Strategy Research Project

Reinforcement of Values to Better Serve Veterans and Employees

by

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Department of Veterans Affairs

THE
UNITED STATES
ARMY WAR COLLEGE

STRENGTH and WISDOM

United States Army War College
Class of 2015

REPORT DOCUMENTATION PAGE

Form Approved--OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

1. REPORT DATE *(DD-MM-YYYY)* 01-04-2015	2. REPORT TYPE STRATEGY RESEARCH PROJECT	3. DATES COVERED *(From - To)*

4. TITLE AND SUBTITLE Reinforcement of Values to Better Serve Veterans and Employees	5a. CONTRACT NUMBER
	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S) Ms. Elizabeth E. Torres Department of Veterans Affairs	5d. PROJECT NUMBER
	5e. TASK NUMBER
	5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Dr. George Woods Department of Command, Leadership, and Management	8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army War College, 122 Forbes Avenue, Carlisle, PA 17013	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT
Distribution A: Approved for Public Release. Distribution is Unlimited.

13. SUPPLEMENTARY NOTES
Word Count: 7,267

14. ABSTRACT

The Department of Veterans Affairs (VA) has been plagued by problems with Veterans' access to benefits and care for decades. Criticism from the media, Congress, and other stakeholders about the growing bureaucracy, constrained resources, and an overburdened system led to ethical failures, and the eventual resignation of Secretary Shinseki amid a crisis that erupted in the Spring of 2014. This paper seeks to understand the underlying causes of the failures and demonstrate how one senior leader's approach to culture change, specifically, Secretary Robert McDonald, compares to Schein's theory of organizational culture and its effect on values. It will look at the environmental conditions that played into the crisis, analyze and understand the problem, and evaluate the approach taken by Secretary McDonald in addressing the problem.

15. SUBJECT TERMS
Espoused Values, Enacted Values, Culture Change

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES 44	19a. NAME OF RESPONSIBLE PERSON
a. REPORT UU	b. ABSTRACT UU	c. THIS PAGE UU	UU		19b. TELEPHONE NUMBER *(w/ area code)*

Standard Form 298 (Rev. 8/98), Prescribed by ANSI Std. Z39.18

USAWC STRATEGY RESEARCH PROJECT

Reinforcement of Values to Better Serve Veterans and Employees

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Title: Reinforcement of Values to Better Serve Veterans and Employees

Report Date: 01 April 2015

Page Count: 44

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Key Terms: Espoused Values, Enacted Values, Culture Change

Classification: Unclassified

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Reinforcement of Values to Better Serve Veterans and Employees

To care for him who shall have borne the battle, and for his widow, and his orphan by serving and honoring the men and women who are America's Veterans.

—Abraham Lincoln[1]

The Department of Veterans Affairs (VA) has been plagued by problems with Veterans' access to benefits and care for decades. Criticism from the media, Congress, and other stakeholders about the growing bureaucracy, constrained resources, and an overburdened system led to ethical failures, and the eventual resignation of the Secretary amid a crisis that erupted in the spring of 2014. This paper seeks to understand the underlying causes of the failures and demonstrate how one senior leader's approach to culture change, specifically, Secretary Robert McDonald, compares to Schein's theory of organizational culture and its effect on values and behavior. It will look at the environmental conditions that played into the crisis, analyze and understand the problem, and evaluate the approach taken by Secretary McDonald in addressing the problem.

Edgar Schein's book *Organizational Culture and Leadership* provides one of the models that the Army War College espouses in its Strategic Leadership course, because Schein is one of the most well-respected organizational culture experts. His analysis of organizational culture and embedding mechanisms form the primary basis of the approach to the VA problem.

Organizational Culture

Edgar Schein analyzes organizational culture on three levels, with the most tangible overt demonstrations to the least overt, internal assumptions held by the individuals in the organization. This can be thought of as an iceberg, with artifacts being

the most visible part of the organization layered on top of espoused values, which, in turn rest on the underlying basic assumptions taken for granted by the group (see figure 1).
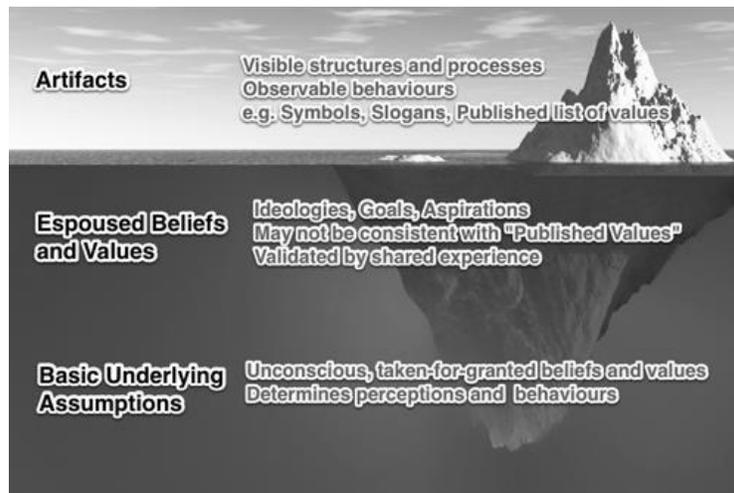
Figure 1. Schein's Organizational Culture Model [2]

Artifacts are the visible products of the organization--not only its physical environment, but also things like its language, technology, creations, styles, myths, published values, and observable rituals.[3] In the case of VA, the mission is proudly posted on the front of the headquarters building. The mission of VA emanates from President Lincoln's second inaugural address in the wake of the Civil War, addressing the need to take care of America's Veterans and their dependents. As one of VA's most prominent artifacts, it has rich symbolic meaning in expressing one of VA's cultural assumptions.

Figure 2. VA's Mission Statement [4]

Another prominent artifact of VA is the I CARE values statement included in the signature line of most VA employees.

VA Core Values: Integrity, Commitment, Advocacy, Respect, Excellence ("I CARE")
VA Core Characteristics: Trustworthy, Accessible, Quality, Innovative, Agile, Integrated

Figure 3. VA's Core Values Statement [5]

The majority of VA employees possess a strong desire to help Veterans. This is an underlying assumption that is congruent with VA's espoused values. It is so embedded in the consciousness of VA employees that when asked why they work for VA, the automatic first response is "because I care about Veterans and want to help them." However, in the idea that Veterans are best served when more claims are

processed, turning the claims process into an ersatz assembly line, the rewarded value does not correlate with the espoused values embodied by I CARE. Schein states that: "If the beliefs and values that provide meaning and comfort to the group are not congruent with the beliefs and values that correlate with effective performance, we will observe in many organizations espoused values that reflect the desired behavior but are not reflected in observed behavior."[6] This is often related to, or the result of unintended consequences of a decision made previously.

History of VA[7]

VA has a rich and long history dating back to 1636, when pilgrims passed a law that required the colony to care for disabled soldiers. By 1776, the Continental Congress declared that the U.S. would provide pensions for disabled soldiers, and in 1811, the first Federal medical facility for Veterans was founded. After the Civil War, hospital treatment and other care was expanded for all Veterans, but it was following World War I that Congress established a new system of care for Veterans that included disability payments, insurance, and vocational rehabilitation for disabled Veterans. At that time, Veteran care was distributed to three agencies: he Veterans Bureau, the Bureau of Pensions of the Interior Department, and the National Home for Disabled Volunteer Soldiers.

On July 30, 1930, President Hoover created the Veterans Administration, and the three component agencies became bureaus within the Veterans Administration. These three bureaus then became administrations in 1989 when President Bush elevated the Veterans Administration to a Cabinet-level organization, changing the name to the Department of Veterans Affairs. VA's major divisions are currently called the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the

National Cemetery Administration (NCA). VBA handles all claims applications, and administers programs such as GI Bill educational benefits, home loan guaranty, and vocational rehabilitation. VHA, as the largest health care system in the United States, handles all Veteran health care. NCA administers the National Cemeteries and all burial benefits.

VA Structure

As Veterans' benefits increased, VA expanded the organization. The expansion created levels of bureaucracy within each administration and the administrations became increasingly "siloed"--meaning that the administrations became increasingly self-sufficient, with redundant staff capabilities (overhead) and little communication between them. The current structure shows the three administrations, and the many supporting staff offices.
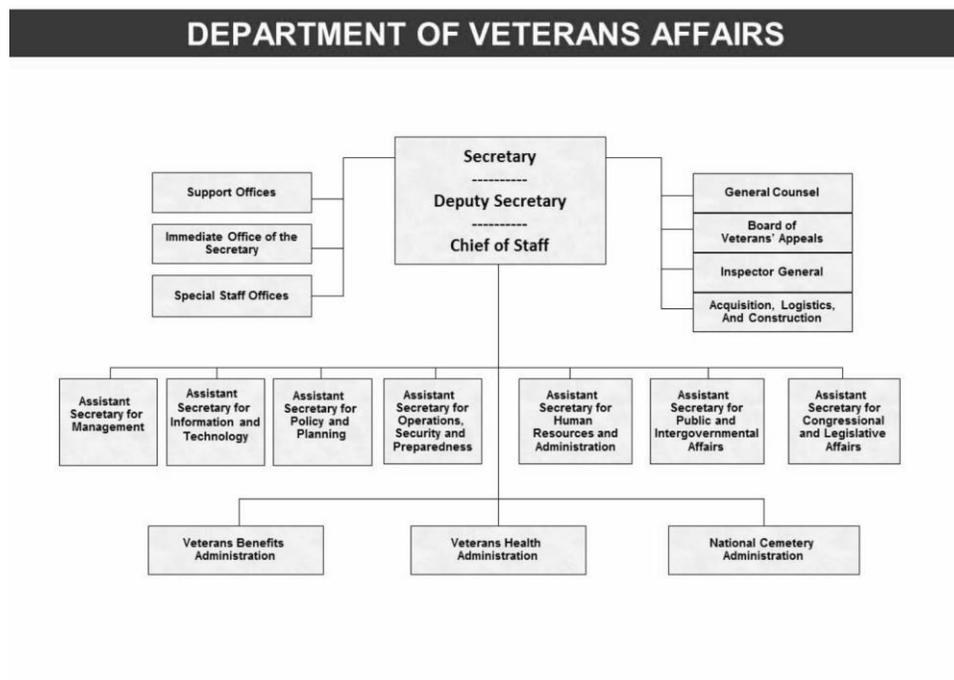

Figure 4. VA Organizational Chart[8]

The Environment

In analyzing VA's problem, this paper uses the design methodology to organize the analysis. The organizational design methodology provides a brief exploration of the environment, the problem, and the approach.

<u>The Media</u>

In the spring of 2014, VA came under attack. It began at a hearing of the House Veterans Affairs Committee titled "A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths" on April 9, 2014. In response to a question during the hearing, Chairman Jeff Miller stated: "I have been made aware of internal emails from within the VA that suggest that Phoenix VA may have been using an unofficial electronic waiting list where Veterans were placed on that unofficial list until an appointment became available."[9] At that time, he ordered that any scheduling records from the Phoenix Veterans Affairs Medical Center (VAMC) should be preserved.

On April 23, 2014, CNN released a report on the Phoenix VAMC alleging that 1,400 to 1,600 Veterans appeared on a secret wait list for appointments, and that as many as 40 Veterans had died while waiting for an appointment with a primary care provider.[10] This widely viewed report raised many questions as to whether this was an isolated case or systematic corruption within the Department. VA responded two days later with a statement that declares that they seriously consider all allegations about patient care or employee misconduct, and that Secretary Shinseki directed the VA Office of the Inspector General (OIG) investigate. They asked for patience as the reviews are conducted, that if the allegations are substantiated, swift and appropriate action will be taken.[11]

The CNN report and the coverage given by all the news outlets to this issue soon led to Congressional hearings, further investigations, and ultimately, the resignation of the Secretary of Veterans Affairs, Eric Shinseki. Upon becoming Secretary of VA, Shinseki established guiding principles for the Department of being people-centric, results-driven, and forward-looking. He also established three agency priority goals of increasing Veterans' access to benefits, eliminating the disability claims backlog, and ending Veteran homelessness by 2015. To monitor progress on these goals, various metrics are reported in the monthly performance review meeting chaired by the Deputy Secretary. For example, the VHA aggregated information collected from each of the VAMCs to report on metrics such as average wait time for appointments, while the VBA reported on various metrics such as number of claims processed and average processing time for claims. Leader bonuses and other rewards were based on reducing patient wait times and how quickly claims could be processed. Some leaders began to manipulate data and keep alternate wait lists in order to reach targets for production and receive bonuses.

By May 1, 2014, three employees of the Phoenix VAMC, including the Director and Deputy Director, were placed on administrative leave by Secretary Shinseki when Chairman Miller sent a follow up letter to VA threatening to subpoena VA officials if they could not explain the destruction of a secret wait list at the Phoenix VAMC and preserve documents for an OIG inspection. Miller threatened to call an emergency committee meeting to subpoena the information.[12]

On May 4, 2014, USA Today reported that the VA clinic in Fort Collins, Colorado also falsified appointment records.[13] By May 14, 2014, the New York Times reported

that secret waiting lists were the norm in Arizona, Colorado, Texas, Wyoming, and other places, and that the Senate Veterans Affairs Committee will hold a hearing the next day.[14] To address the issue of secret waiting lists, Secretary Shinseki was accompanied to the hearing by the Under Secretary for Veterans Health, Dr. Robert Pezel, who disavowed any knowledge of the lists. Shinseki stated candidly that:

> Any allegation about patient care or employee misconduct are taken seriously. And based on the background you just described, that I've followed most of my life for 38 years in uniform, and I now have this great privilege to care for people I went to war with many years ago, and people I have sent to war, and people who raised me in the profession when I was a youngster--any allegation, any adverse incident like this, makes me mad as hell.[15]

By this time, members of Congress, and leaders of Veterans Service Organizations called for Shinseki's resignation. Realizing that some VA employees had been less than truthful, Shinseki held his head of VHA accountable and asked for Dr. Pezel's resignation. Dr. Pezel resigned on May 16, 2014.

On May 28, 2014, the OIG released its interim report on the review of the Phoenix VAMC scheduling practices. The report "confirmed that inappropriate scheduling practices are systemic throughout VHA."[16] Additionally, it states, "That their reviews had identified multiple types of scheduling practices not in compliance with VHA policy, and that multiple lists may be the basis for allegations of creating 'secret' wait lists."[17] Secretary Shinseki immediately began the process of firing those found responsible, cancelled bonuses for all VHA senior executives, and ordered that all Veterans on the Phoenix lists be personally contacted to schedule appointments.

Secretary Shinseki was perceived by VA employees, Veterans, and others as a paragon of integrity. With increased clamor for his resignation, Shinseki realized that his continued presence at VA had become a distraction, and submitted his resignation to

President Obama on May 30, 2014. Shortly before submitting his resignation, Secretary Shinseki spoke with an advocacy group for homeless Veterans and stated: "I can't explain the lack of integrity among some of the leaders of our healthcare facilities. This is something I rarely encountered during my 38 years in uniform. I cannot defend it because it is indefensible. But I can take responsibility for it, and I do."[18]

<u>Expanding Population</u>

Economists and social scientists embrace the law of unintended consequences that postulates that actions people or governments take will always have effects that are either unanticipated or unintended.[19] In VA's case, it is the priority goals established by Secretary Shinseki to: 1) eliminate the disability backlog; 2) improve Veteran access to VA benefits and services; and 3) eliminate Veteran homelessness.[20] These goals, not only ambitious and forward thinking, were also the right thing to do for Veterans, and in the five years since they were announced, VA made significant strides toward meeting them.

Improving access to VA benefits by including Agent Orange exposure for Vietnam Veterans added 230,000 claims at the same time that 14 years of war in Afghanistan and Iraq also increased the number of claims exponentially, adding to the already large backlog of disability claims. Although VA processed over one million claims annually in fiscal year (FY) 10–FY 13, there are still more claims waiting than can be processed within the regulatory time frame.[21] These processed claims also feed in to the VA health care system. Advances in medical technology mean that more Soldiers are surviving what would have been fatal injuries in past wars, leading to severely injured Veterans in need of more extensive and prolonged care. When coupled with the aging population of Veterans in the system (on average, utilization of services and

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benefits increases with age), the number of Veterans needing care also exceeds the limitations of the health care system. Requirements between the administrations did not support each other. The emphasis in VBA is to process as many claims as possible to eliminate the backlog of claims, while the goal in VHA was to provide Veteran health appointments within 14 days of the request.

By the close of FY 2014 (September 30, 2014), VA's Performance and Accountability Report for FY 2014 included the following statement in the "Performance Summaries by Program" section of the report.[22] In issuing a statement, VA strives to show that it is taking responsibility for its actions after discovering systemic and unacceptable lack of integrity. VA initiated a nationwide audit of scheduling practices and identified:

1) significant lack of clarity regarding scheduling policies and practices across our system;

2) an inflexible and unrealistic 14-day standard for appointment times;

3) inadequate staffing of providers and clerical support at many of the sites that were experiencing the greatest surge in patient demand; and

4) rigid and obsolete scheduling software.[23]

Fiscal Constraints

VA's Veteran population increased and systems, including both health and benefits, became increasingly stressed. This resulted in both larger backlogs and longer wait times for appointments. The media raged, and Congress responded by increasing VA's budget from $97.7 billion in FY 2009 to $168.9 billion in FY 2014, an increase of 73 percent.[24] VA increased its number of employees from 280,000 to 322,000 in that time. Increased funding brought with it increased pressure from Congress to reduce the

backlog and the waiting time for medical appointments. This created a sense of urgency in VA leadership to show progress in these areas. Congress decreased the VA FY 2015 budget from the FY 2014 budget by $6.4 billion, while the mission and goals remained the same or expanded.[25] Systems and processes became increasingly antiquated and inadequate to meet the mission and values of VA.

To compound the problems, the VA OIG recently found that VHA misdirected $92.5 million from medical support and compliance (MS&C) funds to the development of a new healthcare claims processing system.[26] The result of this action is that the Chief Business Office violated appropriations law when it obligated about $92.5 million of MS&C appropriations for the development of the new system, which extends the time to put the new system in place.[27]

The Problem

To analyze the problem, it is important to understand the causes of the divergence between VA's espoused and enacted values, as well as the results shown in the organizational culture. Some organizations suffered from toxicity--behaviors that include:

1) tearing others down;

2) passive aggressive leadership;

3) destructive gossip;

4) devious politics;

5) negativity;

6) aggressiveness;

7) narcissism;

8) lack of credibility;

9) passivity;

10) disorganization;

11) greed;

12) paranoia; and

13) the resistance to change.[28]

On the surface, it would seem that toxic factors such as greed and paranoia led to unethical behavior and the shift away from placing Veteran needs as a top priority. In examining all of the factors, one must decide if the toxic factors were actually caused by other influences, or if the toxicity was already embedded in the culture prior to contributing factors accrued over the past 15 years.

To more fully understand the situation, one must realize that the top leaders in most government agencies, including VA, are politically appointed to leadership positions. Frank Ostroff noted in an article in the *Harvard Business Review* that due to the election cycle, the average tenure of political appointees is effectively 18 to 24 months.[29] Many of these leaders, realizing their short span of influence are eager to make changes that would ensure they had a lasting impact on the organization. Because of this, the changes are often policy reforms that can be enacted quickly, and show quick and easy metrics of impact.[30] They feel pressure, especially from outside stakeholders such as Congress, the media, and special interest groups, noting that the consequences of "failure are almost always greater than the rewards for exceptional performance."[31]

The legacy siloed structure of VA dating from its roots was exacerbated by the increasing demands created by the expansion of benefits and eligibility. The

administrations continually created organizations within themselves that were redundant with organizations within the department. These equivalent organizations had very little communication with each other, and more layers of management were added to try to facilitate communication. Further, these types of structure stymie transformation and frustrate employees.[32]

As layers of bureaucracy were added, each developed individual metrics to determine their individual organizational performance. These measures, often based on very narrow output goals, did not directly measure how the organization contributes to the mission and values of VA.

Metrics

The pressure to show quick and quantifiable progress on eliminating the backlog and ensuring the 14-day appointment goal focused VA leadership on applying quantifiable output metrics as a measure of success. Ostroff points out that there is a proclivity for an agency to become a captive of metrics originally intended to show progress toward a goal, but over time becomes an end in themselves.[33] Eventually, employees lose sight of the original mission and "come to care only about those things they can directly control, like protecting their own turf."[34] These metrics reinforce an output mentality, and shift the focus away from VA's espoused values--CARE.

Metrics, put in place to monitor the number of claims processed, thus turned individual Veterans into numbers. Performance measures included the percentage of disability and pension claims inventory greater than 125 days, percentage of disability claims greater than 125 days, and percentage of original and reopened pension claims inventory greater than 125 days.[35] Medical services performance measures included the

percentage of Veterans receiving appointments within 14 days of the request, a measure eliminated in the wake of the secret waiting list scandal.[36]

In an effort to reduce claims processing and medical appointment times, aggressive metrics were put in place to increase the number of claims processed, and reduce the waiting time for medical appointments. The unintended consequence of these efforts was to place the emphasis on timely production, reducing VA employees to effectively becoming assembly line workers aimed solely at increasing production. Veterans became numbers when VA employee metrics were based on output rather than Veteran outcomes. Employees are rewarded for reducing time spent listening to Veterans, resulting in increased numbers of contacts and increasing the time spent per case.

A particular example of this type of metric was expressed at several locations, with employees stating: "Employees are encouraged to send letters rather than call Veterans because the points [evaluation metric] are higher--.7 versus .1."[37] Further, employees also repeatedly pointed out that their environment is oriented by production rather than customer service, as "performance metrics incentivize outputs, not good customer service."[38]

Toxic Leadership and its Effects on the Organization

Toxic leadership degrades performance and leads to a hostile environment. In defining toxic leadership, Jean Lipman-Blumen states that toxic leaders "have poisonous effects that cause serious harm to their organizations and their followers."[39] The toxins they secrete include both policies and practices, such as unreasonable performance goals, thereby creating a culture where excessive internal competition leads to an environment of blame. These leaders often place their personal goals and

well-being over both the organization and employees, resulting in unethical, illegal, or criminal behaviors. They wreak serious, lasting harm on their employees and the institution.

Lipman-Blumen asserts that toxic leaders are motivated through a number of drivers including:

1) cynicism;

2) greed;

3) corruptibility;

4) narcissism;

5) paranoia;

6) grandiosity;

7) megalomania; and

8) even stupidity.[40]

Further, they are malevolent or embody evil intent.[41] Their success is often contingent on bringing others down. These leaders have a direct impact on the decline of an organization. It can be thought of as a downward spiral; as the organization's productivity declines, the leader becomes more aggressive, resulting in further decline.

Several authors provide hope in that the organization can be redeemed. Marcia Lynn Whicker states that: "Like any sickness, organizational sickness resulting from toxic leadership, perhaps confounded by a downturn in economic conditions, can be overcome in most instances."[42] Overcoming this decline, the organization must take steps perceived as major changes. This can be done in a number of ways, with the two most effective ways of removing the toxic leader, and/or restructuring the organization.

An underlying assumption for this paper is that several leaders within VA may have exhibited many of the characteristics of toxic leadership, and that the result was an incongruence between VA's espoused values and its enacted values. An organizational climate study discussed later in the paper supports the assumption. While some were motivated by greed to receive bonuses for meeting certain performance metrics, others were seemingly motivated by paranoia or grandiosity--both resulting in ethical lapses.

Kusy and Holloway did a study on toxic leadership, and noted six primary ways that an organization's culture promotes toxic personalities. One that is particularly closely linked to VA's enacted values is "The organization tolerates toxicity, provided the individual is productive."[43] The idea is based not so much on promoting the productive toxic personality as in tolerating or enabling the behavior due to the individual's success in meeting a production metric. Unfortunately, there are often hidden costs to this productivity manifested in the loss of other workers, polarizing of staff, and long-term effects on the team or organization caused by passive-aggressive behaviors.[44]

Did VA Create Toxic Leaders?

David Wilson contends that toxic leaders thrive in hierarchical organizations where performance is evaluated in a top-down fashion.[45] These individuals may already have the propensity for toxic behaviors, and given the right impetus and climate, they lose sight of their values, or enact their preferred toxic style, in favor of results, regardless of how their behavior affects those around them. The pressure to produce, and the measures dictated from the highest levels of management at VA, help create the environment where leaders' actions drifted from the institution's values. The output mentality was compounded by the fact that leaders were rewarded for producing metrics not in line with VA's values. These leaders, rewarded with promotions and

bonuses, reinforced the actions that diverged from VA's values. This confirmation resulted in some leaders resorting to the use of alternative waiting lists for appointments, and claims processors who did not effectively communicate with Veterans when evaluating disability claims.

Climate Variations

Burke and Litwin note that "climate is much more in the foreground of organizational members' perceptions, whereas culture is more background and defined by beliefs and values."[46] They contend that climate links psychological and organizational variables.[47] The differences between equivalent organizations within VA, but at different locations, may be explained by organizational variables such as toxic leaders.

Employee focus group feedback identified a number of issues that affected the problem. Given that the focus groups were held in a number of locations that were the same type of organization, one would expect that the culture and experiences would be relatively consistent from center to center in equivalent organizational types, e.g., medical centers, regional offices, etc. The engagement team found some notable variations between the locations, and pointed out two examples of very positive climate locations and one location with an egregiously negative climate. The locations with a positive climate, Salisbury, North Carolina and Palo Alto, California, represent role models for other centers. The location that was negative appeared to suffer from the Director's toxic leadership.[48]

Espoused Values versus Enacted Values

Schein defines espoused values as the beliefs, norms, and rules of behavior that the members use to depict the culture to both themselves and to outsiders.[49] Enacted

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values are the observed behavior, and according to Argyris and Schön became the theory-in-use. Norms or theories-in-use govern an individual's actions, regardless of its compatibility with the individual's or organization's espoused values, and whether or not the individual is even aware of the incompatibility.[50]

Professors Robert Kreitner and Angelo Kinicki of Arizona State University provide a simple and concise description of the dichotomy between espoused and enacted values:

> Espoused values represent the explicitly stated values and norms that are preferred by an organization. Enacted values, in contrast, reflect the values and norms that actually are exhibited or converted into employee behavior. Employees become cynical when management espouses one set of values and norms and then behaves in an inconsistent fashion.[51]

VA's enacted values are not in sync with its espoused values. Unethical behavior and mistrust between leadership and employees resulting in reduced quality of customer service for Veterans is inconsistent with doing what is right for Veterans. Poor organizational climates from across centers, often fostering toxic leadership, also degrades Veteran and employee outcomes. Moreover, VA's espoused values emphasize integrity and customer service, yet its enacted values emphasize production volume leading to the de-humanization of Veterans.

The issues that VA experienced regarding the drift from espoused values to enacted values is not unique to VA. Wong and Gerras examined a similar breakdown of integrity in the Army as the result of an institutional environment that places excessive requirements and sets high expectations that leaders find impossible to achieve.[52] Under this type of pressure, leaders often rationalize their deceptive actions. The paper cites several examples of fraudulent reporting that has become pervasive throughout the ranks. Officers frequently justify their lack of honesty as prioritization of

requirements, only actually completing those requirements they feel are directly connected to their core mission. This routine of dishonesty has become so commonplace that any ethical angst about these mistruths no longer draws notice.[53] This is what is referred to as "ethical fading"--a method that individuals use to convince themselves that "considerations of right or wrong are not applicable to decisions that in any other circumstances would be ethical dilemmas."[54] To further exacerbate the problem, Wong and Gerras point out that if there are no direct consequences for these types of actions, senior leaders know they are wrong and tolerate them.[55] Similar to the problem Wong and Gerras identify in the Army, the pressure in VA to reduce the backlog of claims or ensure Veterans are seen within 14 days, coupled with a lack of adequate staff to complete the requirements and few direct consequences to a lack of integrity when dealing with Veterans, leads to dishonest reporting and ethical fading.

In analyzing this collection of events and circumstances leads to the ultimate question for this paper: how can the VA values of I CARE be reinforced throughout VA to better serve our Veterans and employees? Because the breakdown at VA had multiple causes and effects, this paper will focus more narrowly on how Secretary Robert McDonald is using embedding and reinforcing mechanisms to lead change at VA.

<div align="center">Who is Secretary Robert McDonald?</div>

Secretary Robert McDonald, graduated in the top two percent of his class at the U.S. Military Academy at West Point in 1975, and earned a Master of Business Administration from the University of Utah in 1978. He served with the 82nd Airborne Division, and earned the Ranger tab, the Expert Infantryman Badge, and Senior Parachutist wings.

Leaving the Army as a Captain, he joined the business world, and remains committed to values-based leadership and improving the lives of others. He and his wife founded the McDonald Cadet Leadership Conference at West Point. This biennial conference connects the best and brightest from universities around the world with senior business, non-governmental organizations, and government leaders.

Prior to becoming the Secretary of Veterans Affairs in July 2014, Secretary McDonald served as the Chief Executive Officer (CEO) at the Proctor and Gamble Company (P&G). While there, he recalibrated its product portfolio; expanded its marketing footprint; and grew the organic sales by an average of three percent per year, resulting in a 60 percent increase in the stock price over his five-year tenure, Further, he garnered accolades as the best company for developing leader talent, its environmental and social sustainability initiatives, as well as being consistently cited in the top tier of the best companies for Leadership Study.[56]

As the former CEO of P&G, he mastered factors that play into the transition of a large organization like VA from a government bureaucracy to an organization that is focused on customer service and living up to its mission and values. While at P&G, he produced a number of short videos on his vision for leadership that, along with a shared services model, carry over to express his vision for the transformation of VA to a Veteran-centric model of customer service. His seven principles include:

1) promote from within;

2) develop leaders;

3) hire the best talent;

4) conduct interviews – success factors and drivers;

5) emphasize new hire training;

6) synthesize on-the-job training and cross training; and

7) create a culture of constant learning.[57]

Secretary McDonald's Actions

In August 2013, under former Secretary Shinseki, VA created the acronym I CARE to help employees embody its espoused values of Integrity, Commitment, Advocacy, Respect, and Excellence. These values directly support the VA mission "to care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans. Because I CARE was implemented less than one year before Secretary Shinseki's departure, it is unclear how firmly embedded the program became with VA employees. However, the new Secretary of Veterans Affairs, Robert McDonald, immediately affirmed his commitment to these values, and asked that all VA employees reaffirm theirs when he first assumed office.

Employee Focus Groups

Early in his tenure, Secretary McDonald also conducted a series of focus groups across the country. They were designed to collect feedback from a representation of employees from the three administrations--VHA, VBA, and the NCA--as well as union representatives, local leadership, and representatives from the Office of Information Technology and the Office of General Counsel. Held in 20 locations throughout the country, the sessions were designed to collect feedback on: employee ideas to improve customer experience; how to demonstrate VA unity; how to simplify the way Veterans view VA; and to understand impediments to employees' ability to provide excellent customer service. The engagement team held more than 150 listening sessions to

gather the information. The findings served as the basis for creating a new VA office

called "My VA"--an office chartered to the creation of a unified VA with the goal of

regaining Veterans' trust in VA.

The report on the findings identified three consistent employee needs and five

process and systems improvement suggestions.

Employee needs:

1) staff across all business lines to execute the high volume of work;

2) parking spaces to prevent patients from giving up and missing their

appointments; and

3) building space and exam rooms so employees have the space and

resources to do their job.[58]

Process and systems improvement:

1) Changing the performance management system from a production

measurement to encouraging improved customer service;

2) Integrating of information technology systems for a unified experience;

3) Adding more baseline VA knowledge and management training across

the workforce;

4) Simplifying of communications materials and improved outreach to

Veterans; and

5) Simplifying of the contracting/acquisition processes.[59]

VA has long been criticized for lengthy processing times for benefit claims

applications, long waiting times for medical appointments, and a legacy view that VA

medical care is inadequate and institutionalized. Legacy views, as portrayed in the 1989

movie "Born on the Fourth of July," persist. VA has made exemplary progress in the quality of its care. A Rand study from 2010 declared that the VHA system is among the best health care organizations in the country.[60]

Another common theme from the report suggests that processes and systems also contribute to the degradation of customer service, noting that "Paper claims can take 14 days to sign and scan, while electronic signature would shorten the process by 10 days; and call center staff have no way to expedite claims, even in cases of terminal illness."[61] Strict hierarchical structures create additional delays and degradation of customer service, as "Veteran-facing employees do not feel empowered to make decisions."[62] VA's espoused values are noble. Its values support its mission to "care for him who shall have borne the battle, and for his widow, and his orphan," and "provide a baseline for the standards of behavior expected of all VA employees."[63]

McDonald's Report Card

Schein provides that leaders, like McDonald at VA, can affect change in the culture by using embedding and reinforcing mechanisms. Embedding mechanisms create the new assumptions into the organization, while the reinforcing mechanisms support the newly embedded assumptions.[64] Schein lists six major tools that leaders can use to embed the desired cultural change, and six reinforcing mechanisms. These are:

Embedding Mechanisms:

- What leaders pay attention to, measure and control on a regular basis;

- How leaders react to critical incidents and organizational crisis;

- How leaders allocate resources;

- How leaders deliberately role model, teach, and coach;

- How leaders allocate rewards and status;

- How leaders recruit, select, promote, and excommunicate.[65]

Reinforcing Mechanisms:

- Organizational design and structure;

- Organizational systems and procedures;

- Rites and rituals of the organization;

- Design of physical space, facades, and building;s

- Stories about important events and people;

- Formal statements of organizational philosophy, creeds, and

  charters.[66]

Examples of how McDonald has used the embedding and reinforcing

mechanisms follow.

Table 1. McDonald's Report Card[67]

EMBEDDING MECHANISMS		
Mechanism	Yes/No	Percent Used
What leaders pay attention to, measure and control on a regular basis	Yes	66%
How leaders react to critical incidents and organizational crises	Yes	
How leaders allocate resources	No	
How leaders deliberately role model, teach, and coach	Yes	
How leaders allocate rewards and status	No	
How leaders recruit, select, promote, and excommunicate	Yes	
REINFORCING MECHANISMS		
Organizational design and structure	Yes	100%
Organizational systems and procedures	Yes	
Rites and rituals of the organization	Yes	
Design of physical space, facades, and buildings	Yes	
Stories about important events and people	Yes	
Formal statements of organizational philosophy, creeds, and charters	Yes	

What leaders pay attention to, measure, and control is the most powerful and obvious way that leaders communicate to the organization what they truly care about, and what subordinates will focus on.[68] Secretary McDonald has made it clear that upholding VA's mission and values and genuinely caring for Veterans is his primary intent. The challenge in measuring adherence to values is much more difficult to measure than quantitative output. It is also much more subjective. Additionally, Schein stresses there must be consensus throughout the organization on how it measures and defines success. He cautions that "if consensus fails to develop, and strong subcultures form around different assumptions, the organization will find itself in conflicts that can potentially undermine its ability to cope with the external environment."[69]

Louis Gerstner, when faced with a similar challenge, transformed IBM when the company lost sight of its basic values and customer service. He noted that the company values themselves were good, smart, and creative. However, they had become perverted into dysfunctional, self-reinforcing practices. The biggest challenge Gerstner experienced was to keep the values while rooting out the dysfunctionality and realigning priorities within the company's original espoused values.[70]

McDonald's approach mirrors Gerstner's in realizing that changing culture is a long and slow process. Further, it needs to be led from the top. This requires a great deal of personal time and energy, as well as the commitment from the leadership team.[71] VA may prove more difficult to obtain the leadership team buy-in, given the traditional reduced tenure of political appointees in government leadership positions. However, Ostroff suggests that, since many career employees stay in their positions for a long time, they provide an opportunity for continuity and sustained cultural change.[72]

He notes that about one quarter of employees embrace the change, one quarter resist, and about 50 percent are ambivalent.[73] In this case, it is important that the change effort is congruent with the employees' values to keep those that are supportive.[74] Retaining those that are supportive, and winning over those who are 'on the fence', depend very much on the embedding and reinforcing mechanisms used.

Both internal and external stakeholders become judgmental on leader reactions to critical incidents and organizational crisis. How leaders react to crisis embeds the underlying assumptions and creates new norms.[75] This is closely related to the leader's use of deliberate role-modeling, teaching, and coaching. During his short tenure to date, Secretary McDonald has faced not only the crisis that brought him into the position, but critical incidents in highlighted in recent headlines. He figuratively stood up for the department and its employees by confronting antagonistic questioning during a Congressional hearing, noting that the culture changes in VA do not happen overnight.[76] He modeled the behavior desired by providing Veterans and others with his private cell phone number so that Veterans can provide him with feedback on whether or not he is making a difference.[77] Additionally, when he misspoke about his military record in an attempt to connect with a homeless Veteran, and was publically called out on his declaration, he immediately took ownership of his action, admitted the mistruth, and apologized for his statement.[78]

How leaders select, promote, and excommunicate is a method used by leaders to perpetuate the newly embedded assumptions in the next generation of leaders.[79] VA recently created the Office of Accountability Review "to ensure a well-coordinated, transparent, and consistent approach to addressing wrong-doing related to access and

patient scheduling data manipulation."[80] At this time, it is still too early to see the results

of this action.

The mechanism how leaders allocate resources refers to budget decisions, and

that leaders support resource decisions that align with the leader's assumptions and

beliefs. How leaders allocate rewards and status refers to the actual practice used by

leaders to reward wanted behavior. Due to McDonald's limited tenure in his position, it

is too early to determine the embedding mechanisms' effects.

Reinforcing Mechanisms

However, the reinforcing mechanisms, organizational design and structure and

organizational systems and procedures, represent the most sweeping reform that

McDonald envisions for VA. Schein would argue that the embedding mechanisms are

much more important than that reinforcing mechanisms, yet McDonald seemingly has

focused more on the reinforcing than the embedding. Why?

Kotter offers an explanation. He states that "customer-focused visions often fail

unless customer-unfocused organizational structures are modified."[81] He further cites

four ways that structure undermines the change effort:

Table 2. Kotter's "How Structure Can Undermine Vision"[82]

The Vision	The Structure
Focus on the customer	But the organization fragments resources and responsibility for products and services
Give more responsibility to lower-level employees	But there are layers of middle-level managers who second-guess and criticize employees
Increase productivity to become the low cost producer	But huge staff groups at corporate headquarters are expensive and constantly initiate costly procedures and programs
Speed everything up	But independent silos don't communicate, and thus slow everything down.

McDonald's actions support the need to get the structure in place to facilitate

embedding the I CARE values throughout the organization. In creating the *MyVA* Task

Force[83], McDonald hopes to realign VA's regional structure "with the ultimate goal to orient all VA operations to the needs and expectations of our Veterans and beneficiaries."[84] He is passionate in his message to VA employees regarding *MyVA*. In a message commemorating the 150th anniversary of Abraham Lincoln's second inaugural address on March 4, 2015, McDonald lays out his vision for the transformation.[85]

Secretary McDonald also addresses the use of formal statements of organizational philosophy, creeds, and charters when he reinforces both VA's mission and the I CARE values:

> We answer that mission every day by living our I CARE Values – by interacting with Veterans and fellow employees with unimpeachable Integrity; by renewing our Commitment to the best outcomes for Veterans; through rigorous Advocacy characterized by profound Respect for those we serve; and by doing all of that with unparalleled Excellence in delivering the world-class benefits and health care that Veterans have earned.[86]

Finally, the design of physical space, facades, and buildings is addressed in a request for VA to run its own version of Base Realignment and Closure (BRAC). Stating that VA currently has 336 buildings that are either vacant or less than 50 percent occupied. McDonald proposes to close these facilities and divert the estimated $24 million in savings to hire more nurses, and increase the number of primary care visits and nursing home care hours for Veterans.[87]

Outcome-based Metrics

Secretary McDonald vows that VA will use a single metric to measure success going forward--Veterans' outcomes. This will be a significant departure from the hundreds of output measures VA tracked for several years. Measuring outcomes is more difficult than measuring output. When looking at outcomes, it is more important to

measure why an organization's program was set up, rather than what the program does. It will be important to VA to clearly define what success means, gain consensus on the definition, and develop the right outcome to measure its definition of "success".

Once the definition of "success" is determined, McDonald can complete his efforts to transform VA's culture by determining what and how to measure progress. Philip Atkinson stresses that cultural change is "about shaping behavior and processes to become more effective in your mission and in your market."[88] He says it is imperative that culture be tangible, observable and measurable, and quantifiable.[89] Not only do outcomes need to be measurable, but the environment requires both leading and lagging measures to help predict, determine, and influence the desired outcome.[90] David and Gwendolyn Army state there are three interdependent aspects to measuring behavior: cognitive, action, and emotional.[91] They stress the importance of determining and defining behaviors that demonstrate the values. These behaviors are then measured by both observation and self-reporting. They also suggest graphically displaying behaviors against performance.[92] This type of assessment can be used for both individual performance and organizational performance.

Many management consultants advocate the Balanced Scorecard as a method to measure service quality, customer relationships, and employee satisfaction. Managers contend that improvement in areas such as employee satisfaction has an impact on customer loyalty, and in the long run, an impact on a company's bottom line.[93] Ann All points out that outcome-based metrics make it more difficult for employees to game the system, and encourages them to become more directly involved in service improvement efforts.[94]

Conclusion

VA's crisis was created by a number of environmental circumstances that led to actions taken to correct the dilemma. The goals created to correct the environmental issues had unintended consequences of increasing both toxic leadership and unethical behavior. This paper described the environmental influences that created the latest VA crisis. It analyzed the problem created by environmental factors and the unanticipated consequences of how VA addressed them. Finally, it evaluated how Secretary McDonald actions thus far compared with acknowledged theories on organizational cultural change.

It is important for VA to move from measuring outputs to measuring Veteran outcomes, and changing behaviors to those that are congruent with VA's espoused values is key to a successful change. Secretary Robert McDonald's actions taken to date are consistent with the theories of Schein, Kotter, and other organizational culture and change leadership experts. The department is showing some short-term wins in creating more appointment times through night and weekend hours, and increasing patient visits by 1.8 million over the same period in 2014. Changing culture and regaining trust is a slow process, and improved Veteran outcomes may not be seen for two to five years, but the progress shown thus far is promising if it can be sustained.

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> *MyVA* is a historic, Department-wide transformation making Veterans the center of everything we do. And it may well become the largest restructuring in the Department's history. *MyVA* is about improving Veterans' experiences, and it includes organizational reforms to unify our work for Veterans.
>
> And it's about improving our employees' experiences – your experiences – and eliminating barriers to providing Veterans timely, quality care and services. We want to focus on our people so we can best serve Veterans. We're going to improve internal support services and enhance our strategic partnerships. And we're establishing a culture of continuous improvement so those of you at the front lines of service can correct problems you identify more immediately. Then, we can replicate your proven solutions across all facilities.
>
> Reorienting us around the needs of Veterans, *MyVA* will revolutionize our culture and allow us to give every Veteran a seamless, integrated, and responsive customer service experience, every time. And we'll measure our success by the only metric that counts – Veterans' outcomes. *MyVA* is a product of your heartfelt dedication to the men and women who have served our Nation so selflessly and so honorably.

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