


**Control limits  
(calculated  
from data) added  
to plot**

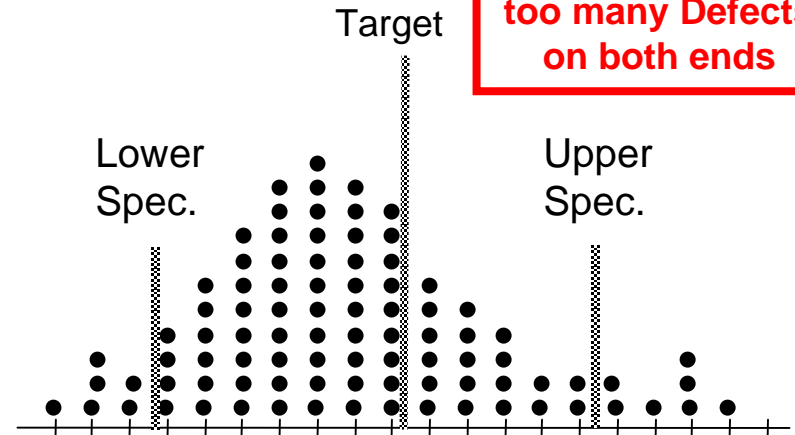
**Centerline usually  
average instead of  
median**

# Measure: Process Capability

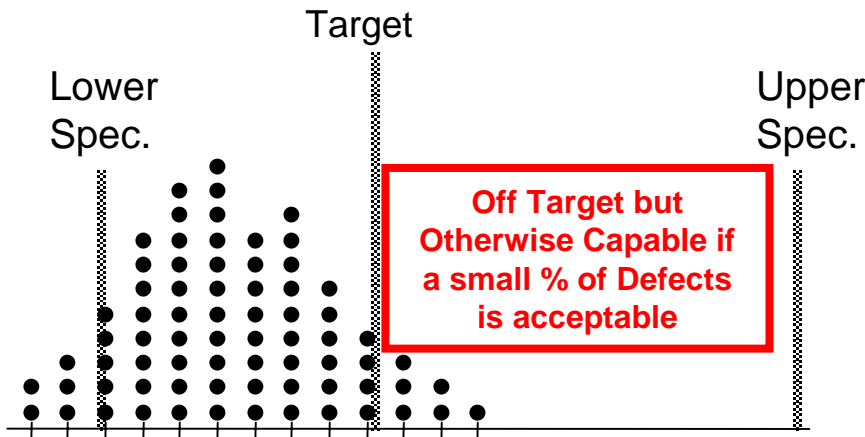
**On Target and Capable of Meeting Customer Needs**



**Not Capable Even if On Target too many Defects on both ends**



**Off Target but Otherwise Capable if a small % of Defects is acceptable**



# Measure: FMEA (funneling the x's)

- FMEA identified 3-5 Input Variables that were causing the majority of the concerns within the process

Input X's from Process Map	In what ways might the process potentially fail to meet the process requirements and/or design intent?	What is the effect of each failure mode on the outputs and/or customer requirements? The customer could be the next operation, subsequent operations, another division or the end user.	How Severe is the effect to the customer?	How can the failure occur? Describe in terms of something that can be corrected or controlled. Be specific. Try identify the causes that directly impacts the failure mode, i.e., root causes.	How often does the cause or failure mode occur?	What are the existing controls and procedures (inspection and test) that either prevent failure mode from occurring or detect the failure should it occur? Should include an SOP number.	How well can you detect cause or FM?	SEV x OCC x DET
Not Global	Not look at all parameters of the process that might effect customer satisfaction rating	Departments cannots improve process to have an impact to customer satisfaction	9	Process to obtain feedback only focuses on one part of the process from lead to audit, thus data is not global.	9	None	9	729
Subjective Vs. Objective	Inaccurate data	In ability to impact satisfaction	9	Not a universal or objective measurement system	9	None	9	729
BIAS	Inaccurate Data Collected	Cannot improve process	9	Not collected by 3rd party; Results impacted by current system operations, such as uptime	9	None	9	729
Not understood by the customer	Not clear on the process	minimal impact to satisfaction	5	No proper explanation of the process	5	Review with internal customer of data	5	125
Measurement Interval	Not measuremd consistently	Do not know impact	5	Lack of interval established	5	None	5	125
No Standardized Measurement	Inconsistent data	Inaccurative corrective actions	2	Different resources using different collecton collection tool methods	2	None	2	8
Alignment to Strategic Imperiaives	Not relevent to organizations goals	Not relevent to organizatoin's goals	2	No alignment	2	None	2	8
NPS	Included/not included	Not included in satisfaction rating	1	Incorporate into rating	1	None	1	1
						Total		2454



# Measure: FMEA (funneling the x's)

- FMEA identified 3-5 Input Variables that were causing the majority of the concerns within the process

			How often does or does not occur	Severity	Ranking
			90%	Highest probability does not occur	9
			50%	Moderate probability it does not occur	5
			10%	Low probability it does not occur	1
			Probability of failure	Occurrence	Ranking
			90%	High probability of failure most of the time	9
			50%	Moderate probability of failure most of the time	5
			10%	Low probability of failure most of the time	1
			Detection	Detection	Ranking
			90%	Highly likely will not detect	9
			50%	Moderately likely will not detect	5
			10%	Low probability it will not detect	1

Input X's from Process Map	In what ways might the process potentially fail to meet the process requirements and/or design intent?	What is the failure mode and/or customer concern? The customer's operation and the end user's experience.
Not Global	Not look at all parameters of the process that might effect customer satisfaction rating	Departm improve impact t satisfact
Subjective Vs. Objective	Inaccurate data	In ability satisfact
BIAS	Inaccurate Data Collected	Cannot t
Not understood by the customer	Not clear on the process	minimal satisfact
Measurement Interval	Not measuremd consistently	Do not k
No Standardized Measurement	Inconsistent data	Inaccura actions
Alignment to Strategic Imperiaives	Not relevent to organizations goals	Not rele goals
NPS	Included/not included	Not incl rating

# DMAIIC – Measure (its all about the Current State – is it Capable?)

- Value Stream
- Process Map
- Data Collection Plan – how much is enough?
- Is Current State in Control? – Control Charts
- Is Current State Capable? – Specs (VOC) vs. Control Limits
- Funneling – the trivial many X's – FMEA

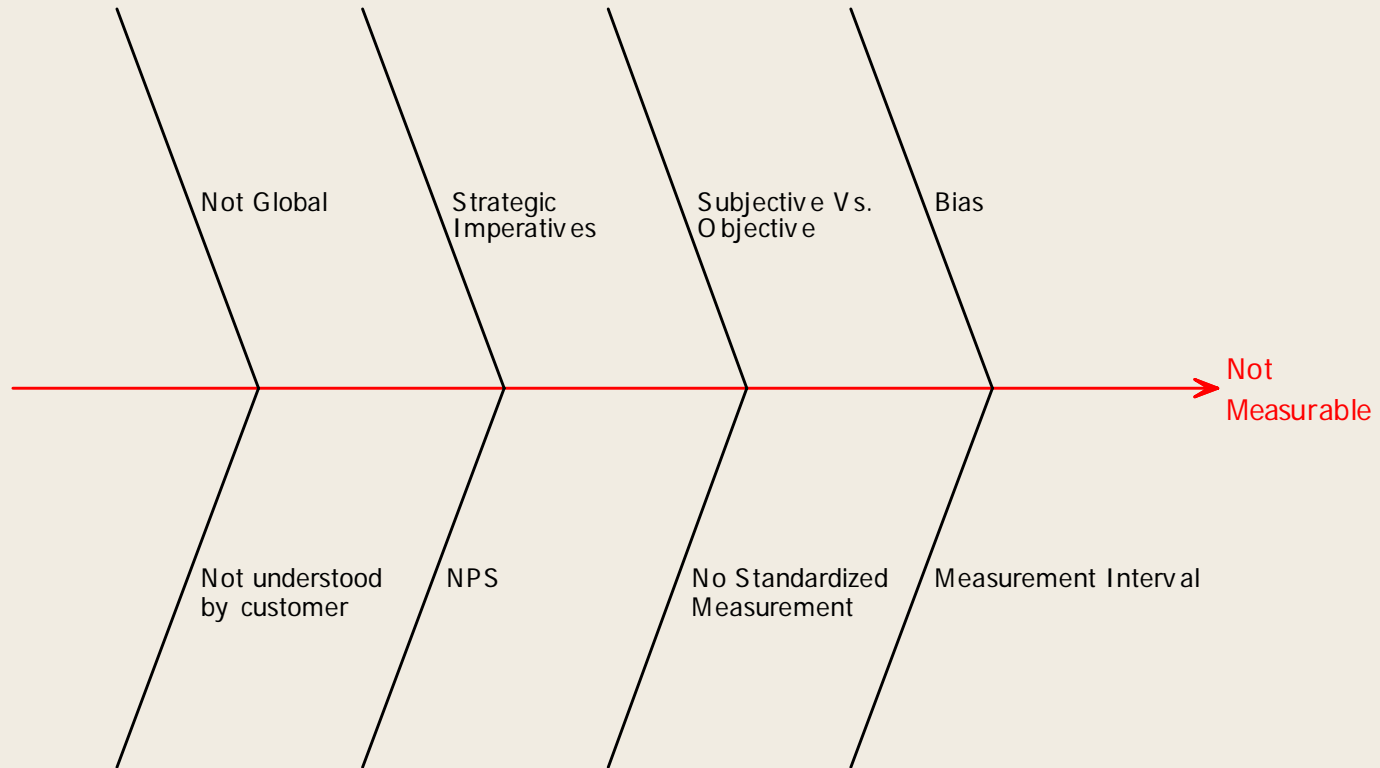
# DMAIIC – Analyze (what is the relationship of my “vital few” x’s, input, to my Y, output?)

---

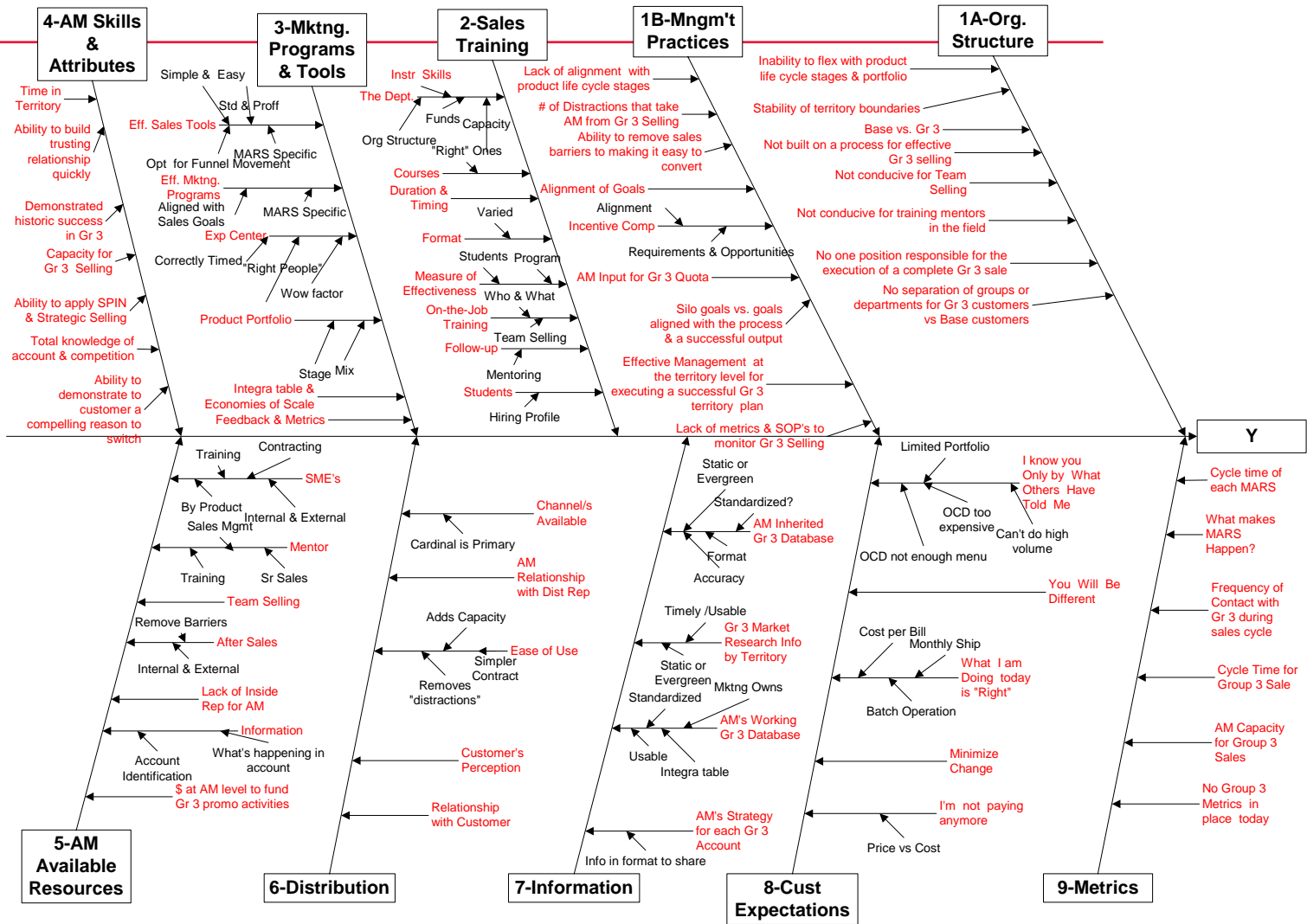
- The “Holy Grail” – the predictable equation –  $Y=f(x_1, x_2, \dots, x_n)$
- Root Cause Identified
- Fishbone Diagram
- Regression Analysis
- Design of Experiments (DOE)

# Analyze: Fishbone Diagram (vital few X's that impact Y)

## Cause-and-Effect Diagram



# Analyze: Fishbone Diagram (vital few X's that impact Y)

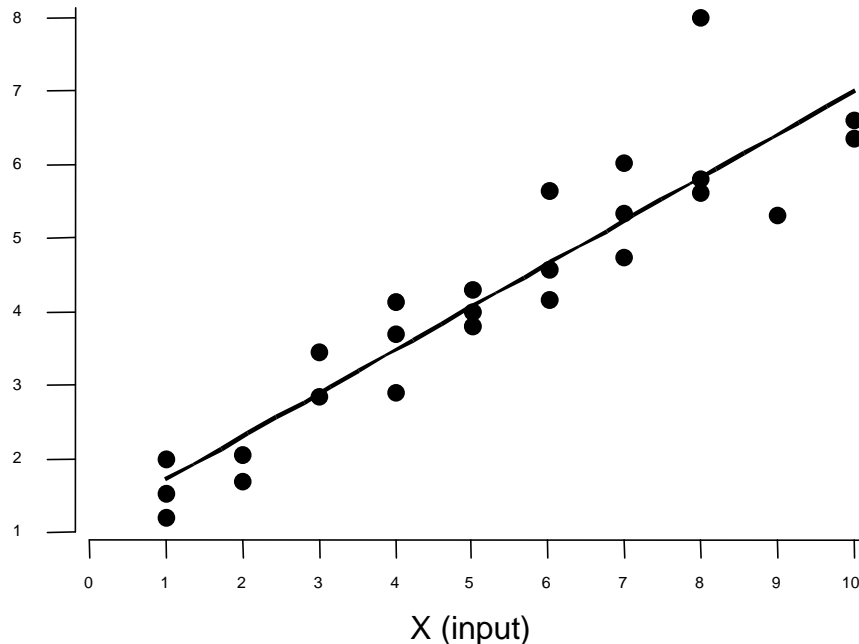


These 10 "branches" were deemed the "Vital Few X's" since they represented all the Affinity Groupings and the Top 15 High RPN's were embedded within the "branches".

# Analyze: Regression Analysis Quantifies the Relationship Between X and Y

Regression analysis generates an equation (represented graphically by a line) that quantifies the relationship between X and Y.

Y (output)



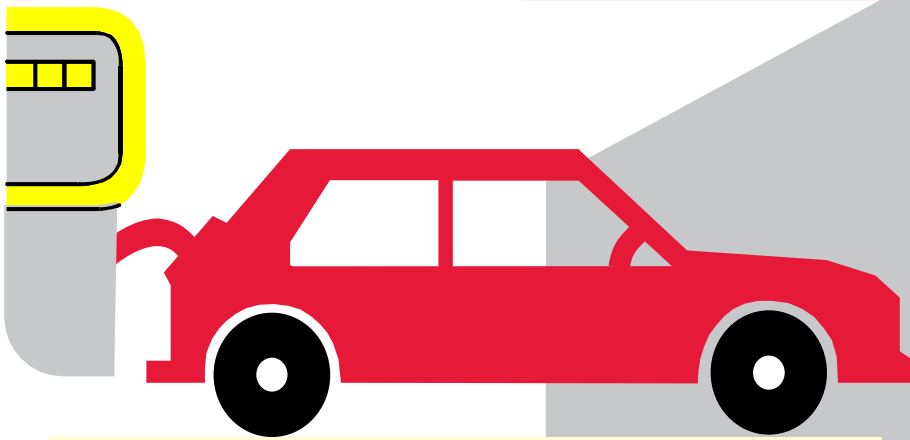
The line, or **regression equation**, is represented as

$$Y = b_0 + b_1X \quad y = mx + b$$

$b_0$  = **intercept** (where the line crosses  $X=0$  or the Y axis)

$b_1$  = **slope** (rise over run, or change in Y per unit increase in X)

# Analyze: Design of Experiments (DOE)



**PROBLEM:** Gas prices have been skyrocketing. The fuel economy of the company car is 20 MPG. Management would like an increase to 30 MPG

## BRAINSTORM LIST OF WAYS TO IMPROVE MPG:

- Change brand of gas
- Change octane rating
- Drive slower
- Tune-up car
- Wash and wax car
- Buy new tires
- Change tire pressure

**QUESTIONS:** How can you “rule in” or “rule out” these possible causes?

How would you know if these possible causes act alone or if they interact with any of the others?

# Analyze: Design of Experiments (DOE)

Std. Order	Factor 1	Factor 2	Factor 3
------------	----------	----------	----------

1	-	-	-
2	+	-	-
3	-	+	-
4	+	+	-
5	-	-	+
6	+	-	+
7	-	+	+
8	+	+	+

• A **full factorial** involves all possible combinations

- For 3 factors, each at 2 levels, there are  $2 \times 2 \times 2 = 8$  combinations of factor settings
- $2 \times 2 \times 2$  is often written as  $2^3$ 
  - The superscript 3 indicates the number of 2's multiplied together
- For 3 factors there are  $2^3 = 8$  possible combinations of factor settings

After I am done with this I should have a Predictable Equation for my Y/Y's. Be sure to test Predictability!



# DMAIIC – Analyze (what is the relationship of my “vital few” x’s, input, to my Y, output?)

---

- The “Holy Grail” – the predictable equation –  $Y=f(x_1, x_2, \dots, x_n)$
- Root Cause Identified
- Fishbone Diagram
- Regression Analysis
- Design of Experiments (DOE)

# Bringing Order to Chaos:

---

**Improve an Existing Process**

**Create a New Process**

**Create a New Product**

• **DMAIIC**

• **DMADV**

• **DESIGN EXCELLENCE**

**Define**

**Measure**

**Analyze**

**Innovative Improvement**

**Control**

**I See**

**What I will do & How it compares**

**How I will make it last**

# DMAIIC – Innovative Improvement (create solution, pilot, compare & implement)

---

- Brainstorm
- Solution Prioritization Matrix
- Effort vs. Impact Graph
- Kaizen on Current State Value Stream to Create Future
- 5S (Sort, Set in Order, Shine, Standardize, Sustain)
- Mistake Proofing
- Flow
- Pilot
- Retest Process Capability
- Revisit FMEA (calculate new RPN's for improved process)
- Implementation Plan

# Innovative Improvement: Brainstorming Techniques to create solutions

---

- **Quick and Dirty Techniques:**

- Think Like a Kid
- Challenge the Rules
- Set a Deadline
- Get Rid of Excuses

- **Alternatives to**

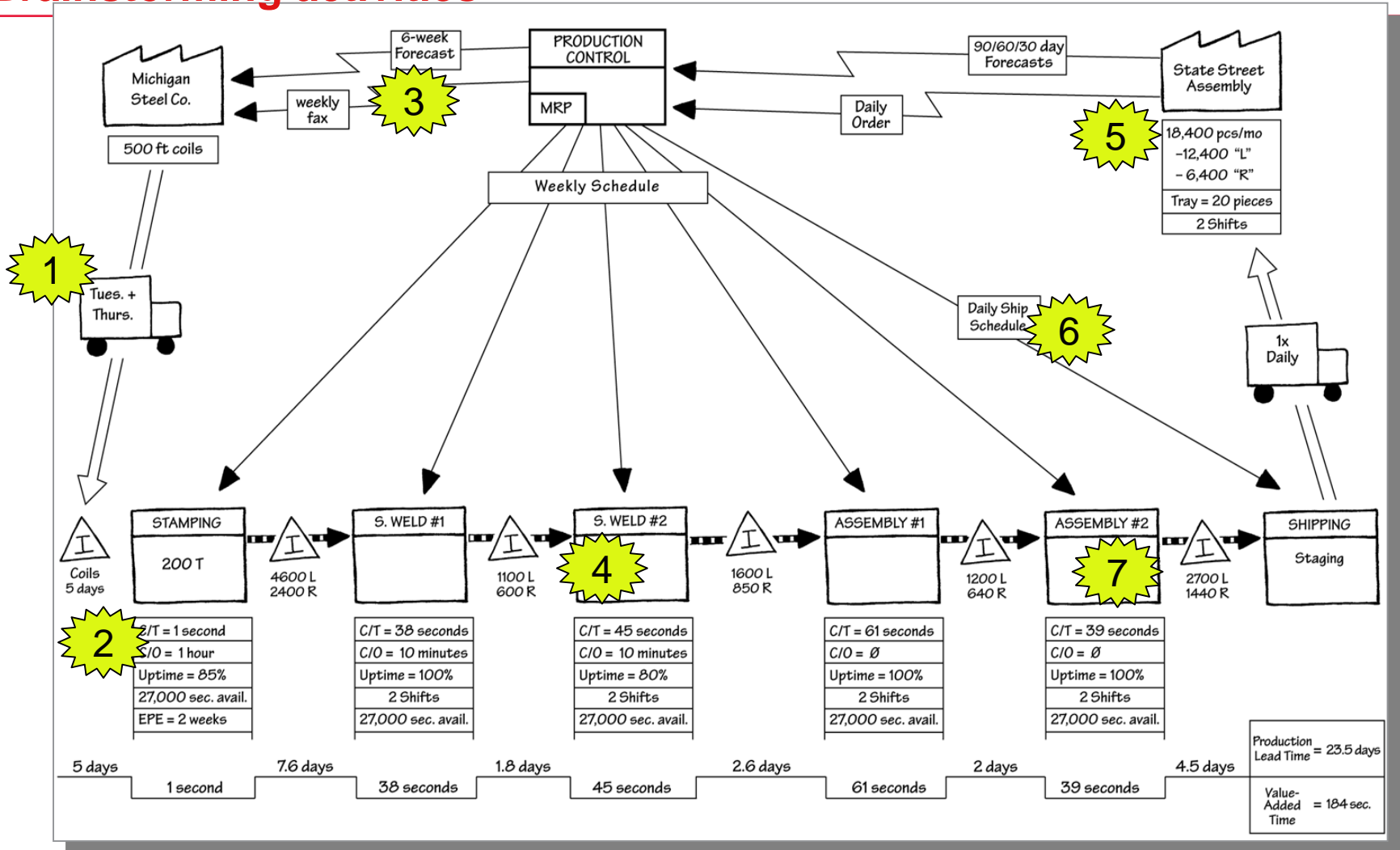
- **Face to Face:**

- Chain Letter
- Billboard

- **More Involved Techniques:**

- Channeling
- Anti-Solution ('Evil Twin')
- Analogy
- Musical Chairs
- SCAMPER
- Slice and Dice
- Idea Box
- Brutethink

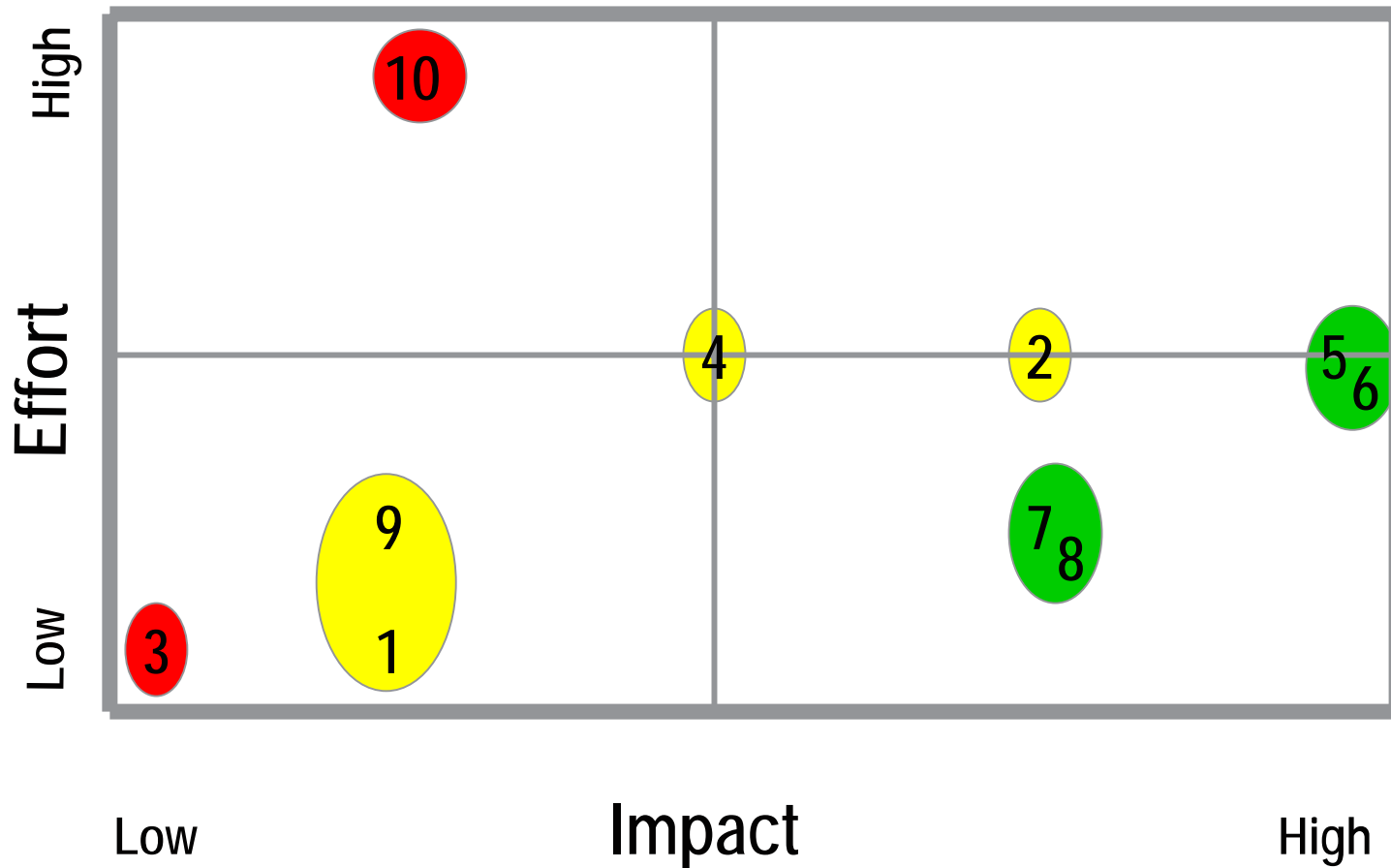
# Innovative Improvement: Current Value Stream Map with Kaizen Bursts indicating opportunity areas for improvement from Brainstorming activities



Ref "Learning to See" Rother & Shook

# Innovative Improvement: Effort vs Impact Graph for prioritizing all possible solutions

---



# Innovative Improvement: Solution Prioritization Matrix for prioritizing solutions

This is a team exercise! Has to be collective alignment of your project team!

Alternative  
Solutions

<b>Criteria&gt;</b>	Cheap Implem.	Quick Implem.	Compat. Technol.	Cheap to Operate	Satisfies CTQs	<b>SUM</b>
	<b>Weight&gt;</b>	4	5	2	1	
<b>Alt. A</b>	1	5	1	5	9	108
<b>Alt. B</b>	5	1	5	1	5	76
<b>Alt. C</b>	9	1	9	9	1	76
<b>Alt. D</b>	5	9	5	5	5	120

# Innovative Improvement: Lean Improvements

---

## Pictures of Lean examples:

- 5S (Sort, Store, Shine, Standardize, Sustain)
- Mistake Proofing
- Flow

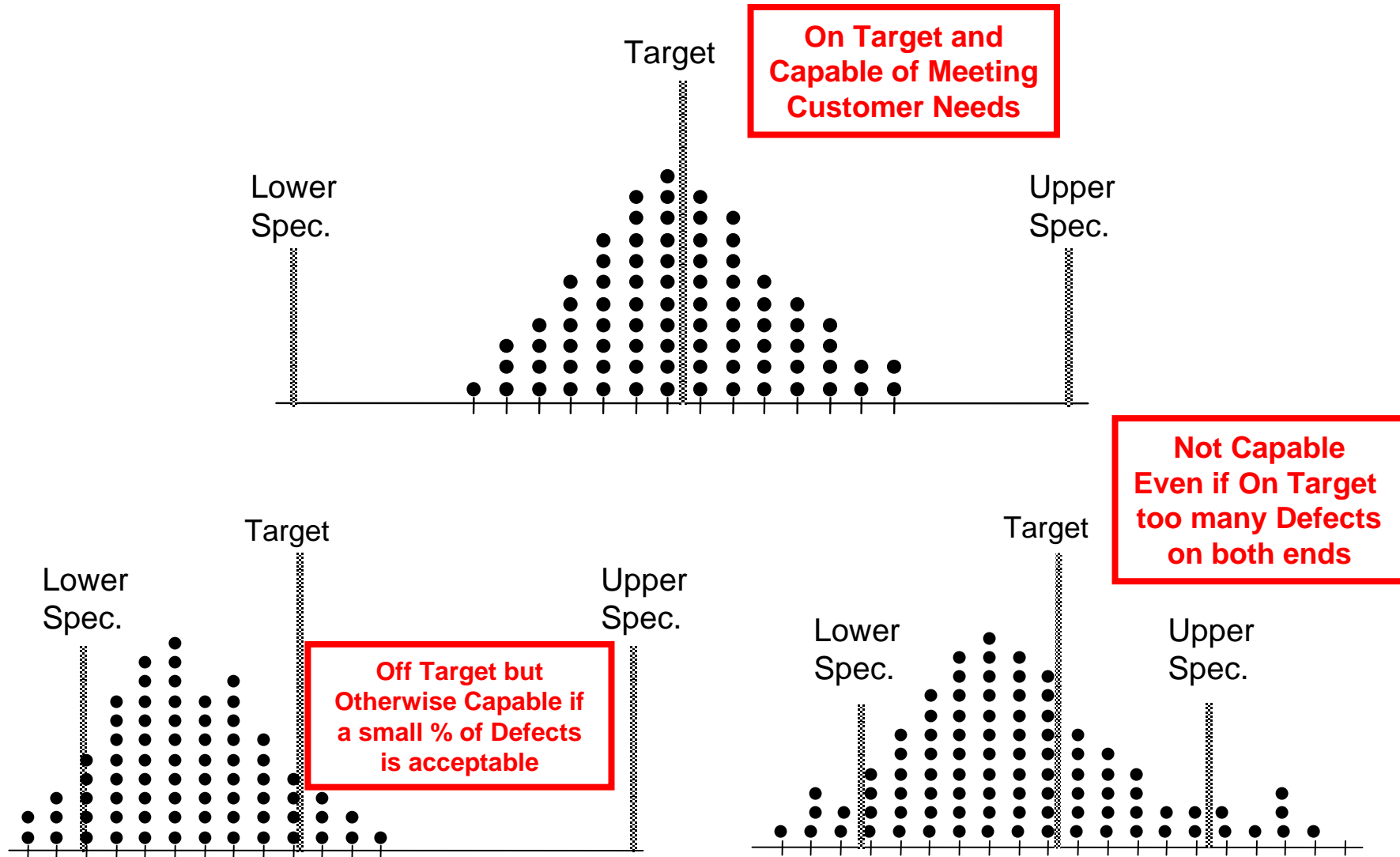


# Innovative Improvement: Run the Pilot

---

**Take the best solution/s  
and run a pilot!**

# Innovative Improvement: Redo Process Capability with New Process to be sure the New Process is Fully Capable



# Innovative Improvement: ReVisit the FMEA & reclassify with improvements

- FMEA identified 3-5 Input Variables that were causing the majority of the concerns within the process

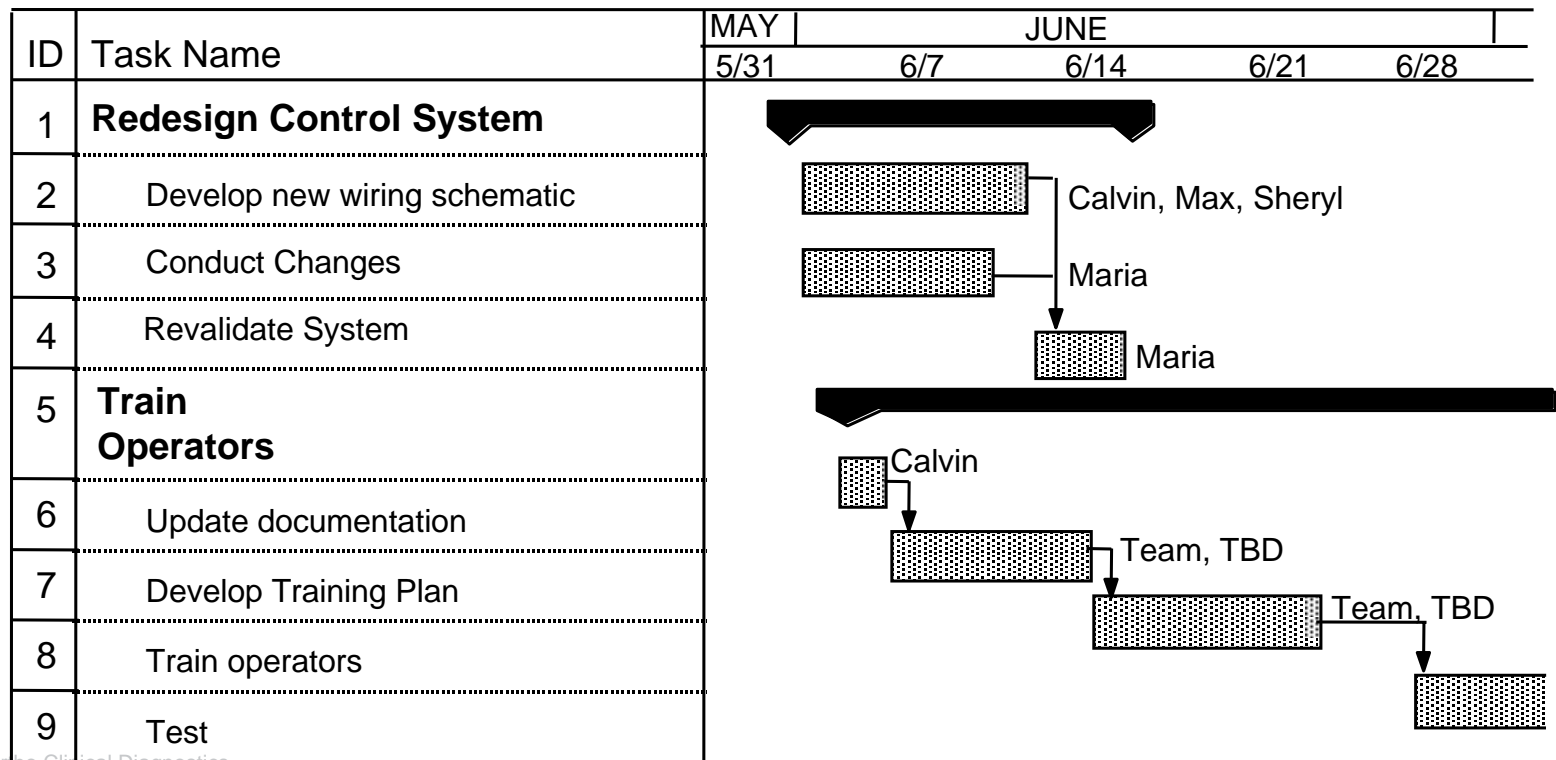
Input X's from Process Map	In what ways might the process potentially fail to meet the process requirements and/or design intent?	What is the effect of each failure mode on the outputs and/or customer requirements? The customer could be the next operation, subsequent operations, another division or the end user.	How Severe is the effect to the customer?	How can the failure occur? Describe in terms of something that can be corrected or controlled. Be specific. Try identify the causes that directly impacts the failure mode, i.e., root causes.	How often does the cause or failure mode occur?	What are the existing controls and procedures (inspection and test) that either prevent failure mode from occurring or detect the failure should it occur? Should include an SOP number.	How well can you detect cause or FM?	SEV x OCC x DET
Not Global	Not look at all parameters of the process that might effect customer satisfaction rating	Departments cannots improve process to have an impact to customer satisfaction	9	Process to obtain feedback only focuses on one part of the process from lead to audit, thus data is not global.	9	None	9	729
Subjective Vs. Objective	Inaccurate data	In ability to impact satisfaction	9	Not a universal or objective measurement system	9	None	9	729
BIAS	Inaccurate Data Collected	Cannot improve process	9	Not collected by 3rd party; Results impacted by current system operations, such as uptime	9	None	9	729
Not understood by the customer	Not clear on the process	minimal impact to satisfaction	5	No proper explanation of the process	5	Review with internal customer of data	5	125
Measurement Interval	Not measuremd consistently	Do not know impact	5	Lack of interval established	5	None	5	125
No Standardized Measurement	Inconsistent data	Inaccurative corrective actions	2	Different resources using different collecton collection tool methods	2	None	2	8
Alignment to Strategic Imperiaives	Not relevant to organizations goals	Not relevent to organizatoins goals	2	No alignment	2	None	2	8
NPS	Included/not included	Not included in satisfaction rating	1	Incorporate into rating	1	None	1	1
						Total		2454

Reclassify the severity, occurrence, and detection ratings with the new improvements to get a new, lower RPN. Proving that the improved process is quantifiably better.

# Innovative Improvement: Create an Implementation Plan, e.g. Gantt Chart

- A Gantt chart is a diagram that shows the timing, duration, and interrelationship of steps in a plan. See sample below, made in Microsoft Project software:

## Rearrange Machine Controls



# DMAIIC – Innovative Improvement (create solution, pilot, compare & implement)

---

- Brainstorm
- Solution Prioritization Matrix
- Effort vs. Impact Graph
- Kaizen on Current State Value Stream to Create Future
- 5S (Sort, Store, Shine, Standardize, Sustain)
- Mistake Proofing
- Flow
- Pilot
- Retest Process Capability
- Revisit FMEA (calculate new RPN's for improved process)
- Implementation Plan

# Bringing Order to Chaos:

---

**Improve an Existing Process**

**Create a New Process**

**Create a New Product**

• **DMAIIC**

• **DMADV**

• **DESIGN EXCELLENCE**

**Define**

**Measure**

**Analyze**

**Innovative Improvement**

**Control**

**I See**

**What I will do & How it compares**

**How I will make it last**

# DMAIIC – Control (sustain the gain!)

---

- Visual Controls
- Production Metrics
- Audits
- SOP's
- HR Performance Measures
- Huddles
- Kaizens

# Control: Visual Control in the Workplace

---

Pictures of Lean examples of Visual Control in the Workplace



# Control: The Periodic Audit (great tool for sustaining improvements)

## Rating Scale Guide

Score	Description of Score
1	No apparent attempt to institute/enforce &/or adhere to the principle
2	Principle has been instituted, but no apparent attempt to enforce or sustain
3	Principle has been instituted and displays signs of sustainability and enforcement
4	Principle is being sustained and enforced, and there are positive signs of a plan to track performance
5	Principle is sustained and enforced. Kaizen events occur frequently.

[Main Menu](#)

[5S](#)

[Operations](#)

[Metrics](#)

[Supply Chain](#)

# Control: The Periodic Audit (great tool for sustaining improvements)

## Auditor's Checklist

1	<input type="checkbox"/>	WORK SCHEDULE WITHIN HEPATITIS TESTING AREA
2	<input type="checkbox"/>	SCHEMATIC DIAGRAM OF HEPATITIS WORK CELL
3	<input type="checkbox"/>	SCHEMATIC DIAGRAM OF PRODUCT / OPERATOR FLOW
4	<input type="checkbox"/>	SOP OF HEPATITIS WORK CELL OPERATIONS
5	<input type="checkbox"/>	SOP FOR HEPATITIS TESTING AND / OR REPEATS
6	<input type="checkbox"/>	DOCUMENTATION OF PREVENTATIVE MAINTENANCE
7	<input type="checkbox"/>	DOCUMENTATION OF QUALITY CONTROL LOG
8	<input type="checkbox"/>	DOCUMENTATION OF PRODUCTION METRICS
9	<input type="checkbox"/>	Example of LIS Printout
10	<input type="checkbox"/>	DIGITAL CAMERA

# Control: The Periodic Audit (great tool for sustaining improvements)

## Section 2: Work cell Operations

### 2.1 FLOW

2.1.1 Tubes received into ID testing area are batched according to assay family?

Yes  No

2.1.2 Defects are being detected and documented throughout the process?

- Pre-Analytical Area

Yes  No

- Analytical Area

Yes  No

- Post-Analytical Area

Yes  No  Not Applicable

2.1.3 Each person(s) is only working on one process at a time and completing the process prior to moving to next tube

Yes  No

- Flow of Operator adheres to schematic diagram

Yes  No

2.1.4 Flow of Product adheres to schematic diagram

Yes  No

#### 2.1.6 VISUAL MANAGEMENT CONTROL

2.1.6.1 Are tubes presented visually for processing?

Yes  No

Is there a specific area designated for the activity above?

Yes  No

2.1.6.2 Are repeats / defects presented visually for corrective action?

Yes  No

Is there a specific area designated for the activity above?

Yes  No

2.1.6.3 Are tubes presented visually for cold storage racking?

Yes  No

Is there a specific area designated for the activity above?

Yes  No

# Control: The Periodic Audit (great tool for sustaining improvements)

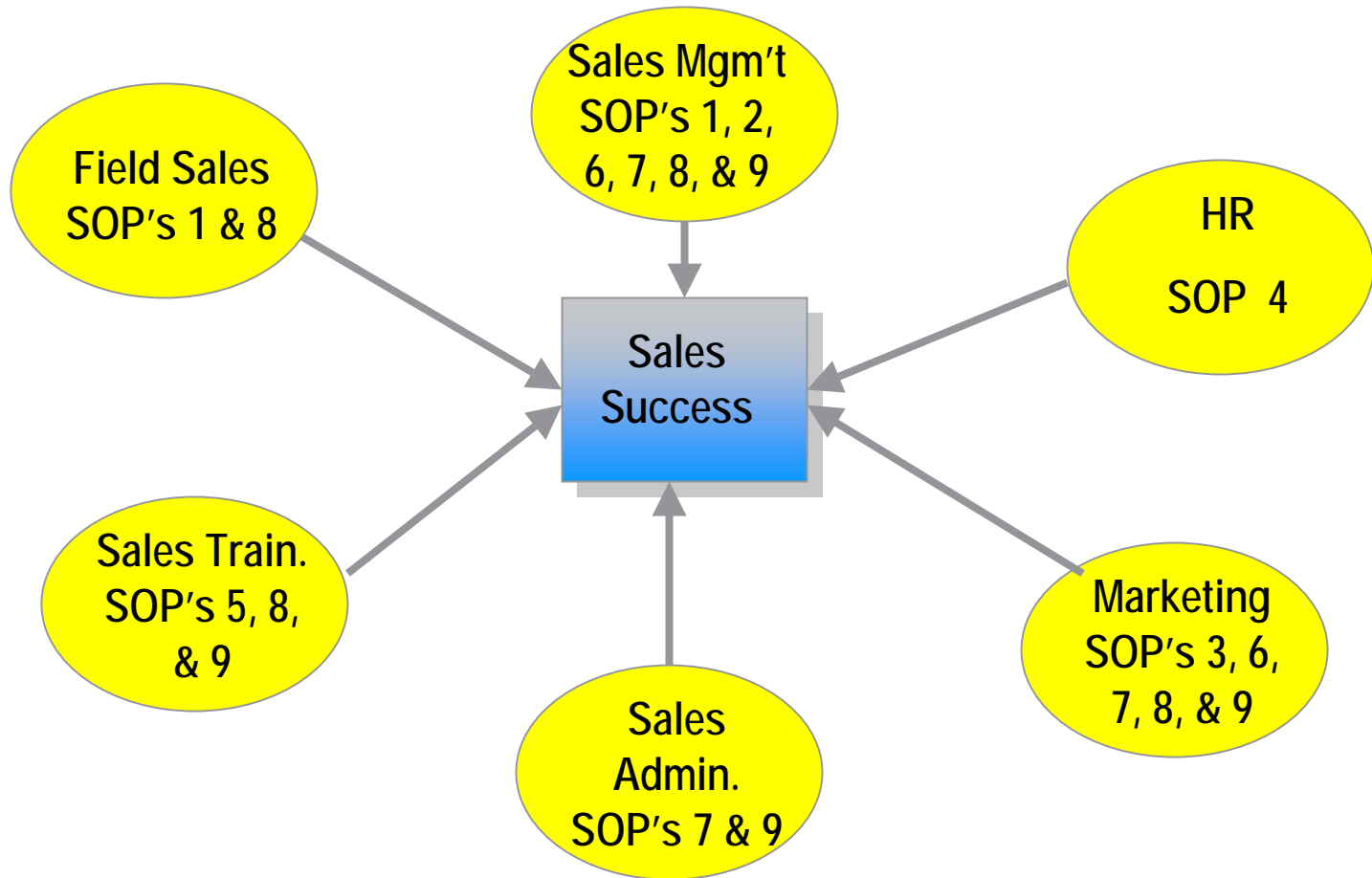
## Section 5: Integrated Supply Chain

### 5.1 VISUAL MANAGEMENT CONTROL - 5S

	<b>RATING</b>
5.1.1 Are supplies and reagents neatly organized and labeled properly?	2
5.1.2 Is there method standardization for storing and stocking of supplies and reagents?	2
5.1.3 Evidence of Re-Order points and/or Kanban cards?	1
5.1.4 Evidence of Product Stock rotation - FIFO Methodology?	1
5.1.5 Evidence of Poka-Yoke system for new lots received?	1
5.1.6 Evidence of Poka-Yoke system for product replenishment at Hepatitis work cell?	1

# Control: SOP Integration for Success

---



**Sales Success was the “Y” of the project**

# DMAIIC – Control (sustain the gain!)

---

- Visual Controls
- Production Metrics
- Audits
- SOP's
- HR Performance Measures
- Huddles
- Kaizens

# Bringing Order to Chaos:

---

**Improve an Existing Process**

**Create a New Process**

**Create a New Product**

• **DMAIIC**

• **DMADV**

• **DESIGN EXCELLENCE**

**Define**

**Measure**

**Analyze**

**Innovative Improvement**

**Control**

**I See**

**What I will do & How it compares**

**How I will make it last**

# Intent:

---

## **Using the DMAIC Process to Direct the Sequencing of Lean/Six Sigma Tools for Successful Project Outcomes**

**The purpose** of this presentation is to share with the attendees my experience over the past 5 years using the DMAIC Process how to determine what Lean and/or 6 Sigma tools is the best to use when for assuring successful outcomes of your projects.

### **Learning Objectives:**

- 1.) Clear understanding of DAMIC Process
- 2.) Clear understanding of which common Lean and 6 Sigma Tools are best used in what stage of DMAIC
- 3.) Clear understanding of how to assess success for a project and know if you have achieved it.

### **After Attending the attendees will:**

- 1.) Know what the DMAIC process is and how it is applied in project planning
- 2.) Understand which Lean and 6 Sigma tools are used in what sequence to assure successful project outcomes



# Using the DMAIC Process to Direct the Sequencing of Lean/Six Sigma Tools for Successful Project Outcomes

## GOOD LUCK!!

Ortho Clinical Diagnostics  
a *Johnson & Johnson* company

Jim Ellis

Certified Master Black Belt J&J PE  
Director – US Sales Strategic Accounts

[jellis@its.jnj.com](mailto:jellis@its.jnj.com)

