MITOCW | Ses. 2-4: Improving the Enterprise, Healthcare Option

EARLL MURMAN: OK, the title of this module is Improving the Enterprise. And just to put it in context, we inherited a poorly performing clinic. We have applied lean, what we call local lean. But now we're going to look at, how do you handle issues that are outside the span of control of the clinic? And this is where you usually end up.

That's the objective for the rest of the afternoon, with the exception of the very-- at very end, we're going to tee you up on a homework assignment. OK, so if you want to improve the whole enterprise, you can't just do it locally. You'll end up suboptimizing the enterprise. You may optimize yourself locally, but you'll suboptimize the enterprise.

So we want to work through on how organizations can adapt to external constraints and implement lean. And the mode we're going to do this is something called a rapid process improvement workshop, which is one way to implement lean across a wider group than what you have here. We're going to look at including a daily management system, which is a little bit of an add-on. And then we're going to see we have some trouble doing that, and we'll discuss it.

OK, so just to frame this, health care operations are often impacted by decisions which are outside the control of the clinic. I mean, this is regulations, insurance, resource constraints. We had something earlier this afternoon, where we had some change of employees. It was beyond the purview of the clinic. We had to adjust for that. That was a disruptive thing we had to handle, which is not unusual.

And we need to optimize at the enterprise level, as I've already said. Otherwise, we may not optimize across our whole enterprise. OK, I think this has already been contained. What I'd really like to do is get some examples from your own experience. Or what are some external things that you've experienced that have disrupted your enterprises you work with? Yeah?

AUDIENCE: Well, just patients showing up all in one bunch. Like when I was on triage as a medicine resident, all of our admissions would show up at 4:30 in the afternoon. Because everyone was coming to the ER in the afternoon. And then, by the time they got worked up, that load would hit the medicine admitting team at 4:30. So it's kind of the--

EARLL MURMAN: So yeah, this is a classic thing, isn't it, that the one department in the enterprise impacting the other department. And it's out of your control. And of course, yeah, exactly. And it can happen the other way, too, that the admissions, they're not being admitted into the hospital. So they're piling up in the ER and affecting the ER. OK. Other things? Yeah?

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: Pardon?

AUDIENCE: Funding.

EARLL MURMAN: Funding. OK, so resources-- here's the thing, where you know you can do something. You want to do something, but you can't get the funding. Or maybe you get the funding, and then there's a reduction.

I mean, that's happening in my local hospital now in Washington state. The state's grappling with a $2 billion budget shortfall gap. And they provide basic health coverage for underemployed people in the state. I live in a rural community.

My hospital has a lot of these people. They're about ready to lose all that money, and they still have to treat the patients. OK. It's beyond their control. I mean, they can go down to Olympia and lobby a little bit. But basically, it's beyond their control. Yeah?

AUDIENCE: So I've been working on a telephone operations improvement project recently with an ancillary department, where we only have three front desk staff. And our intervention was to separate one of the front phones in the back area and then have just the front desk staff locked at the front, directly interact with patients, and not have to worry about phone calls.

And in doing our pilot, to the two-week PBSA pilot, some days, we only had one staff actually show up to work. So obviously, our plan didn't go as it would have, if we had the three staff.

EARLL MURMAN: Yeah. So there you got an employee issue. Yeah. It might have unreliable employees, or maybe there are complications in their family life, that they couldn't come or whatever.

AUDIENCE: [INAUDIBLE] sick.

EARLL MURMAN: Sick, yeah. Any other examples? Yeah?

AUDIENCE: The recession-- our economics and how it affects our patients [INAUDIBLE].

EARLL MURMAN: Yeah, I mean, we can't control the world, right? We're in an environment imposed on us, and we have to deal with it. Yeah. Any examples you can think of?

AUDIENCE: Space constraints.

EARLL MURMAN: Space constraints.

AUDIENCE: When your capacity exceeds your [INAUDIBLE].

EARLL MURMAN: Yeah, just not enough facilities. OK, so these are not unusual disruptions. OK, so we say this is a statement. I suppose it may be more of a hypothesis. But the lean organizations, by their nature, are maybe more adaptable to change than other organizations.

First of all, you're process-oriented. You think about processes. You think less about side or turfs or rice bowls, or those kinds of things. You get process-oriented and think about, how do you change your process?

If you have standardization, which you should if you're a good lean organization, it means you're going to have fewer things to change. You have a stable base on which to change, as opposed to many things that have to be changed.

You're used to thinking of things in rapid cycle times. And that's going to be really this whole rapid process improvement workshop, adapting to change quickly. And you just have a culture where you're accepting of change.

Lean is a Journey. You're always changing. You're always trying to get better. So you're not fearful of change. So these are all things that, in terms of a lean organization, help you in dealing with these external constraints.

Just to anchor this back in this process improvement framework we've been using-- and by the way, a copy of this is in your folders, just for your reference purposes. And why we put it there is to try to impart a thought process of structured approach to change and not ad hoc approach to change. So this is one structured approach. There are many other structured approaches. This is one that we adopted, just to give you one.

And right now, we're in here. We're going to be doing another. We're going to have some changes we're going to introduce to you. They're going to be beyond your control. And we're going to have to figure out how to respond to them, develop an implementation plan, and try it out.

And in doing this, as you go beyond your clinic, you're going to have to interact with a wider group of stakeholders. And that's part of the complexity of it. We've heard from Beau, for example, already about that.

So let's talk a little bit about stakeholders. We had this slide up yesterday in a slightly different format. But a health care enterprise like yours has a lot of stakeholders. And let's just try to identify, in the interest of time and keeping this focus, for our clinics here, who are our major stakeholders?

AUDIENCE: Patients.

EARLL MURMAN: Patients, OK. OK.

AUDIENCE: Suppliers.

EARLL MURMAN: Suppliers, OK.

AUDIENCE: Providers.

AUDIENCE: Providers and doctors and the medical staff.

EARLL MURMAN: Yeah, so you have the staff, medical staff. Why don't we just put all the staff together. There's the medical and the administrative. For now, let's just call it staff. Any other stakeholders in our simulated clinic environment?

AUDIENCE: Investors?

EARLL MURMAN: Investors, OK.

AUDIENCE: The government.

EARLL MURMAN: OK. The government is an important stakeholder, but probably not so much for our classroom environment here. But there is another important-- yeah?

AUDIENCE: Oh, whoever's regulating.

EARLL MURMAN: We've got management. It's called managers-- CFO or CMO, or whatever it is. You've got somebody you're reporting to. They keep imposing new things on you and saying, you can't do this, you can't do that.

AUDIENCE: You've got the payers as well.

EARLL MURMAN: Payers, OK. We haven't actually collected any money from them yet. . OK, this is a pretty good group. So let's just stay with that group. But you can imagine, in a more complex enterprise, you're going have more people. You'll have regulators. You might have partners.

My hospital, for example, can't do a number of procedures as a small hospital. So partners with Swedish Hospital, in Seattle, and Harrison Hospital, in Bremerton, these are important stakeholders; EMS systems. They're all sorts of other partners.

Now, we had this slide up yesterday, too. But each of these stakeholders expects some value from your enterprise. So let's just think, what value do patients expect from your clinic?

AUDIENCE: Quality.

EARLL MURMAN: Quality. OK, so remember, we've been doing that managements ask you, every so often, did some patient get treated incorrectly? That's a concern they track that.

AUDIENCE: Affordability.

EARLL MURMAN: Affordability. OK. Maybe we should introduce a pay for service, pay for performance option in this simulation. We haven't done that yet. OK.

AUDIENCE: [INAUDIBLE]

AUDIENCE: Quick access?

EARLL MURMAN: Access, yep. Access-- they want to get treated.

AUDIENCE: The time.

EARLL MURMAN: Time?

AUDIENCE: Time.

EARLL MURMAN: Time. OK. That's a metric we've been tracking.

AUDIENCE: Safety [INAUDIBLE]. Safety.

EARLL MURMAN: Safety. Yeah, it's a little bit related to quality, but we'll put it here. OK, how about the suppliers? What are they? And by the way, also, this is a two-way street. I mean, they expect value, and you expect value. Suppliers-- what are some of the value considerations that come in with suppliers?

AUDIENCE: Accuracy? You got the order accuracy.

EARLL MURMAN: Accuracy, OK.

AUDIENCE: Timeliness.

EARLL MURMAN: Timeliness.

AUDIENCE: Cost.

EARLL MURMAN: Cost. And what do you expect from your suppliers? What value do you expect to get?

AUDIENCE: [INAUDIBLE]

AUDIENCE: Quality.

EARLL MURMAN: Quality.

AUDIENCE: Reliability, in both ways, I guess, that they rely on a steady stream of orders.

EARLL MURMAN: Oh, OK. And you rely on them delivering it when you need it.

AUDIENCE: Yeah. I mean, they don't want you to go to their competitors.

EARLL MURMAN: Are you guys happy with your suppliers?

AUDIENCE: I don't know.

AUDIENCE: Generally.

EARLL MURMAN: If you had to rate 0 to 10, how would you rate your suppliers, 0 to 10.

AUDIENCE: 8.

EARLL MURMAN: 8.

AUDIENCE: Probably just a [INAUDIBLE]. 5.

[LAUGHTER]

EARLL MURMAN: Our supplier just joined us. OK.

[LAUGHTER]

OK, what value do the staff expect?

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: What do you want to get out of your clinic?

AUDIENCE: Not feeling overloaded.

EARLL MURMAN: OK. You want an acceptable workload.

AUDIENCE: Just then value-added work.

EARLL MURMAN: Value-added work, OK. Do you feel like they're doing value-added work now?

AUDIENCE: Yes.

EARLL MURMAN: Yes? Good. All right. Thinking back to the exercise in the people module yesterday about some of the things you value as employees-- you're the staff-- what are things that come to mind?

AUDIENCE: [INAUDIBLE] respect.

EARLL MURMAN: Respect.

AUDIENCE: Cooperation.

EARLL MURMAN: I know it's most the clinics are working overtime. Is that something you like?

AUDIENCE: [INAUDIBLE] or something.

[LAUGHTER]

EARLL MURMAN: Yeah, salary was important, too, wasn't it?

AUDIENCE: Communication.

EARLL MURMAN: Communication. OK. I'll show you a little later on a slide. But my local hospital, what the staff picked is their measure. Their surrogate metric they track for their satisfaction is finishing work on time and not taking anything home. That was the one metric they track. And they tracked that metric.

AUDIENCE: Safety to [INAUDIBLE].

EARLL MURMAN: Safety, yes.

AUDIENCE: And [INAUDIBLE].

EARLL MURMAN: Oh, teamwork, teamwork-- got you. OK, so there's a long list here. OK, let's not spend too much more time on this. Let me just skip these two, because they aren't really too much players in our system. But what about our management? What are they looking for?

[INTERPOSING VOICES]

EARLL MURMAN: Perform [INAUDIBLE]. Performance. We've got some metrics up here they're tracking. We know they're tracking performance. We're measuring it in terms of patients served. We're looking at error safety, basically, or errors, like quality. OK.

Legal reliability.

EARLL MURMAN: Reliability.

AUDIENCE: Legal liability.

EARLL MURMAN: Oh, legal liability.

AUDIENCE: Patient satisfaction [INAUDIBLE].

EARLL MURMAN: Yeah, they don't want to hear from angry patients. Luckily, our patients aren't talking.

[LAUGHTER]

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: OK. Patient satisfaction. OK, well, I just wanted to make-- we wanted to bring some of these out. And we're going to start addressing them. So let's move on. I'm going to skip the next slide, which is our discussion slide, which we just did.

I'm going to put this up here. But we're not going to spend much time on ideal state now. Because we're a little behind schedule. But we have a value stream. We have an improved value stream. And we've talked before about thinking of the ideal state value stream.

And this is a nice quote that comes from Sue's partner, Cindy Jimmerson, whose book I recommend to you, that this is what the ideal state would be. "Giving the customers exactly what they want, when they want it, is a core principle of an ideal state." OK, well, our customers, our main customers, are our patient.

So this is what we would really like to do for our patient. So "as you observe work in progress, note the delays in care created by caregivers waiting for the necessities from their suppliers." Now, we don't have a lot of suppliers here. But we have had to wait for them. But that kind of delay is just passed on.

So this is another reason. If you want to optimize the performance of your clinic or improve it, you're probably going to have to include your suppliers. That's very common. I'm going skip over this.

OK, so that's just some sort of framing discussion for what we're going to do. Now, management's told me-- and the reason they had me come today to do some training, because management told me that there are going to be some disruptions coming soon from the enterprise, from these CXOs. And they wanted me to get you ready for handling those.

OK, so this is going to involve working across clinics to handle these disruptions. By the way, in terms of access, and we have a problem with access here, some patients aren't being treated. We don't have the right diagnostic equipment. So we're sending them home untreated. And the management's not happy about that. The patients are unhappy about that.

So how do we go about working across clinics? OK, a good way to do it is something called a rapid process improvement workshop. And what is that? Well, that's a focus on a specific improvement opportunity, as we're going to have coming up here in a minute. It's an event that's chartered by a sponsor in the organization, one of the managements, who sets the goals, the what has to be done, and the constraints, and provides the resources.

And the resources are-- we'll get to those in a minute. But they're mainly people. They provide coaches and facilitators to help you.

A rapid process improvement workshop never goes over a week. Most of them are a week long. Sometimes they're less, if it's a less complex problem. But it takes several months of planning to get ready for this.

And what it does is it brings together, for the week, all the people who need to interact to address this improvement opportunity. And the opposite of that is that these people-- the contrast would be that these people are mainly doing their day jobs, wherever they are, and you're trying to do this improvement opportunity over a distributed group of people in time and space. And what might take six months to a year just to coordinate, you get done in one week.

But in that week, that's all these people do. They're released from all their other activities, and they participate in this. And this is the kind of thing that Sue does. I presume you run these, don't you?

AUDIENCE: Some of them.

EARLL MURMAN: Yeah. Yeah. OK, so it involves all the stakeholders. It's a very data-driven process. We've been trying to emphasize you work with data. You get the value-stream data. The week ends with actually a beginning of an implementation and a plan for final implementation.

And so this is how you get a whole enterprise together by getting the right people. This is an example of one I've drawn these slides from, where I sat through with this.

AUDIENCE: [INAUDIBLE] you're actually implementing.

EARLL MURMAN: Yeah, we actually implement. But we implement, but there may be additional training and other things that need to be done. And we'll show you that in a minute. Here's diagrammatically what that is.

So we have a rapid process improvement workshop that's going to be three to five days, say. And it starts by understanding what is important to improve in the enterprise. And there's always more to improve than resources.

So you do some kind of Pareto chart. We've done that informally with this kind of thing we had, which was, what were the big bottlenecks you had to address? So you pick some target. You make a strategic choice on what you're going to improve.

And then you may take three months or so to get ready. You have to go out and get the data. You have to figure out who are the right stakeholders. You have to plan it so the stakeholders can be available. You're going to pour a lot of resources in for one week. But you'll probably pour a lot less resources than if you try to stretch it over six months to a year.

PROFESSOR: And the agreement has to be that the stakeholders do not leave the room, turn off cell phones, and they're cloistered for the whole time.

EARLL MURMAN: Yeah. And they don't arrive late, and they don't go back to some other meeting. That's it. And that's why you need this top level support. OK, then that group is given a charter. And they're given the resources they need and the data they need. And that's a really intense week.

Has anybody participated in one of these rapid process improvement workshops? Sue, Sue and I, and Hugh. You think this course is maybe intense. These are much more intense than that. But the outcomes are great.

So out of that comes your future state and implementation plan. And as Sue said, you actually do the prototype implementation in place. Sometimes you can't do the final implementation.

And then you track it and make sure that it's performing the way you think. And oftentimes, you've misjudged. You made a mistake somewhere. Training is a typical one. You didn't get people trained properly, or something like that. And so you may have to do some follow-up action. And then you feed that back in and do the next rapid process improvement event.

Who are these stakeholders? Well, you want to have the people actually doing the work. In this case, that's you. OK? You want to have some facilitators and coaches. That's Beau and me. And you might think of Hugh as our sponsor.

If we were doing something where suppose we're going to implement some new protocol. Well, we need people from the training department to come. We may need some IT people to write some software.

If we're doing something more physical, we might have facilities on board. They just saw down the walls and move them, right during the week. I mean, this is really action-oriented. OK, so you may need some support facilities. And you want somebody up there at the CEO level who's championing it.

And here's what takes place during the week. So day one-- this is for a five-day-- you come together. You do some team-building. Make sure you're all being able to work with each other. You go to the Gemba and actually see what's happening, make sure you understand what the real problem is.

You'll probably come in with a current state map already done, because that takes some time. And you do a lot of brainstorming. How are we going to address this improvement opportunity that is given to us in our charter? So day one is really getting started.

Day two-- go home and sleep out. You come back on day two, and you say, OK, from our brainstorming, we think this is the way we can go. Here's going to be our draft future state map and strategy. And you have senior management come in the afternoon of day two and say, here's where we're at. And this is the direction we want to go. Do we have your approval?

Let me give you the example I went through in this one, which the pictures are taken from. This was, how do we treat STEMI cases in our hospital? And our hospital can't do a catheter-- doesn't have a catheter lab. And the treatment time was from a presentation to when they were getting finally sent down to Bremerton. Treated was-- I've forgotten, something like several hours.

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: Pardon?

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: STEMI is S T Elevated--

AUDIENCE: S T segment elevation. It's higher tech.

EARLL MURMAN: It's a blockage [INAUDIBLE].

AUDIENCE: A research pattern that shows up, a leakage [INAUDIBLE] right now.

EARLL MURMAN: OK. So we gathered on day one. And we immediately found out, on day one, there was a constraint that was so great, we couldn't solve the problem. And that was, we simply physically couldn't get the patient to my town, to Bremerton, within the 90-minute window that you use for STEMI treatment. And so actually, we were stuck.

And then what happened, we got the cardiologist on the phone and said, we're stuck. And he said, well, if you're stuck on that, the next best thing is to get him the thrombolytic drugs as quickly as possible and then get him to Bremerton.

So we came up with plan B. And plan B, put together that Monday day-- this all happened Monday morning, Monday afternoon-- was to focus on the patient. And the patient was the organizing-- everybody organized around focusing on the patient.

By the way, he had six organizations involved in this workshop-- two hospitals, two EMS drivers, and two cardiologist groups. And decision was, the best we can do is give the patient the thrombolytic drugs in the EMS vehicle on the way to Bremerton. OK? And basically, we put the hospital where the patient was, is what we did.

And the big hangup was, who pays for the thrombolytic drug? Because it's $3,000. They've never gone to the hospital, so the hospital can't be billed for it. The EMS company has no authority to bill for drugs. They can only bill for transportation.

So we had a solution, but a complete blockage. We brought in senior management. And the CEO, right there, Vic Dirksen, said, this is the right solution for the patient. Do it. We'll figure out how to pay for it.

And we really needed that. Without that commitment that he would pay for the drug-- that happened here. Then the team put together the new protocols. Here's the mock-up kit for the thrombolytic drug that's going in the ambulance, training materials, and so on. And by Friday afternoon, we got by everybody we needed to do this. And by Friday afternoon, the protocol was established.

But it took about two or three months to train the medics and to make sure that the hospitals were ready for it, and all that. And that's now the protocol in my community. And there are articles about how many lives it saved in my community. OK, that would have taken two years to do by any other way.

So that's one way to do it. I just want to ask, how does change take place in your organizations compared to this? You're mostly students. But how about--

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: Jennifer, I could ask. OK, good, and I'll Jennifer, because she--

AUDIENCE: In our resident, internal medicine residency program, we were pretty active in [INAUDIBLE] going along with lean thinking, maybe not the formal process on how much the interns and residents were walking out each day, going back and forth between floors, caring for patients, and then trying to move towards a more geographic lean system-- so things like that that affected our work [INAUDIBLE]. So it was kind of doing some trials and then going back and see if [INAUDIBLE].

EARLL MURMAN: Not as focused as this.

AUDIENCE: Not nearly as focused as this. It took a long time.

EARLL MURMAN: It probably took a long-- that long, yeah. Yeah, Martha?

AUDIENCE: I was just going to say, working in a lot of under-resourced areas, the way it really seems to work in real life is that it's based on a branch, or a regulation, or a staff shortage, or a work-around, is how change happens because it has to.

EARLL MURMAN: [INAUDIBLE]

AUDIENCE: Catastrophic event [INAUDIBLE].

EARLL MURMAN: Yeah, or a catastrophic event, yeah. Laura, what about the [INAUDIBLE]?

AUDIENCE: Well, I'm at the medical school. And I teach a course with first and second year medical students. And that course, is constantly evolving. So they do a lot of real-time changing based on feedback. But I'm not so sure that that's always-- it was maybe a little bit too rapid, with not enough-- enough real evaluation of what's going on.

EARLL MURMAN: But this is still a fairly small group? I mean, how many people--

AUDIENCE: The class is-- well, there's about 100 students in a class. And the class manages both first and second year class. So about 200 students total are managed in the class.

And then, when there are other problems that need to be changed, it does take a long time to actually change the facilitator's manual to actually institutionalize some changes. So in some ways, some of the changes take place in a rapid fashion, based on the student input. And then some of them, actually, because the process has to go through the dean and whatnot, it actually doesn't get done.

EARLL MURMAN: And well, it sometimes just dies.

AUDIENCE: It just dies. There's a lot of talk, and then it kind of fizzles-- a lot. And I even think, in residency, there's a lot of ideas that come out. And then they just fizzle away. Because nobody has a real time to actually dedicate to seeing the process through.

EARLL MURMAN: Yeah. So you can't do this for everything. Because this takes a real focused application of resources. So you have to do it for the most important things.

AUDIENCE: Dartmouth has a really complex and wonderful quality department.

AUDIENCE: Yes, so the TDI can handle it.

AUDIENCE: A TDI that can handle a lot of these kinds of things. If you go to them and with a proposal, and they can put a team together.

AUDIENCE: Yeah, yeah. So I'm speaking specifically about at the medical school, what I'm working with at the hospital. Yeah, the TDI works closely with Dartmouth Hitchcock. And they do a lot of some lean and some other. You would know more. But they incorporate a lot of continuous quality improvement, methods--

AUDIENCE: [INAUDIBLE], things that are, I mean, for many years, before they call it lean.

EARLL MURMAN: We had an interesting thing. And I keep drawing on my health care system, because it's my base of firsthand knowledge. But we had an urgent care clinic and a regular clinic in the system. And for financial reasons, it was decided to co-locate them and physically move them and that they would share examination rooms. And these are two groups which had never worked together.

And the groups were not happy about this, this new one. So they had a three-day rapid process improvement workshop. And I was fortunate to go to the final report out on the third day.

And the nurse from the clinic started by saying, Sunday night-- the thing started Monday and finished on Wednesday. She said, Sunday night, I didn't sleep. So I came into this Monday morning just knowing this wasn't going to work, that the whole thing was just going to break down, and we wouldn't be able to work together, and that there was no way we could share examination rooms.

And she came in totally convinced this wouldn't work. By Wednesday afternoon, she and the staff in the urgent care clinic were the best of friends. They had worked through all their issues. She said, this is just remarkable.

Now, can you imagine how long it would have taken for that to happen, if they didn't get this intense environment, with the facilitators and the objective? It probably would have died. Or either that or it would have been dictated by the CEO-- we're going to do it, in which case, they would have not had any ownership in it. And it would have always been a burr under the saddle. So it's really amazing how these things work.

AUDIENCE: I think that the times that I've really seen change work in our department is when, unfortunately, it's mandated. Because we have a lot of people who come with particular interests and establish relationships, people who have decided not to get along, people who have decided that they don't want to collaborate, who have just created their own separate worlds that spin in parallel laws of duplication.

And it really wasn't until the chairman of the department was sitting at a table in a meeting that was called and basically said, this division of labor is unacceptable, and we all have to change, that change actually happened. And then, once that mandate was there, people decided that they were going to try to get along. But unfortunately, the top-down-- the bottom-up approach didn't work, and it had to be a top-down.

EARLL MURMAN: You're lucky you're in an organization where the people eventually decide to get along. Because there are a lot of organizations where people say, we'll just wait till that guy moves on. There really is no bonding. So you're very fortunate on that. Yeah.

OK, so anyway, this is a proven way to implement change, where you've got multiple stakeholders involved. But you've got to do it right. And there's a lot of dynamics going on this week, that you have to have somebody skilled to see.

OK, so what we're going to do is we're going to do a mock RPIW for your next change. We're going to do this five-day in about an hour and a half. But we're going to get to the point where you're actually going to implement your new system. You'll see in a minute what management is going to tell you to do. But we're going to do it like a mock RPIW.

The other thing we're going to do, which is really not as much of an enterprise thing, is we're going to implement a daily management system. Now, a daily management system is an approach where-- in this case, one of our clinics at 7:55 each morning, the entire clinic staff meets for five minutes. And they go over the status of the clinic and what's coming up for the day.

They have a board prepared. This is prepared by the clinic administrator. So it would be like the scheduling person. Here is the previous days-- just like in the New Balance chart, basically, the New Balance thing-- the previous days by provider, how many people they were expected to see, how many they actually saw, all the way down. And this part is the upcoming day, how many people are scheduled and how many open spots there are.

This is feedback from the patients. This is feedback from the workforce staff. I mentioned they track, did everybody go home on time with no work to do? If not, why? And there's some quality metrics they track.

So the clinic administrator gets this all prepared. There's a stopwatch here somewhere. At 7:55, she punches a stopwatch. The meeting starts. At 8 o'clock, it goes off, and the meeting's over. It's not really a meeting. It's--

AUDIENCE: [INAUDIBLE] puddles.

EARLL MURMAN: Yeah, yeah. I've heard it--

AUDIENCE: [INAUDIBLE]

EARLL MURMAN: Yeah. And here's the staff. And this gets everybody in line for the day. And many times, we'll come out as-- find out, well, we've got a patient coming in, and we don't have all the paperwork ready, or something. So they get on top of that right away and get that done.

So we're going to, I believe-- am I right? See, we're going to try to implement daily management system here, too? OK. So right now, the people in the clinic don't see what's coming. Right? Only the scheduler knows what's coming. OK? So we didn't know had three gray bodies coming in. OK? We're going to get that up where it's very visually available to everybody in the clinic, and you can track it in real time.

So the wrap-up is that optimizing lean at the local level is a good place to start. But you can only get so far. And the biggest problem we have right now is that some of your patients aren't getting treated, and there's nothing you can do about it. So we need to solve that problem. And I think there are going to be some other disruptions, that management is thinking about, we have to implement.