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The root cause of dysfunction within the VHA lies in the organizations continued focus on addressing symptomatic acute problems vice promoting broad reaching cultural change. Inefficiencies in the VHA, driven by poor management practices, create an environment difficult to retain talented employees, comply with transparency expectations and provide Veterans the healthcare they deserve. Cultural adoption of Continuous Process Improvement (CPI) and Lean Six Sigma (LSS) analysis will increase efficiency in key performance indexes while maximizing holistic Veteran healthcare.

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VETERANS HEALTHCARE ADMINISTRATION (VHA)
CULTURE PROBLEMS AND INEFFICIENCIES
*Continuous Process Improvement and Lean Six Sigma
approaches for improvement in Veteran healthcare*

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Executive Summary

Title: Veterans Healthcare Administration (VHA) Culture Problems and Inefficiencies

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Thesis: The root cause of dysfunction within the VHA lies in the organizations continued focus on addressing symptomatic acute problems vice promoting broad reaching cultural change. Inefficiencies in the VHA, driven by poor management practices, create an environment difficult to retain talented employees, comply with transparency expectations and provide Veterans the healthcare they deserve. Cultural adoption of Continuous Process Improvement (CPI) and Lean Six Sigma (LSS) analysis will increase efficiency in key performance indices while maximizing holistic Veteran healthcare.

Discussion: The VHA fosters a culture and environment tolerant of fraud, waste, and abuse derived from low-risk regulation enforcement and high-gain performance-based incentives. The results of this climate result in delayed access to healthcare of Veterans and in some cases, wait-related deaths. Since the public whistle blowing events of 2014, the VHA operational transparency increased to appease public and congressional demands but is not sufficient for long-term stability. Additional funding to hire new healthcare staff, both providers and administrators, yielded positive short-term results. Three years after the new hiring wave, the results from limited vetting of credentials resulted in higher turnover rates of both new and veteran employees due to the poor integration, inefficient operations and talent distribution. The culture of the VHA needs to foster a backbone of transparency and complete reporting for long-term positive change. United States Veterans deserve healthcare equal to, or greater than, the national average. LSS approaches identify problems, foster solutions, and track improvements. LSS techniques have proven successful in limited VHA departments. Mass adoption of CPI and LSS throughout the administration will yield quantifiable short-term results and develop a culture of long-term improvement. A VHA culture that self-analyzes, promotes transparency, encourages feedback, fosters and supports change, while providing whistleblower protections for administrators and healthcare providers will establish the VHA as the leader in healthcare systems.

Conclusion: The VHA has taken great steps to address publicly identified and ridiculed practices. Improvements in patient care and internal management of the organization are going in the right direction but is still not satisfactory. The culture problems of meeting external expectations vice changing culture to produce internal standards that exceed external expectations will continue to sequester Veterans healthcare. Throwing money at a problem to buy more of an existing problem does not change culture. The Secretary of the VHA must lead the way in culture change to promote existing intelligent programs of CPI and LSS analysis while maintaining integrity and whistleblower protection.

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Table of Contents

Page

EXECUTIVE SUMMARY.....	ii
DISCLAIMER	iii
INTRODUCTION.....	01
VHA BACKGROUND.....	05
Theory.....	05
Mission and Vision.....	06
Blueprint for Excellence.....	07
PROBLEMS	08
Culture	08
Leadership	09
Healthcare Providers.....	10
More Money	11
Transparency	12
PAST ATTEMPTS TO IMPROVE	13
VA Accountability Act.....	13
Fixing Funding	14
Whistleblower Protection.....	15
Outsourcing.....	16
Lean Approaches.....	17
LEAN SOLUTION.....	18
Implementing Lean Six Sigma	19
Proof of Concept	19
Application Process	20
Methodology Driven Outcomes.....	21
Healthcare Specific Approach.....	22
SUSTAINMENT	24
Culture	24
Employee Retention.....	25
Patient Satisfaction.....	26
COUNTER ARGUMENTS.....	27
CONCLUSIONS.....	28
APPENDIX 1.....	32
BIBLIOGRAPHY	33

“The mission of the Department of Veterans Affairs (VA) was borne from the immortal words of Abraham Lincoln’s second inaugural address. “To care for him who shall have borne the battle, and for his widow and his orphan.” The Veterans Health Administration (VHA) embodies the promise of a grateful nation in the form of the quality health care that Veterans earned through their service and sacrifices. Although the covenant with Veterans is immutable, health care evolves and so must VHA.”¹

INTRODUCTION:

United States military veterans deserve the best this country has to offer. The evolution of healthcare and the VHA as described above in the *Blueprint for Excellence*, emphasizes the importance of the VHA to provide veterans their entitled healthcare. As civilian healthcare evolves, so must the VHA, which includes paramount changes in culture, managed expectations, and efficiency.

In 2014, wide-reaching problems within the VHA were identified. Problems ranged from mismanaged funding, falsified performance indexes, scandalous bonus structures, and worst of all, deaths linked to long wait times. The initial response from the VHA was to address acute problems with additional funding. This did not address any of the chronic, underlying culture problems. The VHA primarily focused on delivering specific end-results vice holistically addressing broken or inefficient processes. Ironically, the VHA continues to maintain continuous process improvement (CPI) programs, to improve efficiency and culture within their acquisition corps, but has not expanded such programs to the VHA at-large. Proliferation of CPI cultures in the VHA similar to Lean Six Sigma (LSS) would constantly evaluate VHA systems and sub-systems, identify inefficiencies and non-value added processes, then address root causes and long-term solutions toward maximizing efficiencies thus improving key performance

indices. More generally, CPI and LSS collects *all* relevant raw data of key performance indices, analyses that raw data in open forum for identifies of problems or inefficiencies, systematically provide solutions or improvements, monitors key performance indices for quantifiable results, then repeats the process.

There is an inherent necessity in the private sector of healthcare to create efficient operations and productive cultures that deliver patient (customer) satisfaction in order to maximize profits. In stark contrast, the VHA is a non-profit government organization that does not pay competitive wages to their employees not does it have share-holders to satisfy by maximize profits from standardized compensation from Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). Additionally, Congress routinely approves additional VHA funding even without a clear path of funding utilization or return on investment.² The VHA has the lowest employee overhead cost, the highest amount of funding and is the United States largest healthcare infrastructure. The resources for providing the best healthcare service for Veterans remains in place. If the VHA can promote a culture of integrity and efficiency, then utilize the savings of time, resources and money toward improved employee satisfaction, the desired patient satisfaction will ultimately improve. However, the current problem of limited reporting of funding utilization, high employee turnover, and limited improvements in performance metrics, indicate two possible conclusions about the VHA:

- 1) There is significant waste, fraud and abuse in the VHA system and;
- 2) Additional funding to broken or inefficient process does not improve results.

The *Blueprint for Excellence* provides a design for VHA operations and expectations that should prevent the two aforementioned conclusions. More specifically, CPI and LSS are explicitly included in *Blueprint for Excellence* to improve overall efficiency and create a culture

of transparency and continuous improvement. Non-compliance with organizational mission or vision usually occurs for one of two reasons; either it is not read or known by the organization writ-large or, the actionable items contained with-in are not reasonable or achievable.

In discussions with VHA staff, employees are not required to read, nor be held accountable to the *Blueprint for Excellence*. However, VHA incentives and bonuses within specific reporting metrics are well-known and published widely to employees. Competing cultural priorities (holistic healthcare versus bonuses and pay) leads to issues with integrity, transparency and completeness of reporting. Secondary and tertiary effects of this mis-guided culture are systemic in the VHA. An organization cannot identify problems nor success without completeness of reporting. VHA incentive programs create a culture where the risk for underpaid employees to report bonus worthy results is not outweighed by the consequences for incomplete or falsified metrics. The VHA culture created an environment where employee compensation outweighed moral, legal, and ethical obligations as government employees. Incentives are only useful so long as the risk for integrity violations are low and are aligned to promote process and culture improvements, vice end-results.

As long as mis-aligned bonuses remain in place and the benefits of an organization wide culture of CPI is not emphasized the VHA is subject to continued waste, fraud and abuse. Third-party auditors like ATLAS and MITRE are subject to the same temptations to report convenient or limited metrics that are beneficial for the VHA to solve quickly, while ignoring problems that require more time and resources to evaluate and address.

The *Blueprint for Excellence* disappeared from the VA website sometime after January 20th with no equivalent policy in place nor publicly disseminated reason for its removal. The *Blueprint for Excellence* provided achievable and reasonable expectations for the VHA to deliver

on Lincoln's promise to Veterans, establish a culture of CPI and integrity of reporting.

Organizations like the VHA that change or remove reasonable and achievable guiding principles, vice changing culture to meeting the guiding principles, are destined to maintain status-quo of sub-standard performance while promoting waste, fraud and abuse. Despite the redaction of the *Blueprint for Excellence*, the application of CPI and LSS principles remain principles of the VHA acquisitions department.

VHA healthcare providers are not required to practice or train in CPI or LSS analysis. A healthcare providers role is focused primarily on providing patient care. When and if available, only limited time and resources are dedicated to process analysis and improvement.

Implementing culture change within the medical community has been routinely difficult to establish. However, if accomplished, the education of providers on CPI and LSS management practices could improve the VHA in the following areas:³

- Combating non-productive waste, such as production defects, overproduction, waiting, non-utilized talent, excess motion, and extra processing.
- Providing senior managers and leaders techniques to engage front-line workers through mid-level management staff to identify improvement opportunities in their work areas.
- Promote local innovation and improvement as a basis for organizational learning and potential systemic improvement.
- Measurement and analysis of efficient clinical processes using industry-standard models of physician and staff productivity.
- Providing insight for optimizing clinical workflow that, in turn, can allow clinicians to work at their highest levels of competence.

- Bringing awareness to utilizing the full potential of each clinical workday, by assuring timely starts to clinic sessions, supporting physician practices with adequate non-physician staff for team-based and efficient care, and removing non-value added administrative burden.⁴

The list above illustrates to health care providers how LSS and CPI can be used to improve almost every aspect of their daily routine, long-term culture and ultimately patient satisfaction and quality of care. It is clear the solution to all of the VHA problems can be addressed, solved and verified using LSS and CPI methods. Despite limited past attempts at CPI and LSS healthcare management, the VHA needs to reinvigorate their commitment and support to all employees for not just passive knowledge and application of CPI and LSS, but to embrace and practice CPI and LSS daily.

VHA BACKGROUND:

Theory

The VHA embraced change since the 1990's to keep up with the evolving and expanding needs of veterans as demonstrated by the transition from a "hospital-centric model" to a "delivery system," broadening the expectations of VHA services and becoming more aligned with the private sector. The *Blueprint for Excellence* compares and contrasts how the VHA is aligned with the private sector by focusing on "the 'triple aim' for better health, better care and better value." The VHA prides itself on becoming a "truly integrated network of services organized around Veteran needs." More simply put, the VHA is dedicated to providing holistic care for Veterans similar to private-sector healthcare norms.⁵

Despite the expressed desire to provide healthcare for Veterans equivalent to the private sector, much effort has been made throughout the *Blueprint for Excellence* to differentiate expectations with phrases like “Military service presents unique and exceptional occupational health risks,” and “Roughly two-thirds [of Veterans] are over 65 years of age, have higher rates of physical and mental illness, and are poorer than age-matched non-Veterans.” This prospective is contradictory to the historic demographic the VHA presents about Veterans as being “healthier and better off financially than the average American.”⁶ Despite the mixed messaging, and the unique challenges and benefits of providing healthcare for Veterans, the commitment to provide holistic care by VHA is consistent. What is not consistent, is the expectations of employees to know and practices similar commitments outside of patient care.

If the *Blueprint for Excellence* was read, understood and implemented as the cultural standard within the VHA, vice guiding principles left on the internet to passively browse, the VHA would be the gold-standard of healthcare systems. After reading, employees would fully understand the unique challenges facing Veterans after service, their broader expectations within the VHA, and opportunities to improve their areas of influence.⁷ Employee training and cultural propagation is foundational to team dynamics. The VHA has the tools and talent to build continuing building on the LSS and CPI foundation found in their acquisitions department.

Mission and Vision-

The Mission and Vision of the VHA are reasonable and achievable. “Honor America’s Veterans by providing exceptional health care that improves their health and well-being.” This statement is closely aligned with healthcare providers Hippocratic Oath to, “do no harm.” The VHA narrows the focus to “patient centered and evidenced based” service. This narrowing of focus is where some of the results-based incentives develop based on patient satisfaction

reporting or statistical data of provider metrics. As with many other healthcare services the VHA asserts itself to be the “benchmark of excellence.” What is lacking from internal and external dissemination is the benchmarks for comparison to other healthcare systems. Transparency of specific expectations and performance with regard to benchmarks is not reported clearly, consistently, or publicly. Furthermore, the VHA lacks non-patient centered benchmarks addressing administration issues.

The VHA concludes their mission statement by describing CPI as their key to success their own words, “This care will be delivered by engaged, *collaborative teams* in an *integrated environment* that supports *learning, discovery and continuous improvement*.” The power of this conclusion is anti-climactic as mandatory CPI training is limited to just VHA acquisition teams. CPI training is available for all employees who can attend, but attendance outside of the acquisition requires supervisor support and self-motivation to pursue.⁸ Individual benefit of attending is small despite the deep reaching benefits of the training on the organization at large.

Blueprint for Excellence-

Most successful organizations have a foundational references or cultural doctrine comparable to the VHA’s *Blueprint for Excellence* covering what the organization does, where they came from, where they are going, problems and challenges they expect to encounter, and how they intend to overcome them. Documents like the *Blueprint for Excellence* provides organizations opportunities to spread cultural and manage expectations. Conversely, organizations are held accountable to these blueprints which entails an inherit risk of failing to cultivate culture or meet expectations. When the VHA failed to develop the right culture and consistently underperformed in accordance with the *Blueprint for Excellence*, the guiding principles were redacted without equivalent replacement.

The *Blueprint for Excellence* frames four themes and ten essential strategies to transition the VHA from "sick care" to "health care." The themes and essentials captured many CPI and LSS business and system solutions for effective, efficient, value added, transparent, accountable and measured outcomes. These solution terms are used repeatedly throughout the descriptions of the four Themes and 10 Strategies.⁹ LSS and CPI methodology leverage all of the all of these terms to produce or facilitate positive change to a system, process or organization. More specifically, LSS processes are specifically identified in the *Blueprint for Excellence* to “focus on combating non-productive waste, such as production defects, overproduction, waiting, non-utilized talent, excess motion, and extra processing,” and “optimizing clinical workflow that, in turn, can allow clinicians to work at their highest levels of competence.”¹⁰

PROBLEMS:

Culture-

The *Blueprint for Excellence* provided cultural guidance on how to meet all internal and external expectations of the VHA. The VHA struggled to build their ideal culture due to lack of internal promulgation “four Themes and 10 Strategies.” Instead focusing on cultural changes, the VHA focused on the addressing the barrage external symptomatic reports ranging from insufficient quantities of primary care providers, to rampant declining facility conditions and scheduling problems convoluting.¹¹

Hiring more healthcare providers, improving facilities, and buying new scheduling software with additional Congressional funding did not equate to better results nor change the underlying culture problems within the VHA. The VHA failed to properly empower employees to openly report raw data, share productive initiatives, and dissuade fear of retribution from well-

intentioned failure. This lack LSS and CPI culture led the VHA to develop a wide-spread culture falsely or incompletely reported performance due to the likelihood of receiving a bonus outweighed integrity and responsibilities. When an institution implements a zero-defect or “no excuses” environment the risk versus reward for lying is more a matter of self-preservation than of integrity and honor.”¹²

Employees that cannot openly report issues or seek out resolution without fear of unwarranted retribution or loss of pay, become cancers within an institution and spread down through organizations and externally to customers (patients). Southwest Airlines took a unique top down approach where they, “Focus on taking care of their employees first, knowing if their employees are treated right, their customers will be treated right.” If the VHA Secretary takes a similar approach to VHA culture, secondary affects will result in improved veteran healthcare.

Leadership-

Cultural issues reside throughout the VHA, but the source of the problems stem from the administration. Leadership within the VHA continue to show signs of maligned cultural priorities. In the Summer of 2017, President Donald Trump signed into law “VA Accountability Act” which significantly reduces the bureaucracy out of firing personnel involved in fraud, waste or abuse. This new law was utilized to fire Brian Hawkins, the DC VA Medical Director for “failure to provide leadership,” in July of 2017. Unfortunately, the undertrained administration failed to provide adequate supporting evidence and Hawkins was reinstated after a Merit System Protection Board reviewed the firing.¹³ Despite good intentions to purge poor culture out of the VHA, leadership failed to understand empowering laws designed to help their organization.

It was later revealed Hawkins was fired based on an Inspector General complaint claiming he was putting patients at "unnecessary risk." After reinstating Hawkins, he was

ultimately fired a second time later in 2017 for emailing sensitive VA information to his private accounts. Despite the potential for purging problematic leadership with the aid of the Accountability Act, the VHA continues to struggle to identify root causes and provide long-lasting corrective actions and positive cultural change.¹⁴

Healthcare Providers-

The VHA, *internally* identified an insufficient number of Physicians, Nurses, and other primary-care providers as the root cause for failure to deliver adequate healthcare to Veterans. In response, the VHA initially shifted their focus to “training, quality, and on their people getting it right the first time.” This well-intentioned focus was too generic and did not clearly define the training or quality, which should have been aligned to CPI and LSS practices. Unfortunately, non-CPI or LSS analysis teams were unable to draw conclusions linking investments in the development of employees to an increase in performance metrics.¹⁵ This initial attempt was leveraged to hire more doctors, nurses and healthcare providers instead of addressing why the training was ineffective to develop desired return on investment (ROI) or long-term cultural changes. New and existing VHA primary-care providers continue to lack LSS and CPI culture training.

Primary-care providers, in general, typically do not measure the efficiency of their provided healthcare with LSS or CPI metrics. Hospitals use different metrics for baseline performance numbers to include patient wait time, patient appointment time, and worst of all, patient satisfaction levels. Healthcare providers treat patients holistically, regardless of wait times and surveys. The conflict in priorities between the VHA administration and healthcare provider translates proportionally to the priorities of patients some prioritize speed of care or quality, while others are vice-versa. The challenge is to maximize provider talent without rushing

or shortchanging Veteran care, while also simultaneously achieving administration benchmarks derived from CPI and LSS approaches.

The *New England Journal of Medicine* proposed a solution to this widely recognized problem on misguided provider talent, “conceptualizing access to care in terms of a ‘continuous healing relationship,’ the [VHA]...should facilitate caregiver-patient connectivity... assessments should determine whether VHA facilities are using technology to leverage the best possible "care delivery return on investment" and whether personnel are working at the top of their skills.”¹⁶ This approach begins to provide primary-care providers and administrators with a common CPI and LSS approach to cultural improvements. The problem lies in getting both sides to understand and support the role CPI and LSS play in improving organizational culture and improving holistic healthcare.

More Money-

According to a 2011 study of change in suicide rates of homeless Veterans populations, with the change in VHA expenditure by state (appendix 1) concluded, “spending more on veterans and increasing their per veteran expenditure budget was *unable* to curb veteran homelessness and suicide rates. Even though every state spent more on veterans than the previous year, there was no consistent decrease in negative outcomes for veterans across the board.”¹⁷ The study goes to draw conclusions that additional money spent, especially non-specific expenditures not only has no noticeable effect on Homeless Veteran population, but also had no correlation to a decreased suicide attempts/rates.¹⁸

Conclusions about cost, veteran statistics, and budget is best summarized in a 2014 *Chicago Tribune* article, “The [VHA] department's budget has tripled since 2001, even while the number of veterans was falling.” This illogical relationship is best attributed to the sharp rise in

veterans diagnosed with PTSD following 2001 with the Iraq and Afghanistan campaigns, offset by the rising rate of Korea and Vietnam veteran deaths.¹⁹ Additional VHA funding does not generate a higher ROI of healthcare services nor is there a correlated reduction in Veteran suicide rates. Therefore, additional funding does not translate to better care for Veterans.

Transparency-

Full transparency is difficult to prove. The VHA will always comply with Congressional inquiries and Freedom of Information Act (FOIA) requests, but general self-reporting of negative statistics and problems is not a requirement. Short of Congress or a citizen at large willing to make a directed FOIA request, full transparency to the tax-payer and even VHA employees can be assumed as limited to bare minimum required for compliance. It is this lack of complete public, and maybe even internal, reporting that makes the application of CPI and LSS techniques near impossible due to not knowing the entirety of a system or process. These limitations compounded by a history of falsified or incomplete document reporting minimizes the effectiveness of CPI and LSS approaches. The VHA must implement cultural changes that promote complete and accurate reporting of key performance indices.²⁰

The secretary's short-term plan for fixing the VHA, which also included replacing the VA's ancient Web sites, addressed not just the needs of the VHA for whistleblower protections, but also meeting the public and Congressional transparency desires.²¹ The updated web site provided significantly more data and tools for Veterans and employees. What the website continued to lack was self-reported weaknesses and raw data of performance available for third-party analysis but was a major step in the right direction.

In the Summer of 2017, Congress unanimously passed the Department of Veterans Affairs Bonus Transparency Act, aimed at "increasing the oversight and maximizing

transparency of VA bonuses... requiring Congress at the end of each fiscal year to list bonuses awarded to senior-level staff.”²² The Transparency Act does not provide complete transparency of all reportable metrics, but it does represent a large step forward to providing the transparency needed to make CPI and LSS processes effective.

PAST ATTEMPTS TO IMPROVE

VA Accountability Act (VAAA)-

“A recent study completed by the U.S. Government Accountability Office found that, on average, it takes six months to a year to remove a permanent civil servant in the federal government. Oftentimes, it takes even longer...”²³

The problems facing the VHA with disbanding government workers is not new or unique within federal service organizations. Complacency, ignorance, fraud, waste and abuse exist in all levels of the government and it may not be possible to fully capture accurate data on the size and breadth of this issue. The VAAA is leading the charge in its ability to reduce the bureaucracy required to fire a deserving federal employee. President Obama stated, “if you engage in an unethical practice, if you cover up a serious problem, you should be fired. Period. It shouldn't be that difficult....there are still too many bad apples within the department...”²⁴

A short-list of retained federal employees and/or situations identified in a Congressional hearing targeted by the VAAA for firings include; “An employee who engaged in an armed robbery; Recoupment of \$400,000 in unauthorized relocation benefits from two senior employees who abused their authority; No employees were held accountable for their failures to manage major construction projects, including the new hospital in Aurora, Colorado, that is now several years and nearly a billion dollars over-budget; It took a year to fire a nurse who assisted

in a veteran's emergency surgery while under the influence of alcohol.”²⁵ These examples of integrity and ethics violations prevent the application CPI and LSS.

The VAAA is meant to give the VA secretary power comparable to supervising in the private sector. Since the VAAA was passed, firing of personnel can happen almost immediately when done at the Secretary level. The fired personnel is also protected by an expeditious 45 day or less appeal process as compared to the previous process which make take as long as 264 days. The VAAA also provides provisions to rapidly place and shift personnel to fill critical roles left by those of whom have been fired minimizing exposure or lack in provided services. Despite some early missteps as previously mentioned in the rapid execution of the new law, the VAAA provides the Secretary and his staff the ability to efficiently remove employees that are not committed to a positive culture change of transparency in reporting and ethical behaviors.²⁶

Fixing the Funding

One of the initial addresses by the VHA Secretary to Congress following the 2014 scandals was the need for “tens of thousands of new doctors, new nurses, new clinicians -- emphasizing the significance of a shortage of employees who are directly involved in treating patients.”²⁷ The Secretary’s well-chosen words solicited immediate support from Congress and subsequent additional funding to hire additional healthcare professionals. Despite the money being appropriately spent on healthcare workers, the distribution of talent did not flow to the right locations, thus continuing the wrong cultural of blindly throwing money at a problem and vice applying a systematic approach to efforts as would be derived from CPI and LSS.

The newly hired healthcare workers were assigned to reduce the 15.5% vacancy rate, (four times the national unemployment rate) encompassing almost 46,000 vacancies with in the VHA. The additional personnel were required talent acquisitions, but a subsequent analysis

would later illustrate that not all places required additional hires. A LSS analysis would have illustrated a need to coincide a shift in talent along with the new hires, to level load experience with the new/novice VHA providers.²⁸

Whistleblower Protection-

One of the first attempts to “fix” the VA came from Robert McDonald, the new secretary of the Department of Veterans Affairs, in September of 2014, when he laid out a 90-day plan to fix the VA. The primary focus of this plan was to significantly reduce the wait times from booking to attending appointments. The exorbitant wait times were attributed to preventable Veteran deaths. Causes for the delayed ranged included falsified scheduling records, treatment delays and retaliation against whistleblowers.²⁹

McDonald’s plans sought the first real attempts at broad reaching CPI and LSS analysis throughout the VHA. He was determined to “see everything through the eyes of the veteran,” by further stating LSS principles, “if doesn't add value to the veteran, we'll stop doing it and redeploy those assets to veterans.” By providing whistle blower protections, McDonald increased transparency throughout the VHA allowing raw and complete data to be analyzed for process improvements and positive long-term culture growth.

As whistleblower protections increased, integrity grew within the VHA and the likelihood of maligned behavior decreased, supporting a culture of complete and accurate reporting. With less whistleblower reports, protecting the few whistleblowers becomes more manageable and easier to protect, while simultaneously increasing the number of assets available to address the wrongs reported. The Secretary promised "to ‘flatten’ the power structure inside the country's second-largest federal agency,” further stating he “wants an organization where everyone is called by the first name.”³⁰ This translates to both a cultural change where

employees will become comfortable enough to report issues both up and down the chain of command, but may lead to reporting of peers more difficult.

McDonald promptly “proposed disciplinary action against three senior employees at the Phoenix VA clinic where the record-keeping scandal first came to light,”³¹ showing both the administration and the public, the VHA was not going to drag its feet any longer when prosecuting suspected fraud, waste or abuse. Firings, appeals and decisions following said whistleblower filings has been significantly hastened IAW with the FAAA and provided a catalyst for culture change.

Outsourcing

In 2014, Congress created the \$10 Billion Choice Plan, which allowed for veterans to be referred out to private doctors under the following circumstances they lived more than 40 miles from a VHA hospital or could not get an appointment within 30 days.³² This was a major step forward for both addressing the “provider shortage” as well as “fake appointments scandal.”

While the Choice Plan was designed to be a temporary fix, and the VHA could find itself relying more on the private-sector for long-term solutions in low demand regions. If current utilization trend of private-sector referrals remains constant, than a predicted 60 percent of veterans utilizing will utilize private health care by 2034. The exponential rise in private-sector utilization continue as trends predict, the complexity of internal CPI and LSS analysis increase, but could still yield over all improvements for VHA efficiencies and Veteran care.³³

Conversely, if a VHA clinics become underutilized for healthcare , a perceived increase in available VHA services becomes available, but at a much higher cost to the VHA due increased overhead cost per veteran served and can quickly exceed national averages. When this occurs, a region or hospital would become a candidate for closure due to lack of demand and/or

excessive costs. When closures occur, all Veteran care is pushed to the private sector or results in Veterans traveling excessive distances for care. The employees are displaced, but become a talent pool for reallocation to facilities in need of experienced providers. Some dissatisfaction over all will be reported, but the VHA would gain more options in cost controls and talent allocation. This reallocation of talent and resources may lead to over increases in efficiency, cost savings and patient care.³⁴

The key to managing this paradigm shift in outsourcing Veteran healthcare, as reported in the *New England Journal of Medicine*, revolves around, “participating fully in [common] performance-reporting initiatives, expanding learning-and-improvement partnerships with outside entities (as it did in the late 1990s in spearheading national patient-safety improvement efforts) and making performance data broadly available.” Having commonality between the VHA and the private sector is the only way to ensure the cost-benefit of outsourcing remains advantageous for the VHA. With costs ever changing, consistency in reporting metrics are critical to managing the balance of in-house care with outsource options.³⁵

Lean Approaches-

Many of the VHA approaches to fixing problems are acute but temporary. LSS and CPI are mentioned continuously throughout the *Blueprint for Excellence* and statements on the methodology in which the VHA is going to investigate, propose and implement systematic measurable improvements across the board. Unfortunately, this proven system, both internal and external to the VHA and healthcare at large, are underutilized and rarely accredited for the positive improvements they bring to an organization both long and short-term.

The VHA developed the Strategic Analytics for Improvement and Learning (SAIL) dashboard, which focuses on “28 meaningful metrics including access to care, mortality rates,

infection rates, and patient satisfaction, is a good start that will improve with use and would help hold the VA accountable for results.”³⁶ Developing this baseline is fundamental for measure future success or failure after applying LSS and CPI techniques. Furthermore, standardizing these metrics also allows for cross-comparison with the private sector to analyze feasibility of outsourcing.

LEAN SOLUTION

The greatest aspects of implementing a broad spectrum LSS solution to the VHA is that the philosophy and proof-of-concept already exists within the VHA acquisition department and is practiced in varying levels of integration throughout the rest of healthcare. The VHA acquisitions teams are trained in “LEAN Sigma,” which is simply the VHA proprietary version of LSS.³⁷ LEAN Sigma, should be expanded to become relevant and applied to all aspects of the VHA to better align themselves other major medical institutes.

The Cleveland Clinic, The Mayo Clinic and Johns Hopkins are amongst the largest and earliest adopters of wide spread LSS and CPI culture change. This paradigm shift is a leading factor in why these healthcare facilities consistently rank amongst the top in the world.³⁸ At the most fundamental levels LSS as applied to healthcare is about:

- fixing the broken systems and processes that hinder medical professionals from doing what they do best
- empowering each employee to make improvements
- reducing time and costs
- synchronizing processes
- and improving quality and the patient experience³⁹

By December of 2016, the VHA set a goal to have “10% of target candidates trained.”⁴⁰ This is a surprising low number, that eludes the administration still not believing in wide spread applicability, but furthermore that only 1 in 10 of the applicable target candidates will possess even the LSS training, never mind proven capabilities.

Implementing Lean Six Sigma-

LSS is a proven methodology to track, identify, develop solutions and monitor effectiveness. Where LSS has struggled in healthcare is with effectively measuring customer satisfaction. It is not predictably quantifiable due to the qualitative nature of the of subjective satisfaction reporting. The VA Secretary proposes to, “bringing in the best practices and strategies from business and government...blending approach for the VA... combining it with Human-Centered Design...to understand and satisfy consumer needs and wants.”⁴¹ This blended approach appears to be scalable both in mass adoption and the proportionality of the applied approaches to improve the VHA.

Proof of Concept-

Over the course of one year at the VHA, a combined effort of applying LSS techniques with an additional 15,000 employees (or 5% increase in work force) produced the following results from June 2014 to June 2015:⁴²

- 7 million more medical appointments seen than it had in the previous 12-months:
 - o 97% of appointments are within 30 days
 - o 92% are within 14 days
 - o 87% are within seven days
 - o 3% are same day,⁴³
- Claims and care time are also being processed more quickly.

- Average wait time for a claim reduced to about 93 days, down from 250 (63% reduction in wait time)
- Specialty care wait time is six days.
- Primary care is four days.
- Mental health care is three days.⁴⁴

These numbers have been found to be at or above the expectations of the veteran patients and aligned with national averages. “The cost of training is minimal, and the efficiencies gained through the applied methodologies can be substantial enough to recoup training costs. Lean Six Sigma makes these processes effective, efficient and repeatable,”⁴⁵ Secretary McDonald stated. All of these positive and sustainable results mark the beginning of long-term improvements to healthcare delivery and administration.

Application Process-

Value-added activities must be identified as “key contributors” for the success of lean application. Any remaining activities that don not make the “value-added” cut, as assessed by LSS trained teams, should be considered for elimination or repurposing.⁴⁶ This categorically created efficiency lines of efforts to attack or avoid based on ROI levels between different processes and applications.

The VHA administration should expect initial resistance from staff to new processes and procedures imposed from executive management or suggested from other hospitals. Resistance to change can become a hurdle but should not be considered an unsurmountable object for mass adoption. The few addiment nay-sayers should be, “identified and eliminated, and the new procedures developed by the personnel who are and will be carrying out changes, shall results in higher levels of buy-in to the new process.”⁴⁷ An organization culture of CPI and LSS analysis,

will deliver transparency of reporting and quantifiable improvements in efficiency and delivered health care.

Trust in the process and the institution is paramount for changing the previous poor reputation of keeping the VHA cards close and only selectively reporting convenient data. The VHA needs to proactively report short-comings and increase transparency to negate future articles like this from the *Federal Information & News Dispatch*, "For months now, requests for information on those deaths and other incidents across the country involving questionable VA conduct have been met with silence or obfuscation."⁴⁸ These types of reports will subside as transparency increases as required for LSS analysis.

Methodology driven outcomes-

When the VHA must avoid addressing specific short-term wins if they are at the cost of long-term solutions. Many healthcare providers cannot see or feel the outcomes of the LSS and CPI in relation to providing their patients better care. The VHA needs to clearly illustrate to providers the variety of positive outcomes that can be achieved through CPI and LSS, which lead to higher levels of holistic care for their patients. In a private sector LEAN study in 2013, a hospital Labor and Delivery department, showed evidence of "significant time reduction, not only in the registration process but also in the 'Time to Arrive to the Physician.'" This was accomplished simply by "focusing on the application of a modeling and simulation methodology," and not on the final outcome.⁴⁹

The process is more important than the outcomes. To demand a 10% reduction in a departments budget to reduce overall costs is the wrong approach to long-term cost savings. A better method is to improve all processes in the department with regard to efficiency and waste.

The following example illustrates how an Emergency Department (ED) applied LSS process with the goal complete the processing of an ED patient in under an hour:

“In an Ohio hospital ED, for example, a one-week focus on supplies in 20 treatment rooms resulted in more than \$6,000 worth of extra supplies being returned to a central location. Also, by looking at the entire workflow of the ED department, the hospital found placement of a printer or patient monitor eliminated five minutes of walking back and forth for physicians or nurses.⁵⁰

By reducing wasted products, centralizing locations to reduce time searching for products, and optimizing placement of equipment to reduce travel time, the ED was able to improve its efficiency goals by improving their processes. These process changes did not cost any additional funding, are long-lasting, low-effort changes. The hardest part of making these changes is to get employees to carve time, for LSS analysis of their work environment and foster feedback and change implementation.⁵¹

Healthcare specific approach-

The solutions developed in the manufacturing world often involve quantitative analysis or bistable results (passed or fail QA inspection). Many LSS Black Belts with extensive experience outside of the Healthcare industry have struggled or failed to directly apply manufacturing based LEAN theories to the qualitative holistic service industry of healthcare. A *Quality Progress* article from 2005 proposed the following for applying LEAN techniques with healthcare providers:

1. Seek to fully understand physician needs in general and within the specific process to be changed during the prework, define and improve phases of a DMAIC project and learn the degree of support required.

2. Seek to build trust.
3. Educate physicians in all aspects of healthcare management, financial management, regulatory environment and competitive pressures with an aim to establish a true visioning partnership about the future.
4. Seek win-win projects.⁵²

Defect-free processes or saving every life is appealing but impossible for healthcare providers. Perfection or zero-defect is never an achievable goal, but striving to reach these goals will ultimately lend itself to delivering the longest-lasting, highest-level, holistic patient care. Skepticism from both executives and physicians to deliver each other desired end-states through a common process will be fraught with challenges and conflicts of opinion. However, focusing on cultural changes within healthcare, where all sides recognize improvements, is an achievable end-state all parties can recognize. Isolated success should be recognized, but when every process change yields a “win-win” situation for all parties, cultural change has occurred and LSS process has proven itself, and CPI process shall remain.⁵³

The radiology department at a Commonwealth Health Corporation hospital in Kentucky, made an 18-month commitment to applying LSS with the healthcare focus previous discussed with phenomenal results as follows:⁵⁴

1. CHC experienced an \$800,000 decrease in total radiology operating costs during phase
2. Radiology costs per procedure decreased 21.5% from \$68.13 to \$49.55 per procedure.
3. Projected operational cost savings are expected to exceed \$1.65 million per year, which are cost savings directly attributable to performance improvements identified with Six Sigma.
4. Errors in the MRI ordering process decreased 90%.

5. Patient satisfaction ratings improved when waiting and exam times decreased.
6. Total patient volume increased by 25% while the department reduced staffing by 14 Full-Time Employees.⁵⁵

Recognition of the performance data above should bridge the VHA Executive – Provider disparity in healthcare performance. Exposure and proof-of-concept with succinct demonstrations of success with LSS in health can be presented in less than one hour. The details of applicable will come from each individual team, but mass acceptance should be an easy sell. The VHA has an opportunity to recognize immediate and long-term improvements for patients, providers and administrators.

APPLICATION

The VHA already has an organized and structured training department for LEAN operations called the VA Acquisition Academy. But by all estimates it is significantly underutilized by the majority of the VA or VHA. The LSS program taught to VHA acquisition teams is called *Performance Excellence* (PE) and captures many aspects of LSS such as “cross-functional analysis, diagnostics, learning and performance interventions...optimize performance of the acquisition ecosystem... culture change initiatives and promote a data driven culture.”⁵⁶

Culture -

The VA is capable of creating, implementing and maintaining cultures, as illustrated by their ICARE (Integrity, Commitment, Advocacy, Respect and Excellence) philosophy.⁵⁷ The mechanisms for training and executing a LSS culture exist in the VA acquisition Academy, the propaganda machine perpetuating the ICARE illustrates culture sustainment ability, and more than sufficient funds exist to grow and sustain a culture shift of LEAN practices.

The key for momentum is growing the existing culture, vice starting new. VA Secretary McDonald, has publicly endorsed this culture shift and proliferation stating, "...every employee should 'own what they do, and that they should always have a personal project ongoing to improve what they do.'" Furthermore, employees who are part of his leadership development teams must execute a, "100-day improvement project using the skills they had learned [about LEAN processes]." Secretary McDonald has shifted the responsible for efficiency improvements from upper management down to the lowest and often times individual levels.⁵⁸

The previously mentioned radiology department that reported significant improvements long-term improvements from LSS became the kindling for a firestorm of cultural change throughout the hospital. The Executive Vice President the hospital noted, "Six Sigma was viewed as the catalyst for corporate-wide transformation of the existing culture. Six Sigma relies on a foundation of methodically collected and analyzed data, rather than managerial experience or expertise."⁵⁹ Cultural shifts are hard to implement without proof of concept. The VHA has proof of concept, both internal and external, about the wide-reaching benefits of LSS and CPI. This message needs to reach healthcare providers in every department of the VHA and at all levels.

Employee Retention-

High employee turnover linked to dysfunctional work culture created by a lack of transparency resulted in lost talent, increased training time and costs but most of all communications. When an employee leaves a company, expertise and culture are lost with that employee. Minimizing employee turnover or maximizing retention is critical for long-term improvements and continuity. The VHA recognizes the unique challenges faced as a healthcare institution confined by the limitations of government regulations. Funding limitations, salary

caps, bureaucracy in policy changes all hinder talent acquisition and retention. What the VHA has to do is manage expectations and emphasize that all employees embrace “the mission that matters - a shared love of serving veterans.”⁶⁰

The VHA recognizes many of its providers could be compensated up to four times as more in the private sector vice civil service. Instilling a culture of attribution free reporting and transparency will build a culture that develops pride in the VHA mission. Once the right culture is developed secondary gains in relationships with co-workers, labor-management relations and management will flourish in the VHA. All employees that work for the VHA do it for a higher cause, and it is imperative the VHA organizationally continues to recognize those who serve and work for the VA are appreciated and are taken good care of within the limits of the government complex. LSS and CPI combined with attribution free transparency will free up bandwidth for employees that no longer stress about desired results, which creates a better workplace for employees and a better veteran experience.

Regardless of culture, positive work environment and those working for the VHA for altruistic reason, higher salaries will always draw away a limited number of employees. With financially disadvantaged workers, there will always be the temptation to cheat the system to try and equalize the pay in benefits gap with private industry counterparts. Transparency in reporting baseline metrics (required for LSS analysis) will not only provide more accountability, but minimize temptation to cheat the system due to higher risk of being caught, resulting in less integrity violations and unplanned employee losses.

In limited surveys as to why VHA employees stay with the organization, it was found that 58% of the survey participants chose to stay because of the benefits, followed by retirement, salary then time off (work/life balance).⁶¹ These surveys illustrate where and how the VHA

wastes times on functions they do well and do not dig into where they perform poorly. The VHA should be focusing on is exit survey's of employees in the process of transitioning out of the VHA to gather data on where they can improve the retention capabilities.

Patient Satisfaction-

A 2008 Nova Southeastern University study on medical administration efficiencies in Little Rock Arkansas determined, "The most important aspect of service is reliability. This is consistent with other studies which also determined reliability is the most important aspect of service."⁶² Reliability is a generic term that includes reliability in booking and making appointments, appointments being on time, consistency in providers, and quality of care. The VHA has debatably failed in all of these aspects over the past decade to varying degrees.

By applying all of the previous LSS and CPI techniques, to develop the right culture for improvement and taking care of the VHA employees, patient satisfaction will ultimately improve as a by product of doing everything right before the patient is involved. Southwest Airlines philosophy does not *directly* put the customer first. Employee satisfaction is prioritized by administration knowing that the frontline employees that interact with customers will focus on the customer needs if they know Southwest administration is taking care of them. This is prime example of the culture explanation the VHA should promulgate internally to their employees.

COUNTER ARGUMENTS

When surveying VHA physicians about what LSS, many of them come up with a response along the lines of "it is a method of accurate data analysis applied to manufacturing to reduce imperfections and increase efficiency...which doesn't apply to me in the world of healthcare." Within the VHA, it is noted that there is a "strong cultural bias in the healthcare

industry against the sharing and publication of errors and defects.” This goes beyond HIPAA rights and protections. Most employees do not want to live or work under constant scrutinization of their work practices and culture, thus many practitioners resist LSS and CPI adoption. What the VHA needs to do is illustrate the benefits and protections afforded to physicians and reaffirm the focus is on patient care and not profits.⁶³

More generically, CPI and LSS assumes there are inefficiencies in every organization and process which need improvement. This can lead to worthless changes. When changes are made that are not seen as significant by the personnel involved in the process change it leads to negative opinions and lack of commitment to the process. This will lead to organizations that report LSS and CPI being ineffective as one study reported “67 percent improvement in the key process metric at the SS/LSS study conclusion, but only 9 percent reported sustained improvement.”⁶⁴

These reports are often used to justify a consultant type philosophy where broad sweeping changes are recommended and made to show instant and short-term improvements in efficiency and bottom-line budget, but often fall apart long-term due to a lack of cultural adoption or commitment to CPI.⁶⁵ LSS can solve the objective issues, but when it comes to services, especially healthcare, a human approach and understanding is needed for long-term success.

Chip Caldwell Jr., a LSS healthcare application specialist, further states, "Sometimes senior leaders are overly tactical in their implementation efforts, not strategic."⁶⁶ When leaders and executive focus on micromanagement or tactical application of LSS, the larger strategic plan is lost. This is evidenced by the type of questions being asked. A tactical team *asks how* to improve a process looking for an *answer of what* they need to do. A strategic team *asks what*

they want to do and looks for *answers of how* to do it.⁶⁷ LSS forces teams to think strategically about change and look for new and better answers to problems they did not know existed.

CONCLUSIONS

The VHA continues to be challenged by skepticism of transparency in operations and reporting. Application of CPI and LSS approaches expose internal short-comings, but it is inherent to the VHA to report these findings publicly and without provocation to change this skepticism. The observed culture indicates continued limited transparency and reluctance to holistically change. Congress and the public should expect the status-quo from the VHA of carefully selected third-party auditors (ATLAS) reporting only limited data sets and proposing easy low-cost and short-term solutions to validate effectiveness of the auditing process. The VA will continue to sponsor third-parties events such as PEX V.A. (Process Excellence in the V.A.) put on by the Institute for Defense and Government Advancement (IDGA) to illustrate a commitment to CPI awareness publicly but limited application internally.

Veterans and tax payers will continue to pay the price for incentivized executive and leaders. Good providers will ultimately leave for higher paying jobs with better workplace cultures. The VHA possesses the tools, doctrine, resources and finances to become the leader in healthcare systems. A dedicated, wide-spread culture change toward CPI and LSS analysis will generate secondary and tertiary results felt by Veterans, VHA employees and the American tax payer. It is up to the Secretary of the VHA to make culture changes, not policy changes to fix the VHA.

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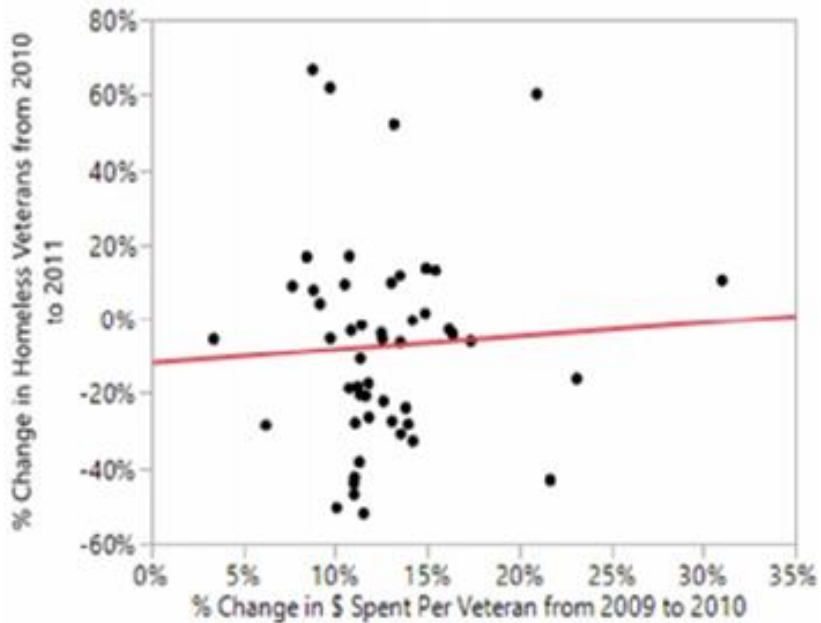
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Appendix 1



The Relationship Between Percent Change in Homeless Veterans (2010-2011) and the Percent Change in the Amount of Money Spent Per Veteran (2009-2010), by State

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