2000 Presidential
Transition Series

June 2000

Transforming Government:

The Revitalization of the Veterans Health Administration

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The PricewaterhouseCoopers Endowment for
The Business of Government

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Foreword

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On behalf of The PricewaterhouseCoopers Endowment for The Business of Government, we are pleased to present this report by Professor Gary J. Young, "Transforming Government: The Revitalization of the Veterans Health Administration." This is the third report in The Endowment's "2000 Presidential Transition Series," which is aimed at providing insights and guidance to new political executives interested in learning from the experience of previous political executives who successfully transformed their organizations.

There are many similarities between the transformation experiences of Dr. Kenneth Kizer, profiled in this report for his leadership of the Veterans Health Administration (VHA), and James Lee Witt, administrator of the Federal Emergency Management Administration (FEMA), whose revitalization efforts were described in an earlier Endowment report. A major lesson learned from both case studies is the importance of experience. In this report, Professor Young found that the success of the VHA transformation was partially the result of the match between the professional experience and qualifications of Dr. Kizer and the needs of VHA at the time of his appointment. In the FEMA case study, R. Steven Daniels and Carolyn L. Clark-Daniels found that "experience counts" and that the prior emergency management experience of Director Witt and his leadership team were major factors in the successful transformation of FEMA.

In addition to the importance of experienced leaders, Professor Young found that another key to the VHA success — like the successful FEMA transformation — was a focused and coherent transformation plan, which included a vision for the agency, a new organization structure, and a new accountability system.

As new political executives arrive in Washington during the next administration, we hope that they will take the time to review and reflect on the experiences of successful government executives — like Ken Kizer and James Lee Witt — who fundamentally transformed their organizations into high-performing agencies delivering dramatically improved service to the American people.

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Executive Summary

During the 1990s many organizations in both the private and public sectors underwent large-scale transformation to improve their performance. This report presents findings from a longitudinal case study of the transformation of the Veterans Health Administration (VHA). VHA, a primary operating unit of the U.S. Department of Veterans Affairs, is a federally funded and centrally administered health care system for veterans. The case study was intended to gain insight into the opportunities and problems organizations face when attempting large-scale transformation.

This case study has been conducted on an ongoing basis since the transformation began in 1995. VHA employees at all levels of the agency were interviewed, as well as individuals who observed the transformation as members of organizations that interface with VHA. Information for the case study was also obtained by conducting employee surveys and by examining VHA internal documents and data sets.

As a general finding, VHA's transformation has been highly successful. Between1995 and 1999, the agency has made substantial improvements on a number of important performance indicators. The transformation has also had limitations that reflect the challenges and tensions inherent in large-scale organizational change. Although each organizational transformation is unique, VHA's experiences offer a number of lessons for future transformation efforts. Based on the case study, the following seven lessons have been identified.

Lesson 1: Appoint Leaders Whose Backgrounds and Experiences Are Appropriate for the Transformation.
The individual appointed to lead the VHA transformation had three attributes that were particularly relevant for the task at hand: outsider status, substantial leadership experience in the public sector, and knowledge of private-sector innovations in the financing and delivery of health care services.

Lesson 2: Follow a Focused and Coherent Transformation Plan.
The senior leadership team for the transformation focused on four interrelated initiatives that formed a coherent and effective transformation plan: creation of a vision for the agency, adoption of a new organizational structure, establishment of an accountability system, and modifications in agency rules and regulations.

Lesson 3: Persevere in the Presence of Imperfection.
All transformations generate controversy and criticism that can distract the leaders from focusing on the central goals of the change effort. In the case of VHA, the senior leadership team kept its sights fixed on key transformation goals while making midcourse corrections to address technical problems as they were recognized.

Lesson 4: Match Changes in the External Environment with Changes in the Internal Environment.

Leaders of transformation are often consumed with managing the internal changes of an organization. VHA's transformation reveals the importance of managing external changes to complement internal ones.

Lesson 5: Develop and Manage Communication Channels from the Highest to the Lowest Levels of the Organization.

VHA's transformation offers another of many examples where conventional communication strategies did not work to keep frontline employees informed during a transformation effort. To reach frontline employees, future leaders of transformation should carefully consider opportunities for developing communication channels at the lowest levels of the organization.

Lesson 6: Do Not Overlook Training and Education.

During the transformation, many managers reportedly struggled to adapt to a management system that required them to develop new skills and capabilities. The difficulty of this struggle was compounded by a lack of training and educational opportunities for managers.

Lesson 7: Balance Systemwide Unity with Operating-Unit Flexibility.

The transformation entailed a dramatic push to decentralize decision making after years of micromanagement on the part of VHA headquarters. However, the swing from centralized to decentralized management appears to have allowed little opportunity for careful planning in the reorganization of certain functions and programs at agency headquarters. VHA's experience reveals the importance of planning decentralization efforts carefully so that an appropriate balance is struck between system-level coordination and control and operating-unit flexibility.

Part One: Lessons Learned from the Transformation of the Veterans Health Administration (VHA)*

In 1995, the Veterans Health Administration, a primary operating unit of the U.S. Department of Veterans Affairs, embarked on a large-scale transformation. VHA is a federally funded and centrally administered health care system for veterans. The agency is also one of the country's largest providers of health care services. In 1999, VHA's health care system included 172 hospitals, 132 nursing homes, 73 home health care programs, 40 residential care programs, and more than 600 outpatient clinics. In addition, VHA oversees substantial health-care-related research and educational programs, and serves as a contingency backup for the Department of Defense medical care system.

VHA's transformation was in response to several external events and trends that threatened its future viability. In particular, the agency had become out of sync with prevailing trends in the delivery of health care services. VHA also faced the prospect of budgetary cuts and potential competition for patients from private-sector health care organizations. At the same time, the agency's complex mission and highly centralized decision-making structure were substantial impediments to its ability to adapt to these external threats.

A longitudinal case study of the VHA transformation was conducted to gain insight into the opportunities and problems organizations face when attempting large-scale organizational change. As part of the case study, VHA employees at all levels of the agency were interviewed, as well as individuals who observed the transformation as members of organizations that interface with VHA. Information for the case study was also obtained by conducting employee surveys and by examining VHA internal documents and data sets.

As a general finding, VHA's transformation has been highly successful. Since the transformation

* *The case study that this report is based on was supported financially in part by the National Science Foundation (grant number – 9529884). The author is grateful to several members of the Management Decision and Research Center for their help in conducting the case study — Martin Charns, Carol VanDeusen Lukas, and Geraldine McGlynn. The author is also grateful to Richard Coffey of the University of Michigan Hospitals who served as a co-principal investigator on the National Science Foundation grant. The views expressed in this article are those of the author and do not necessarily represent the views of the Department of Veterans Affairs or Boston University.*

began in 1995, the agency has made substantial improvements on a number of important performance indicators. The transformation also has had limitations that reflect the challenges and tensions of conducting a large-scale organizational change. Although each organizational transformation is somewhat unique, VHA's experiences offer a number of lessons for future transformation efforts. Based on the case study, the following seven lessons have been identified.

Lesson 1: Appoint Leaders Whose Backgrounds and Experiences Are Appropriate for the Transformation.

As is often the case with organizational change efforts, VHA's transformation began with new leadership. Toward the end of 1994, Dr. Kenneth W. Kizer assumed the position of under secretary for health, the highest-ranking position within VHA, with a mandate from Congress to transform the agency. Dr. Kizer, a physician trained in emergency medicine and public health, proved to be a highly effective leader for the VHA transformation. His effectiveness, as many of those interviewed repeated, was largely a result of the match between his professional experience and qualifications and the needs of the transformation.

Interviewees referred to three of Dr. Kizer's qualifications as being particularly relevant to his effectiveness. First, he was an outsider. Unlike many of his predecessors, he assumed the under secretary position without progressing through the agency hierarchy. Because of his outsider status, he was not a captive to entrenched interests within the agency. According to interviewees, when previous VHA leaders proposed making large-scale changes to the agency, they would find themselves constrained from going forward by loyalties to old colleagues who opposed the changes. Dr. Kizer was beholden to no one inside the agency. After assuming the under secretary position, Dr. Kizer selected several insiders for his senior leadership team, an action that reportedly helped him compensate for his own limited knowledge of the inner workings of the agency.

Second, although Dr. Kizer was new to VHA, he did have substantial leadership experience in the public sector. In particular, Dr. Kizer had served as director of the California Department of Health Services, where he reportedly learned how to work effectively with both policy makers and career civil servants. Dr. Kizer also had experience as a medical school department chair, a position that helped prepare him to manage VHA's important but complicated relationships with its affiliated medical schools.

Third, Dr. Kizer was an astute student of innovations in the financing and delivery of health care services. He had witnessed many innovations firsthand through his professional experiences in California, a state that has led the country in many innovations in the delivery of health care services. Dr. Kizer brought this spirit of innovation and experimentation to VHA.

VHA's transformation highlights the importance of having leaders whose backgrounds and experiences fit the needs of the transformation. For some organizations undergoing transformation, new leadership may be necessary, but the focus should be on ensuring that selected leaders have the right background and experiences for the transformation.

Lesson 2: Follow a Focused and Coherent Transformation Plan.

Most transformations encompass many different activities and initiatives. Although this is also true of VHA's transformation, the senior leadership team for the transformation focused on four interrelated initiatives that formed a coherent and effective transformation plan. These initiatives were the following:

Creation of a Vision for the Agency

The senior leadership team developed and disseminated a series of documents that presented the vision for the transformation. These documents articulated the basic philosophy, principles, and organizational framework to which a transformed VHA would adhere.

Adoption of a New Organizational Structure

Within the first year of the transformation, VHA's senior leadership team implemented a sweeping change in the agency's basic organizational structure. The new structure decentralized decision-making authority within the agency and created new operating units for carrying out planning and budgeting. The agency's resource allocation system

was also changed so that an operating unit's budget was based on the number of veterans it served rather than its historical costs. The individuals selected to oversee these new operating units were given primary responsibility for achieving transformation goals.

Establishment of an Accountability System
As the centerpiece of a new accountability system, the senior leadership team established performance contracts with upper-level managers. Each manager was required to sign a contract that stipulated a set of performance goals to which he or she would be held accountable. The performance goals related logically to the agenda set forth in the vision documents.

Modification of Agency Rules and Regulations
The senior leadership team sought and obtained reforms to a number of long-standing agency rules and regulations. These reforms provided VHA managers with greater operational flexibility for achieving the goals of the transformation. Some of these reforms entailed changes by the senior leadership team in the agency's own policies while others entailed changes by Congress in legislatively defined regulations for VHA.

These four initiatives formed the basic transformation framework for the agency. Other activities undertaken during the transformation were typically linked to one or more of the initiatives. The senior leadership team's ability to develop and implement each one of the four initiatives was central to the overall success of the transformation.

Lesson 3: Persevere in the Presence of Imperfection.

All transformations generate controversy and criticism. Such criticism and controversy often distract leaders of transformation from focusing on the central goals of the change effort. In the case of VHA, the senior leadership team kept its sights fixed on key transformation goals while making mid-course corrections to address technical problems as they were recognized.

For example, VHA's senior leadership team became deeply embroiled in controversy over the accountability system it had established for upper-level managers. The new accountability system entailed the development of new performance measures and data sets. Initially, managers complained bitterly about the adequacy of the data sets, reliability of the measures, and potential opportunities for gaming the accountability system. They also raised objections based on the number and attainability of performance goals.

Certainly many of the complaints were valid, and efforts were made to improve databases and measures. The senior leadership team, however, believed the value of the new accountability system exceeded its functional capabilities. Indeed, the new accountability system's emphasis on performance data reverberated throughout the agency. Managers at lower levels of the agency began developing data sets for monitoring the performance of their own units in ways that supported the transformation agenda. Moreover, interviewees commented that the senior leadership team appeared less concerned about whether upper-level managers met precisely each and every performance goal in their contracts than whether they met the spirit of their contracts in the sense that performance was moving in a direction that promoted the transformation agenda.

No transformation will be perfect, and those who oppose the changes will seek to exploit flaws or limitations to derail the effort. Leaders of transformation need to be responsive to legitimate criticisms, but they also must avoid being swallowed up in technical details.

Lesson 4: Match Changes in the External Environment with Changes in the Internal Environment.

Leaders of transformation are often consumed with managing the internal changes of an organization. VHA's transformation reveals the importance of managing external changes to complement internal ones. VHA's senior leadership team collaborated with other interested parties to secure from Congress a number of legislative reforms that were central to the transformation.

For example, the senior leadership team collaborated with veterans service organizations to change patient eligibility requirements that had limited the agency's ability to treat patients on an outpatient

basis. Dr. Kizer reportedly played an important role in winning support for these reforms from certain key members of Congress who had long been opposed to them. He gained their support by presenting the reforms as a necessary step to achieving agency accountability for the goals of the transformation. In addition, the reforms expanded VHA's authority to contract with private-sector entities, facilitating the agency's ability to build its infrastructure for outpatient care.

Lesson 5: Develop and Manage Communication Channels from the Highest to the Lowest Levels of the Organization.

VHA's transformation offers another of many examples where conventional communication strategies did not work to keep frontline employees informed during a large-scale change effort. To inform employees about the transformation, the senior leadership team distributed written notices and videotapes, held town meetings, and conducted video conferences. However, the survey data collected as part of this study indicate that these methods of communication were not reaching frontline employees.

What strategies can managers use to communicate effectively with their employees during a transformation? Some management consultants advocate that organizations plan for communication to be handled face-to-face between frontline employees and the supervisors to whom they report directly. Along these lines, at Ford Motor Company the CEO has embraced the concept of what change expert Noel Tichy calls the teachable point of view. This philosophy calls for a carefully planned initiative whereby managers at each level of an organization, from highest to lowest, spend time with the employees they supervise directly to convey and discuss key organizational principles. Under this approach, frontline employees meet to discuss a change effort with their immediate supervisors, who have had similar meetings with their own immediate supervisors.[1]

[1] *See T.J. Larkin and S. Larkin, "Reaching and Changing Frontline Employees,"* Harvard Business Review*, 1996 May-June, 95-104.; S. Wetlaufer, "Driving Change: An Interview with Ford Motor Company's Jacques Nasser,"* Harvard Business Review*, 1999 March-April, 77-88.*

Lesson 6: Do Not Overlook Training and Education.

By implementing, as part of the transformation, a sweeping change in the agency's organizational structure, VHA's senior leadership team created in a sense a test case for a long-standing debate over how quickly a transforming organization should implement major changes in organizational structure. Some experts on organizational change recommend that organizations make gradual changes in structure to allow employees an opportunity to adjust to new work requirements. Others contend that sweeping changes in organizational structure can "unfreeze" the organization from its existing state and allow the transformation to proceed.

Although the VHA experience cannot resolve this debate, it does point to an important role for training and education in transformation efforts. For VHA managers, the sweeping change in organizational structure thrust them into a trial by fire situation. Many managers reportedly struggled to adapt to a management system that now called for them to make innovative and strategic decisions in a turbulent environment. Such decision making was not the common experience of most VHA managers who had spent much of their careers carrying out directives from agency headquarters. Some managers adapted, some did not. Interviewees repeatedly noted that many managers lacked the skills to operate effectively in the new environment and that there were few educational or training resources available to them. Although VHA's senior leadership team did plan for several educational and training initiatives as part of the transformation, most of these initiatives were not in place at the time the agency was undergoing its sweeping change in structure. It appears that in setting priorities, VHA's senior leadership team placed too little emphasis on training and education.

Accordingly, in situations where swift change is deemed necessary, senior managers should not overlook the importance of training and education to support employees in developing needed skills in a timely manner.

Lesson 7: Balance Systemwide Unity with Operating-Unit Flexibility.

Leaders of all multi-unit organizations struggle with the issue of how much decision-making authority should be given to operating units and how much should be reserved for headquarters. The issue is frequently central to transformations, which are often undertaken by organizations in part to improve the fit between their decision-making structure and business requirements. The management literature recommends a number of factors that organizations should consider in addressing this issue, such as the magnitude and pace of technological and market changes in the external environment.[2]

In the case of VHA, a dramatic push occurred to decentralize decision making after years of micromanagement on the part of headquarters. However, the swing from centralized to decentralized management appears to have allowed little opportunity for careful planning in the reorganization of certain functions and programs at agency headquarters. Some programs were left in disarray without clear lines of responsibility or systemwide criteria for coordinating activities across operating units. There also appeared to be an absence of central oversight mechanisms to ensure that operating units followed consistent data collection and reporting procedures. This problem was noted in reports by the Senate Committee on Veterans' Affairs, the General Accounting Office, and VHA's own Office of the Inspector General.[3] Interviewees from within and outside the agency also expressed concern that the new decentralized decision-making structure provided limited opportunities for sharing best practices among the agency's operating units.

VHA's experiences reveal the need to carefully plan decentralization efforts so that an appropriate balance is struck between system-level coordination and control and operating-unit flexibility.

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[2] *See, generally, P. Leatt, S. Shortell, and J. Kimberly, "Organization Design," in (S. Shortell and A. Kaluzny, eds.)* Health Care Management: Organizational Design and Behavior, *Albany, New York: Delmar (2000).*

[3] *U.S. Senate, Minority Staff of the Committee on Veterans' Affairs,* Staff Report on Quality Management in the Veterans Health Administration*, Department of Veterans Affairs (December 1997); General Accounting Office,* Major Management Challenges and Program Risks: Department of Veterans Affairs*, GAO/OGC-99-15 (January 1999); U.S. Department of Veterans Affairs, Office of the Inspector General,* Quality Management in the Department of Veterans Affairs Veterans Health Administration*. Office of Healthcare Inspections, Report 8HI-A28-072, Washington, D.C. (February 1998).*

Part Two: The VHA Case Study

Introduction

During the 1990s, many U.S. organizations in both the public and private sectors underwent large-scale transformation to improve their performance.[4] This report presents findings from a longitudinal case study of the transformation of the Veterans Health Administration. VHA's transformation, which began in 1995, is worthy of careful study for several reasons. First, the transformation overcame substantial obstacles to achieve many impressive results and is a potential source of best practices for other organizations undergoing transformation. Second, VHA's transformation, while generally a success, has not been without shortcomings that offer insight to the challenges and tensions that underlie many transformations. Third, VHA is one of the largest agencies in the federal government, and the size and scope of its transformation is itself a remarkable story of large-scale organizational change in the public sector.

Part 2 of this report consists of four primary sections. The first section provides background information on VHA. The next section presents the context in which the VHA transformation was launched. The third section focuses on the appointment of new leadership for VHA as the beginning of the transformation effort. The fourth and final section discusses four key initiatives that define the VHA transformation.

VHA Background

VHA is a federally funded and centrally administered health care system for veterans.[5] The agency is one of three primary components of the U.S. Department of Veterans Affairs, which was formed in 1988 as a cabinet-level department within the executive branch of the federal government. The Department subsumed the former Veterans Administration, which was established in 1930 to consolidate most veterans programs within a single agency. Through its two other primary components, the Department of Veterans Affairs administers on behalf of veterans a program for disability benefits and a national system of cemeteries.

VHA has a four-part congressionally mandated mission: patient care, research, teaching, and contingency backup for the Department of Defense

[4] *Although no studies document comprehensively the proportion of transformations that actually fail, experts seem to agree that the majority of transformations fall very short of the expectations of those who initiated them. See, for example, J.P. Kotter, "Leading Change: Why Transformation Efforts Fail,"* Harvard Business Review*, 1995 March-April, 59-67; G. Hall, J. Rosenthal, and J. Wade, "How to Make Reengineering Really Work,"* Harvard Business Review*, 1993 November-December, 119-130. Some evidence suggests that transformation of public-sector organizations is less likely to succeed than transformation of private-sector organizations (P. J. Robertson and S. J. Seneviratne, "Outcomes of Planned Organizational Change in the Public Sector: A Meta-Analytic Comparison to the Private Sector,"* Public Administration Review*, 1995, 55 [16]: 547-558).*

[5] *Information contained in this section was drawn from both published sources as well as internal VHA documents. For published sources, see generally K. W. Kizer, "The 'New VA': A National Laboratory for Health Care Quality Management,"* American Journal of Medical Quality*, 1995, 14: (1): 3-19; E. S. Fisher and H.G. Welch, "The Future of the Department of Veterans Affairs Health Care System,"* Journal of the American Medical Association*, 1995, 273 (8):651-667; K.W. Kizer, "Re-engineering the Veterans Healthcare System" in P. Ramsaroop, J. Ball, D. Beaulieu, and J.V. Douglas, eds.,* Advances in Federal Sector Health Care, *New York: Springer (in press).*

medical care system. With respect to patient care, VHA is one of the country's largest health care delivery systems. In 1999, VHA's health care system included 172 hospitals, 132 nursing homes, 73 home health care programs, 40 residential care programs, and more than 600 outpatient clinics. Through this nationwide health care system, VHA provided services to 3.6 million veterans in 1999, approximately 14 percent of the more than 25 million veterans in the U.S. Most of the veterans who use the VHA system meet at least one of two criteria that affords them priority status under the agency's patient eligibility rules, namely a low income or a disability that is connected to military service.

VHA's research and teaching activities are also quite extensive. The agency manages research programs in biomedical sciences, rehabilitative medicine, and health services delivery systems. These research programs have produced numerous medical innovations in such areas as cardiac care and hypertension. VHA fulfills its teaching mission through academic affiliations with many of the country's medical schools and schools of allied health professions. In particular, the agency is an integral component of the country's system for graduate medical education, providing financial support and clinical training to approximately one-third of the country's medical residents.

In terms of its role as a contingency backup for the Department of Defense medical care system, VHA has two primary responsibilities. One is to provide support to the Department of Defense medical system during times of war. The other is to assist the Public Health Service and the National Disaster Medical System in providing emergency care to victims of natural and other disasters.

As noted, VHA is a federally funded health care system. However, in contrast to Medicare, which is a federal health insurance program for the aged, VHA is not an entitlement program for its beneficiaries. The agency's funding is subject to discretionary appropriations from Congress. In 1999, VHA operated with a medical care budget of over $17 billion. The agency's workforce, which has undergone substantial reductions in recent years, now consists of approximately 180,000 individuals. A large percentage of the agency's workforce consists of clinical personnel such as physicians, nurses, and therapists. The senior official for the VHA, who carries the title "under secretary for health," is appointed by the president of the United States for a term of four years. By law the under secretary must be a physician.

VHA operates in a highly politically charged environment where its activities are closely monitored by a variety of organizations. As part of a cabinet-level department, the agency is subject to particularly close scrutiny by both the General Accounting Office and the Office of Management and Budget, as well as by congressional oversight committees. VHA also is under the close scrutiny of several different veterans service organizations (VSOs) that represent the interests of various veteran constituency groups. Two internal oversight groups — Office of the Inspector General and Office of the Medical Inspector — also oversee agency activities.

Context for VHA Transformation

The impetus for most transformations is a set of external events or trends that threaten the transforming organization's future viability. At the time VHA embarked on its transformation in 1995, several external developments had placed its future in peril. At the same time, however, VHA faced significant internal barriers to changing itself to adapt to these developments.[6]

[6] *Information contained in this section was drawn from a number of sources. See Paralyzed Veterans of America,* The VA Responsibility on Tomorrow's National Health Care System: Strategy 2000*, Washington, D.C. (1992); Mission Commission,* Report of the Commission on the Future Structure of Veterans Health Care*, Washington, D.C (1991); E. S. Fisher and H.G. Welch, "The Future of the Department of Veterans Affairs Health Care System," and J.K. Iglehart, "Reform of the Veterans Health Care System,"* New England Journal of Medicine*, 1996, 335 (18): 1407-1411; K. W. Kizer, "Health Care, Not Hospitals: Transforming the Veterans Health Administration," in (G.W. Dauphinais and C. Price, eds.)* Straight from the CEO*, New York: Simon & Schuster (1998); S. Findlay, "Military Medicine: The Image and the Reality of Veterans' Hospitals,"* U.S. News & World Report*, June 1992; Department of Veterans Affairs (Management Decision and Research Center), "Analysis and Recommendations for Reorganization of Veterans Health Administration," (October 1993); Task Force on the Reorganization of VHA Central Office, "Veterans Health Administration Central Office Reorganization," (September 1994); Northwestern University (Kellogg Graduate School of Management), "Analysis of the Organizational Structure and Management Functioning of VA's Health Delivery System (1991); K.W. Kizer, "Re-engineering the Veterans Healthcare System" in P. Ramsaroop, J. Ball, D. Beaulieu, and J.V. Douglas, eds.,* Advances in Federal Sector Health Care, *New York: Springer (in press).*

External Threats

Shifting Priorities in the Delivery of Health Services: By the early 1990s,VHA had become out of sync with prevailing trends in the delivery of health care services. The advent of health maintenance organizations and developments in medical technology had been shifting resource priorities in the delivery of health care services away from inpatient-based tertiary care medicine to outpatient-based primary care medicine. At this time, however, much of VHA's material and intellectual resources were invested in the delivery of inpatient care. Most of VHA's hospitals, which historically have served as the agency's primary operating units, were large, technologically intensive, and often underutilized facilities. VHA physicians who staffed these hospitals were medical specialists with little expertise or interest in primary care medicine. Moreover, VHA lacked a well-developed infrastructure for providing services in the community.

Prospect of Competition: VHA also faced the prospect that it could lose many of its patients to the private sector. More than 50 percent of the veterans who use VHA services have low incomes and thus typically lack alternative sources of health care. However, during the early 1990s national and state-level health care reform proposals were advanced that included provisions to expand the accessibility of low-income individuals to private-sector health care. Although these health care reform initiatives did not come to pass, VHA officials were left to ponder the agency's ability to compete with private-sector health care organizations should such reforms come to pass in the future. VHA officials knew the agency would have to its advantage a strong reputation for excellence in many areas of specialty medicine, but they also realized that unless changes occurred, the agency would have to its disadvantage a reputation for long waiting times, fragmented care, and a cumbersome bureaucracy for accessing services.

Other external threats: VHA confronted at least two other substantial threats to its viability. One such threat concerned the efficiency of the agency's operations. Although VHA had been searching for ways to achieve cost savings for some time, the issue became much more pressing in 1995 when Congress indicated its intention to freeze the agency's budget. Another threat was an unfavorable demographic trend in the agency's patient population. Over time VHA's patient population has become increasingly older and sicker than the U.S. population generally. In the absence of any future military conflicts, this trend would result in the agency caring for a sicker but dwindling patient population.

The sum total of these external threats created a black cloud over VHA's future. To ensure its viability into the next century, VHA needed to significantly change the way it provided health care services, improve patient satisfaction, and increase the efficiency of its operations.

Internal Problems and Barriers to Change

Centralized and Bureaucratic Decision-Making Structure: Like many large, established organizations, VHA was not oriented to flexibility and change. The agency's management systems and culture were deeply rooted in a command and control, military-style mind-set. In particular, decision making was highly centralized and bureaucratic. VHA headquarters tended to micromanage many of the decisions and activities of the agency's hospitals and other operating units. This decision-making structure impeded operating units from adapting to local circumstances in a timely manner. Additionally, VHA's system for allocating resources to operating units, which was based largely on units' historical costs, did not provide incentives for the efficient and effective delivery of health care services to the patient population.

Multiple Stakeholders: As a public-sector health care system, VHA has multiple stakeholders who have different and sometimes conflicting interests regarding the agency's activities. This has presented a substantial complication to any agency change effort. Congress, a primary stakeholder, has long wanted to see the agency provide veteran constituents with more accessible and cost-effective health care services, though its individual members have also been wary of any changes that might have a negative impact on VHA facilities in their own districts. VHA's affiliated medical schools are also stakeholders. They have had a strong interest in maintaining the agency's capacity to provide high-tech inpatient care, since this capacity supports their residency programs and faculty research. Indeed, approximately 70 percent of VHA physi-

cians have faculty appointments at the affiliated medical schools, an arrangement that has reinforced the agency's inclination toward high-tech inpatient care. The previously noted veterans service organizations are also major stakeholders with their own agencies and constituents. In addition, several different unions represent much of VHA's workforce and have an interest in protecting the jobs of employees within the agency.

Legal Barriers: As a federal agency, VHA operates within a framework of legislatively defined rules and regulations. At the time of the transformation, a number of these rules and regulations were barriers to the agency's ability to adapt to its changing circumstances. In particular, complex patient eligibility rules limited the agency's ability to treat patients on an outpatient basis. The agency also operated under rules that limited its ability to contract for services with private-sector organizations. This restriction impeded VHA from expanding community-based services to meet the needs of its patients.

Appointment of New Leadership

Many experts on organizational change view leadership as the most important factor for launching a successful large-scale transformation. These experts typically define a "transformational leader" as an individual who is capable of developing a vision for the transformation and who also can secure the necessary commitment from employees to pursue the vision.[7]

As is the case with many transformation efforts, VHA's transformation began with new leadership. Toward the end of 1994, Dr. Kenneth W. Kizer was appointed as VHA's under secretary for health and given a mandate by Congress to transform the agency. The appointment of Dr. Kizer, a physician trained in emergency medicine and public health, was, in essence, the beginning of VHA's transformation.

Dr. Kizer proved to be an effective leader for VHA's transformation. While not the originator behind all of the key ideas and initiatives that defined the transformation, he was, in the opinion of virtually everyone interviewed, a tireless champion for the transformation who was able to keep it moving forward despite formidable obstacles. In this respect, he possessed several attributes that were relevant to his effectiveness as the leader of the VHA transformation.

Outsider Status: Unlike his most recent predecessors, Dr. Kizer had not built his professional career within VHA. According to interviewees, when previous VHA leaders had proposed large-scale changes to the agency they were constrained from going forward by loyalties to old colleagues who opposed the changes. By contrast, Dr. Kizer was beholden to no one inside VHA. He did select several insiders to form a senior leadership team for the transformation. These insiders, in the words of one former VHA official, "provided Kizer, a newcomer, with needed guidance about the inner workings of the agency."

Relevant Experience: Although Dr. Kizer was new to VHA, he did have substantial leadership experience in the public sector. In particular, he had served as director of the California Department of Health Services, where he reportedly learned to work effectively with both policy makers and with career civil servants. In his discussions with members of Congress about VHA's transformation, Dr. Kizer was reportedly "unusually candid and direct for an agency official." But he also gained the trust of many members of Congress by keeping them well informed of all major changes he was planning to make at the agency. Dr. Kizer also had prior experience as a medical school department chair, a position that helped prepare him to manage VHA's important but complicated relationships with its affiliated medical schools. Dr. Kizer was, as noted by a staff member of the Senate Committee on Veterans' Affairs, "exceptionally well qualified for the job."

In addition, Dr. Kizer was an enthusiastic and knowledgeable student of private-sector innovations in the financing and delivery of health care services. Through his professional experiences in California, a state where managed care organizations have a strong presence, he developed an expertise in managed-care principles and practices. Dr. Kizer brought a spirit of innovation and experimentation to VHA. Because of his affinity for and knowledge of such private-sector innovations, Dr.

[7] *A cornerstone of this literature is J. Burns,* Leadership, *New York: Harper & Row (1978).*

Kizer developed a reputation within the agency as a private-sector disciple, despite the fact that he had worked in the public sector most of his career.

Good Timing: In the words of one interviewee: "Timing may not be everything, but Kizer certainly had his timing right." Dr. Kizer took the helm of VHA at a time when Congress, the veterans service organizations, and many of the agency's own employees were ready to see the agency undergo change. As a result, Dr. Kizer had a window of opportunity to remake the agency without some of the constraints and close scrutiny that would have certainly impeded his predecessors. Dr. Kizer appears to have capitalized on this opportunity to its fullest. Nevertheless, the difficulties of reconciling the interests of so many different stakeholders also took their toll on him politically. His reappointment to another term as under secretary proved to be a contentious matter in Congress. As the end of Dr. Kizer's initial appointment approached, members of Congress extended the appointment nine months so they could further deliberate on the matter of reappointment. When the nine-month period expired without resolution about his reappointment, Dr. Kizer, rather than endure the process further, stepped down.

Transformation Framework

Most transformations encompass a wide range of activities and initiatives. Because of the difficulty of delimiting a transformation effort, it was important to identify those initiatives of VHA's senior leadership team that were *central* to the transformation.

Four initiatives were identified that formed the basic framework for the transformation. These four initiatives, presented in Figure 1, are: the creation of a vision for the future, the adoption of a new organizational structure, the establishment of an accountability system, and modification in agency rules and regulations.

Collectively, the four interrelated initiatives played a central role in VHA's ability to achieve a number of impressive results during the first five years of its transformation (1995 to 1999). These results, which speak to the general success of VHA's transformation, are presented selectively in Figure 2. In general, they reveal a substantial shift in agency priorities and activities relative to outpatient care and primary

Figure 1: VHA's Transformation Framework

- Creation of a Vision for the Future
- Adoption of a New Organizational Structure
- Establishment of an Accountability System
- Modification in Agency Rules and Regulations

care. The General Accounting Office, which has monitored the VHA transformation closely, recently reported to Congress that the VHA transformation has made "significant progress."[8] Additionally, a recent national survey of veterans, commissioned by the National Partnership for Reinventing Government, points to the success of the transformation. The survey used the American Customer Satisfaction Index (ACSI), which tracks customer satisfaction for more than 170 private and public sector organizations and is produced by a partnership among the University of Michigan Business School, the American Society for Quality, and Arthur Andersen. Approximately 80 percent of the survey respondents reported that the care provided by VHA had improved in the last two years. Further, VHA's satisfaction scores compared very favorably to the scores of other organizations that had been surveyed using the ACSI.[9]

The remainder of this section of the report discusses VHA's experiences with each of the four initiatives that comprised the transformation framework.

Creation of a Vision for the Future

It has become a well-established principle that successful transformation requires a clear and comprehensive vision of the organization's future.[10] Early in the transformation effort, VHA's senior leadership

[8] *General Accounting Office,* Veterans Affairs: Progress and Challenges in Transforming Health Care*, GAO/T-HEHS-99-109 9 (April 1999).*

[9] *K.W. Kizer, "Re-engineering the Veterans Healthcare System" in P. Ramsaroop, J. Ball, D. Beaulieu, and J. Douglas, eds.,* Advances in Federal Sector Health Care*, New York: Springer (in press).*

[10] *For a recently published book that discusses the concept, see R.M. Miles,* Leading Corporate Transformation*, San Francisco: Jossey-Bass (1997).*

Figure 2: Selected Transformation Results

- **Orientation to Outpatient-Based, Primary Care:**
  - Annual inpatient admissions have declined by more than 32 percent while outpatient care visits have increased by more than 45 percent.
  - Percentage of surgeries performed on an outpatient basis has increased from approximately 35 percent to over 70 percent.
  - Approximately 60 percent of hospital beds have been eliminated.
- **Convenience and Accessibility of Care:**
  - Over 300 new community-based out-patient clinics have been established.
  - Telephone-linked care has been established at all hospitals.
- **Operational Efficiency:**
  - The number of full-time equivalent employees has been reduced by more than 14 percent while the number of patients treated per year has increased by more than 25 percent.
- **Patient Satisfaction:**
  - Patient satisfaction scores for outpatient care (based on VHA's own national surveys of patients) have improved by more than 15 percent.
- **Quality of Care:**
  - Percentage of patients receiving cancer screening for early detection of several types of cancers has increased substantially (e.g., colorectal cancer screening from approximately 34 percent to 74 percent).
  - Percentage of patients receiving treatments for preventing or controlling disease has increased substantially (e.g., cholesterol management for heart disease from approximately 74 percent to almost 100 percent).

Source: VHA internal documents and databases; General Accounting Office, Veterans' Affairs: Progress and Challenges in Transforming Health Care*, GAO/T-HEHS-99-109 9 (April 1999).*

team developed such a vision. After his appointment as under secretary, Dr. Kizer held several months of planning meetings that included representatives from different parts of the agency. Based on these meetings, the senior leadership team prepared a document entitled *Vision for Change*.[11] The document articulated the basic philosophy, principles, and organizational framework to which a transformed VHA would adhere. As a follow-up to *Vision for Change*, the senior leadership team prepared two other related documents that provided greater operational guidance to VHA managers regarding the transformation.[12]

Clear Purpose and Goals: The vision documents provided a comprehensive statement of the purpose and goals of the transformation. The documents made clear that the "transformation would fundamentally change the way veterans health care is provided" and that this would include "increasing ambulatory care access points and a marked emphasis on providing primary care, decentralizing decision making, and integrating the delivery assets to provide a seamless continuum of care." Interviewees referred to the documents as forming a "true charter" for the transformation.

High Standards: The vision documents established high standards for the transformation. VHA was to provide care at a level that "must be demonstratively equal to, or better than, what is available in the local community." Although VHA officials had always spoken with pride of the quality of care that the agency offered veterans, interviewees repeatedly referred to the vision documents as presenting a direct challenge to the agency to provide the best care available anywhere in the country.

Difficulties in Reaching Frontline Employees: VHA experienced the same difficulty that many transforming organizations do when trying to communicate a future vision to frontline employees. VHA's senior leadership team used several conventional strategies to communicate the transformation goals throughout the agency, including town meetings,

[11] *Veterans Health Administration,* Vision for Change: A Plan to Restructure the Veterans Health Administration*, Washington, D.C. (February 1995).*

[12] *Veterans Health Administration,* Prescription for Change: The Strategic Principles and Objectives for Transforming the Veterans Healthcare System*, Washington, D.C. (January 1996); Veterans Health Administration,* Journey for Change*, Washington, D.C. (April 1997).*

video conferences, written notices, and videotapes. These communication efforts were not effective in reaching frontline employees. The employee surveys conducted for this report indicate that after the first year of the transformation, frontline employees, including physicians in non-supervisory positions, had substantially less understanding of the purpose and nature of the transformation than did those to whom they reported. For example, one of the questions on the survey asked employees to indicate on a five-point scale the degree to which they understood the goals the transformation was intended to accomplish (where five was very strong understanding and one was no understanding). The mean score for frontline employees on this question was slightly below two, whereas the mean score for employees occupying managerial or supervisory positions was approximately four. The interview data also indicate that VHA's communication efforts had limited success in reaching frontline employees. In a series of focus groups conducted for the case study, frontline employees repeatedly expressed their frustration with communications. One employee appeared to sum up the sentiments of many of the focus group participants when she remarked that "[frontline] employees had too much rumor and too few facts about the change process."

Adoption of a New Organizational Structure

Within the first year of the transformation, VHA's senior leadership team implemented a sweeping change in the agency's organizational structure. The new structure entailed the reorganization of all VHA operating units into 22 networks known as Veterans Integrated Service Networks. The design of the networks was intended to reflect actual and potential patient referral patterns among VHA hospitals and other service organizations.

Within this structure, the networks replaced the hospitals as the primary planning and budgeting units within VHA. In addition, much of the authority for operational decision making was effectively transferred from headquarters to the networks. The role of VHA headquarters, which as part of the transformation had its staff cut by more than a third, was to set overall policy and to provide technical support to network managers. The senior leadership team selected a director for each network. Of the first group of 22 directors, about one-third were drawn from outside the agency. In addition, changes were made to the agency's internal resource allocation methods so that a network's budget depended on the number of veterans served rather than its historical costs (which was the case for hospitals in the past).

By implementing this sweeping change in structure at such an early point in its transformation, VHA became, in a sense, a test case for a long-standing debate over how quickly a transforming organization should implement major changes in organizational structure.[13] Some experts argue against dramatic changes in organizational structure or management systems on the ground that employees will be mentally and emotionally unprepared to adapt to the new job requirements that such changes entail. These experts often recommend that organizations make gradual changes to allow employees to adjust to their new circumstances. Other experts, however, contend that dramatic changes in structure are sometimes needed to overcome the inertia that often attends transformation efforts. These experts contend that sweeping changes in organizational structure can "unfreeze" the organization from its existing state and allow the transformation to proceed.

In general, VHA's sweeping change in organizational structure had a positive impact on the transformation, though certain problems did in fact emerge.

Affirmation of a New Era: The sweeping change in organizational structure appears to have affirmed the emergence of a new era in VHA's history. Prior to the transformation, VHA employees had witnessed other attempted change efforts only to see them abandoned before they were fully implemented. The expression "this too shall pass" became a rallying cry for VHA employees who opposed the transformation. However, the dramatic change in structure could not be overlooked; it provided a strong signal that the transformation was not a passing fad. One longtime VHA manager summed

[13] *See, generally, L. E. Greiner, "Patterns of Organizational Change,"* Harvard Business Review*, 1967 May/June, 119-128; M. Beer, R.A. Eisenstadt and B. Spector,* The Critical Path to Corporate Renewal*, Harvard Business School Press, Boston (1990); D.A. Nadler, R.B. Shaw, and A.E. Walton (editors),* Discontinuous Change*, Jossey-Bass, San Francisco (1995); R.K. Reger, L.T. Gustafson, S. M. Demarie, and J. Mullane, "Reframing the Organization: Why Implementing Total Quality Is Easier Said Than Done,"* Academy of Management Journal *1994, 19 (3): 565-584.*

up the comments of many of the interviewees about the sweeping change in structure: "VHA needed clear, decisive action that would ensure that the agency would never return to its past." Still, there were many examples where longtime headquarters staff tested the boundaries of the new power structure by attempting to impose central policy initiatives on network directors. Interviewees commented that when such circumstances arose, the senior leadership team stepped in and reaffirmed the transfer of decision-making authority to the network directors.

Effective Platform for Change: By giving network directors substantial decision-making authority, the new structure by design created an opportunity for experimentation. The result was a wave of new ideas and entrepreneurial activity. For example, in an effort to save money and streamline care, network directors consolidated hospitals in more than 45 locations where two or more facilities operated in close proximity to each other. Network directors also implemented many innovative organizational arrangements to coordinate patient care across operating units within the same network. These arrangements often featured managed-care principles related to primary care and preventive services. One network director, a longtime VHA manager with over 20 years' experience with the agency,commented, "I saw more innovation at the agency during the first three years of the transformation than I had seen during all my previous years combined." Another network director, who had been a longtime hospital manager, remarked, "The new freedom I had to make decisions was absolutely invigorating."

Problems of Adaptation to the New Structure: Although the new organizational structure helped achieve credibility for the transformation and stimulate innovations, not all network directors and lower-level mangers were prepared for the new challenges ahead of them. Many managers struggled in their efforts to adapt to a system that now called for them to make innovative and strategic decisions in a turbulent environment. Such decision making was not the common experience of most VHA managers, who had spent much of their careers carrying out directives from agency headquarters. Interviewees noted that in the new structure, managers needed but often lacked the background to conduct sophisticated analyses for strategic and marketing plans, capital investment decisions, and contract negotiations with private-sector organizations. In a report to Congress, the General Accounting Office was particularly critical of VHA managers' efforts to plan and conduct feasibility studies for hospital consolidations.[14]

Interviewees repeatedly noted that few educational or training resources were available to managers to help them develop the necessary skills for adapting to the new structure. Although VHA's senior leadership team did plan for several educational and training initiatives as part of the transformation, most of these initiatives were not in place at the time the agency was undergoing its sweeping change in structure.

Problems in Lack of Uniformity: VHA's sudden swing from centralized to decentralized management appears to have allowed little opportunity for careful planning in the reorganization of certain functions and programs at agency headquarters. Some programs were left in disarray without clear lines of responsibility or systemwide criteria for coordinating activities across networks and operating units. Functions and activities were also sometimes eliminated without careful review and evaluation. There also appeared to be an absence of central oversight to ensure that networks followed consistent data collection and reporting procedures. As noted by one VHA manager who played a prominent role in the transformation process: "We were moving so quickly that we probably in some instances could not help but throw out the baby with the bathwater."

The problem was noted in reports by the Senate Committee on Veterans' Affairs, the General Accounting Office, and VHA's own Office of the Inspector General.[15] The report by the Senate Committee on Veterans' Affairs criticized the

[14] *General Accounting Office,* Major Management Challenges and Program Risks: Department of Veterans Affairs, *GAO/OCG-99-15 (January 1999).*

[15] *U.S. Senate, Minority Staff of the Committee on Veterans' Affairs,* Staff Report on Quality Management in the Veterans Health Administration, *Department of Veterans Affairs (December 1997); General Accounting Office,* Major Management Challenges and Program Risks: Department of Veterans Affairs, *GAO/OGC-99-15 (January 1999); U.S. Department of Veterans Affairs, Office of the Inspector General,* Quality Management in the Department of Veterans Affairs Veterans Health Administration. *Office of Healthcare Inspections, Report 8HI-A28-072, Washington, D.C. (February 1998).*

agency for not maintaining a cohesive, systemwide quality management program, noting, "headquarters does not require that its hospitals and clinics use uniform methods for collecting data."[16] Members of several federal agencies who were interviewed also commented that the transformation had resulted in substantial problems with the comparability of operational and performance data among VHA operating units.

Although problems in the comparability of data among VHA operating units had existed before the transformation, the network structure had both exacerbated and magnified these problems.

Interviewees also remarked that the new structure provided limited opportunities for sharing best practices among the networks. Although VHA headquarters holds monthly group meetings for network directors, these meetings have largely focused on administrative matters.

Establishment of an Accountability System

As another key transformation initiative, the senior leadership team established an accountability system for network directors. Performance contracts were the centerpiece of the new accountability system. Each director was required to sign a contract that stipulated a set of performance goals to which he or she would be held accountable. The contracts provided directors with financial incentives in the form of a bonus for achieving performance goals. The goals changed each year to reflect new agency requirements and priorities. Some performance goals required network directors to develop core competencies in such areas as interpersonal effectiveness; some called for directors to implement programs or functions; and other goals called for directors to achieve quantitatively measurable improvements in key efficiency and quality indicators for their network (e.g., patient satisfaction). It was also Dr. Kizer's intention that each network director would negotiate certain elements of his or her performance contract with the senior leadership team so that performance goals would reflect the variation among directors and networks in terms of capabilities and limitations.

To monitor performance, the senior leadership team used existing data sets and measurement systems and also created new ones. Reports were routinely generated and disseminated to provide feedback on each network's relative performance on key measures and indicators for the transformation.

Alignment of Goals and Behaviors: The accountability system strategically linked a network director's performance goals to the agenda set forth in the vision documents. The agency had not previously had an accountability system that integrated the performance goals of operating units with agencywide strategic goals. As one interviewee noted, "The accountability system created a very sustained focus on the ultimate goals of the transformation at levels of the agency where the goals could best be translated into action."

Symbolic Value: The new accountability system had as much a symbolic role in strengthening performance management in VHA as it did a functional role. Initially, the functionality of the new system was subject to much criticism from network directors and other agency managers who complained bitterly about the adequacy of data sets, reliability of measures, and potential opportunities for gaming the system. There were also complaints about the number and attainability of performance goals.

The senior leadership team was responsive to but not deterred by these criticisms. Certainly, many of the criticisms were valid, and efforts were made to improve databases and measures. The senior leadership team, however, believed the value of the accountability system exceeded its functional capabilities. Indeed, the new accountability system's emphasis on performance data reverberated throughout the agency. Managers at lower levels of the agency began developing data sets for measuring the performance of their own units or departments in ways that supported the transformation agenda. These new performance systems often came to be known by such clinically-oriented nicknames as pulse points and vital signs. The result was a substantial shift in focus among VHA managers, a shift away from inputs (i.e., how large my budget is and how many staff do I have) to that of outputs as defined by the goals in network directors' performance contracts. Moreover, interviewees commented that the senior leadership team appeared less concerned about whether net-

[16] *U.S. Senate, Minority Staff of the Committee on Veterans' Affairs,* Staff Report on Quality Management in the Veterans Health Administration*, Department of Veterans Affairs (December 1997).*

work directors met precisely each and every goal stipulated in their contracts than whether they met the spirit of their contracts in the sense that performance was moving in a direction that promoted the transformation agenda.

Problems of Implementation: The performance contracts were not implemented as fully as they were intended. As noted, Dr. Kizer intended the performance contracts to be negotiated agreements between network directors and the senior leadership team. In addition, it was the hope of Dr. Kizer that performance contracts would become a widely used concept throughout the agency for managing performance. He envisioned that the concept would diffuse throughout the agency. However, there was reportedly little negotiation around performance contracts and little diffusion of the performance contract concept. The reasons for this are not entirely clear. Some interviewees commented that the senior leadership team presented performance contracts to network directors without affording them an opportunity to negotiate performance goals; others remarked that network directors passively accepted the performance goals that were presented to them. Nevertheless, it does seem that inexperience with such concepts as performance contracts on the part of both the senior leadership team and network directors was a factor in the limited implementation of the concept. Many interviewees commented that negotiation of performance goals was very much outside "the traditional skill set of VHA managers."

Modification in Agency Rules and Regulations

The VHA transformation included reforms to agency rules and regulations. The primary reforms pertained to patient eligibility requirements that provided the agency with more flexibility to shift patient care to outpatient settings. These reforms also provided the agency with more opportunity to market its services to veterans who lacked priority status under the traditional eligibility requirements. Other reforms gave agency managers expanded authority to contract with private-sector organizations and to dismiss physician employees.

Effective Management of the External Environment: Although patient eligibility reforms had been in the planning stage long before the transformation began, VHA's senior leadership team worked closely and effectively with the veterans service organizations and other interested parties to win the approval of Congress for legislative reforms that became part of the Veterans Eligibility Reform Act of 1996.[17] In particular, Dr. Kizer reportedly won support for the reforms from several members of Congress whose support was critical to obtain the necessary votes to move the proposed reforms forward into legislation. These members of Congress initially opposed the reforms because of concerns that they might translate into increased service utilization and thus higher agency costs. Dr. Kizer countered this opposition by presenting the reforms as a necessary step to achieving agency accountability for the goals of the transformation, such as shifting service orientation from inpatient care to outpatient care. Interviewees familiar with these events noted Dr. Kizer's "political acumen in reframing the debate over the reforms from one of access and cost to one of agency accountability." These reforms also expanded the VHA's authority to contract with private-sector entities for various services, facilitating the agency's ability to build its infrastructure for outpatient care.

Hardball: The senior leadership team eliminated a long-standing agency policy that prevented dismissal of physician employees except for clinical incompetence. Although this reform created some bitter feelings on the part of VHA physicians, it reportedly conveyed a necessary message to all VHA employees that they needed to change their attitudes and behaviors to serve the goals of the transformation. On this point, Dr. Kizer remarked: "It always was our hope to achieve compliance by offering employees a carrot, but we could ill afford not to have a stick available to us."

Future Challenges: Network directors have generally capitalized on patient eligibility reforms to increase the number of veterans receiving services from the agency. However, it is not yet clear whether the agency has the resources and processes in place to care for more patients without compromising the quality of service.[18] The higher patient volume will undoubtedly test the ability of VHA managers to adapt to higher levels of workload.

[17] *U.S. Congress, "Veterans Eligibility Reform Act of 1996." Public Law. 104-262, Washington, D.C., 1996.*

[18] *General Accounting Office,* Major Management Challenges and Program Risks: Department of Veterans Affairs, GAO/OCG-99-15 (January 1999).

Part Three: The VHA Transformation As Viewed by Dr. Kenneth W. Kizer

Former Undersecretary for Health, U.S. Department of Veterans Affairs

Ken Kizer's description of the VHA transformation originally appeared in *Straight from the CEO: The World's Top Business Leaders Reveal Ideas That Every Manager Can Use* (Simon & Schuster, 1998), edited by G. William Dauphinais and Colin Price.

One of the most profound transformations of any organization in U.S. history has been happening at the Veterans Health Administration for the last couple of years. Replacing an older, monolithic, military-style top-down organization, this turnaround has involved a 180-degree shift in management philosophy and execution, plus an intense application of integrated management network systems.

The VHA's ambitious networks are the kind of new organizational structures that are rapidly coming to dominate the health care field. They have piqued the interest of management academics and researchers because these novel organizational links and architectures point to the way many large-scale institutions, both public and private, will be managed in the next millennium. The seed of the VHA's transformation came not from within government, but rather was inspired by such outside organizations as Kaiser Permanente and private health care groups.

However, what is remarkable at the VHA is that no other organization has heretofore applied the integrated network management concept on such a large scale. And none have had to first break down and reconstruct such a huge existing organization and aggregate of physical structures, while at the same time continuing to maintain good service delivery to the client population. Few entities anywhere have been at the nexus of as many forces of change.

Transformation Through New Alliances — Internal and External

What is an integrated service network? Conceptually, it is based on the simple idea that whoever controls and coordinates the supply, production, distribution, and marketing of service delivery will be a vastly more efficient producer than the non-integrated operator. An integrated network is a

superior form because it has a higher rate of asset and service utilization. It can also bring to bear at one point and at one time a superior package of services.

Because it offers the opportunity to serve specific populations with uniform quality services at standardized prices, the relevance of this idea to the once highly fragmented U.S. health care market cannot be overstated. In an integrated health system, physicians, hospitals, and other components share the risks and rewards — supporting one another, blending their talents, and pooling their resources. The network requires management of total costs, plus a focus on populations with common needs rather than on disparate individuals. Furthermore, it requires a data-driven, process-focused customer orientation.

A second innovative organizing principle at work in the VHA's transformation is the concept of the "virtual health care organization," which first emerged in the 1980s. It is based largely on experiences in the biotechnology industry, when businesses invented integrated capabilities by creating a wide array of discrete corporate partnerships, alliances, and consortia to either develop or market specific products. A number of private health care companies have used this approach to form virtual organizations that are held together by (1) the operating framework — that is, the aggregate of agreements and protocols that govern how patients are cared for, and the systems that monitor patient flow; and (2) the framework of incentives that governs how physicians and hospitals are paid.

Virtual health care systems invest substantial resources in developing their provider networks, which have a strong focus on community-based networks of participant physicians. The skills demonstrated by these virtual organizations are likely to become increasingly important in all facets of the economy and society.

Chained to the Past

The VHA, at least in theory, was ripe for the application of the integrated service network and the virtual organization. And, in fact, all the necessary ingredients were buried within this monolithic, old-fashioned, hospital-centered organization. The first step was to liberate these serendipitous ingredients from their chains! It was clear that the VHA had to deconstruct its old organization simply to keep abreast of the frenetic pace of change in U.S. health care delivery.

Further pressure for action came from a Congress skeptical of the wildly skewed cost-benefits of the old hierarchical methods. Plus there were mounting complaints about inadequate and inconsistent VHA services from veterans' organizations. For years, these groups had been voicing their dissatisfaction over the long waits to see a doctor, being treated with a lack of respect, and long hospital stays for conditions better treated in an outpatient setting, such as the removal of cataracts.

The old VHA management was centralized to an absurd degree, and thus highly ineffective. Permission for leasing small amounts of space, or for such trivial expenditures as $9.82 for an individual's purchase of a computer cable, had to be approved at the CEO level. The center was so inundated with trivia that, by default, too much power had come to reside in the VHA hospitals. Given these handicaps, it's amazing that the VHA could have provided such a relatively good level of care and services to its constituencies.

But this is far more than a tale of a long-overdue cleanup of an inept government bureaucracy. This is a story of how we jump-started change thanks to a sweeping application of the integrated service network, and in the process lowered costs and improved services.

Contrary to popular belief, most of the nation's 26.1 million veterans are not eligible for care at the VHA. In essence, only veterans with service-connected disabilities or who are poor can receive care at the VHA. Nevertheless, the VHA grew to its present size in response to the enormous influx of wounded at the close of World War II. And 50 years later it was still trying to handle a completely different set of needs with the same structure.

Here's an idea of the magnitude of the problem: There are some 11.6 million eligible veterans who are 60 or over, and another 8.3 million who are between 40 and 55. Before its recent transformation, the VHA was treating some 900,000 patients a year at the 173 VHA hospitals. The average length

Kenneth W. Kizer's Key Principles of Transformation

1. **Clearly articulate your vision, intent, and principles of change.** The VHA's statement is about "why," not "how." With a clear end-purpose in mind, we used certain principles of modern health care to lay the framework for transformation at the VHA, as well as the new managerial system that would implement it:
   - The VHA is in the business of health care, not of running hospitals.
   - Health care is now primarily a local outpatient activity.
   - The VHA's critical mandate is to provide good value.
   - The success of future health care systems will depend on their ability to integrate and manage information.
   - Health care must reorient itself to become more population-directed, community-based, and health-promotive.
   - Health care must become more accountable and responsive to those who purchase it.
   - Medical education and research must be accountable to the public good.
2. **The process of change should be broadly inclusive.** The top manager should allow all members of the organization to have their say in some form or forum — and what they say should be taken seriously and sincerely. However, that inclusivity should be flexible enough to embrace partnerships and outside associations that can facilitate the new vision.
3. **Change within an organization must move in harmony with environmental or externally focused change.** Top managers, particularly those in the public sector, cannot hope to stand against the "forces of nature" — this constitutes bad management. In the case of the VHA, that means being in sync with broad trends, such as the national revolution in health care, the explosion of biomedical research and knowledge, the shift to an "information society," and the aging of the eligible VHA population.
4. **The top manager must make key personnel decisions.** Bad hires stay around to haunt you; good ones make you look good. Here are seven key characteristics of the good hire:
   - Committed to change
   - Shares the vision
   - Experienced, knowledgeable
   - Innovative, nontraditional
   - Respected
   - Empowered
   - Willing to get his or her hands dirty
5. **Set high expectations.** People will meet them — unless your system impedes their best efforts.
6. **Focus on rigorous execution, including minimizing errors.** Innovative, nontraditional thinkers will make errors because errors are inherent to trailblazing. These should be openly discussed without instilling the kind of fear that engenders complacency. However, stupid, careless mistakes should not be tolerated.
7. **Anticipate problems.** Change, by definition, is rarely neutral. It will create new problems — but they shouldn't come as a surprise.

of stay in fiscal 1993 was nearly three times greater than the U.S. average — with only a small part of this difference attributable to the advanced ages of these patients.

The system was convoluted, fragmented, and self-defeating. It emphasized medical specialization, high technology, biomedical research, and acute inpatient services at a time when all trends in health care were heading in the opposite direction, toward primary care, or basic services.

Even more importantly, the VHA lacked the ability to adequately serve its aging customers, many of whom were on the edge of poverty and suffering from non-war-related illnesses — the two most common medical problems among all veterans being alcoholism and schizophrenia.

A "Vision" for Dramatic Change

The challenge was clear: The VHA had to transform itself from a hospital-based, specialty-focused health care system to one rooted in ambulatory care. Accordingly, in October 1995, the VHA consolidated its 173 independent and often competing hospitals, over 400 clinics, 133 nursing homes, over 200 counseling centers, and various other facilities into 22 Veterans Integrated Service Networks, or VISNs (pronounced "visions").

This new operating system emphasizes efficiency, collaboration and cooperation, and the quest for productivity by eliminating layers of bureaucracy and streamlining communications. The goal: To have all patients assigned to a dedicated generalist physician, or physician-led team of caregivers, responsible for providing readily accessible, continuous, coordinated, and comprehensive care.

No sooner were the VISNs up and running than a number of service improvements were pushed through. For example, in 1994 only a few VHA facilities had telephone advice services; within two years, all of them did. Adding to the new momentum at the VHA was the elimination of some 2,626 types of forms (64 percent of those in use), and the marked simplification and automation of the remainder. In addition, many tens of millions of dollars in savings resulted from an aggressive program to increase the number of goods and services acquired through bulk-purchase agreements, and a pharmaceutical prime vendor program.

Under the VISNs strategy, the basic budgetary and planning unit of health care delivery shifted from the autonomous medical centers to the networks — with each of these networks being responsible for all VHA activities in a specified geographic region. The VISNs promote better integration of resources and the expansion of community-based access points for primary care. The paradigm under which they operate is made up of strategic alliances between neighboring VHA medical centers, sharing agreements with other governmental providers, and other relationships, including direct purchases from the private sector.

The Hospital Becomes Part of a Larger Picture

In this scheme, the hospital becomes a component of a larger and better-coordinated community-based network of care — embracing both ambulatory and acute and extended inpatient services. The superiority of the network is that it focuses on customer needs from primary to tertiary care.

The VISNs are a revolutionary organizational form, based on patient referral patterns, hospitals, and other VHA assets. Their mission is to conduct population-based planning, to increase patient access, and to pool and align local resources to provide a seamless continuum of care. The individual VISNs are like strategic business units. As the basic budgetary and planning components of the system, each one is measured against specific performance contracts.

The heads of the various hospitals and facilities report in to their VISN, which optimizes the networks and extracts the highest value for the resources allocated. All VISNs have procedures for input from the VA's internal and external stakeholders through a council that consists of facility directors, chiefs of staff, nurse executives, union representatives, and others. The council debates and makes recommendations to the VISNs directors.

The VISNs' big point of departure is that they are in part virtual health care systems — in that they may deliver services through contractual agreements

with other institutions. Traditional, nonvirtual health care systems rely on ownership of assets and employment of their own professionals. In the new configurations, the once-central position of the VHA hospitals would be moderated by the needs of more coordinated, community-based care. The first outreaches of the network have already been built. The VHA has developed new joint-venture relationships with the Juvenile Diabetes Foundation, the National Cancer Institute, and the Shriner's Hospitals. Other such alliances are under discussion.

Changing the People — and the Culture

The VISNs had to be created out of whole cloth. As undersecretary it was crucial for me to have deep personal involvement in the networks' design, as well as in the recruitment of their leaders. I began by developing the questions to be asked of all candidates, and I personally interviewed all 90 finalists for the 22 positions. In the end, eight of these positions were filled by outsiders, some from private industry — a big break with VHA tradition.

The VISNs are the VHA's chief tools of transformation. In both image and substance, they are sweeping away the old view — prevalent inside and outside the VHA — that it was a kind of public works program in building construction and lifetime jobs. Such a culture of stasis is typical of large bureaucracies, which tend to focus on self-propagation at the expense of purpose. And in fact, even as the VISNs were being instituted, there remained the lingering attitude that, "Well, this too will pass. It won't be long before we get back to the old way of doing things." It took us a little while to stamp out passivity and negativity — much of it fostered by a reduction of staff from 205,000 to 181,000 and the elimination of 17,000 acute-care beds.

A New Role for Headquarters

If the VISNs are doing all the heavy lifting, what's the role of the Washington, D.C., headquarters? It has shifted its orientation away from hierarchical dominance to seeking ways to support the field — by offering governance principles and consulting advice, and by leading the system through the dynamic and turbulent changes ahead. To the degree that headquarters displays leadership capabilities and insights, the field managers will continue to seek its advice and counsel — not because of its position in the hierarchy. One of the chief missions of headquarters is to foster and demand new behaviors and attitudes that further the goals of the new overall structure.

A major block to change was a 1947 policy stipulating that VHA physicians could not be terminated for any reason short of malpractice. That law institutionalized complacency, and its repeal — which came in 1995 — was essential for the success of the reorganization. Another block was that the VA's research arms had splintered into isolated pockets that placed researchers' personal agendas ahead of customer service. Under the new network regime there must be a demonstrable link between research and patient care. In 1994, the VHA implemented its first-ever customer service standards, and patient surveys in 1995 and 1996 indicated statistically significant improvements.

A Work in Progress

Systemic change at the VHA is still a work in progress. Challenges remain. There still needs to be more managerial accountability, and there still needs to be more flexibility and latitude to make tough decisions. Some of the old culture of insularity remains — but the message is getting out.

This is an era in which the entire health care industry is in transition. It's our belief that by the time the transformation of the VHA is complete, it will be a fully integrated health care provider — one capable of competing with private entities.

Appendix: Study Methods

This report is based on a longitudinal case study of VHA's transformation. The study began in 1995 at the time the transformation began. The findings presented in this report are drawn primarily from the following sources of information.

Literature Review

A literature search was conducted to identify both conceptual issues and empirical findings that have emerged from previous research on transformations. These concepts and findings were used as a framework for studying VHA's transformation.[19]

Interviews

During the study period, interviews were conducted with more than 100 individuals who had been involved directly or indirectly with the transformation. These interviews were conducted using semi-structured interview protocols. The majority of interviews were with VHA employees at all levels of the agency's hierarchy, including the senior leadership team. Other interviews were with individuals who have observed the transformation as members of organizations that interface with VHA. This included the General Accounting Office, Office of Management and Budget, and veterans service organizations. We also interviewed staff members of the offices of senators and representatives who have served on congressional oversight committees for VHA.

Secondary Data

Internal VHA documents, reports, and databases were examined. These secondary sources of data provided information about VHA's transformation activities and operational performance.

Surveys

During the course of the transformation, several surveys of VHA employees were conducted. These surveys focused on employee perceptions of the nature and impact of the transformation effort.

[19] *For example, I used as part of my framework a model of the change process that was originally proposed by Kurt Lewin. In this model, transforming organizations are conceptualized as moving through three stages or states of equilibrium — frozen, unfrozen, and refrozen. The model does not consider strategies or tactics that move organizations from one stage to another. K. Lewin, "Group Decision and Social Change" in* Readings in Social Psychology*, rev. ed., edited by G. E. Swanson, T. N. Newcomb, and E.L. Hartley. New York: Holt (1952).*

About the Author

Gary J. Young is a senior researcher at the Management Decision and Research Center, a research and consulting component within the Veterans Affairs Health Services Research and Development Service. He is also an Associate Professor of Health Services at the Boston University School of Public Health and Co-Director of the School of Public Health's Program on Health Policy and Management. Dr. Young previously worked as a senior associate for a national health care management and policy consulting firm and as an analyst for the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.

His research and publications focus on organizational, managerial, and legal issues associated with the delivery of health care services. He recently completed a project for the Robert Wood Johnson Foundation that examined the community impact of nonprofit hospital conversions and a project for the Agency for Health Care Policy and Research that examined from an antitrust perspective the pricing patterns of nonprofit hospitals. He is currently conducting a project for the National Science Foundation to identify strategies for managing organizational change efforts in health care organizations. His published work has appeared in such journals as *Health Services Research, Inquiry, Health Affairs, Medical Care, Journal of Health Politics, Policy and Law*, and *Journal of Management.* Dr. Young also has served on various advisory groups focusing on health policy issues. He currently serves as a member of a National Academy of Social Insurance study panel on restructuring the Medicare program.

Dr. Young has received a number of awards for his research from such organizations as the Academy of Management and the American College of Healthcare Executives. In 1998, he received the John D. Thompson Prize for Young Investigators from the Association of University Programs in Health Administration (AUPHA).

Dr. Young earned a Ph.D. in management and a law degree from the State University of New York.

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