LEAN Enterprise Methods in Healthcare:
VA Boston Mental Health

Jordan Peck
LAI Annual Conference
March 25, 2010
VA Mental Health – Boston

ESD.62J/16.852J: Integrating the Lean Enterprise

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Jordan Peck, Facilitator
Agenda

- Project Overview
- Enterprise Description
- X-Matrix
- Process Waste
Project Overview

- Collect Data
  - 11 individuals interviews
  - Phone and site interviews—Brockton, Bedford, Jamaica Plains
  - Metrics, process and procedure, organizational charts, financial statements
- Conduct Analysis
- Validate Findings
- Formulate Recommendations
- Present Recommendations

Project Goals

- Analyze the VA BMHS through a Lean assessment and suggest strategy for a Lean transformation
Enterprise Description

Mission & Vision
- To serve the veteran through the delivery of timely quality care by staff who demonstrate outstanding customer service, the advancement of health care through research, and the education of tomorrow's health care providers.

Strategic Goals
- Serve Boston Health Services
- Team-oriented and Integrated Care
- Quality Improvement
- Compliance
- Evidence-based Care through Educational Residencies
- Become World Class Research Hospital System
- Accessible Care

Overview
- Boston Mental Health Service is largest within VA New England region
- Locations – Brockton, Jamaica Plains, West Roxbury + CBOCs
- Services – Inpatient, Outpatient, Residential Programs
Key Insights
- Funding and strategic planning is driven from the top down
- Programming and research is volatile and dependant on politicians
- Communication channels between each enterprise
Financials

Key Insights
- Budgets are based on previous years number of patients and number of complex patients
- Support processes and research is managed by VA Boston Health Services
Lean Insights

- Mapping the relationship with stakeholders offers insights for enterprise operations.
# Customer Value Exchange

<table>
<thead>
<tr>
<th>Value Expected from the Enterprise</th>
<th>Stakeholders</th>
<th>Value Contributed to the Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accurate diagnosis</td>
<td>Customers</td>
<td>• Co-pay Money for services</td>
</tr>
<tr>
<td>• Eliminate pain/discomfort</td>
<td>Patients</td>
<td>• Money from health insurance provider</td>
</tr>
<tr>
<td>• Treat condition with correct therapy immediately</td>
<td></td>
<td>• Meeting Congressional Goals</td>
</tr>
<tr>
<td>• Be treated with dignity and respect, compassion and caring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• As pleasant an extended stay as possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information on managing illness or maintaining health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safety/security while on premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• To be returned to normal life and normal life activities as quickly as possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enterprise Metric</td>
<td>Sub-Category</td>
<td>What is measured</td>
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<tr>
<td>----------------------</td>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td>Access</td>
<td>MH: CBGC - % MH specialty access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MH: Homeless Contact access to MH/SUD (form X revised version)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MH: Homeless Program access to MH/SUD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MH: Homeless Program access to Eval &amp; Mgmt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MH: Homeless Program Flu in MH/SUD</td>
</tr>
<tr>
<td></td>
<td>MH: SMI - MHICM Capacity</td>
<td>MH: SMI - MHICM Capacity</td>
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<tr>
<td><strong>Waiting Times</strong></td>
<td>Clinic</td>
<td>New Patients (NP): % Seen by acceptable provider within 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Established Patients (Est Pt): % Scheduled within 30 days of desired date</td>
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<tr>
<td></td>
<td></td>
<td>Missed Opportunities (Missed Appointments) - No Show and Clinic Cancellations</td>
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<tr>
<td><strong>Substance Use</strong></td>
<td>Disorder: % of patients with</td>
<td>Screened for at risk alcohol usage - AUDIT-C with doc responses</td>
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<tr>
<td></td>
<td></td>
<td>90 Day Continuity of Care</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Measure</td>
<td>Post Traumatic Stress Disorder Screening annually for 1st five years after most recent separation and then every five years thereafter with doc responses (PC PTSD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening annually with doc responses (PH-Q2)</td>
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<tr>
<td></td>
<td>Major Depressive Disorder: % of</td>
<td>New Dx of Depression - Provider Follow-up</td>
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<tr>
<td></td>
<td>patients:</td>
<td>New Dx of Depression - Medication Coverage</td>
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<tr>
<td></td>
<td></td>
<td>Offered medication to assist with cessation in past year - Nexus - MH Subgp</td>
</tr>
</tbody>
</table>
Research is a goal but not

Facilities and Maintenance

Well-documented

Processes addressing the

Discharge from Residential

Transfer from Inpatient to

References to Residential

Strong alignment in areas

Residential Treatment

Referral to Inpatient

Walk-in to Outpatient

Clinic

Strong alignment with

Enterprise

X-Matrix

Metrics vs. Objectives

Very strong alignment with

most metrics on target

Goals are not formal or
documented

Research is a goal but not measured locally

Values vs. Goals

Strong alignment with areas in service, care, & research

Gap lies in aligning goals to values such as:

- Operating within budget
- Well-documented monetary transactions

Processes vs. Values

Strong alignment in areas of service, research, & quality

Processes addressing the least stakeholder values are primarily patient movement

Processes vs. Values

Strong alignment with outpatient treatment and clinic wait times

Missing metrics for key processes
- Transfers to inpatient
- Program referrals

Metrics vs. Processes

Vals vs. Goals

Strong Alignment

Weak Alignment

http://lean.mit.edu

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### Strategic Objectives

- Transfer from VA ER to Inpatient
- Transfer from Urgent Care to Inpatient
- Transfer from Outside ER to Inpatient
- Inpatient Treatment
- Transfer from Inpatient to Residential
- Discharge from Inpatient
- Residential Treatment
- Transfer from Residential to Inpatient
- Discharge from Residential
- Transfer to Outside Facility
- Outpatient Treatment
- Referral to Inpatient
- Referral to Residential
- Walk-in to Outpatient
- Purchasing (Supplies & Services)
- Patient Data Management
- Research
- Facilities and Maintenance
- Quality Assurance
- Payroll
- Human Resources

### Key Processes

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<th>Process</th>
<th>Value</th>
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<td>Vocational Industry Program</td>
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<tr>
<td>Substance Abuse Intensive Outpatient Program</td>
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<tr>
<td>Substance Abuse Usually Frequent Program</td>
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<tr>
<td>Residential Program - Day Program</td>
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<td>Mental Health Outpatient</td>
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<td>Outpatient Treatment</td>
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<td>Impatient Service</td>
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<td>Tobacco Measure</td>
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<td>MH: SMI - MHCM Capacity</td>
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</tr>
<tr>
<td>Mental Health Access</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health Measure</td>
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</table>

### Stakeholder Values

- Efficient Resource Management
- Accurate and well-documented monetary transactions
- Upstanding member of local community
- Knowledge Transfer
- Communication and Implementation of VA culture and values
- Observation & Implementation of VA culture and values
- Sufficient Inpatient and Outpatient Capacity
- Reasonable expectations and respectful treatment of employees
- Correctness of diagnosis and treatment
- Timeliness of diagnosis and treatment
- Quality of patient experience (minimal discomfort respectful etc)
- Safety Security of premises
- Clean High Quality Facility
- Accurate Patient Records
- Availability of medications supplies and equipment
- Operating within budget
- Fair Wages for services
- Correctness of diagnosis and treatment
- Timeliness of diagnosis and treatment
- Quality of patient experience (minimal discomfort respectful etc)
- Safety Security of premises
- Clean High Quality Facility
- Accurate Patient Records
- Availability of medications supplies and equipment
- Operating within budget
- Payroll
- Human Resources

### Metrics

- Inpatient Treatment
- Discharge from Inpatient
- Transfer from Inpatient to Residential
- Residential Treatment
- Transfer from Residential to Inpatient
- Discharge from Residential
- Transfer to Outside Facility
- Outpatient Treatment
- Referral to Inpatient
- Referral to Residential
- Walk-in to Outpatient
- Purchasing (Supplies & Services)
- Patient Data Management
- Research
- Facilities and Maintenance
- Quality Assurance
- Payroll
- Human Resources
Stakeholder Value Comparison

**Methodology**
- Inferred Stakeholder Importance from Strategic Objects & Value Delivery from the Key Processes
- Used weighting algorithm to calculate positions
- More research & data needed on weights, and to validate results.
LESAT Gap Analysis

High interest in Lean

Low Lean awareness

Lean Transformation Leadership

- Highest Scores
  - Developing Lean structure and behavior
  - Adopting Lean paradigm & value stream focus
- Lowest Scores
  - Creating & implementing Lean initiatives plan
  - Enterprise strategic planning

Life Cycle Processes

- High Scores
  - Developing product & process
  - Producing the product
- Low Scores
  - Business acquisition and program management

Enabling Infrastructure

- Equal Scores
  - Lean organizational enablers
  - Lean process enablers
Enterprise Processes

Non-VA ER Transfer

VA ER Transfer

VA Urgent Care Transfer

Walk-In to Outpatient

Referral from Primary Care

Scheduling

Treatment

Chronic Care

Acute Care

Substance Abuse

PTSD

Women

General Mental Health

Community Residential

Domiciliary

Bedford Stabilization Program

Outpatient Treatment

Non-Emergency

Walk-In to Outpatient

Referral from Primary Care

Outpatient Clinics

West Roxbury

Jamaica Plain

Brockton

Outside the Enterprise

Bedford Stabilization Program

Enabling Infrastructure

Purchasing

Patient Data Mgmt

Research

Quality Assurance

Payroll

Human Resources

http://lean.mit.edu

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<table>
<thead>
<tr>
<th>Supplier</th>
<th>Long wait times in admitting, transferring, and discharging processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>Need to spread knowledge of service lines among staff and overcome training siloing</td>
</tr>
<tr>
<td>People</td>
<td>Opportunity for improvement with patient teams</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Inefficiencies in resources by providing treatments at multiple sites</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Transportation waste: moving people among sites</td>
</tr>
<tr>
<td>Information Flow</td>
<td>Little accesses to patient records from the Department of Defense</td>
</tr>
<tr>
<td>Information Flow</td>
<td>Lack of documentation from transfers and referrals</td>
</tr>
<tr>
<td>Supplier</td>
<td>Emergency and non-emergency hospitals sending ineligible veterans to Mental Health</td>
</tr>
</tbody>
</table>
## Enterprise Waste

<table>
<thead>
<tr>
<th>Customer</th>
<th>Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Patient opting not to conform to treatment and developing dependency on system for support and shelter</td>
</tr>
<tr>
<td></td>
<td>- Multiple visits for complete evaluation</td>
</tr>
<tr>
<td></td>
<td>- Commuting home to site and site to site</td>
</tr>
<tr>
<td></td>
<td>- Resource limitations with beds and program capacity</td>
</tr>
<tr>
<td>Physicians</td>
<td>- Redundant testing from patients who are referred from the military and other institutions</td>
</tr>
<tr>
<td></td>
<td>- Resource limitations with beds and program capacity</td>
</tr>
<tr>
<td></td>
<td>- Commuting home to site and site to site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Strategic goal and objectives are not published</td>
</tr>
<tr>
<td></td>
<td>- Strategic goals not fully aligned among parent-child enterprises</td>
</tr>
<tr>
<td></td>
<td>- Inadequate communication channels between VA New England and VA Boston Mental Health Services and between VA BMHS and VA BHS</td>
</tr>
</tbody>
</table>
Enterprise Architecting
Veteran Affairs
Boston Mental Health

Enterprise Architecting
May 13, 2009

Team:
Oladapo Bakare
Jordan Peck
Orietta Verdugo
Agenda

- Current Architecture
- Enterprise Vision
- Candidate Architectures
- Architecture Evaluation
- Transformation Plan
Current Architecture
Needs more integrated understanding of the process flow; Build artifacts of standard processes and documentation across all sites.

Lacks strategy within the organization, only top levels have input to strategy.

Lacks clear organizational direction from leadership; Needs an employee feedback loop and more collaboration between sites, departments, and networks.

Main driver of business strategy and services; Government and policy driven; Public Relations plays a factor as well.

Main focus of the enterprise as its mission is servicing the veterans and their needs.

Clear knowledge exchange is needed; Meetings and emails are primarily communications; Not enough knowledge sharing between leadership within VISN.

IT system that links VA documentation and procedures across the enterprise (IT ahead in national health care); Infrastructure has various locations.
The Ilities

- Agility: Ability for a system to readily expand capacity
- Scalability: Ability to reduce defect & optimize service
- Survivability: Veteran’s ability to access & afford services
- Responsiveness: Ability to quickly respond to changes or needs in the system
- Quality: Ability to reduce defect & optimize service
- Safety: Ensure wellbeing of patient & employees
- Customizability: Ability to treat a patient based on their particular needs
- Serviceability: Ability to treat a patient based on their particular needs
- Demonstrability: Ability to measure performance
- Standard Compliance: Meeting VA national & accreditation board requirements
- Ability to adapt to changes & process requirements
- Ability to treat a patient based on their particular needs
Enterprise Future Vision
Future Vision

Strategic View

- Strategy driven by all levels of the organization, through continuous improvement methods
- Create and maintain strategy document that delineates the actionable strategic goals at all levels of the organization
- Increase strategy visibility and awareness through meetings between professionals

Process View

- Integrate understanding of the process flow through standard processes and documentation across all sites
- Obtain process measurements that directly align to strategic goals
- Transparency throughout the organization of processes and performance
- Continuous process improvement; Yearly goal to meet, incentivizing improvements, educate and give resources for improvement.
Future Vision

Organizational View

- Clear organizational direction from leadership on all levels to proactively push agendas
- Increase collaboration between sites, departments, and networks
- Incentivize employees to take ownership of patient services
- Create an employee feedback loop to communicate needs, best practices, and change
- Lean Six Sigma department throughout VA to drive quality and continuous improvement initiatives

Knowledge View

- Clear knowledge exchange between employees, programs, and sites
- Incorporate knowledge exchange programs with other VA campuses to share best practices
- Increase leadership communication amongst VISN, departments, and networks
Future Vision

IT View

- Upgrades given to all sites within the same time frame
- Ensuring there is a sufficient IT budget each year
- Making sure practitioners are able to make changes to the system to facility processes/procedures
- Ability to communicate efficiently with all campuses
- Proficiency and acceptance from all staff
- Expansion of utility to customers to reduce costs from excess or forgotten appointments

Policy View

- Making sure practitioners are able to make changes to the system to facility Being active in driving policy and program initiatives
- Increase agility in responding to policy changes
- Ability to buffer themselves from extreme political changes
- Understand the needs and expectations of veterans, families, and community
Future Vision

Service/Product View

- Improve service efficiency
- Expand services to fit all incoming customer needs
- Measure services more carefully
- Re-design services for continuum of care approach
- Insulate services from outside factors
- Make service offerings clearer to potential patients
- Integrate services and improve ability to customize based on patient needs
Candidate Architectures
Candidate Architectures

Illness Based

Pros:
• Continuous care in a given category can be easily tracked and traced
• Flexible if new mental disorders, programs, or illnesses arise in the future

Cons:
• Many patients fall into more than one category
• Wasted resources on programs that have low volume or excess capacity

Patient Length of Stay

Pros:
• Resources can be maximized through each department

Cons:
• Unbalanced system with excess capacity in some units and overflow in others
• Patients currently transition between some or all of the programs
• Metrics will be focused on local maximization rather than focusing on optimal flow across the organization
Candidate Architectures

Profession Expertise

Pros:
• Allows medical staff to create optimal treatment plans by working within their specialty
• There is a direct connection with leadership team and employees

Cons:
• Difficult to collaborate with other specialties
• Supervisors will not be capable of treating specific illnesses

Area Based

Pros:
• Leadership oversight is more direct and site specific
• Initiating change in each location is more manageable

Cons:
• Scalability of any one location is limited to capacity constraints
• Quality of treatment programs may vary across locations
Axiomatic

Pros:
- Director responsibilities are clear and aligned
- Connection between leadership and treatment professionals are more transparent

Cons:
- Departmental imbalance due to program sizes and patient needs
- Requires significant re-organization of the enterprise
Architecture Evaluation
## Ranking Illities

<table>
<thead>
<tr>
<th>Definition</th>
<th>Ranking</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Agility</td>
<td>2</td>
<td>9.00%</td>
</tr>
<tr>
<td>Scalability</td>
<td>1</td>
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</tr>
<tr>
<td>Quality</td>
<td>3</td>
<td>15.00%</td>
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<tr>
<td>Accessibility</td>
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<td>9.00%</td>
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<tr>
<td>Standards Compliance</td>
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<td>3.25%</td>
</tr>
<tr>
<td>Customizability</td>
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<td>15.00%</td>
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<tr>
<td>Demonstrability</td>
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<td>15.00%</td>
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<tr>
<td>Safety</td>
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<td>Responsiveness</td>
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<td>Serviceability</td>
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<tr>
<td>Survivability</td>
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### Ranking Definitions

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<tr>
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<td>2</td>
<td>Medium</td>
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<tr>
<td>3</td>
<td>High</td>
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## Concept Scoring Matrix

### Architecture Evaluation

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<th>Weighted Score</th>
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</thead>
<tbody>
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<td>Customizability</td>
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<td>0.45</td>
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<td>0.30</td>
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<td>0.07</td>
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<td>0.10</td>
<td>4</td>
<td>0.13</td>
<td>3</td>
<td>0.10</td>
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<tr>
<td>Responsiveness</td>
<td>15.00%</td>
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<td>0.45</td>
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<td>2</td>
<td>0.30</td>
<td>3</td>
<td>0.45</td>
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<td>0.60</td>
</tr>
<tr>
<td>Serviceability</td>
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<td>0.27</td>
<td>4</td>
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<tr>
<td>Survivability</td>
<td>3.25%</td>
<td>3</td>
<td>0.10</td>
<td>5</td>
<td>0.16</td>
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<td><strong>Total Score</strong></td>
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<td><strong>2.40</strong></td>
<td><strong>2.61</strong></td>
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<td><strong>2.40</strong></td>
<td><strong>2.61</strong></td>
<td><strong>2.28</strong></td>
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<tr>
<td><strong>Rank</strong></td>
<td>2</td>
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</tbody>
</table>

1-5 Success Ranking for Architectures
5=high, 1 = low

Used Current State as benchmark
Proposed Architecture

Department of Administration
- Director
- Lean Leader
- Associate Director
- Quality Leader
- Department Heads

Supporting Infrastructure
- Purchasing
- Research
- Human Patient Data Mgt
- Finance
- Resources

Department of Patient Identification
- Homeless Program
- Center for Returning Vets
- Shelter Relations

Department of Patient Reintegration
- REACH
- RISE
- CWP
- Com. Res Care
- Private Homes
- Follow-Up Programs

Department of Treatment

Off-Campus
- Outpatient Clinics
- Urgent Care
- Hospital Office

On-Campus
- Other Resources
- Drugs
  - Electroshock
  - General Neuro Psych
  - SA Long Term Stay
  - Impatient
  - SARRTP
  - Detox

Women’s Program
- WITRP
- Managing women in the system

SMI
- PATH
- PRRC
- Impatient

PTSD
- PTSD Clinic
- Impatient
Transformation Plan
Three Lens Evaluation

Cultural Lens
• Represents implicit aspects of the architecture such as organizational norms, behaviors, actions, and processes

Political Lens
• Symbolizes the power struggle and interactions within a changing architecture

Strategic Lens
• Provides insight into the logical interactions that drive decisions for the enterprise
Three Lens Evaluation

### Cultural Lens

- **Current State**
  - Limited communication and Knowledge Transfer between teams, functions, and programs
  - Employees do not feel Empowered to influence change

- **Future State**
  - Interminable Transparency and effective Feedback Loop between teams, functions, and programs
  - Employees Empowered to make meaningful changes within the enterprise
Three Lens Evaluation

Political Lens

• Current
  • Federal government mandates enterprise Program Initiatives
  • Teams work in Functional Silos and are unable to share knowledge for optimal patient care

• Future
  • Drive Policies and program initiative to influence policy makers
  • Enterprise is Patient Centric and knowledge of patient continuum of care is shared
Three Lens Evaluation

Strategic Lens

- **Current**
  - Employees are constantly ‘fire fighting’ and **Reactionary** to issues
  - Current **Metrics** that are in place are **Insufficient** to provide optimal patient care
- **Future**
  - System can mitigate unplanned events through **Proactive Care** programs
  - **Performance Metrics** directly monitor localized initiatives for optimal patient care coverage
Matrix of Change

Matrix interaction identifiers in Separable blocks

Existing Architecture

Cultural
Knowledge xfer: Knowledge transfer between teams, limited communication between functions & programs
Cultural
Poor Empowerment: Not all workers have mechanisms to influence change or make improvement
Program initiatives: Program initiatives are handed down from gov't
Political
Isolos: Mentality of hierarchy by function/profession. Each group is set up as functional silos-hierarchy
Strategic
Reactive: Constantly in fire-fighting mode
Strategic
Inadequate metrics: Strategic metrics per department should be floor-level to get the optimal to get better coverage. By LOS, unique patient issue, and number of patients

Goal/Future Architecture

Transition/Difficulty

Stability

http://lean.mit.edu
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Closing Remarks