9-1-2007

Bend the Curve CIP-News - September, 2007

Bend the Curve Continuous Improvement Practitioners

CI-P News

Bend the Curve

The Ten Commandments of Government: 1) Avoid Mistakes. 2) Avoid Mistakes. 3) Avoid Mistakes. 4) Avoid……

— Walter E. Lowell

September 2007

Volume 2, Issue 9

I remember when I was a kid it seemed like I was always in trouble for something. I didn't follow the rules and there always someone after me, my Mom and Dad, my older brother, my teachers. It was always something.

For a long time I thought that was the way life was and then I got a little older. I actually remember once thinking, "Gee, I'm not in as much trouble as I used to be." This, of course, was an interlude.

When I entered Junior High, older High School boys would, on occasion, drive by me as I was riding my bicycle, stop their car, and start chasing me. Usually, this was over a girl (they said) and fortunately they never caught me, but I almost always lost the girl.

Time eventually had its way with me and I did grow just a little wiser and could run a lot faster! Although I know of at least one who might say the benefit of experience was lost on me, but that's another story.

I recently learned that the brains of boys grow slower than those of girls. Now pay attention all you moms of adolescent boys out there. It turns out the left frontal cortex, the site of decision-making, is not fully myelinated in boys until their early twenties. This sort of means it is prone to short circuiting. Big surprise, huh, mom.

So it's comforting to know that, on the one hand, back then, nature was working against me, but it is scary to think about what my son is currently up to now!

Mistakes — we all make them, don't we?

Mistakes at work happen for all kinds of reasons. Sometimes it's because no one taught us what to do or the right way to do it; sometimes because we don't have all the right information; sometimes because we are just so busy; and sometimes it's all of the above. Despite the reasons, mistakes are costly, and it is not just the big ones. The little ones that often go undetected can get compounded and easily become large ones.

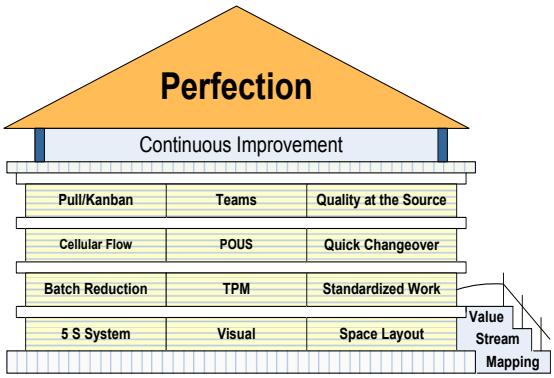
In business, mistakes passed on to customers means loss of business, even threatening the life of the business itself. While in government, when mistakes are passed on to the citizens we serve, the response can be unforgiving and sometimes life-threatening. Worse even, they come to disrespect the very thing — Government — that brings order to our lives.

Cont'd on p.7 —

Inside this issue:

Special points of interest:

- Next Clinicals
  - September 21 - Study Mission
  - October 19
- DOP 1-4 being held 9/17-21/2007 at China Lake Conf. Center



....[The] capacity to anchor a diverse set of constituencies to a strong, common root then enables you to have many branches that can sway in the breeze and move . . . without toppling over and without becoming uprooted.

Ronald Heifetz. Interview. Harvard. Center for Public Leadership. Kennedy School Insight. Research and Policy. October 31, 2005.

Development of Continuous Improvement CI-Ps
DOP 1-4: Level 1 Introductory Training Flow

Day 1- Monday	Day 2- Tuesday	Day 3- Wednesday	Day 4- Thursday	Day 5- Friday
Create Learning Organization	**Directly Observe Work Activities, Connections, Flows**	**Systematic Waste Elimination**	**Establish High Agreement What and How**	**Systematic Problem-Solving**
7:30 Gather, Breakfast 8:00 Welcome • Start-up & Overview • Break • 5 Lean Principles • Learning Community and Organization • Learning trios • CIP Consulting Process	7:30 Gather, Breakfast 8:00 Start-up • Facilitation • Break • Process Mindset • Break • Customer-Supplier • Relationship (simulation)	7:30 Gather, Breakfast 8:00 Start-up • Principle: Systematic Waste Elimination • Language of Waste • Break • Apply Lean Concepts • Break • Change: Individual-Team	7:30 Gather, Breakfast 8:00 Start-up • Principle: High Agreement of What/How • Standardization • Break • Standardization cont' • Facilitating High Agreement	7:30 Gather, Breakfast 8:00 Start-up • Principle: Systematic Problem Solving • Problem Solving Tools (simulation) • Break • Facilitating Probing Deeper • Follow-up & Evaluation
12:30 • Lunch	12:30 • Lunch Trios	12:30 • Lunch	12:30 • Lunch	12:30 • Lunch
1:15 • Envelope Simulation • Contracting • Break • Describing Current System • Give & Recv Feedback • Reflection & Integration • Review & preview ◊ Assignments 5:30 • Adjourn	1:15 • Measurement • Map Current State (VSM) • Break • TOOT • Reflection & Integration • Review & preview ◊ Assignments 5:30 • Adjourn	1:15 • Map Future State • Break • TOOT • Reflection & Integration • Review & preview ◊ Assignments 5:30 • Adjourn	1:15 • TOOT • Implementation Planning • Break • Change: Organization • Project Management • Reflection & Integration • Review & preview ◊ Assignments 5:30 • Adjourn	1:15 • Development planning • Closure/re-contracting • Next Steps • Closing Ritual 4:00 • Adjourn

Don't define the problem as a conflict between competing solutions. Define it in terms of conflicting needs and then generate your [alternate] solutions.

Thomas Gordon. Leader Effectiveness Training L.E.T. G.P. Putnam's Sons: New York. 1977. p.195.

The Ins & Outs of CI-Ps

✶ David Welch resigned from MDOL effective 8/20 — we'll miss his sharp wit and observations.

✶ Kim Johnson, Director of DHHS OSA & one of the original January '05 trainees, submitted her resignation effective the end of September. She's accepted a position with the University of Wisconsin, Institute for Addiction Treatment.

BTC Lean Events

Date	Time	Topic	Location	Contact
Sept 17-21	8-4:30	DOP 1-4	China Lake Conf. Center	ASD
Sept 21	8-4:30	Clinical Sup -Study Mission	HETL, 221 State St.	WEL
Oct 19	8-4:30	Clinical Supervision	Greenlaw	ASD
Nov 16	8-4:30	Clinical Supervision	Greenlaw	ASD
Dec 21	8-4:30	Clinical Supervision	Greenlaw	ASD
Jan 18 2008	8-4:30	Clinical Supervision	Greenlaw	ASD
April 7-11		DOP 2-2	China Lake Conf. Center	ASD

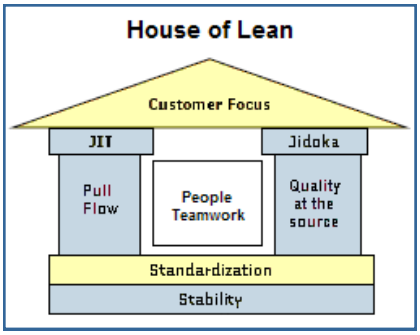
* *To add or see more events or detail, go to the Bend the Curve Calendar in Outlook's Public Folders.*

MaineDOT Report

——Mike Burns

A LEAN team from the MaineDOT's Western Region office completed a value stream map of the Department's Pugmill operation. The Pugmill uses recycled asphalt pavement salvaged from construction projects, liquid asphalt, and water to produce a cold mix that is placed on roads to restore shape and add strength. The mix is then covered with a layer of new hot mix pavement. The operation is a combination of private and State resources. This is the second year for this work. Recommendations were made in three categories with items titled "Just Do It", potential Kaizen events, and long-term projects.

Another value stream map will be developed in the Southern Region office to detail the existing process for the Maintenance Surface Treatment (MST) program. MST is a thin layer of pavement applied to roads in poor condition to maintain serviceability until funding is available for more substantial work. Hot mix asphalt is purchased through contractors, MaineDOT hauls the mix, MaineDOT directs the work, and contracted paving machines place the mix. The Department then "backs up" the shoulders and stripes the road. The value stream map will allow us to identify process steps that we will need to review further as we strive for continuous process improvement.



Clinical Supervision: September 21st - Study Mission

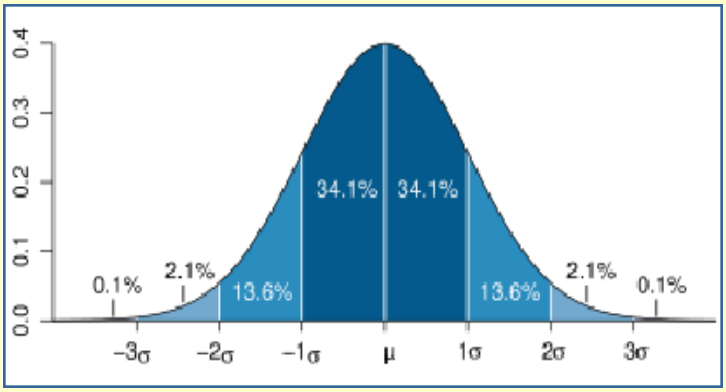
Because of DOP 1-4, instead of the regular Clinical Supervision agenda, the 9/21 Clinical will be a Study Mission to the award-winning Maine CDC Health & Environmental Labs.

Six Sigma (Wikipedia): Sigma (the lower case Greek letter σ) is used to represent standard deviation (a measure of deviation) of a population (...an estimate, based on a sample). The term "six sigma process" comes from the notion that if one has six standard deviations between the mean [average] of a process and the nearest specification limit, there will be practically no items that fail to meet the specifications. ™ Motorola Corp.

Six Sigma™ 6σ

Standard Deviation (Wikipedia): The standard deviation of a probability distribution, random variable, or population or multiset of values **is a measure of the spread of its values**. It is defined as the square root of the variance...[and] measures the spread of data about the mean [average], measured in the same units as the data....A large standard deviation indicates that the data points are far from the mean and a small standard deviation indicates that they are clustered closely around the mean.

Rules for normally distributed data



Dark blue is less than one standard deviation from the mean. For the normal distribution, this accounts for 68.27 % of the set; while two standard deviations from the mean (medium and dark blue) account for 95.45 %; and three standard deviations (light, medium, and dark blue) account for 99.73 %. In practice, one often assumes that the data are from an approximately normally distributed population. This is frequently justified by the classical central limit theorem, which says that sums of many independent, identically-distributed random variables tend towards the normal distribution as a limit. If that assumption is justified, then about 68 % of the values are within 1 standard deviation of the mean, about 95 % of the values are within two standard deviations and about 99.7 % lie within 3 standard deviations.

Real-life examples

The practical value of understanding the standard deviation of a set of values is in appreciating how much variation there is away from the "average" (mean).

Weather

As a simple example, consider average temperatures for cities. While two cities may each have an average temperature of 60 °F, it's helpful to understand that the range for cities near the coast is smaller than for cities inland, which clarifies that, while the average is similar, the chance for variation is greater inland than near the coast. So, an average of 60 occurs for one city with highs of 80 °F and lows of 40 °F, and also occurs for another city with highs of 65 and lows of 55. The standard deviation allows us to recognize that the average for the city with the wider variation, and thus a higher standard deviation, will not offer as reliable a prediction of temperature as the city with the smaller variation and lower standard deviation.

Sports

Another way of seeing it is to consider sports teams. In any set of categories, there will be teams that rate highly at some things and poorly at others. Chances are, the teams that lead in the standings will not show such disparity, but will be pretty good in most categories. The lower the standard deviation of their ratings in each category, the more balanced and consistent they might be. So, a team that is consistently bad in most categories will have a low standard deviation indicating they will probably lose more often than win. A team that is consistently good in most categories will also have a low standard deviation and will therefore end up winning more than losing. A team with a high standard deviation might be the type of team that scores a lot (strong offense) but gets scored on a lot too (weak defense); or vice versa, might have a poor offense, but compensate by being difficult to score on - teams with a higher standard deviation will be more unpredictable.

Trying to predict which teams, on any given day, will win, may include looking at the standard deviations of the various team "stats" ratings, in which anomalies can match strengths vs. weaknesses to attempt to understand what factors may prevail as stronger indicators of eventual scoring outcomes.

In racing, a driver is timed on successive laps. A driver with a low standard deviation of lap times is more consistent than a driver with a higher standard deviation. This information can be used to help understand where opportunities might be found to reduce lap times.

(*** Clear as mud? Try also: Standard Deviation for Journalists - http://www.robertniles.com/stats/stdev.shtml)

Understanding Six Sigma

— Jane O'Loughlin French, MA

OK, so I have trained to facilitate work groups through the LEAN process. I have really dedicated myself to thinking lean, getting it right the first time, and to asking the pesky questions about why we work hard, not work smart.

In all this I had a vague notion of what I considered nice buzz words, "Six Sigma". Perhaps it was the rough equivalent of a fraternity or sorority of those "in the know," maybe it was about some Toyota part I was supposed to know all about. My Subaru didn't have one?

Knowledge is a curious thing. Sometimes directly acquired, sometimes intuited, and in my mind "Six Sigma" sort of lurked fuzzy, and for a time safely tucked loosely into the basket of my fear-filled "math" hopper of half-defined and shaky concepts.

I am comfortable in the world of incidents, accidents, and analyzing opportunities for "do-overs." My career to date has brought me through many permutations of residential support and community rehabilitation programs for persons with disabilities. I have had extensive opportunity as a manager in state government, as well in the private sector, to look at, trend, offer improvement options, or levy penalties when things "go wrong."

Fascinating stuff, really. It is a world of distracted, often over-tasked workers, forgotten medications, procedures gone awry, folks left unattended, kids "playing" with toasters, and the list goes on endlessly.

Malfunctioning equipment, fallible people, and procedures gone wrong have become the stuff of my everyday work.

So then, what if we had a system so taut, so tight, so error-free that when an error occurred it was so rare as to be so far out on the bell curve of data measurement as to be so past the norm — the high bump as it were on the curve — that we would know for sure it was a genuine mistake, very past any statistical explanation of a single or even two "standard deviations" from the mean?

Now this, I can understand. I work in a world that says if your "intelligence" (as we define it!?) is measured to be past two standard deviations below the mean you have a pervasive problem — you have a "disability". So, the idea of standard deviations, I can understand.

Now, I get it. Six deviations out. The far, far right lane toll booth.

The awareness for me is this: While obviously people are not products, what we do to serve them is. And six standard deviations is seriously into our products' "flat line" on the curve. With a determined focus on decreasing errors/inconsistencies, these 6σ could, however be well within our quality goals.

A system so refined, it has wrung out the anomalies, so perfected that the mistakes are past "oops" and "darned if I know" and able to be recognized as an error ("product defect") that it is almost a one in a million occurrence.

Now, in my world, I get it.

Bad followers are as integral to bad leadership as are bad leaders.

Barbara Kellerman. Bad Leadership: What It Is, How It Happens, Why It Matters. Harvard Business School Press. September 2004.

Rapid Improvement Event: Intervention Evaluation

Date: Clinical Supervision 8/17/2007 **Practitioner: Rae Brann**

Problem Statement

The current evaluation form & process produce little feedback that enables me to improve my intervention practice & process. The forms do not get filled out; participants are not forthcoming about negatives/improvements; the process does not give us the information we want; the use of the evaluation form has not been required. How can we make our evaluation more useful for our improvement purposes?

Current Situation

a. Forms are filled out at the end of the session. Participants are tired and want to leave.
b. Evaluation at end of intervention may be far separated from event.
c. Form content does not elicit desired improvement feedback: What worked for you? What could be improved?
d. Participants do not remember details after multiple sessions and activities, such as current state and future state. Perhaps one form for every phase of the intervention.
e. Feedback is or is seen as being tied to the CI-P – it is personal.
f. No indication how or if results are used.
g. Users-CI-Ps are not clear about what we want or how to get it or who will use it.
h. Form elicits overly positive responses and relatively few specifics.
i. Use of the form itself at all by CI-Ps has not been known to be required.
j. Process and results are not standardized, managed, monitored, or reported out.

Ideal Situation

Feed back from participants is ongoing, interactive, and provides specifics about intervention practice, process, forms, materials, etc. that work well and those that can be improved. Participants feel free to comment on and understand the need for continuous improvement. We understand our objectives and have designed a process to determine from participants how we are doing at achieving those.

Target Measures

The evaluation forms haven't been formally tracked or analyzed - so, no existing data. Target measures were not identified.

RIE Plan

A. Establish a workgroup to develop an evaluation process that -
   1. Incorporates more frequent request for feedback.
   2. Uses check-out more effectively.
   3. Gets right feedback from right source: What do we want?
   4. Is interactive – engage participants in data-collection dialogue.
   5. Asks questions such as "Do you feel what is on the board reflects your process?" "If not, why?" "Do you feel what is on the wall reflects your current state process?" "Are you prepared to move on to future state?" (do not ask first day).
   6. Does not do in-depth evaluation at end of day one. Though participants should gain insight, for example, into why first day was necessary to get to finished product (revisit asking participants how they feel).
   7. Includes brief check-out evaluation in some form at the end of each day.
   8. Gets across that we honestly want feedback about our 'practice' as CI-Ps.

B. Eliminate current formal evaluation form.
C. Explore evaluation by expert observer who understands the process and can offer useful suggestions for improvement.

The Ten Commandments of Government (cont'd from p. 1)

The world is a dangerous place and fraught with opportunities for things to go wrong. Problems just seem to find us.

In part, our work in Lean is a lot about finding, correcting, and preventing mistakes. Lean evolved as a strategy to counter-balance all the unpredictable things that can happen in our day-to-day work, to make work go smoother and faster and less error prone.

Standardization, tightly connected value streams and all the other tools we learn about are designed to either find problems and mistakes quickly or to prevent them from happening in the first place. Team work assures that the experience of many eyes and ears are brought to bear on the process, enhancing our chance to minimize errors and mistakes.

When mistakes happen, we are left with the consequences, and often they are not pleasant and for well intentioned people, as we all are, it leaves us with feelings of failure. In a sense, it is a lose-lose situation. There is nothing sadder then failing to meet the expectations of another person, another customer. Our apologies are borne and die on a forgiving heart. And you know somebody may be crying.

Yet, without mistakes we learn nothing — we don't grow. It was God's intent for Eve to find the apple; otherwise, why the apple tree in the Garden? Was it Eve's mistake to give the apple to Adam and Adam's mistake to eat it? So there you have it. Greek for *sin*, after all, is to be "off the mark". Read : 'you made a mistake'.

Mistakes, however, are not always negative, if we choose to learn the lessons from them.

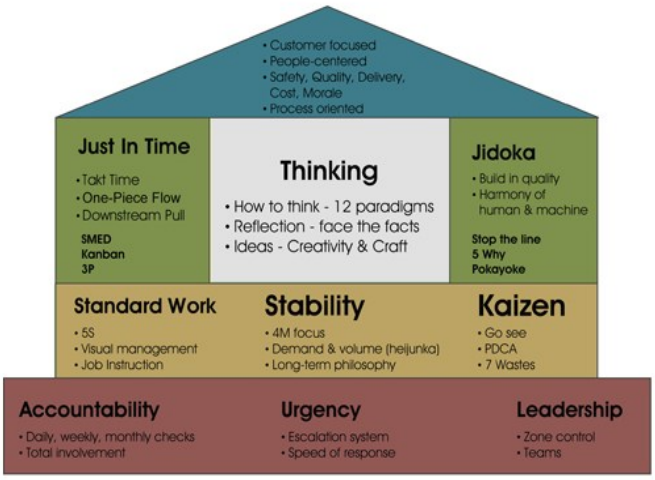
First and foremost is that to be human is to be error-prone - none of us escape. Acknowledging this sets us free from guilt which enables us to act. Second, and as a result of the first, we are born with a forgiving heart and the will to use it or not. We are also born with an acute intelligence. Our challenge is to use these to capture the experience gained from mistakes and errors so we all learn and can prevent them from happening again.

This is the engine of all progress and evolution. It is also why the foundation of a Lean Organization (*see figure below*) is a Learning Organization and why organizations are inevitably drawn to it. Lean is designed to find opportunities to learn something new, to grow and to improve.

And then there are those Ten Commandments of Government. I seem to remember in the movie of a similar name, Hollywood had Moses come down from the mountain with a tablet in each hand, and then he threw them down and they shattered to pieces. The symbolism was to drive them into the hearts of his People. Centuries later, the Christian Gospels summarized the Ten to just Two.

I would suggest the ten commandments for government need to be shattered and rewritten as well, to wit: 1) Avoid Mistakes, 2) Improve processes.

— Walter E. Lowell



Notes on the August 17th Clinical Supervision

CHECK-IN: Peter Diplock facilitated this Clinical. Announcements: 13-14 participants are confirmed for DOP1 -4. The curriculum can accommodate 21 so there is room for 7-8 more participants.

LEAN LEARNINGS: *The Hitchhiker's Guide to Lean* by Jamie Flinchbaugh & Andy Carlino. Chapters 4 & 5: John asked: *What in each chapter re-enforced or moved you to alter a view on lean or our implementation of it?*

Chapter 4. A Thousand-Step Journey: Five *Phases of the Transformation Roadmap.* *The 5 phases* are Exploration, Building the foundation, Expanding with tools & deeper thinking, Integration & reinforcement, Building momentum. The Learnings are:

- Go for "Pull": What is it? How to Id? Foundation/ momentum/flow.
- "Building an airplane in flight" versus learn/do/ evaluate.
- Seeding lean as exploration/foundation.
- Knowledge to results ratio.
- Baggage – we all have it
- Book is better at identifying problems than providing solutions – short on "how" points.
- Tension & stress often lumped together. Tension can be good & stress is not OK - tension is important for movement.
- Gap between reality & ideal –not seen or detected—important to know when to move.

Chapter 5. Pulling it all together: Five *Dimensions of an Operating System*. The 5 dimensions are Thinking, Systems, Tools, Evaluation, Consistency. The Learnings are:

- Reinforced better lean understanding & harmonious tools.
- Leans as Operating System & way to explain. Driving is an example.
- Focus builds templates & fosters common understanding.
- Lean as label.
- Reinforced: imitation is sincerest form of flattery.
- Operational excellence thru operating system.
- We don't recognize our own systems.
- Language versus questions.
- Leadership sees role as high view (50,000 feet).
- Teachable approach, helps orient new employees & how to propagate. .

INTERVENTION DESIGN - STANDARDS AND PRACTICE: Visualizing the Practice. Facilitated by Arthur Davis. Based on reviewing the complex value stream map from the State's payroll system VSM that was on the wall, we responded to the following questions structured by Arthur:

1. When you see the value stream maps that result from VSMs, list 3 lean tools or principles that come to mind:

- Plant layout – P
- Waste – P
- Transportation – P
- Batch – T
- Pull – P
- Root Cause/5 whys – T
- Creating agreement – P
- Creating learning org – P
- Visualization/observations – P
- Current & Future State – P
- Customer services – P
- Consolidation/streamlining – P
- Customer in mind – P
- Overproduction (repeated processes) – P
- Quality source – P
- Teams – T
- 5 S – T
- VSM – T
- Standardization – T
- Flow – P
- Visual – T

2. What might be the 5 benefits of keeping/displaying the map of the value stream in its original state?

- Defines the process
- Helps clarify
- Details get preserved.
- Color & handwriting equals theirs
- Values team's work
- Infers the work
- Original more human (electronic = distance)
- Historical snapshot – so what?
- What do you mean about "keeping it?
- Personal—it's theirs.
- Keeping some = beneficial
- Touchable, = very powerful
- Highlights process complexities
- Going up somewhere so that others can see
- Opportunity to emphasize value of data
- Illustrates all work can be messy & that's OK.
- Need to do both, original & electronic (different purposes & ease of use/sharing)
- Documents process-draws attention & support
- Tangible/ "Causes" emotion – powerful—WOW factor! Visual wake-up call.
- Keeping until the end of the intervention

— contributed by Tim Griffin

- People have to come to it to see it – brings people together
- Flexible – Can physically & immediately move steps/notes around, perhaps more easily than in other media

3. If there is a history of invisible processes and/or a lack of "process mind set", outline the talking points you would use to support one or two of the items of questions 1 & 2.

- My job – can now be seen
- Color is extra important
- This theirs/negates their work
- What about bringing the sponsor/manger to this room to see the payroll process Maps?
- Practically, what would happen if we had the sponsor/manager to "come see"; put up the map
- Impact — In your face!
- Size equals impact
- Shows complexity
- We use "lean here"
- Benefits/works the process
- Provides data points
- Passive/aggressive – do you have a better idea of how to get equal results?
- Setup for comparison to ideal state
- Wonderful representation of "waste"
- Physical place to point to documents
- This is educational – shows C.S.F.S.
- What if in Visio? Lacks the impact.
- Begin to question (& start) "what is going on in the other processes"
- Lacks connectiveness

4. How do you think your comments or conclusions would stand up to reasoning of yours? *Did not get to.*
5. How can you make practical use of this information? *Did not get to.*

OPEN FORUM: Outside Participation in DOP: Should the private sector be invited to DOP trainings? The training fee is subsidized and there are fixed costs. The training is geared to State employees and government service/ transaction. There is one contractual "employee" already signed up for the DOP 1-4. Where is the line drawn? At this time, we will not be deliberately recruiting outside of State government; however, referrals can be made to Arthur.

New employee orientation: BTC/Lean should be included statewide in standardized orientations. Will help them understand and feel engaged in lean.

Developing lean management and leadership training: Culture of "not allowing" – of "getting to No". Managing (current reality) versus leading (innovation/change/future). Need to be more strategic & invest time in engaging others to be Lean leaders and managers. Lean management/leadership training is to be developed.

Clinical Minutes in *CI-P News*: Feedback requested re: what CI-Ps want for the content and format for the minutes of Clinicals. What is useful? To check their own reactions, CI-Ps can review minutes in recent *CI-P News* & provide feedback re: what works, what doesn't, suggestions at next Clinical.

Tracking Interventions and Results: Future agenda item? What interventions actually resulted in implementation of implementation plan? Need better monitoring of results and communication with staff. What can we do as change agents and BTC program to improve implementation?

Concern with losing CI-Ps: Will continue to train new people & look at the possibility of holding a kaizen on the dropping out of CI-Ps. Appropriate selection a factor? Two CI-Ps have been hired by private employers for their lean expertise – Arthur noted this could be a compliment, especially if they stay with and are promoted by the new employers.

RAPID IMPROVEMENT EVENT: Rae Brann facilitated the RIE re: obtaining feedback from participants in BTC interventions. Initially, we focused on the evaluation form that some CI-Ps hand out, but broadened the scope to include the eval. form & process, which then included other forms of feedback retrieval such as one-on-one conversations with the participants. The current form & process provide little information and uniformly result in overly positive feedback & offer no suggestions for improvements. We decided to eliminate the current evaluation form as it is not giving useful feedback . *(See Rapid Improvement Event, page 4)*

CHECK-OUT: Next Month's Clinical Supervision: September 21st — Study Mission. Because of DOP 1, instead of the regular Clinical Supervision agenda, the 9/21 Clinical will be a Study Mission to the Maine CDC's Health & Environmental Labs, 221 State Street, Commissioner's Conference Room. Need a team leader to organize the study mission. If interested, contact Arthur or Walter. Arthur will send out the duties of team leader to help in making the decision to lead the study mission. October's Clinical Supervision: is October 19th. & need a facilitator for that Clinical. Contact Arthur or Walter if interested.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor — Brenda M. Harvey, Commissioner

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The primary purpose of the *Bend the Curve* Team is to provide support, consultation, assistance, and leadership in process and other improvement approaches and activities for State staff and work teams as they seek to continually improve their work culture, procedures, processes, and environments – in order to meet the mission of the department and the expectations of Maine citizens.

We're on the net !
http://inet.state.me.us./dhhs/bendthecurve
http://www.maine.gov/labor/bendthecurve/

Bend the Curve

DOP 1-4 Coming Right Up Sept. 17-21

The CI-P introductory training DOP 1-4 is this September 17-21 at the China Lake Conference Center. DOP 2-2 enhanced training is tentatively scheduled for April 7-11, 2008. If you think you should attend DOP 2, please start making arrangements now with your supervisor. Approval from your supervisor (whose support & agreement to pay are required) is to be sent to Arthur. Remember, too, you can play an important role in DOP trainings by participating in the CI-P Instructor process.

Continuous Improvement Practitioners: BTC Intervention Facilitation Status

DHHS		DOL		DAFS	
Kate D. Carnes	L	Jorge A. Acero	IA-O	Rae-Ann Brann	L
Nancy Desisto	L	Michael T. Brooker	IA-O	Wendy Christian	O
Jane French	L	Stephen C. Crate	IA-O	Rebecca S. Greene	L
James Fussell	L	Arthur S. Davis	C	Lyndon R. Hamm	CL
Kimberly Johnson	C-O	Merle A. Davis	L	Alicia Kellogg	C-O
Julita Klavins	L	Peter D. Diplock	O	Billy J. Ladd	CL
Don Lemieux	C-O	Anita C. Dunham	IA-CL	Michaela T. Loisel	L
Muriel Littlefield	C-L	Karen D. Fraser	L		
Walter E. Lowell	L	Timothy J. Griffin	L	**DOT**	
Jack Nicholas*	C-O	James J. McManus	CL	Michael Burns	C-O
Ann O'Brien	L	Bruce H. Prindall	IA-L	Sam McKeeman	C-O
Cheryl Ring	CL	John L. Rioux	L	Jeffrey Naum	IA-O
Terry Sandusky	L	Sheryl J. Smith	L	Robert Slocum	IA-O
Jeffrey Shapiro	IA-O				
Clough Toppan*	C-CL			**DEP**	
				Carmel A. Rubin	IA-O

* Community CI-P	IA - Inactive	C - "Champion for Lean"	
L - Lead	CL - Co-Lead	O - Learning Observer	