ILLUSTRATIVE EXECUTIVE ADVISORY BRIEF

Lean Six Sigma Process Improvement Assessment: Illustrative Executive Brief

FICTIONAL DECISION-SUPPORT EXCERPT · NOT CLIENT WORK · EXECUTIVE STRATEGY

Lean Six Sigma Process Improvement Assessment: Illustrative Executive Brief **Illustrative sample only.** Northstar Community Services, its people, workflow, and figures below are fictional. They show the decision-support analysis DecisivIQ may provide from client-supplied materials and one stakeholder interview. They are not findings about an actual organization and do not predict results.

Executive premise

[Northstar's intake-to-service-enrollment workflow is absorbing leadership attention without reliable visibility or a dependable client experience. The immediate question is not whether to automate everything. It is whether management should first stabilize handoffs and ownership, then decide what technology or staffing changes are justified.]
[The available evidence points to a manageable operating problem: delay, repeated outreach, incomplete case records, and uneven supervisory escalation. The assessment should protect service continuity while making the process easier to run and inspect. That requires a narrower first move than a wholesale redesign.]

Illustrative decision situation

[In this fictional example, a referral enters through email, web form, or partner call. An intake coordinator logs it, a program lead reviews eligibility, a scheduler contacts the client, and a supervisor resolves exceptions before enrollment closes. Management reports a 12-day average elapsed time, but the underlying log captures only receipt and closeout. It cannot show where work waited, how often a file returned, or who owned an inactive referral.]
[A recent increase in referral volume has exposed an existing weakness. Staff describe duplicate follow-up and late discovery of missing information. The executive sponsor must decide whether to authorize a focused 60-day stabilization effort, fund a new intake system, or accept current performance while other priorities take precedence. Needed evidence is specific: representative case artifacts, current procedures, backlog and error patterns, communication examples, and a 60-minute working interview with the process owner.]

Decision-quality observations

01 The reported cycle time masks the real queue.
A single end-to-end average may look tolerable while urgent cases sit before eligibility review. Until timestamps are captured at receipt, completeness check, eligibility decision, scheduling contact, exception resolution, and closeout, management cannot distinguish capacity pressure from poor routing. This is a measurement gap, not proof that one team is underperforming.

02 The process has handoffs without explicit acceptance.
Intake appears responsible for sending a case forward, but no role confirms that the next role can act. That design invites silent queues. An accept, return, or escalate rule would make stalled work visible, but adds discipline to busy roles. Leaders should agree how exceptions will be handled.

03 Rework is being treated as normal work.
Incomplete referrals return through informal email threads, often without a common reason code. Likely root causes are variable submission quality, unclear completeness criteria, and no controlled return path. This hypothesis requires validation against recent cases, not a conclusion about partner performance.

04 Controls exist, but the management signal is weak.
Supervisory review occurs when an individual raises concern rather than at a defined workflow point. The resulting control gap is not necessarily a policy failure. The organization lacks a routine signal for aging cases, repeat returns, and unresolved exceptions. A compact weekly review could close that visibility gap without creating a new meeting culture.

DECISIVIQ / STRATEGY INTO OPERATING DISCIPLINE

Choose with clarity. Execute with control.

Options and material tradeoffs

Option A: stabilize the current workflow first.
Define handoff acceptance, a standard completeness check, exception routing, and a limited management view. This is the lowest-disruption path and generates evidence for later decisions. It will not remove every manual touchpoint.

Option B: launch a system-led redesign now.
A new tool may improve intake structure and tracking, but risks digitizing unclear rules and consuming scarce sponsor attention before root causes are tested. It is appropriate only if the current platform cannot support the agreed controls.

Option C: add temporary capacity.
Extra coverage can protect near-term service levels, but without clearer queues and ownership it may conceal the design problem. Use it as a time-bounded safeguard, not the primary improvement thesis.

Recommended action architecture

01 Decision point 1
Establish the minimum viable control loop within 15 business days. The executive sponsor should name one accountable process owner and authorize a cross-functional working group to define acceptance criteria, return reasons, aging thresholds, and escalation. The decision point is whether leaders will enforce one shared definition of a ready referral. The review measure should show volume, age by stage, returns, and unresolved exceptions.

02 Decision point 2
Run a bounded case-file validation sprint. The process owner should review a representative, client-selected sample of recent referrals against the proposed map, documenting evidence separately from hypotheses. Test where waiting occurs, why cases return, and whether urgent cases follow a different path. This is not a formal time study or independent data collection. Its purpose is to confirm changes worth managing now.

03 Decision point 3
Make the technology decision after the control loop is tested. At a 30-day management review, compare the stabilized workflow's visibility and burden with the current tool's limits. The sponsor can then retain the approach, make a targeted configuration investment through the appropriate internal process, or separately scope a redesign. This sequencing preserves optionality and avoids a capital decision on anecdote.

Executive questions to test

01 Which role has unambiguous accountability when a referral has waited beyond the agreed threshold, including after a return for missing information?
02 What evidence would demonstrate that incomplete inputs, rather than staffing capacity or approval delay, drive the largest share of rework?
03 Which service, governance, budget, or capacity constraint would make the proposed control loop impractical, and who has authority to resolve that conflict?

Professional boundary

This fictional brief represents operational planning and decision-support materials, not implementation, change-management execution, system configuration, staff training, ongoing project management, formal time studies, on-site observation, surveys, audit services, certification preparation, or independent data collection. DecisivIQ does not provide legal, tax, accounting, investment, regulatory, procurement, or compliance advice; make regulatory, contractual, procurement, or compliance determinations; create binding instruments; submit filings; or represent clients before a government body. Authorized leaders and appropriate counsel remain responsible for decisions and actions.

Engagement snapshot

Offer: Process Improvement and Lean Six Sigma Assessment **Price: $ 895 Timeline: 7 business days** after complete client inputs are received and the 60-minute stakeholder interview is completed.
The assessment covers **one defined end-to-end workflow or service line**, from trigger through handoff and closeout. Deliverables are an Executive Operational Diagnostic Brief, Current-State Workflow and Friction Map, Root-Cause and Control-Gap Register, and Prioritized Improvement Roadmap. The work prioritizes workflow friction, likely root causes, control gaps, ownership, dependencies, and review measures. One consolidated clarification or refinement revision is included when submitted within five calendar days of delivery; it does not add a new workflow, evidence collection, or expanded diagnostic.

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