

# The Power

## of Frontline Workers in Transforming Healthcare Organizations:

**The Upstate New York  
Veterans Healthcare  
Network**



Timothy J. Hoff, PhD.

December 2003

Sponsored by IBM Center for  
Healthcare Management

## Foreward

December 2003

On behalf of the IBM Center for Healthcare Management, we are pleased to present this report, “The Power of Frontline Workers in Transforming Healthcare Organizations: The Upstate New York Veterans Healthcare Network,” by Timothy J. Hoff. An earlier version of this report was published by the IBM Center for The Business of Government in April 2003.

The report tells the story of how the Upstate New York Veterans Healthcare Network dramatically improved its performance in the late 1990s. In the mid-1990s, the Department of Veterans Affairs created 22 integrated service delivery networks. Since the creation of the networks, the Upstate New York Veterans Healthcare Network has rated consistently among the best of the 22 networks in terms of efficiency, access, clinical performance, and patient and employee satisfaction.

Professor Hoff was intrigued by the question of how the Upstate New York Veterans Healthcare Network improved its performance so dramatically. Over a two-year period, he conducted extensive interviews at three of the five medical sites in the network (Albany, Buffalo, and Syracuse). He found that a key to the performance improvement in the network was that the leadership of the Upstate New York Healthcare Network made a conscious attempt to unleash the power of frontline employees by creating an increased patient focus, adopting a learning environment, increasing frontline autonomy, encouraging grass-roots innovation, and developing esprit de corps among frontline workers.

While this report is a case study of one network in the Department of Veterans Affairs, the lessons learned from the Upstate New York Veterans Healthcare Network are clearly applicable to other healthcare organizations. We trust that this report will be both informative and helpful to all healthcare executives who are seeking to increase the performance of their organizations and their delivery of services.

Neil E. de Crescenzo  
Partner-in-Charge  
IBM Center for Healthcare Management  
neilde@us.ibm.com

Paul Lawrence  
Partner-in-Charge  
IBM Center for The Business of Government  
paul.lawrence@us.ibm.com

## **Table of Contents**

<b>4</b>	<b>Executive Brief</b>
<b>7</b>	<b>Introduction</b>
<b>13</b>	<b>Frontline Entrepreneurship in Healthcare Organizations: Case Studies</b>
<b>26</b>	<b>Lessons Learned on Unleashing the Power of Frontline Workers in Transforming Healthcare Organizations</b>
<b>33</b>	<b>Appendix: Study Methods</b>
<b>35</b>	<b>Endnotes</b>
<b>39</b>	<b>Bibliography</b>
<b>41</b>	<b>About the Authors</b>
<b>42</b>	<b>IBM Center for Healthcare Management Reports Available</b>
<b>47</b>	<b>Books</b>

## Executive Brief

This report examines how healthcare organizations undergoing transformation pursue innovation through frontline entrepreneurship and the managerial factors that give rise to such entrepreneurship. It presents three case studies of innovation occurring in the Behavioral Health Service Line (BHSL) of the Upstate New York Veterans Healthcare Network, one of 22 such networks in the Veterans Health Administration (VHA). While the larger VHA transformation has been documented and studied, this report looks at how a single organizational subcomponent tapped into the creative power of employees to help them meet the challenges of greater performance accountability, enhanced service quality and diversity, and increased customer access.

Three case studies analyze innovation through employee entrepreneurship:

- Introducing behavioral health care services into existing primary care-oriented, community-based outpatient clinics
- Meeting increased performance expectations within outreach programs designed to assist homeless veterans
- Developing a new self-sustaining, customer-focused vocational rehabilitation program for veterans recovering from substance abuse and behavioral health problems

Each case study addresses a key strategic change that needed to be implemented quickly, and each involves a core service component within the BHSL. This organization succeeded in the early phases of these innovations because its leadership went against the traditional norms of bureaucratic management, with its emphasis on formal procedure and centralization, and instead embraced the organization's frontline workforce as the critical resource to making things work. When there is a lack of experience or implementation history around strategic initiatives, and environmental imperatives demand quick results, codifying and micromanaging frontline work processes become anathema to organizational success.

During 2001, interviews, focus groups, and observation were conducted at three of the five medical center sites in the Upstate New York Veterans Healthcare Network (Upstate NY VHA Network): Albany, Buffalo, and Syracuse. In addition, various archival materials such as internal strategic planning documents, performance reports, and correspondence were examined. Qualitative methods of data analysis were employed in describing the three case study innovations in the report, and in analyzing the role individual employee entrepreneurship played in the success of the innovations. Collecting data at all levels of the organization, particularly at the level of program line staff, allowed examination of how macro-level strategic imperatives were ultimately implemented and thought about by line staff on an everyday basis. This analytic focus on the entire organization is both rare and valuable in the study of organizational transformation. It allows a fuller, richer picture to be gained of the transformation process than through reliance on top or middle management interpretations alone.

## Recommendations

Five recommendations emerge from the three case studies, which collectively provide a blueprint for how managers can leverage frontline employee entrepreneurship in spurring innovation within their organizations.

### Recommendation 1: Create a patient focus.

- Redirect efforts and fill service gaps that involve customers' failure to fit into neatly defined organizational categories or performance measures.
- Create the capacity for patients to define their own needs as they see them.
- Encourage line employees to identify program "failures" in serving customers and communicate those failures up through management.
- Promote feelings of personal commitment among line employees toward their patients.
- Place employees close to the patient on an everyday basis so that communication can be ongoing and open and trust can develop between the two entities.

**Recommendation 2:****Adopt a learning environment.**

- Give “voice” to those who carry out production within the organization by encouraging ad hoc or informal approaches to strategic implementation.
- Build an institutional history of successful strategic implementations, a database that can be used to identify and standardize (across programs) key characteristics of successful implementation approaches.
- Embrace a situational approach to strategic implementation, allowing that the same strategic imperative may play out differently depending on factors in the everyday service delivery environment.
- Use episodes of program failure to question and revise the underlying assumptions of how services are delivered to customer groups.

**Recommendation 3:****Increase frontline autonomy.**

- Allow key implementation decisions to be made by frontline management and staff.
- Make sure top management communicates clearly the strategic imperatives and mission of the organization at all times to frontline staff.
- Create opportunities for empowerment among line staff and link them explicitly to improving organizational performance.
- Reward rather than punish frontline creativity and willingness to take implementation chances.

**Recommendation 4:****Encourage grass-roots innovation.**

- Create an employee culture in which the norm is to identify gaps between formal performance expectations and the realities of customer service needs.
- Provide incentives for employees to explore the potential for improvement in their everyday activities.
- Encourage employees to critique how work is “normally” done within their programs, rather than rewarding an exclusive focus on desired, formal performance outcomes.
- Make sure management is willing and able to modify formal performance outcomes in light of the need to experiment within new means of strategic implementation.
- Make sure management slows change demands enough for programs so that line staff have time to reflect upon prior performance.

**Recommendation 5:****Develop esprit de corps among frontline workers.**

- Encourage camaraderie among line staff with respect to their everyday work.
- Create opportunities for those employees doing similar work to develop group trust and cohesiveness.
- Develop criteria for employee recruitment that can facilitate the development of group trust and cohesiveness among line staff.
- Keep program staff together within the same program for an extended period of time.
- Encourage an us-versus-them mentality within the organization that produces “creative tension” rather than hostility between line workers and management.

To further innovation through individual entrepreneurialism at the program level, managers in healthcare organizations must take primary responsibility for setting the strategic direction, communicating formal expectations, and worrying about the “big picture.” They also must acknowledge that their distance from the actual production process means they know less about how to implement strategies than do line staff. Managers should create, disseminate, and strategize around mission, vision, and organizational goals. They should avoid thinking they know best how to make things work “in the trenches.”

In general, that was the experience found in the BHSL. Top and middle managers held firm to the organization’s need to survive and make a successful transformation. They expected and received consistent information around program performance. They also held those programs accountable for performance shortfalls. In return, they afforded line staff a degree of autonomy in everyday action, thereby conveying a sense that they were counting on those staff members to help make things work through their own creativity, commitment, and action.

The BHSL case studies also demonstrate that innovation through individual entrepreneurship benefits from an organizational structure that allows reciprocal communication flow, decentralized decision making, timely information production at the program level to assess implementation in “real time,” and cross-fertilization of expertise through the use of interdisciplinary teams. The BHSL was part of an organizing structure within the Upstate NY VHA Network rooted in the ideal of “service or product line” management that helped to provide the above ingredients.

The service line structure emphasizes a focus on customers through its attention to output rather than input. It encourages program solidarity by uniting line staff according to whom they serve rather than what they do. If committed to in its fullest sense, the service line structure produces a highly adaptive culture throughout the entire organization—a culture that buys into the need for constant reassessment and change in the face of uncertain environments. In the case of the BHSL, there is evidence this type of structure was a positive force in linking innovation with employee entrepreneurship.

## Introduction

### The Birth of a Veterans' Health Care System

During the first half of the 1990s, the Veterans Health Administration (VHA) needed to change the way it did business. Calls to privatize the health care system for veterans in the United States, the threat of health care reform that would marginalize the VHA's role in serving veterans, negative publicity in the media about the VHA's perceived care of patients, stagnant funding, and increased congressional oversight of the VHA were environmental factors that coalesced in the early 1990s to threaten the organization's existence as a public sector agency.<sup>1</sup> Being the largest integrated health care delivery system in the United States, and part of a 70-year-old, highly political government bureaucracy (one of three components of the Department of Veterans Affairs) with more than 200,000 employees, the VHA would not change easily.<sup>2</sup> Before the process of change was over, it would lead to the organization's reorienting its service focus, redefining its customer base, becoming more accountable to its constituents, gaining greater efficiency, and increasing quality of care (see "The Transformation

of Veterans' Health Care"). Specifically, health care for veterans needed to shift its strategic focus from costly inpatient care toward ambulatory, primary, and preventive-oriented care. In the process, the system would have to attract significantly more new patients than ever before.

For the Upstate NY VHA Network, one of 22 networks within the VHA system, the challenge faced in 1997 was even greater because of the need to downsize and do all of the above. Faced with a decreasing number of eligible veteran patients in its service area, patients whose advanced age made them more expensive to serve, the Upstate NY VHA Network looked to an innovation cultivated in the private sector to create efficiencies in how they managed and delivered services. This innovation was the adoption of a service or product line structure. Such a structure represented a radical departure from the traditional medical-center-focused, clinically compartmentalized patient care approach typifying the VHA system nationally. The service line structure ideally would produce a more holistic management strategy, a higher quality approach to patient care, efficiencies of scale, enhanced accountability, greater collaboration among health

### The Transformation of Veterans' Health Care

*To help achieve the changes needed to ensure the survival of the VHA, a major reorganization occurred in the mid-1990s under then director Kenneth Kizer. Kizer implemented a service delivery structure that focused on funding for and care of populations, a departure from the traditional budgetary focus on individual VHA facilities like medical centers. To achieve this new focus, the VHA was organized nationally into 22 integrated service delivery networks, or VISNs. All 172 hospitals in the VHA became part of a larger regional network of care. Because the individual networks were to be managed holistically, the management structure of each included a network director who assumed primary decision-making authority (from those who had traditionally filled such a role, i.e., directors of the 172 individual hospitals). Ideally, each network would consist of hospitals, nursing homes, home health programs, and outpatient clinics. The latter were also started at the same time to further move the redirected focus away from inpatient care and toward primary care for veterans, in addition to increasing access to care for the veteran population.*

*Funding for the network concept also changed. Instead of each individual hospital receiving dedicated funding based on historical allocations, the VHA moved toward a more capitated or population-based means of budgeting. Called VERA, or Veterans Equitable Resource Allocation method, the new funding formula provided dollars annually to each of the 22 networks based on the number of patients served. This method would reward networks that attained efficiencies and increased access for veterans. Networks would also be allowed to pursue innovations to help achieve greater access and efficiency. The Upstate New York Veterans Healthcare Network is one of the 22 VISNs (VISN 2), covering a service area comprising 49 counties and more than 500,000 eligible veteran patients.*

care professionals, and more sensible resource allocation for particular health services derived from bottom-up assessments of program needs.<sup>3,4</sup> Whether it would work, however, was uncertain, especially since the Upstate NY VHA Network would be the first of the 22 VHA networks to adopt it (see “The Transformation of the Upstate NY Veterans Healthcare Network”).

Regardless of the type of organizing structure, however, the Upstate NY VHA Network had to implement new ways of providing quality health care quickly, demonstrate the success of those innovations quickly, and get new patients to come to the VA for their medical care quickly. Given the time imperative, only the people working within the organization and relied upon to make things happen could make the service line approach work. A more deliberate, incremental implementation strategy for the new structure was not an option. Nor would there be enough time to take full advantage of the opportunities offered by the structure itself, because some (e.g., greater performance accountability) could be realized only through resource investments and organizational capacity building that would take several years to realize. As a result, the Upstate NY VHA Network was one organization that during the late 1990s demanded and elicited the very best of its employees’ entrepreneurial talents, in some cases pushing individuals to the brink of their capacities to change, handle uncertainty, and remain satisfied in their work.

### **The Start-Up Success of a “New” Upstate New York Veterans Healthcare Network**

As of 2003, the overall transformation of the veterans’ health care system can be classified an impressive success. The successful outcomes, as well as the process by which the transformation unfolded, have been discussed extensively elsewhere.<sup>5</sup> However, perhaps none of the 22 networks within the VHA system has achieved more performance gains over the past five years than the Upstate NY Veterans Healthcare Network (see Tables 1, 2, and 3).

A recent winner of the Robert Carey Award for performance excellence in the VA (an award given to only one organization annually within the Department of Veterans Affairs), the Upstate NY

VHA Network, although forced to reduce its staff and budget, managed to boost productivity, enhance quality of care, and increase patients’ satisfaction. The network has been at or near the top in achieving gains in both service delivery efficiency and patient care access since moving to the service line structure (see Table 1). Its decrease in average total expenditure per patient during the time period 1996–2001 was second best among the 22 networks. The network achieved the largest decrease in inpatient care bed days over this same time period, thus making the successful transformation to a more primary-care-oriented service delivery model.

As a subset of the Upstate NY VHA Network’s exceptional overall performance in various quality arenas, the performance of the BHSL is particularly noteworthy. On several key clinical performance measures related to behavioral health care, the service line leads all VHA networks nationally (Table 2).

In less than five years, the BHSL went from a relatively poor performer to a leading performer among mental health service providers in the VHA system<sup>6</sup> (Table 3). The Upstate NY VHA Network has created an employee culture in which change is realized, accepted, and responded to in a timely fashion. For instance, employee surveys demonstrate an understanding of the change situation at every staffing level of the organization.<sup>7</sup> This does not mean everyone is happy about the changes that have occurred—some feel alienated, some are angry, and some have developed a mistrust of the larger VA, their organization, and management.<sup>8</sup> However, most employees have chosen to deal with change in a manner beneficial to the organization and how it serves customers, regardless of their personal feelings.

This change-oriented culture has laid the foundation for the performance results listed in Table 3, results that show how a workforce facing job cuts, insufficient budgets, and new service mandates still delivers high-quality, patient-centered care. For example, despite losing 18 percent of its workforce between 1996 and 2001 and going from 6,300 to 5,200 employees, the Upstate NY VHA Network managed to increase the total number of patient visits to its facilities by 74 percent over this same

## The Transformation of the Upstate NY Veterans Healthcare Network

The Upstate NY VHA Network's move to a service line structure in 1997 represented a significant break from the past. The traditional medical-center-focused structure in VISN 2 was characterized by:

- Primacy of medical center over network-wide service delivery imperatives
- Greater attention paid to service process over service outcome evaluation
- Use of anecdotal and historical rationales (e.g., "it's always been done this way") to justify decisions rather than basing decisions on their fit with strategic goals and specific pieces of quantitative data
- Split management authority between medical center directors and clinical service chiefs (e.g., medicine, nursing)
- Less ongoing contact or integration among medical centers in the network
- Potential duplication of services in the network
- Lack of an overt customer-focused (e.g., VA patients, Congress) orientation.

In short, it was a structure ill suited to meet the new environmental imperatives facing the VA. While other networks in the VA took less drastic approaches to reorganization, VISN 2 decided to largely do away with the traditional structure and organize around a promising but unproven service line structure.

Service lines are multidisciplinary, have a clinical care mission, and provide a mechanism for integrating personnel and services across professional disciplines and delivery sites. Deriving from the product line management approach used in other industries, service line management ideally improves both the quality and cost-effectiveness of health care services. In health care, service lines ideally achieve integration. The service line model presumably provides a "responsive" structure that health care organizations can use to adapt quickly to environmental demands.

The Upstate NY VHA Network now consists of eight service lines, four of which are clinically based. Clinical service lines include Medical Care, Diagnostics and Therapeutics, Behavioral Health, and Geriatrics. The four management service lines are Financial Management, Information Systems, Management Systems, and Performance Management. Medical Care is the largest service line in the Upstate NY VHA Network. It provides services in the area of physical medicine (i.e., primary and specialty care) to veterans. Diagnostics and Therapeutics is a clinical support line that includes diagnostic imaging, pathology and laboratory medicine, and pharmacy, among other services. Geriatrics includes services such as adult day care, Alzheimer's disease care, and home and nursing home care. The focus of the present study, the Behavioral Health Service Line, or the BHSL, includes outpatient and inpatient mental health services, domiciliary care, homeless services, vocational rehabilitation, and substance abuse treatment.

Mental health services had never been organized in the VHA using a service line approach. A single service line director assumed line and budget authority for all mental health service delivery in the network. This individual oversaw two service line managers per medical center, playing the same role locally that typically five administrators had handled. Such directors coordinated the delivery of mental health services with the local medical center director and service line managers who supervised service delivery in other areas. The Upstate NY VHA Network consists of three large medical center sites that deliver a full range of services, with two smaller sites involved only in basic service delivery and select components of service delivery such as long-term or rehabilitative care.

The BHSL provides mental health services and supportive care to eligible veterans in upstate New York. This care includes a range of treatment, from short-term outpatient care for adjustment disorders to acute inpatient hospitalization and chronic long-term institutional care, such as day treatment and programs for the seriously mentally ill. The care also covers integrating the veteran with mental health needs back into society, through programs that seek to end homelessness among veterans, cure them of substance abuse problems, and develop their skills for permanent employment. Since the move to service lines in 1997, the BHSL has been the most successful of the four clinical care lines in the Upstate NY VHA Network.

**Table 1: Gains in Efficiency and Access for the Upstate NY Veterans Healthcare Network (FY 2001)**

Performance measure	Upstate NY VHA Network performance	Met or exceeded VHA goal, national rate, and/or benchmark?
Average total cost per patient, 1996–2001	20.5% decrease	2nd best of 22 networks (improvement from 18th in 1996)
Average clinical cost per patient, 1998–2001	3.4% increase	3rd lowest increase of 22 networks
Acute bed days per 1,000 patients, 1996–2001	72.4% decrease	Best of 22 networks
Number of patient visits, 1996–2001	52.9% increase	3rd best of 22 networks
Veteran market penetration, low income/ service connected disability, 2001	39.5% of all eligible veterans	4th best of 22 networks

time period.<sup>9</sup> Patient-satisfaction figures are the highest in the VHA system and better than those of the vast majority of health care organizations in the United States.<sup>10</sup>

The Upstate NY VHA Network’s ability to do more with less, and to improve how it does business despite adverse circumstances in its environment, remains a striking achievement. There is evidence that this achievement is due in large part to a motivated workforce of service professionals. Illuminated through the case studies offered in this report, this motivation derives from an equal parts mixture of personal commitment to serving the veteran patient, employee discretion in implementing management strategies, and a continual need for the organization to keep moving forward with new service delivery initiatives. In turn, the high level of employee motivation has fed directly into the kinds of creativity and innovation displayed by individual staff as they attempt to make needed initiatives succeed quickly.

### **The Upstate New York Veterans Healthcare Network in Changing Circumstances**

Throughout their existence, all organizations grapple with the question of what makes them successful. This question was the main reason for examining the Upstate NY VHA Network and its BHSL. Government organizations are often presumed to be condemned by their size, political nature, and bureaucratic personality to be forever resistant to change, and not adept at managing the change they are forced to undergo. They are

thought to exist in relatively static environments in which there are few deviations from the status quo. Their decision making is seen by many as equally slow moving, uneventful, and predictable—not necessarily a negative view given the public service component of their missions. Government organizations are also perceived as lacking innovative and risk-taking abilities. Rather, their hallmarks are dependability and stability.<sup>11</sup> This stereotype persists despite attempts in the 1990s to cast government organizations as capable of “reinventing themselves,” that is, becoming more responsive and entrepreneurial.<sup>12</sup> Healthcare organizations are faced with similar perceptions.

The people who work within healthcare organizations are often branded with the same dysfunctional labels. The stereotypical portrait of healthcare employees—ones who “punch the clock” each day and go about their work in a rigid and sedate manner, emphasizing rules and protocol above creativity and experimentation, preferring safety to risk-taking in their work—continues to this day.<sup>13</sup> Seen through this lens, healthcare organizations are not where the most proactive employees are found. Even if these personnel could exhibit such qualities, the story goes, they would not be able to for long because the system in which they operate ultimately imposes its will upon them. In short, the bureaucratic nature of organizations subsumes individuals, making the personal need to change, as well as the need for individually directed action, anathema to the accepted norms and values of the organization itself.<sup>14</sup>

**Table 2: Clinical Performance Gains for the Upstate NY Veterans Healthcare Network's Behavioral Health Service Line (FY 2001)**

Performance measure	Upstate NY VHA Network performance	Met or exceeded VHA goal, national rate, and/or benchmark?
Percent of appropriate patients who receive a 30-day follow-up after hospitalization for mental illness	97.9%	Yes*
Percent of total patients seen in primary care settings who are screened for depression	89.1%	Yes*
Percent of patients who receive follow-up for a positive depression screen	77.9%	Yes
Percent of patients receiving an antipsychotic medication for at least the past 12 months who have been assessed for abnormal involuntary movement	92.0%	Yes*
Percent of patients seen in a substance abuse treatment program that have an initial Addiction Severity Index (ASI) assessment and a six-month follow-up ASI	79% (ASI baseline)	Yes
	35% (ASI follow-up)	Yes
Percent of veterans from a designated homeless program who at discharge have a secure living arrangement in the community	71.3%	Yes

**Table 3: Enhanced Patient and Employee Satisfaction/Quality Outcomes for the Upstate NY Veterans Healthcare Network (FY 2001)**

Performance measure	Upstate NY VHA Network performance	Met or exceeded VHA goal, national rate, and/or benchmark?
Number of patients per employee, 1996-2001	74.6% increase	Best of 22 networks
Overall inpatient satisfaction, 2001	92.4% rating good to excellent	Exceeds U.S. health organization rate of 75%
Overall outpatient satisfaction, 2001	93.2% rating good to excellent	Best of 22 networks
Problems related to staff courtesies, 1996-2001	67% decrease	Best of 22 networks
Combined veteran satisfaction/quality of care composite measure, 2001	21.2% rate of improvement over 2000	Best of 22 networks
Staff perceptions of quality of care, 2001	3.82/5.00 average score	Best of 22 networks
Annual percentage of lost patients, 2001	13.8%	23% average disenrollment from NCQA plans
Employee turnover rate, 2001	9.5%	20.4% U.S. health care organization rate

However, there is enough evidence to see that healthcare organizations do evolve over time, and they do it in ways that involve innovation spurred by the entrepreneurial activities of the employee workforce. They evolve precisely for the same reasons many organizations have to change, i.e., because technical, political, and cultural problems around the production process arise through the ebb and flow of normal everyday activity.<sup>15</sup> These problems must be addressed, lest they render the organization unable to meet its service obligations adequately.<sup>16</sup> Often, the environment within which healthcare organizations operate changes slowly, and there may be less need for hospitals to act quickly or to innovate, less need to rely upon employees to move change forward. In that sense, maintaining the status quo with respect to work processes and developing reliable workers guided by rules and procedures are key management tasks in attempting to address the problems described above. Radical organizational change or solutions are not needed. The problems can be compartmentalized and addressed through existing structural and cultural means. However, what happens when there are changing expectations for a healthcare organization coupled with events that become so unpredictable the organization faces complete failure if it does not take major risks to quickly and radically transform itself? What happens when the environment refuses to accept how the organization conducts business? In these situations, what must happen to the stereotype of the employee or healthcare organization we have crafted over time?

This is the situation the Upstate NY VHA Network faced during the late 1990s. New, untested, and spearheaded by a relatively inexperienced management team, the service line structure had to depend on individual staff, especially professional service providers, to achieve in a short period of time what environmental stakeholders such as Congress demanded. There was no other choice. *A key point of the three case studies is that organizational innovation during times of transformation depends upon individual employee entrepreneurship.* This point departs from some prior discussions of individual entrepreneurship, discussions that may understate the situational nature of when and where such entrepreneurship is most useful and welcomed in healthcare organizations, and where it may be less helpful and appreciated.

At the end of this report are lessons that particularly leaders and managers of new or transforming healthcare organizations should heed. These lessons speak to the need to approach management and program implementation within such organizations in a way that emphasizes informality, learning from failure, cultural unity with respect to defining and executing a mission, individual creativity, budgeting flexibility, an emphasis on human resource development, line discretion and autonomy in making things work, and customer-defined products and services.

### **Acknowledgments**

---

*Research upon which this report is based was originally funded through the Management Decision and Research Center and Department of Veterans Affairs. Special thanks to Doctors Martin Charns and Scott Murray of the Department of Veterans Affairs.*

## Frontline Entrepreneurship in Healthcare Organizations: Case Studies

We now turn to three case studies—with clear lessons in how healthcare leaders can maximize the creative talents of their frontline employees in achieving success, especially during times of structural transformation. This section discusses three strategic initiatives that the Upstate NY VHA Network has implemented successfully. The term success is defined as an ability to get desired things up and running, sometimes imperfectly, but in a way that lays the groundwork for future growth and development. These case studies do not depict flawless programs. Rather, they illuminate how individuals working in these programs helped achieve initial success for initiatives needed by the programs.

For the Upstate NY VHA Network's BHSL, these programs include the integration of behavioral health services into the network's medical centers and community-based outpatient clinics (CBOC), the development of a new, self-sustaining training opportunity for veterans recovering from substance abuse and mental health problems, and the reinvention of a service program designed to help integrate homeless veterans back into society.

### Case Study One

#### **Making a New Line of Business Succeed: Integrating Mental Health into Community-Based Outpatient Clinics (CBOCs)**

Our first case study of the power of frontline individuals within an organization comes from the Upstate NY VHA Network's Outpatient Mental Health Program. It offers an understanding of how individual entrepreneurship can be used in *getting organizations to create new products that help them add customers, become more accessible to existing customers, and increase efficiency* (see box next page). The new product in question involves the introduction of behavioral health care into existing VHA CBOCs. Frontline managers and professional line staff in the network's mental health outpatient program exhibited entrepreneurship for the CBOC behavioral health integration effort in three areas, all integral to service expansion success:

- Developing relationships with primary care providers and patients in the CBOCs
- Managing key external stakeholders, such as community-based organizations that provide additional mental health services for veterans
- Daily program operations

As the expansion unfolded, no formal guidelines existed that described the process by which mental health providers would interact with primary care providers in the CBOCs to identify, refer, and treat veteran patients with possible mental health diagnoses. Adding to this was the fact that often the primary care physicians in the CBOCs had little knowledge concerning their own roles in relation to the expansion. Many CBOCs employed physicians who did not work directly for the VHA, but the network had contracted with them to provide services. The motivation of these contracted physicians to establish relationships with VHA mental health providers was perhaps less compared to physicians employed directly by the VHA.

Given these realities, mental health professionals in the CBOCs resorted to a variety of tactics aimed at establishing informal working relationships with primary care physicians. These informal relationships could lay the foundation for developing formal policies articulating desired mental health/primary care relationships, while in the meantime helping to get needed mental health care services to CBOC patients. These tactics involved keeping physicians constantly aware of behavioral health activity in the CBOCs through passive means, providing physicians with opportunities to see the value of a behavioral health presence in the CBOC, and creating as little extra work for physicians as possible around the identification and referral of patients with mental health diagnoses. These tactics were used in part to negate the perception among CBOC physicians that the expansion effort interfered with their own attempts to provide medical care to a growing number of veteran patients coming into the CBOCs. They were also meant to create goodwill between the two groups of professionals.

## **Behavioral Health Care and the Community-Based Outpatient Clinics of the VHA**

In the late 1990s, VHA networks nationally had begun to set up CBOCs across their service areas in order to provide primary care to a wider group of eligible veteran patients. These outpatient clinics enhanced access to care, increased the VHA's market penetration into underserved and hard to reach geographic areas, and provided more cost-effective care to veterans by emphasizing preventive services within a setting that had lower overhead costs than the traditional VA medical center sites. The CBOCs were part of a larger VHA strategy to bring services to veterans rather than forcing them to travel longer distances to access medical-center-based care. By 2001, the Upstate NY VHA Network had 29 CBOCs across a service area encompassing 44,000 square miles and an estimated 515,000<sup>17</sup> veterans.

Hugely successful, the CBOCs have played an important role in helping the Upstate NY VHA Network grow in spite of a decreasing number of eligible veteran patients in its service area. However, as of 1999, the CBOCs had yet to incorporate any mental health services into their spectrum of care. This was largely the result of a funding mechanism for the network that provided incentives for CBOC expansion but only in the area of physical medicine. Thus, the majority of the initial CBOCs were staffed exclusively with clinical personnel from the network's medical care line.<sup>18</sup>

Leaders in the network realized the need for behavioral health care services in the CBOCs. They knew of research suggesting that 70 percent of patient visits for primary care services have a psychosocial component, and that 20 percent of the primary care population in general has a diagnosable psychiatric problem. Within the VHA, survey data revealed a 40 percent incidence of depression, post-traumatic stress disorder, or an alcohol-related disorder in the primary care setting. From an efficiency standpoint, the proposed integration of mental health services into the CBOCs also made sense. Fifty percent of the highest utilizers of health care services have mental or addictive disorders, and the top 10 percent of these high utilizers consume 33 percent of ambulatory care services and 50 percent of hospital services.<sup>19</sup>

These convincing data, combined with a new funding mechanism (Veteran Equitable Resource Allocation, or VERA) within the VHA that moved dollars to follow the number of patients, made it imperative for the BHSL to take advantage of the CBOCs as an access point for patients needing mental health services. Thus, the Upstate NY Network and the BHSL decided to move ahead in creating a new product line, a full range of outpatient behavioral health services in the CBOCs. Professionals such as psychologists, psychiatrists, and social workers already working in the medical-center-based Outpatient Mental Health Program in the network would provide care at the CBOCs.

Several barriers stood in the way of this product expansion. These included the lack of new or dedicated funding, the lack of overt support on the part of some CBOCs (some of which were not VHA owned), uncertainty about how much new patient growth could be expected from the expansion, and, perhaps most important, the absence of a formal implementation plan to guide expansion because of the speed with which it would have to occur and a lack of experiential knowledge about what would work.

Facing such barriers, it made sense for VHA leadership to turn to frontline managers and professional staff within the medical-center-based outpatient mental health programs to help make this initiative succeed. When uncertainty about implementing organizational strategy is high, and when the organizational environment is changing rapidly, nonsupportive, and unpredictable, greater decision-making discretion must be given to those in the trenches who are closest to the production process.<sup>20</sup> Providing this discretion creates tactical flexibility within an organization, allowing it to revise the everyday implementation of strategy ad hoc in response to immediate feedback from the environment.<sup>21</sup> It moves key operating decisions to the frontlines, closest to where they are implemented. This concept is akin to the notion of the combat unit that receives a set of mission objectives for an assault, yet must rely on the emergent creativity and resourcefulness of its individual soldiers to make things work successfully as the battle unfolds.

For example, behavioral health professionals described the ways in which they kept physicians apprised of referred patients through such means as quick feedback sessions in the hallways while a physician was between patients (i.e., “running them down” as one mental health provider put it), and brief e-mails that conveyed summaries of longer clinical progress notes in patients’ charts. In this way, physicians did not require access to a patient’s medical record to receive an update on a referred patient’s diagnosis and treatment. They could feel confident that the mental health professional would come to them with this information in the near future. In the opinions of mental health providers, this proactive communication approach created a positive perception of their work on the part of the physician.

Transmitting information rapidly and informally from mental health to primary care providers also enabled the latter group to see the clinical value of having a behavioral health presence in the CBOC. Patients with physical symptoms for which physicians might suspect an underlying mental health problem, such as depression, could receive real-time assessments and treatments. Mental health providers spoke during interviews of creating work schedules that contained adequate room for seeing potential cases immediately in response to a physician’s request. They believed it important to convey to physicians a sense that such services could be accessed quickly. And by receiving the results of the assessments with equal rapidity, physicians could feel they were providing a more comprehensive level of care for their veteran patients. Finally, mental health providers employed a philosophy of giving primary care physicians “success stories,” either verbally or in writing, that outlined the link between treatment of a particular patient for mental health problems and the potential for fewer emergency visits to the primary care provider down the road. This tactic was used to help convince the physician that addressing the mental health issues of a patient almost always led to an improvement in the medical side of the equation.

Individual entrepreneurship was also seen when both management and professional staff had to establish positive relations with external stakeholders in the veteran’s community to get additional buy-in for the CBOC expansion and provide for a fuller range of convenient services locally. Behavioral health providers discussed the proactive manner in which they attempted to create relationships with community-based groups and agencies in a particular CBOC service area that were vital to providing additional services to veterans with mental health problems. Among others, these organizations included non-VHA mental health clinics, as well as day treatment and self-help programs.

Professionals working in the CBOCs would identify, often on their own, the available service organizations in the surrounding area, then contact them to set up a meeting where they could introduce themselves, their role in the CBOCs, and how the community organization could help them better serve the veteran client. By doing this at the beginning of their tenure in the CBOC, providers could cultivate early relationships with needed services, demonstrating to the very first veteran patients served that the VHA was serious about making mental health services more accessible to them. In this way, a mental health “safety net” was created in the veteran’s own community that heightened the prospects for comprehensive mental health care. It was a safety net that initially relied not on formal relationships with the VHA but on personal relationships formed between community-based agency leaders and provider staff in the CBOCs. Facilitating this effort were program managers in the various outpatient mental health programs. These managers often assigned social workers as the primary human resource working in the CBOC. The professional training of social workers resulted in an ideal blend of process-oriented skills that could maximize connecting with the community.

## **Comments by Frontline Entrepreneurs Who Integrated Mental Health Services into the CBOCs Enhancing Customer Relations**

I try to find ways to give providers a couple of successes. Things they can look at and see where they might be getting fewer emergency visits down the road. (Outpatient Mental Health Program Professional Staff)\*

I don't have formal meetings with the providers right now. I might send providers a quick note saying, "I talked with so-and-so." Give a really brief description of what happened. I usually either e-mail them or stop them in the hallway between patients. Maybe poke my head into their exam room. (Outpatient Mental Health Program Professional Staff)

When you start developing larger patient panels, you run into individuals with chronic mental health conditions. And they need sustained care. So I try always to work them regularly into my schedule, no matter how busy I am. (Outpatient Mental Health Program Professional Staff)

You do what you can to attract patients to you for the [mental health] care they need. I will talk with the primary care docs about certain patients, get referrals from them, but I will take individuals and see them right on the spot if the provider wants me to take a look. I will grab them after their medical visit, bring them into any available room I can find, and try to get a sense clinically what might be wrong and how serious it is. Then I can schedule a follow-up depending on my initial assessment. (Outpatient Mental Health Program Professional Staff)

### **Managing Key External Stakeholders**

I've had to learn about the services in the area, the other community agencies that I can refer a patient to. Because the patients might not want to go to the medical center because it is too far away, or they'll have to wait too long to see me again. (Outpatient Mental Health Professional Line Staff)

I have spent a lot of time going to the different agencies and organizations in town around the CBOC, talking with the community-based mental health clinics, various day programs. It has really helped to do some of this initial legwork so now there is more of a relationship developed with them. When I need their services, we can make the referrals more easily. (Outpatient Mental Health Professional Line Staff)

### **Improving Everyday Program Operations**

It was kind of a new business for us [behavioral health in the CBOCs]. We were not sure of the numbers, we had to muddle through and look at veteran penetration in the area, look at the mental health needs of veterans in a particular area. What I decided to do is approach things a little differently, and gradually introduce our staff here in the clinic to one, two, and three days a week working in the CBOCs. So everyone started with one day a week to assess, work with the CBOC staff, see the population's needs, estimate the number of referrals, etc. (Outpatient Mental Health Program Manager)

I went around initially to all the CBOCs and spoke with staff there about behavioral health. How we could utilize each other. I gave an introduction to our services as well. Rather than diving in, I went about getting us in more slowly [to the CBOCs]. It was a way we as a program could educate ourselves about how to proceed and what we needed. (Outpatient Mental Health Program Manager)

We had to figure out ways of doing it. So I sat down with all the primary care providers and told them what we might be able to do. Help out with things like stress management, things like that. We needed to convince them of where we could help them. (Outpatient Mental Health Program Manager)

\* Outpatient Mental Health Professional Line Staff consisted of psychologists, social workers, and psychiatrists.

Frontline managers also contributed to effective internal stakeholder management by creating face-to-face dialogues in which they could discuss with physician leaders of the CBOCs the various challenges and opportunities related to placing behavioral health providers into the CBOCs. These opportunities, seized upon prior to program expansion and supported by the service line's top management team, were used to garner initial support for the expansion among the medical services line of the Upstate NY VHA Network. Managers knew the importance of input from the medical leaders of the network with respect to how to think about mental health service expansion. Thus, some of them decided to use this face-to-face approach to provide information to physician leaders, explaining the rationale behind the program expansion and what could be done to help CBOC physicians participate more fully in it. One frontline manager emphasized the foundation of interpersonal trust that began to develop from such meetings. In this way, individuals from different clinical backgrounds and parts of the network could disagree about the merits or challenges of such an expansion, yet feel fully informed and included in decision making.

In everyday program operations, both staff and management in the outpatient mental health programs across the network exhibited effective entrepreneurship. From the beginning of the expansion, staffing the CBOCs with mental health providers had been problematic because of its zero-sum nature (i.e., resources taken from medical-center-based outpatient programs to staff the CBOCs could not be replaced in the short term). In addition, the organization had no experience on which to accurately assess patient demand in the CBOCs. This left one frontline manager using three approaches to ensure that CBOCs were staffed adequately at all times:

- Involving professional line staff up front in staffing decisions
- Using an incremental, retrospective-based strategy to determine adequate staffing levels
- Frequent and open communication with professional line staff to maintain buy-in and gain reliable information from their work experiences to adjust staffing levels as needed

For example, on starting the initiative in his geographic service area, one program manager called together existing mental health program staff, made them aware of the need to get behavioral health services in the CBOCs, then asked for their ideas on how to make it happen with existing resources. This early commencement of a staff buy-in process helped make them feel personally accountable for the implementation decisions. Staff were asked to volunteer rather than be assigned to work in the CBOCs. They also were asked for their opinions on barriers that would be faced and how to overcome them, given their everyday knowledge of the work they already did within the medical center. As their suggestions were taken up, they would become more wedded to making the initiative a success, mainly because it was their suggestions that were on the line.

This same program manager initially provided only a small amount of staffing at each CBOC, using the experience of a single individual working there to gauge how much patient demand might increase as more staff were added. For instance, one person might be assigned to go to a particular CBOC for one day each week. That person—aware of the general goals of the initiative, such as to increase the number of veterans screened for mental health diagnoses in the CBOC—would be encouraged to report every few weeks to the manager and mental health provider staff about the challenges and opportunities encountered. As the individual's patient panel grew, the program manager could track that information and compare it to other CBOCs also being staffed by mental health providers. Based on this feedback, projections around "normal" or "adequate" staffing levels could be made. These projections, when combined with the staff's own opinions about their workload in a particular CBOC, would form the basis for revising staffing formulas in a CBOC. Being grounded in real-world experience allowed the program manager to make real-time decisions that made sense to everyone. It also formed the basis for educating service line leaders on both the resource limits and requirements of this strategic imperative.

At the line level, professional staff working in the CBOCs discussed the ad hoc ways in which they created an infrastructure for their behavioral health activities. For example, in many CBOCs no space had been allocated for behavioral health care. Thus, mental health providers often created their own working space, perhaps converting large storage areas into offices and exam rooms, or sharing exam rooms with physicians by staggering appointments in the course of a day. In addition, nursing and other staff were already involved full-time with helping physicians provide medical care at the CBOCs. As a result, behavioral health providers needed to perform a wide assortment of work-related activities themselves, such as updating charts with progress notes, following through prescription orders, and entering data into the VHA's computerized medical record. Aiding program operations in this way made the expansion continue within the CBOCs.

The early returns on the expansion of behavioral health into the VHA's community-based outpatient clinics demonstrate the effectiveness of the entrepreneurial activities described above. Mental health visits to the CBOCs have increased each year since the initiative began, and an increasing number of CBOCs now have full-time mental health provider staff to meet this rising demand. Where part-time behavioral health staff are being used in CBOCs, many providers reported increasingly filled schedules. As one behavioral health provider working in the CBOCs put it, "If you get a responsible bunch of caring folks, things will work despite the lack of structure."

## **Case Study Two**

### **Raising the Bar on Performance while Maintaining a Customer Focus: The Homeless Outreach Program**

Our second case study comes from the Upstate NY VHA Network's Homeless Outreach Program. It offers an understanding of how individual entrepreneurship can be used to raise performance standards within a service program while at the same time keeping a customer-driven focus. Perhaps no service program in this network has undergone more structural and cultural change over the past several

years as the Homeless Outreach Program, with its ambitious mission of ending homelessness among veterans through outreach efforts and community partnerships.<sup>22</sup> Program leaders and staff have had to face the reality that they are accountable for their performance as now judged, both more narrowly and quantitatively, by the percentage of homeless veterans who achieve "permanent housing" and "permanent employment" when discharged from the program (see "Meeting the Needs of Customers in the Homeless Outreach Program of the VHA").

When first introduced by the VHA, this emphasis on specific, measurable outcomes was foreign to the program. It differed from the more numerous, process-oriented performance indicators used to gauge activities, indicators that often reflected a short-term focus on the range and number of services provided to the homeless veteran. Yet, there is clear evidence that individual entrepreneurship on the part of outreach staff has enabled the program to become high performing in these narrowly defined areas without sacrificing the wide-ranging needs of the individual homeless veteran. This entrepreneurship has taken three forms:

- Marketing and promoting services to homeless veterans and other key external stakeholders
- Adopting a customer-driven approach to outreach
- Connecting the homeless veteran with needed services in a timely manner

In marketing and promoting services to homeless veterans, program outreach staff has developed new means of accessing potential clients. Realizing that most homeless veterans suffer from substance abuse and mental health problems, coupled sometimes with distrust of government organizations and the VA, outreach workers have formulated their own strategies to actively recruit clients rather than waiting for clients to come to them. This has meant regularly going to homeless shelters, soup kitchens, and city missions, sometimes at night, to promote the services of the VHA to eligible individuals who are in these places simply to get something to eat, stay warm, or catch a few hours of sleep in a safe setting.

## Meeting the Needs of Customers in the Homeless Outreach Program of the VHA

The VHA's Homeless Outreach Program has an ambitious goal: to end homelessness among the veteran population in the United States. It strives to do this through direct outreach efforts and community partnerships, and through services that include residential programs and transitional housing placement, medical care, alcohol and substance abuse treatment, mental health treatment, case management, veterans' benefits counseling, vocational rehabilitation assessment, and links with job training and employment opportunities. The program aims not only to reintroduce homeless veterans to society, but also to make them a viable part of it once again. The program's formal performance goals involve increasing the number of new veterans who can access the VHA system for needed care, increasing the percentage of homeless veterans who find viable employment, and increasing the percentage of homeless veterans who end up in permanent housing.

The program works as follows. Outreach workers, many of whom are trained social workers, actively seek homeless veterans on the streets and where one might expect to find them in the community, such as shelters and soup kitchens. Once identified, homeless veterans must be convinced that the VA, for some a negative symbol of what has happened to them in their lives, wants to help them become more viable citizens. It is the outreach worker who plays the pivotal role in making this happen. These workers begin the process by verifying a veteran's eligibility, performing an initial clinical assessment to determine the type of care needed, and assessing the individual's potential to become employable and independently housed—while attempting to meet the multitude of other needs presented by the homeless veteran at that moment. Key to homeless veterans' willingness to be helped is trust, their level of confidence in the outreach worker's ability and commitment to serving them.

Within the scope of having to achieve more precise performance measures, the Upstate NY VHA Network's Homeless Outreach Program has become a national leader in the VHA system. In fiscal year 2001, it led the country in the percentage of homeless veterans served who achieved independent housing (71.3)<sup>23</sup> and in the percentage of homeless veterans served who were contacted for follow-up within 30 days of discharge from the program (92.7). The program has also found itself near the top of 22 programs nationally in the percentage of homeless veterans served who are employed upon discharge from the program (64.2). For a program described by some as previously lacking long-term deliverables for the veteran patient, these improvements are noteworthy. That they are vastly superior to national averages for the VHA indicates that the program is committed to exceeding and not simply meeting the standards.

Stronger relationships, rooted in the individual outreach worker rather than the larger program, have been established with such nongovernmental service organizations as privately run homeless shelters. Outreach workers have also established their own tailored recruitment strategies within each of these settings. For example, one outreach worker discussed going into soup kitchens and shelters with the intent of demonstrating the willingness of the program to help in any way needed by a veteran, e.g., providing food coupons, a warm jacket, or money for transportation. These efforts are part of an implicit marketing strategy designed to show eligible clients in the shelter or soup kitchen—ones

the outreach worker has no way of identifying initially—that the VHA aims to help rather than “hassle” them. The hope is that such actions compel eligible individuals to come forward and engage the outreach worker for assistance.

Placing outreach programs in low-income areas with their higher concentrations of homeless veterans is another novel idea developed and implemented by program staff. The traditional approach is to house programs in the larger medical centers, which may be some distance away from these areas. For instance, in the Western region of the Upstate NY VHA Network, the homeless outreach program can

be found in the midst of one of the poorest, most blighted sections of the city of Buffalo, sharing space with other non-VHA social service programs for the homeless and unemployed. In closer proximity to organizations that do similar work, such as the Salvation Army, the outreach staff can build informal relationships with them and benefit from their more timely identification of homeless veterans in need of services.

Finally, outreach staff have utilized innovative recruitment strategies such as “stand-downs,” in which they advertise a day in the community when homeless veterans can come to a defined location to get a hot meal, pick up some needed clothes, and (if they so desire) listen to the kinds of services offered by the VHA. Stand-downs are low-pressure events in that they force the homeless veteran to do little but show up and receive only the services he or she wants. For staff, however, they serve as a way to gauge the concentration of homeless veterans in a given geographic area. They also help staff gauge the veterans’ willingness to seek assistance. Through these employee-driven ways of marketing VHA homeless services, the program has increased its potential to bring more individuals into the VHA system. Because increasing the number of new patients is also a formal performance goal of the program, these grass-roots innovations help meet the required strategic imperatives of the organization as a whole.

Individual entrepreneurship is also seen in how outreach workers balance the formal performance expectations of the organization with a customer-driven approach to providing services. Outreach workers know full well that many homeless veterans simply have too many disabilities to ever become employable or live independently. Other veterans are not technically homeless, in that they may sporadically live with a relative or friend, yet they have problems or concerns that VHA intervention could alleviate. Some veterans do not want to be pushed toward employment or housing, but they have everyday needs that must be met to maximize the quality of their lives on the street. If outreach workers were

focused only on serving those individuals who were employable and capable of independent living (the two main performance measures for the program), these groups would undoubtedly be left unserved. However, by maintaining a broad definition of the homeless “customer,” outreach workers enact their everyday jobs in more than just the narrowly defined ways implied by the larger performance measures.

Thus, when connecting with veterans on the street, many outreach workers employ a strategy of “listening to the veteran.” This strategy aims for a balance between formal and informal clinical assessment processes. Outreach workers are required to assess eligible veterans’ ability, once their health-related problems have been addressed, to attain self-employment and independent living. In addition to this formal assessment, outreach workers employ their own customized assessments in which veterans are allowed to verbalize to the worker what they desire in the way of services. In this way, the organization does not impose its notion of service uniformly on every homeless veteran, but rather veterans express themselves as unique individuals with specific needs. By listening to homeless veterans define “need,” outreach staff can provide some type of service to each and every veteran.

For example, one outreach worker discussed his extended conversation with a homeless veteran who had been living temporarily with his daughter. This veteran’s urgent needs were to get his medical bills paid and his medication covered by insurance, not to get employment or permanent housing. The outreach worker took the time to get him enrolled in the VHA system and get his bills to the right places in the system to be paid. The end result would never show up in the raised performance bar for the Homeless Outreach Program, nor would the program get credit for it from the larger organization. However, this was a major outcome for the individual veteran who, according to the outreach worker, was elated by what he had done for him:

## **Comments by Frontline Entrepreneurs Who Reinvented the Homeless Outreach Program Services to Homeless Veterans and External Stakeholders**

We put our office here so we could be close to where the homeless vets are. We get more credibility that way. Like we are coming to them rather than them having to come to us. It lets us be close to the places where we do the best outreach. (Homeless Outreach Program Manager)

We do outreach by hitting all the spots we can here. The soup kitchens, the city missions. We go out at night sometimes to reach the vets, you know, when they are grabbing a hot meal or some sleep in a safe place. (Homeless Outreach Worker)

I always try to learn from the vet. What their needs are. It's rewarding because I'm learning and I'm getting a perspective I don't know much about. You can assess someone, but until he tells you what's going on, you don't really know. (Homeless Outreach Worker)

### **Adopting a Customer-Driven Approach to Outreach**

We have all these expectations on us, but when I make contact with a vet, I always have to have his interests at heart. It's not what I want. It's what he wants. Regardless of what I might see or recommend, I won't impose my own will on the vet. I strive to make clear that I'm here to help him, not tell him what to do. (Homeless Outreach Worker)

Sometimes it's unrealistic what they're [top management and the larger VA] expecting. Because you're dealing with people [homeless veterans] who need something tangible, who need quick fixes. So, you've gotta give them something. That's a strain on us, but we figure out how to do it. (Homeless Outreach Worker)

A lot of the vets aren't going to be employable because of the problems they have. They need a different level of service, one that may not result in high performance as we define it. But it does result in appropriate care for the vet, and that's why it's important to assess the vet's expectations not in light of the performance measures, but in terms of what he needs given his situation. (Homeless Outreach Program Manager)

A lot of homeless vets want services, but they don't want to be dictated to, they don't want to be given demands around having to end up with housing or a job. They don't want the pressure. But that doesn't mean we shouldn't help them. It just means we have to give them some things in the way they need to receive them. (Homeless Outreach Worker)

You never know what is ultimately going to work in this process [coming up with a course of action for a homeless veteran]. It could be that the plan the vet suggests to you works out and not the plans you had in mind. You can't say "I'm right all the time." I have seen it work both ways. When what I have said works, and when what the vet has said works. I have to stay open-minded to everything. Even if it doesn't work out, if I can see some kind of measured progress, sometimes that is good enough. (Homeless Outreach Worker)

### **Connecting Homeless Veterans with Needed Services**

The homeless program is supposed to be for all vets. And yet we don't get credit for the nonservice-connected ones. But we try and set some kind of plan in motion for everyone who walks through our door. We try and hook people up with other services, get them to connect with local community agencies that can help them. (Homeless Program Manager)

I have had to develop a rapport with the people over in eligibility. If I know I need to get a 1010EZ [the means test form used to gain eligibility for the veteran] into the system fast, you know because the vet is going to be getting services in another program that I've referred him to, I might go over there [to the medical center] and ask someone in eligibility personally if they could do it. Or I might call. And I would go about it in a nice way. Because bottom line is that vet can't get services and I can't get my notes into the system until that vet is deemed eligible. So it's key I keep that connection with someone over there [in eligibility]. (Homeless Outreach Worker)

Everyone gets a plan, no matter if they fall into the formal performance measures or not, and you develop these plans by understanding each veteran's mentality that you come into contact with, by spending some time with [individuals], seeing the world through their eyes and what they want. To me, this approach allows me to never lose sight of the fact that these are all people, all individuals. That's something you won't read about in a manual or procedure, it's something you won't get credit for necessarily, but it's something we as outreach have to understand and remember at all times. And I never forget to do my job that way, even if it takes more time and is more of a hassle for me.<sup>24</sup>

A third and final example showing how individual entrepreneurship improved service delivery in the Homeless Outreach Program derives from the perceived need felt by outreach workers to connect the homeless veteran to needed services in a timely manner. This is a population with high rates of mental illness and substance abuse who suffer from multiple medical problems such as diabetes, heart disease, and other chronic diseases. Once an outreach worker performs an assessment on a homeless veteran, there is self-applied pressure to get that veteran to access care quickly. In a large, bureaucratic organization like the VHA, this can be a challenge. Since the services needed fall outside of the Homeless Outreach Program's purview, the program cannot formally influence how quickly a client gets an appointment, a needed physical examination by a physician, or treatment. As one type of VHA patient, the homeless veteran competes with other veteran populations also needing access to similar services. Compounding the problem is the fact that homeless veterans may not be willing or able to keep appointments scheduled too far in the future owing to their transient nature, ongoing skepticism of the VHA system, and existing health problems.

Many outreach workers create ad hoc approaches that help connect the homeless veteran with timely care in other parts of the VHA system. Departing from formal procedures of filling out forms or making referrals on paper to another program for service, these approaches employ the informal

organization as the means of increasing access for customers. Getting to know key individuals within other programs (such as Medicine, Vocational Rehabilitation, and Substance Abuse Treatment), individuals who serve as the gatekeepers for appointments with clinicians, is one tactic outreach workers use to get their clients seen quickly. Once their names will be recognized, outreach workers often can contact these people directly and ask for a favor related to getting a needed service to a particular veteran.

Outreach workers stated that such an approach must be used diligently and not abused. However, they believe that it works in bypassing what often amount to administrative barriers to access, or "rules of the game," in which a patient translates into a properly completed form that must wait weeks or months to move through the system. Outreach workers mentioned specific times during which an informal approach to increasing access to care was employed:

- Getting homeless veterans enrolled and eligible for VHA benefits quickly
- Getting homeless veterans with substance abuse problems assessed and enrolled in treatment programs quickly
- Getting homeless veterans with worsening chronic conditions quicker access to a primary care physician who can begin to identify and coordinate the various forms of care they need

One outreach worker summed up the approach:

If you wait for the system to do everything, there will be times the vet falls through the cracks, doesn't get the care he needs when he needs it, which for some of these guys is right away. I'll go out of my way to get to know the person processing the eligibility forms, the person over in primary care who might be willing to get my client an appointment sooner, if I appeal to her and treat her like a person. I'll even take a ride over there [to the medical center] if I need to, if I am really concerned the vet won't wait long or won't follow up on stuff. You just have to be willing to do that in a bureaucratic system like this.<sup>25</sup>

## Moving Toward Customer-Driven Program Experiences in VHA Vocational Rehabilitation



The Compensated Work Therapy Program (CWT) within the Upstate NY VHA Network's BHSL is a component of the organization's overall vocational rehabilitation effort, designed to provide veterans the training and care they need to be reintegrated into society. Almost all the veterans in the program have substance abuse problems. The general idea behind compensated work therapy is to allow recently recovered veterans the opportunity to reacquaint themselves with the world of work. The hope is that that they will stand a better chance of gaining outside employment, considered a key element in their ability to stay recovered.

This innovative idea acknowledges that individuals recovering from addiction or mental health problems need practice before they can become fully integrated members of society once again. The CWT program provides practice with respect to employment. The program receives individuals referred by other VHA programs, such as Homeless Outreach and the network's Substance Abuse Program (thus helping to make those programs successful as well). By treating recovering veterans as resources capable of contributing meaningfully to the world of work, the CWT program aims to instill in its clients the courage, confidence, attitude, and skills they will need to maintain their progress on an everyday basis.

During 1997, due both to changes in funding and an increased awareness of veterans' needs to have higher-level job training, vocational rehabilitation programming took an entrepreneurial turn. At that time, the head of vocational rehabilitation, substance abuse, and homeless programs, Scott Murray (now the BHSL director), a middle manager brought in to work for the Upstate NY VHA Network from the private sector, developed the concept of a program for developing businesses in collaboration with community partners. This program, subsequently named Job Assistance Veterans Administration (JAVA), would help provide new funding for vocational rehabilitation as well as higher-level jobs that would better prepare veterans for success after treatment. The idea was to leverage the human resources of recovering veterans to build self-sustaining businesses that could help serve the community.

With the support of the Upstate NY VHA Network's top leadership, particularly then network director Fred Malphers, two primary components of JAVA were established: (a) a specialty coffee stand program and (b) a construction program. Both components were developed in conjunction with community partners, typically veterans groups. Both were piloted at one site in the Upstate NY VHA system to demonstrate initial success with an eye toward expansion. JAVA was successful during this pilot phase, solving several bureaucratic problems in the process that allowed it to grow unhindered. Subsequent efforts to expand to other community sites within the network initially raised discomfort among some administrators as well as frontline staff working within the CWT program. However, being able to show positive results during the pilot phase, along with the continued commitment of middle and top management in the network for such a program, line staff began to pursue their own innovative ways to make the program work.

CWT staff and program management saw that a number of participating veterans had skills beyond the traditional shop work that had always defined vocational rehabilitation within the program. Being forced to participate in repetitive work activities that took little advantage of their skills, such as packing boxes with premanufactured products for shipping to retail outlets, often demoralized these veterans.<sup>26</sup> For these individuals, who may have had higher-level jobs before encountering their substance abuse or mental health problems, existing retraining experiences did not prepare them adequately for taking advantage of their more sophisticated capabilities and talents. Thus, many of these veterans would participate for a day or two in compensated work therapy, then leave the program because of a perception that it could not help them gain viable employment in the outside world.

Here was a situation, by no means unique to the VHA system, in which the traditional service offered by government no longer could be conceptualized as a "one size fits all" product. To turn out more veterans capable of pursuing permanent employment appropriate to their prior skill levels, and perhaps to attract more veterans into the VHA system of care, CWT program staff realized they needed a more diverse conception of recovering veteran patients. Only when this was done could the program reassess its employment opportunities and tailor them more closely to particular types of recovering veterans.

These qualities among staff—willingness to act outside the routine of their formal job descriptions, ability to view homeless veterans as individuals with potentially unique needs, unwavering focus on achieving multiple ends for patients rather than strictly complying with formal organizational means, and use of the informal organization—have combined to make this program dependent on its service workforce to remain a national leader in the VHA system.

### **Case Study Three**

#### **Developing a Self-Sustaining, Customer-Tailored Government Program: The JAVA Program Initiative**

The third case study from the BHSL offers an example of how individual entrepreneurship can be used in *getting organizations to tailor services more closely to customers' needs, in addition to developing programs that offer the prospect for financial self-sufficiency*. It involves the Compensated Work Therapy (CWT) Program and its development of a unique job-training program for recovering veterans (see “Moving Toward Customer-Driven Program Experiences in VHA Vocational Rehabilitation”). This case study is one of management creativity and support, the use of public/private partnerships, and line staff effort to make things work by coming to think about the services they offer in a new light. It centers on the development and expansion of a veteran-run coffee stand within the Upstate NY VHA Network.

Staff proceeded to take several self-initiated steps to move the specialty coffee shop effort forward and integrate it into the overall CWT program, despite misgivings about whether or not such a novel effort could succeed over the long term. First, they used their own observations of how veterans performed in traditional CWT vocational rehabilitation programs to develop a new understanding of their clients. For example, rather than ignore the fact that some veterans were entering and leaving the program quickly, they focused on this phenomenon and searched for the underlying reasons explaining the exodus. Thus, by attempting to learn from the customers they were losing rather than just those they were keeping, they identified service gaps that could potentially be addressed with new initiatives.<sup>27</sup> Allowing line staff to identify and communicate to management

what could be classified as current CWT program “failures” was important to the establishment of a true learning atmosphere within the organization—or any organization.<sup>28</sup> However, this communication is often absent because line employees feel there is more to lose than to gain by reporting failures to organizational leaders.

As the coffee shop effort became a specific strategic aim promulgated by management, CWT frontline staff were allowed to improve it with their own innovations. The entrepreneurial output of their efforts resulted in a true integration of the effort, as well as the entire JAVA program (which also included a construction program in which recovering veterans would help refurbish houses in various communities), into the vocational rehabilitation program component of the Upstate NY VHA Network. Once up and running, the coffee shop venture was expected to become self-supporting, using sales revenue to pay the employed veterans and buy supplies. Any additional revenue earned would go toward other vocational programs in the network, such as a furniture-making program. In this way, the employment experience would also be one of observing how businesses grow and learn to support themselves.

The coffee shop component of JAVA represents a complete employment experience for the recovering veteran, involving how to set up, manage, and improve a business. The decision to make it a complete employment experience came from both management and CWT program staff. Thus, it represents a partnership between VHA leaders and line employees, with both groups having something at stake in the outcome. This is because it goes beyond any vocational-type experience ever developed by the network. The business is that of selling various types of coffees and teas to both employees and patients of the VA medical centers throughout Upstate New York, through a coffee cart, a shop-like arrangement. The recovering veterans act as retail business owners involved in all aspects of making the business viable, from tracking sales to ordering products to running everyday operations to bookkeeping. From the beginning of the enterprise, the CWT program staff intended to involve appropriate veterans in a retraining experience that exposed them to, in the words of one CWT professional,

“a little bit of everything they might encounter in a higher-level job.”

The specialty coffee shop effort has been so successful over the past several years that it has expanded from one to nine carts across the Upstate New York region, including three located in the communities served by the network. Each year, approximately 60 to 70 recovering veterans will pass through the program, gaining for themselves a well-rounded, two-to-five-month employment experience that prepares them for a variety of future jobs. From an investment of approximately \$16,000 in supplies and equipment to create a functioning cart, in addition to paying for two full-time work therapy positions to staff the cart, gross sales average between \$60,000 and \$70,000 per year. Once expenses are covered, leftover funds are reinvested into a special CWT program account used for additional vocational activities. Over the past few years, carts have been added to present locations in Syracuse, Buffalo, and Rochester. Coffee shops are now being opened in other public buildings where free space has been donated, for example, in the county courthouse building in Rochester, New York.

For the CWT program, enhanced capacity now exists to meet a range of job retraining needs for veterans. The CWT program has filled a meaningful gap in its services by asking itself the simple question of where it has failed to meet customers' expectations and needs. This question was asked solely because one middle manager encouraged a small group of frontline program staff to reexamine what they did on a daily basis and forge ahead with improvements. In this way, the entrepreneurialism we see in the CWT program is one of an evolving mindset rather than a set of preplanned, concerted actions. It is entrepreneurialism conceived of and driven by management, yet brought to fruition by line employees. Like the recovering veterans to whom they provide assistance, these employees find themselves meeting a more complete mission for their program.

## Lessons Learned on Unleashing the Power of Frontline Workers in Transforming Healthcare Organizations

In his examination of the overall VHA system transformation for the IBM Center for The Business of Government, Boston University's Gary Young states:

Clearly, a general lesson that emerges from the VHA transformation is that organizations and the people who work within them can change. The keys to successful change are more open to debate, as is the generalizability of the VHA's transformation.<sup>29</sup>

This story of frontline entrepreneurship within the BHSL of the Upstate NY VHA Network presents evidence that it has been people working in the service line who have enabled this organization to change effectively. Some of these people are managers. Many are professionals working directly with clients on an everyday basis. Particularly compelling is how a group of employees who were neither necessarily fully satisfied nor completely happy about events in their everyday work lives nonetheless accepted change and grew motivated to produce successes for the Upstate NY VHA. Throughout the study, many individuals in the programs described above expressed dissatisfaction with aspects of the changes occurring in their organizations. A fair number of frontline line staff felt somewhat alienated from the organization. Some resented what they perceived as the arbitrary and hasty decisions of top management.<sup>30</sup> Such feelings and reactions are typical of staff in organizations undergoing major change in a short time period.<sup>31</sup> However, what is striking about the Upstate NY VHA story is that while new faces have emerged within the service line's leadership and on the frontlines of their behavioral health programs, by and large the organization has transformed itself using the same employees it had before the transformation. The same people who express a mix of ambivalence and sometimes resentment toward the rapid way change has come to their once slowly evolving organization.

Given these observations, and the case studies presented here, the initial lessons to take away from this study are:

- You do not need fully satisfied or accepting employees in order to have entrepreneurial employees
- You do not need to start over with a new supply of human capital to transform your organization into a higher-performing one
- You do not have to make the goal of having highly satisfied employees, at least early on, the core focus in getting them to buy into and make change work

What is apparent, however, is that organizational leadership must believe that existing employees can for the most part become the kinds of innovators needed to navigate change. A cultural norm must be established, one understood by all that says everyone is capable of contributing to success—the satisfied and dissatisfied, the true believer, and the skeptic alike. A keen observer of organizations, Douglas McGregor, wrote decades ago:

The motivation, the potential for development, the capacity for assuming responsibility, the readiness to direct behavior toward organizational goals are all present in people. Management does not put them there.<sup>32</sup>

While McGregor's assertion rings true, it is also true that management has the responsibility of triggering this motivation, or tapping this potential for development, and of seizing upon the capacity within the workforce for assuming personal responsibility. *When an organization has transformed itself into a new type of entity to meet emerging marketplace demands, or when an organization is created to meet new service needs, management's most important tasks early in the process must be geared toward releasing the entrepreneurial potential within their frontline workforce.* The overall mission must get clearly defined. The expected outcomes should be known and measurable. But the lack of implementation history, continued uncertainty in the environment, and the need for rapid results make formal planning and micromanagement of frontline work processes anathema to organizational success. Bureaucracy through the guise of these two mechanisms works best in relatively stable, predictable environments. It works less well in fast-moving environments with little prior experience to fall back upon.

The Upstate NY VHA Network succeeded in the early phase of its service line approach because its leadership went against the traditional ideals of bureaucratic management and embraced the organization's workforce as the key resource to making things work. This may not have been the formal intention of network leaders initially. Clearly, though, the leaders and the organization as a whole have promoted certain ideals and actions that have had positive effects for the levels of individual employee creativity and action in the Upstate NY VHA Network. We can take away other core lessons from our three case studies that, when considered together, provide a blueprint for what can be identified as "managing to unleash the power of frontline entrepreneurship within transformed or new organizations."

## Recommendations

### Recommendation 1: Create a patient focus.

In the stories of the Homeless Outreach and CWT programs especially, we see evidence of the benefits associated with the organization's allowing professional line staff to listen to and interpret the needs of their customers or patients, even in the presence of strictly defined performance measures.<sup>33</sup> Significant parts of the entrepreneurial efforts associated with these programs derived from the discovered need to redirect efforts and fill service gaps that involved patients not fitting into neatly defined organizational categories or performance measures. For the Homeless Outreach Program, this involved employees reaching out to homeless veterans on their turf, giving them an opportunity to express their personal needs, and then personally trying to demonstrate that the organization could meet those needs. For the CWT program, it involved employees becoming more comfortable identifying failures of the program to serve customers, then communicating the failures to top management, who in turn provided an idea that helped to meet a more diverse array of customers' needs.

All three case studies about individual entrepreneurship share a common undercurrent in relation to patient focus, i.e., each of the three programs involved had professional staff who exhibited strong personal commitment to the veterans they served. This provides clear lessons for leaders of new or transforming organizations to consider. The first lesson is to recognize that this commitment exists.

The second lesson is to avoid undermining feelings of commitment within frontline staff. This sounds like common sense, but we may not always think of individuals who work for large healthcare organizations as "spiritually" connected to their customers. Yet, this type of bond between employee and client moves the former to take chances on seeing the latter in new, unique ways relative to needs, satisfaction, and service quality. The personal drive within employees to do right by their patients and see the world through their eyes also will lead to frontline staff who can identify and meet a variety of needs, not simply those formally outlined by the organization or program.<sup>34</sup>

These favorable outcomes are seen in the Homeless Outreach Program perhaps most vividly. Many of the outreach staff expressed the feeling that what they did for homeless veterans went beyond the scope of a "job" with its defined responsibilities. Most conveyed a sense of seeing homeless veterans as unique individuals with varying needs based on their particular situations. This led to approaches like "listening to the veteran," in which staff tailored clinical assessments to each veteran encountered. The organization did not mandate these types of assessments and would have had little knowledge that such tailored approaches were even needed. Rather, it was outreach professionals who took it upon themselves to modify the formal assessment approach advocated by the organization.

Although it may be difficult for management to instill such spiritual connections within employees, there is no doubt that care can be taken to make sure any existing connections are maintained. For the organization, an even bigger benefit may be that employees' negative feelings and cynicism about organizational change are mitigated by an enhanced sense that they (employees) are there to protect clients from the deleterious effects of this change on services. Strategically, then, management must make employees believe that their personal dedication to the customer will not be violated in any situation and, indeed, that it is seen as a valuable competitive advantage for the organization as a whole. In particular, new or transforming government organizations need to capitalize on employees' commitment to customers.

As stated previously, it is within the early developmental stages that the organization cannot clearly specify the “right” way to deliver services because it lacks the experience to know the right way. Without the reliability and homogenizing effect that formal procedure and policies have on standardizing service delivery across an organization’s programs, frontline employees become the wild card in making the service encounter either higher or lower in quality. To know that higher quality is being delivered, management should trust that frontline employees are as loyal to the client (or more so) as they are to the organization.

**Recommendation 2: Adopt a learning environment.**

What is the best way to develop formal policies and procedures for service delivery by new or transformed organizations? One answer is by developing an institutional history or database of successful implementation experiences to draw from in standardizing how work gets done within different programs. For the fledgling organization, this history or database derives from individual employees’ informal or ad hoc approaches to solving new problems, dealing with unforeseen issues, and creating opportunities for success where no track record exists. To the extent they are spearheaded by line staff, these approaches give a voice to those who carry out production within the organization—thus increasing the capacity of the lowest levels of staff to innovate and experiment.<sup>35</sup>

Thus, for example, professional staff integrating mental health services in the Upstate NY VHA Network’s community-based outpatient clinics helped increase the number of new patients and enhanced access for hard-to-reach veterans (both formal performance goals of the integration effort) by developing their own working relationships with CBOC primary care providers. Their successful informal approaches (such as giving physicians feedback on patients through e-mail messages and hallway consults) were suggested to program management and became part of the normal procedure around mental health service integration in the CBOCs. In addition, outpatient mental health program management could apply ad hoc staffing formulas to the integration effort, adding or subtracting staff as they received real-time information (from professional

staff) on workload and patients’ satisfaction, then use this experience to develop standardized staffing ratios for each CBOC in the service line.

**Recommendation 3: Increase frontline autonomy.**

Any organization benefits from giving its employees room to exercise discretion in their job duties.<sup>36</sup> This is because not everything can be planned or anticipated at the strategic or management level with respect to new services or initiatives. The high uncertainty associated with providing health care services to special populations makes the need for grass-roots discretion even more apparent. Certain service decisions must be made at the point of service or production. For example, while the strategic aims in moving behavioral health services into the CBOCs was to provide veterans with greater access to mental health services, management was less certain of the best ways to attain primary care provider buy-in, build patient panels in the CBOCs, and deliver the services themselves. The lack of organizational support for this initiative added to the dilemma because without resources, the program initiative would have to succeed initially using existing resources that were already stretched thin.

Yet, it was management’s decision not to develop formal implementation policies and procedures at the outset of this initiative that set the stage for entrepreneurialism on the part of mental health professionals in the CBOCs. The strategic aims of the initiative were made clear to all staff at the beginning. Management gave the outpatient mental health program clear direction on how specific performance measures would be used to evaluate success or failure of the expansion of services. How best to meet these aims on an everyday basis was left to those who would be on the frontlines and in the best position to view the initiative as it unfolded for the first time. Top management did not dictate to line staff how they were to conduct their business. As a result, mental health professionals could pursue informal ways of connecting with the primary care providers in the CBOCs once they determined that this was the best way to establish initial relationships with these providers. They could also develop solutions to emergent problems, such as those concerning space, allowing the scope and definition of the problem, along with an understanding of the particular

situation at hand, to guide them to a tailored decision that stood a higher chance of working, at least for the moment.

Similarly, Homeless Outreach workers were never told *not to listen* to their customers, or not to tailor services to those customers based on unique needs that may not have fit into the general performance measures of employment or housing. Outreach workers were also given the freedom to make key decisions, such as where their offices would be located, where they would go in the community to look for eligible veterans in need of services, and how they would market their services. Creating opportunities for empowerment among line staff, to the extent that those opportunities are focused squarely on improving organizational performance, should be a high priority for managers of new or transforming organizations.<sup>37</sup>

**Recommendation 4: Encourage grass-roots innovation.**

The Compensated Work Therapy Program in the Upstate NY VHA Network developed successful job retraining for its customers because management encouraged frontline staff to take a novel strategic initiative and connect it to existing program failures and service gaps. Professional staff in the Homeless Outreach Program, whether fully aware of it or not, had created an employee culture in which the norm was to identify gaps between formal performance expectations for homeless veterans and the realities of some homeless veterans who had unique personal needs but would never be able to meet the formal expectations of the program.

New or transforming healthcare organizations must encourage their line staff to identify the gaps between the organization's desired outcomes and current realities as areas to be defined clearly and exploited for spurring creativity and program innovation.<sup>38</sup> Employees need incentive to explore the potential for improvement in their everyday activities. This means socializing them to critique the processes of their daily work rather than simply aiming for the desired outcomes. For management, this means continually modifying desired performance outcomes so as not to stymie employees' aspirations to experiment with new methods in their work, and slowing down change demands sufficiently to allow staff to

reflect on their prior performance.<sup>39</sup> It also means rewarding employees who regularly identify areas for improvement and push these ideas up to the highest levels of the organization for consideration.

**Recommendation 5: Develop esprit de corps among frontline workers.**

In the three programs discussed (Homeless Outreach, Outpatient Mental Health, and Compensated Work Therapy), a high degree of camaraderie and agreement developed among line staff concerning the goals they were pursuing and the manner in which they were pursuing them. Healthcare organizations should work hard to make sure that those who do similar work have an opportunity to develop this esprit de corps. First, it acts as a self-regulating check on individuals' behavior, resulting in consistent program behavior and clearly defined norms of service implementation. Second, it maintains staff satisfaction in the face of ongoing unpleasant organizational realities, creating an "in the same boat" feeling within the group.

In all three programs, staff exhibited a high degree of personal commitment to serving veteran patients. This personal commitment helped create a program-specific solidarity that inspired them to feel they were the ones in the best position to make key implementation decisions, not management and not the larger organization. This resulted, in each of the programs, in high degrees of consistency in people's actions, even without the presence of formal policies or procedures.

Homeless Outreach staff believed they knew their customers best. They felt that if one of them believed something outside the formal performance expectations of permanent employment and housing should be done for a homeless veteran, then it was appropriate to do it. Thus, alterations in key work processes within the program occurred efficiently and in a timely manner. Buy-in among the group for grass-roots entrepreneurship was also easier to achieve in this culture of personal commitment. By the same token, mental health staff working to make the CBOC integration effort a success deferred to one another on the best approaches to building patient panels in their locations.

To develop esprit de corps, organizations may allow frontline workers to maintain a feeling of independence from management, communicate to line staff that they “know what’s best” about how to implement strategy, and keep individuals within a program working together for an extended period of time. Management must recruit carefully for key line positions, matching the enthusiasm and skills of an individual with the program that is the best creative outlet for those qualities. If recruitment is done with this in mind, most programs will end up with a staff contingent that has a high probability of gelling.<sup>40</sup>

These tactics may be anathema to some healthcare settings, ones where reorganization occurs frequently, micromanaging from the top levels is common, and rigid rules undermine the development of cohesive program work cultures. Program staff may frequently move within the organization, and there is less emphasis on establishing favorable group dynamics that reflect feelings of identification and solidarity. In these situations, where esprit de corps is not emphasized or possible, an “us versus them” mentality may develop among line workers toward management. However, it will be one that leads to disenfranchisement and breakdowns in productivity, not in the empowerment and productivity boost seen when the “us” truly believe they are being asked to help the organization succeed. An us-versus-them mentality in which management and professional line staff respect each other’s points of view, even if they disagree on key issues, can produce the creative tension between management and the line that leads to higher-quality products.

### **The Roles of Top Management and Structure in Frontline Innovation**

To further innovation through individual entrepreneurialism at the program level, managers in organizations must: (a) take primary responsibility for setting the strategic direction, yet (b) acknowledge that their distance from the actual production process means they know less about how to implement strategies than those closer to the process. Management should create, disseminate, and strategize around mission, vision, and overall organizational goals—but avoid thinking they know best how to make things work in the trenches. This is even truer for new or transforming healthcare organizations with few experiences on which to base

the implementation of new strategies and initiatives. Managers in such organizations face the temptation of assuming too much control, making too many of the decisions, and excessively imposing their own will in making the change process work.

At a highly strategic level, this is appropriate. Managers should clarify the issues for employees, define the direction for change, and instill the responsibility for results in their workforce as well as themselves. This is evident in the evolution of both the JAVA program and integration of behavioral health care into the CBOCs. What management should not do is think they know more about how to deliver a service than the service providers themselves. All three case studies presented here support the point that the core knowledge about the customer lay with line staff, and it is they who have the opportunity to “think on their feet” and act in response to approaches not meeting with success. Management of transforming or new healthcare organizations should embrace a form of benign “ignorance” concerning how best to design and implement core work processes on an everyday basis. First, this ignorance will allow real-time data to flow up from frontline staff on a regular basis.<sup>41</sup> These data can then be used to evaluate the success of new initiatives quickly. Second, line staff will appreciate that management openly accepts its delegation of autonomy and, thus, will often work harder to make their programs and activities successful.

Top management also plays the pivotal role in communicating to employees what the end game for change is in terms of measurable outcomes. Although line employees need to be allowed to participate, they should know there are leaders who can and must make hard big-picture decisions about how to move change forward. Top management must make employees feel confident that the organization will weather harsh environmental demands. It must be a constant presence throughout every level of the organization, providing clear direction for staff and bolstering morale in the process. Providing clear direction is accomplished through frequent and unambiguous communication from the top of the organization to the frontline, development of a vision that allows employees to understand that change is necessary and realistic, numerical

measurement of progress and success through data-driven approaches, delegating accountability to specific individuals for performance improvement, and finding innovative ways to motivate and encourage the line staff. There is evidence that individual entrepreneurialism thrived in the Upstate NY VHA Network alongside these other management-driven tasks.

As illustrated by the JAVA program, management reconceptualized the mission and communicated to CWT program staff the strategic shift toward a more entrepreneurial, private-sector-like approach in the vocational rehabilitation program. In doing so, they set forth a vision and identified parameters to direct the entrepreneurial strategies of line staff. Success would be measured by how well CWT staff could make the new program meet the needs of underserved veterans who possessed higher-level job skills. Quantitative measurements of long-term job placements, veterans' satisfaction with the program, and community satisfaction with program outputs became strict barometers for evaluating the program. Similarly, BHSL leaders communicated to Outpatient Mental Health Program staff the necessity and urgency of integrating behavioral health services into CBOCs. They conveyed the clear, numeric performance standards that needed to be achieved for the program expansion to be judged a success. However, they also gave the program complete freedom with respect to everyday implementation, with the caveat that the program would be responsible for explaining performance over time. Providing freedom of implementation motivated the program staff to succeed.

Innovation through individual entrepreneurship also benefits from an organizational structure that allows reciprocal communication flows, decentralized decision making, timely production of information at the program level that is used for "real time" feedback and implementation assessment, development of program-level solidarity, and cross-fertilization of expertise through the use of interdisciplinary teams. The Upstate NY VHA Network chose an organizing structure rooted in the idea of service or product line management that purports to provide

the above ingredients.<sup>42</sup> The adoption of a service line structure within the Upstate NY VHA Network has laid the foundation for the release of employees' talents and creativity. The move from the traditional medical-center-focused, functional structure to the service line approach sent a clear signal to everyone in the organization that risks needed to be taken, and that business within the Upstate NY VHA Network could not be done as usual. The service line structure, if committed to in its fullest sense, produces a highly adaptive culture throughout the entire organization, a culture that buys into the need for constant reassessment and change in the face of uncertain environments.

An organizing approach that focuses on decision making relative to "outputs" (what's best for customers) rather than "inputs" (what might or might not be best for customers, what is best for internal stakeholder groups such as physicians or medical centers) unites staff around the service or product. This core focus encourages individuals to identify with the product or service as opposed to their geographic work location or professional discipline.<sup>43</sup> Aiding this focus on the product or service is an emphasis on collecting data on outcomes in the areas of quality and satisfaction. The service line structure encourages developing information systems around performance since the structure itself attempts to integrate like efforts and programs across geographic areas into one collective whole. In this way, performance can and must be examined at an aggregate level within the organization. Deviations from a desired performance standard can then be brought down to a specific program within a specific geographic area within the organization. This creates a competitive atmosphere among sub-units in the service line that can spur entrepreneurship.

In addition, the service line structure allows individual service delivery programs more input into the budgeting and strategizing activities of the organization, as service lines ideally look to the grass roots to gain information on how best to allocate resources. As program staff feel more consulted by the larger organization, their willingness to take on more implementation responsibility increases.

## Conclusion

Jeffrey Pfeffer of Stanford University, a noted management scholar, states:

Achieving competitive success through people involves fundamentally altering how we think about the workforce and the employment relationship. It means achieving success by working with people, not by replacing them or limiting the scope of their activities. It entails seeing the workforce as a source of strategic advantage, not just as a cost to be minimized or avoided. Firms that take this different perspective are often able to successfully outmaneuver and outperform their rivals.<sup>44</sup>

The case of the Upstate NY VHA Network BHSL lends credence to this statement. It achieved success during its initial transformation largely by seeing its workforce as crucial to meeting the mission of change on a grand scale. Whereas the hierarchical, bureaucratic governance often associated with the health-care industry creates the perception that healthcare organizations cannot respond to fast-changing environmental demands, the evidence presented here demonstrates that bottom-up action from line staff is necessary to create this responsiveness.

Transforming healthcare organizations must implement strategy in ways that look to individual line staff to make the difference. They simply do not have the historical knowledge base to do otherwise. Having the courage to take this view among managers in these organizations, however, looms as the first and most important ingredient of making it all work.

## Appendix: Study Methods

This report is based on findings from a qualitative case study conducted during 2001 on the Upstate NY VHA Network Behavioral Health Service Line (BHSL). The purpose of the case study was to identify the organizational and human resource dynamics associated with the performance gains the BHSL made from 1997 to 2001. This single organization undergoing major restructuring and change was studied in terms of how it both managed and delivered mental health services. The goal was to gain a retrospective view of the BHSL's transformation from a functionally led and medical-center-dominated health care organization to a product-oriented, program-driven organization. This study was in the tradition of qualitative research and a grounded theory approach to data collection and analysis.<sup>45</sup>

Qualitative research suggests a different way of gaining insight into a phenomenon compared to quantitative research. It means moving closer as a researcher to a particular phenomenon as it occurs naturally within its environment. This requires an appreciation for the inseparability of that phenomenon from its surrounding context. Understanding how and why individual entrepreneurship was able to flourish in the BHSL required knowledge of the types of environmental pressures and imperatives the organization responded to during 1997–2001. It also required an intimate understanding of how employees thought about and went about their work during this time. The qualitative approach facilitated these aims.

### The Study Participants

Two medical center sites in the Upstate NY VHA Network, the Albany and Buffalo sites, were selected purposively as the comparison cases for the study. The Syracuse medical center site was chosen as a third comparison site. Albany and Buffalo served as main foci in examining behavioral health service line operations, structure, and culture as they manifested themselves in two particular behavioral health programs. The Syracuse site was added mainly to validate and confirm preliminary findings from these sites, examine additional research questions raised in one or both sites, and clarify points where the data collected

from the Albany and Buffalo sites conflicted with each other or were not clear in terms of what they suggested.

Within the three sites, data collection “drilled down” across all layers of the organization, i.e., the layers of top, middle, and frontline management and service providers located in the trenches. This approach enriched the study by offering an unbiased, multidimensional view of how individual entrepreneurship manifested itself within the BHSL. It also allowed for connecting particular management styles, cultures, and decisions to the cultivation of entrepreneurial activity among service providers performing the work of the service line each and every day. This approach was important in gaining management lessons that are transferable to other transforming or new government organizations. The study focused in particular on two programs based on the desire to drill down data collection through all levels of the service line structure. The two, the Homeless Outreach and Outpatient Mental Health programs, differed enough from one another that they offered good comparison. Homeless Outreach was smaller, more integrated across sites, more community-based, and less psychologist dominated than the Outpatient Mental Health Program. On the other hand, Outpatient Mental Health was larger, less integrated, dominated ideologically by psychologists and psychiatrists, more closely tied to the medical centers, and narrower in its patient care focus. Both programs were ideal because they were going through major transformations that involved less time for formally planning implementation. Thus, there was an urgent need for individual entrepreneurship with respect to implementing new service initiatives in both programs. The programs were also selected because they seemed to be managing change quite well. Each program was responsible for several exceptional performance accomplishments in the BHSL over the previous couple of years.

### Review of the Literature

Throughout the study, both the management and organizational literatures were consulted to help clarify interpretations of the findings, develop additional research questions directing new data collection, and weave seemingly unique observations into a coherent whole. For this report in

particular, literature related to views of organizations as embedded in life cycles and literature on the importance of promoting individual creativity and empowerment within organizations were drawn upon to help make sense of the data.

### **The Interview Process**

Seventy-six semi-structured interviews were conducted with BHSL management, BHSL providers in each of the two participating service delivery programs, and members of the Upstate NY VHA Network management team. Twenty-nine interviews (38 percent) occurred with top management team members in the care line and/or members of network management. Ten interviews (13 percent) took place with what could be considered middle- or frontline management in the care line and the two participating programs. The remaining 37 interviews (49 percent) were held with professional line staff in the Homeless Outreach and Outpatient Mental Health programs at the Albany, Buffalo, and Syracuse sites. Anywhere from one-quarter to more than half of all provider staff in each Outpatient Mental Health Program at the three sites participated in the interviews. With respect to the Homeless Outreach Program, almost all provider staff across the three sites participated in the interviews. Interviews with management team members were equally distributed across the three medical center sites. Thus, the interview samples were representative of the programs as a whole as well as the programs operating at each site.

### **The Focus Groups**

Six focus groups were conducted with BHSL staff as part of the study. One focus group was held with the service line top management group, one focus group was held with staff from the Outpatient Mental Health Program, and another occurred with frontline managers of the Homeless Outreach Program. The remainder of the focus groups took place with professional line and management staff (combined) in both the Homeless Outreach and Outpatient Mental Health Programs.

### **Examination of Secondary Data**

Various documents were gathered and analyzed in the study. These documents included meeting minutes, correspondence, and e-mail communications deriving from management and staff meetings from within the service line. They also included monthly performance reports, corrective action plans related to performance deficiencies, strategic planning documents, fiscal reports, procedure manuals, and site/program-specific monitoring information related to the performance measures and growth of new patients. These more objective sources of information allowed a deeper understanding of how the care line conducted “business as usual,” and how both managers and professional service providers contributed to making that business successful through their own creativity and ad hoc approaches to work.

### **Discussions with Leaders**

Included in the 76 interviews were a number of ongoing discussions with the BHSL director that helped in assessing preliminary findings, through the eyes of the top decision maker in the service line. This approach of using a key leader as a sounding board with whom to test initial interpretations of the data proved extremely helpful in articulating how the organization and its strategic imperatives provided a crucible within which individual entrepreneurship could occur.

## Endnotes

1. For a general discussion of the Veterans Health Administration transformation, see Gary Young (2000), *Transforming Government: The Revitalization of the Veterans Health Administration*, published by the IBM Center for The Business of Government.
2. See K.W. Kizer, M.L. Fonsica, L.M. Long (1997), "The Veterans Healthcare System: Preparing for the Twenty-First Century." *Hospital and Health Services Administration*, 42(3):283-298.
3. M.P. Charns (1997), "Organization Design of Integrated Delivery Systems," *Hospital and Health Services Administration*, 42(3):411-432.
4. M.P., Charns and L.S. Tewksbury (1993), *Collaborative Management in Health Care: Implementing the Integrative Organization*, San Francisco: Jossey-Bass.
5. See Young (2000).
6. Information about performance of the Upstate NY VHA Network and its Behavioral Health Service Line come from the network's 2001 and 2002 applications to the Malcolm Baldrige National Quality Award Competition and from internal strategic planning documents.
7. This conclusion is drawn from a 2001 survey of network staff, in which high marks were given to network leadership in terms of "recognizing change as a fact" in the organization, "acceptance of change by managers and staff," and "management openness to positive change" within the network.
8. This conclusion is drawn from data collected through interviews and focus groups conducted as part the 2001 case study on which this report is based.
9. Personal communication with Joseph Cohen in the Upstate NY VHA Network Management Office, July 2, 2002.
10. Upstate New York Veterans Healthcare Network (2002), Malcolm Baldrige National Quality Award Application.
11. This discussion reflects nothing new. Government organizations have been cast in this way for a long time by such prominent scholars as Max Weber, James Q. Wilson, Herbert Simon, Woodrow Wilson, Herbert Kaufman, Michel Crozier, and John Dilulio.
12. The seminal work in this regard is D. Osborne and T. Gaebler's (1992) classic book, *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*, Massachusetts: Addison-Wesley Publishing Company, Inc. See also B. Bozeman's (1993) *Public Management: State of the Art*, San Francisco: Jossey-Bass; and H.G. Frederickson and J.M. Johnston (Eds.), (1993), *Public Management Reform and Innovation: Research, Theory, and Application*, Tuscaloosa: The University of Alabama Press.
13. The public management reform discussions of the 1990s have attempted to cast leaders and managers in government organizations as crucial to leading innovative efforts. This literature is also very applicable to the healthcare industry. There is empirical evidence that such leadership and management do exist in the public sector, i.e., leadership demonstrating qualities that are anathema to the stereotype described here. Please see Osborne and Gaebler (1992), especially pp. 321-330. Also see S. Borins (1998), *Innovating with Integrity*, Washington D.C.: Georgetown University Press, especially pp. 37-65; and R.N. Johnson and G.D. Libecap (1996), "Reinventing the Federal Civil Service" in *Advances in the Study of Entrepreneurship, Innovation, and Economic Growth*, pp. 1-29, in G.D. Libecap (Ed.), Greenwich, Connecticut: JAI Press.
14. See M. Crozier (1964), *The Bureaucratic Phenomenon*, Chicago, Illinois: University of Chicago Press.
15. See *National Performance Review* (1993), "From Red Tape to Results: Creating a Government That Works Better and Costs Less," Washington, D.C.: Government Printing Office.
16. A body of management literature viewing organizations as possessing life cycles is especially helpful in drawing similarities between private- and public-sector organizations with respect to a periodic need to evolve in substantive ways. See especially N. Tichy (1980), "Problem Cycles in Organizations and the Management of Change" in J.R. Kimberly and R.H. Miles (Eds.), *The Organizational Life Cycle: New Perspectives for Organizational Theory and Research*, San Francisco: Jossey-Bass.

17. Information in this section comes from a variety of information published by the Upstate NY VHA Network, in particular the organization's 2001 and 2002 Network Strategic Plans.
18. Personal communication with Scott Murray, service line director of behavioral health, January 2002.
19. See K. Kroenke and A. Mangelsdorff (1989), "Common Symptoms in Primary Care: Incidence, Evaluation, Therapy, and Outcome," *American Journal of Medicine*, 86:262-266. See also C. Hankin, L. Kazis, D. Miller, A. Spiro (1999), "Mental Disorders and Mental Health Treatment Among U.S. Department of Veterans Affairs Outpatients: The Veterans Health Study," *American Journal of Psychiatry*, 156:12; and M.E. Arrington, K. Kroenke, A.D. Mangelsdorff (1990), "The Prevalence of Symptoms in Medical Outpatients and the Adequacy of Therapy," *Archives of Internal Medicine*, 150: 1,685-1,689.
20. See P. Nutt (1999), "Surprising But True: Half the Decisions in Organizations Fail," *Academy of Management Executive*, 13(4):75-89.
21. See K.M. Eisenhardt (2002), "Has Strategy Changed?" *MIT Sloan Management Review*, Winter:88-91.
22. Mission taken from the Upstate NY VHA Network's Homeless Outreach Program marketing brochure.
23. Data describing Homeless Outreach Program performance taken from network performance reporting data and a publication entitled "Pulse Points" that is made available to stakeholders via the network's website.
24. Interview with Upstate NY VHA Network Homeless Outreach professional, March 2001.
25. Interview with Upstate NY VHA Network Homeless Outreach professional, April 2001.
26. Interview with Joseph Miller of the Upstate NY VHA Network, manager, CWT Program, July 2002.
27. This step of "listening to the customer" and seeing how one's own actions contribute to the success or failure of the larger whole is a cornerstone of the learning approach described by Peter Senge (1990) in his classic book, *The Fifth Discipline: The Art and Practice of the Learning Organization*, New York: Doubleday. It is also seen vividly in the case of the Salvation Army, as described in R.A. Watson and B. Brown (2001), *The Most Effective Organization in the U.S.: Leadership Secrets of the Salvation Army*, New York: Crown Business Publishing.
28. See S.B. Sitkin (1996), "Learning Through Failure: The Strategy of Small Losses," in M.D. Cohen & L.S. Sproull (Eds.), *Organizational Learning* (pp. 541-578), Thousand Oaks, California: Sage Publications.
29. Gary Young (2000). "Transforming Government: The Revitalization of the Veterans Health Administration," Arlington, VA: IBM Center for The Business of Government.
30. Data supporting these conclusions come from interviews conducted with professional line staff in the Upstate NY VHA Network during 2001.
31. See A.E. Reichers, J.P. Wanous, and J.T. Austin (1997), "Understanding and Management Cynicism About Organizational Change," *Academy of Management Executive*, 11(1):48-59.
32. D.M. McGregor (1989), "The Human Side of Enterprise," in W.E. Natenmeyer and J.S. Gilberg (Eds.), *Classics of Organizational Behavior*, pp. 14-20, Danville, Illinois: The Interstate Printers and Publishers.
33. See especially Ch. 6 in Osborne and Gaebler's (1992) book, *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*. In it, the authors emphasize the importance of maintaining close ties with the customer for enhancing product quality, program responsiveness and accountability, and staff and client satisfaction. This is also a cornerstone of the Total Quality Management approach. However, perhaps the most applicable point from Osborne and Gaebler's discussion to apply to the present case involves the diversity created in a government program's service aims and performance criteria when customer needs are allowed to define "good" and "appropriate" service delivery. A similar discussion in the health care arena is offered by Kenagy, Berwick, and Shore (1999), who state that service quality in health care must be consumer-driven and, if so, implies a wider range of "effective" performance criteria than if solely defined by the health care organization, management, or individual professional. See J.W. Kenagy, D.M. Berwick, and M.F. Shore (1999), "Service Quality in Health Care," *Journal of the American Medical Association*, 281(7):661-665.

34. The notion that organizations need to “engage the spirit” of their workers, mainly by encouraging their feelings of commitment to and identification with the client, is described eloquently in the case of the Salvation Army. See especially pp. 35-57 in B. Brown and R.A. Watson (2001). Among the various examples they use, Watson and Brown cite the Salvation Army’s work with homeless clients as a particular area in which both the employees’ dedication to meeting the diverse needs of homeless individuals and seeing problems through the eyes of the homeless lead to a range of service delivery initiatives being created. The discussion is strikingly similar to some of the findings in the present study of the Upstate NY VHA Network’s Homeless Outreach Program.
35. See R.A. Heifetz and D.L. Laurie (1998), “The Work of Leadership,” in *Harvard Business Review on Leadership*, pp. 171-197, Massachusetts: Harvard Business School Press. Heifetz and Laurie highlight the need for organizations confronting “adaptive challenges,” i.e., the types of challenges faced by the Upstate NY VHA Network, to be able to, in their words, “move back and forth between the field of action and the balcony...” Allowing line employees to take overall mission and strategy and implement them situationally based on their own assessments of their service delivery environments is one way to create tactical flexibility in the organization—flexibility that relies on feedback and information from the frontlines. New or transforming government organizations, because of their lack of implementation history, must possess such flexibility.
36. See P. Nutt (1999). Nutt’s analysis of more than 300 firms suggests that the most sustainable decisions in organizations are those where management sets the overall objectives for employees to fulfill, but then lets employees figure out the best ways to meet the objectives. Rundall et al., in their study of hospital systems, echoes Nutt’s conclusion by stating that the key to effective empowerment of employees is through the process of “bounding,” i.e., setting overall performance goals for the organization such that employees’ efforts must be directed at achieving them, but with wide latitude given as to the means of reaching the goals. See T.G. Rundall, D.B. Starkweather, B.R. Norrish (1998), *After Restructuring: Empowerment Strategies at Work in America’s Hospitals*, San Francisco: Jossey-Bass Publishers.
37. As Kotter (1998) states, creating empowerment for employees is best done through “setting direction” and “aligning” staff with the major performance goals for the transforming or new organization, but then giving employees a high degree of control over local situations and problems. This approach for the organization in the midst of change is not management but leadership, according to Kotter, and it is consistent with the need for a less top-down approach to strategic implementation within the organization. See J.P. Kotter (1998), “What Leaders Really Do,” in *Harvard Business Review on Leadership*, pp. 37-60, Massachusetts: Harvard Business School Press.
38. The recognition and embracing of failure as an opportunity for organizational learning and program enhancement form a cornerstone of the management literature on quality improvement. See Peter Senge (1990, pp. 150-155 especially). Senge’s concept of “creative tension”—the gap between an organization’s vision and its current reality (and the need for employees to be allowed to help define and address that gap)—strikes at the heart of the idea that a true learning organization uses situations in which things do not work out as envisioned as the source of creative energy and innovation.
39. These means of creating a more “failure-oriented” employee culture are expounded upon in S.B. Sitkin (1996), “Learning Through Failure: The Strategy of Small Losses,” in M.D. Cohen & L.S. Sproull (Eds.), *Organizational Learning* (pp. 541-578), Thousand Oaks, California: Sage Publications.
40. The Homeless Outreach Program, for example, tended to consist of social workers for the most part in outreach positions, as well as individuals who exhibited tremendous empathy for the challenges faced by veterans in general. This similarity in training and attitude did not appear to come about by accident, as at least one program manager described an approach to putting the “right” kinds of people together to do effective outreach. Emphasizing employee recruitment as a key to developing a cohesive, customer-focused employee culture is seen in some of the most admired private-sector companies as Southwest Airlines. See J. Pfeffer (1995), “Producing Sustainable Competitive Advantage Through the Effective Management of People,” *Academy of Management Executive*, 9(1): 55-69.

41. This reality also promotes the “lead by listening” approach discussed by Brown and Watson (2001) in their analysis of the Salvation Army. This approach is rooted in management’s reliance on staff as well as outside customers to tell them how the organization is doing.
42. See M.P. Charns and L.S. Tewksbury (1993).
43. Getting employees to identify with the final product or outcome (e.g., a highly satisfied behavioral health patient) is seen in numerous admired companies, such as Southwest Airlines and General Motors’ Saturn Division.
44. J. Pfeffer (1995), p. 55.
45. The grounded theory approach is described in A.L. Strauss (1997), *Qualitative Analysis for Social Scientist*, New York: Cambridge University Press.

## Bibliography

Arrington, M.E., Kroenke, K., Mangelsdorff, A.D. (1990). "The Prevalence of Symptoms in Medical Outpatients and the Adequacy of Therapy." *Archives of Internal Medicine*, 150, 1,685-1,689.

Borins, S. (1998). *Innovating with Integrity*. Washington, D.C.: Georgetown University Press.

Bozeman, B. (1993). *Public Management: State of the Art*. San Francisco: Jossey-Bass.

Charns, M.P. (1997). "Organization Design of Integrated Delivery Systems." *Hospital and Health Services Administration*, 42(3), 411-432.

Charns, M.P., Tewksbury, L.S. (1993). *Collaborative Management in Health Care: Implementing the Integrative Organization*. San Francisco: Jossey-Bass.

Crozier, M. (1964). *The Bureaucratic Phenomenon*. Chicago: University of Chicago Press. Drucker, P.F. (1970). "Entrepreneurship in the Business Enterprise." *Journal of Business Policy*, 1(1), 10.

Eisenhardt, K.M. (2002). "Has Strategy Changed?" *MIT Sloan Management Review*, Winter, 88-91.

Fonsica, M.L., Kizer, K.W., Long, L.M. (1997). "The Veterans Healthcare System: Preparing for the Twenty-First Century." *Hospital and Health Services Administration*, 42(3), 283-298.

Frederickson, H.G., Johnston, J.M. (Eds.) (1993). *Public Management Reform and Innovation: Research, Theory, and Application*. Tuscaloosa: The University of Alabama Press.

Hankin, C., Kazis, L., Miller, D., Spiro, A. (1999). "Mental Disorders and Mental Health Treatment Among U.S. Department of Veteran Affairs Outpatients: The Veterans Health Study." *American Journal of Psychiatry*, 156, 12.

Heifetz, R.A., Laurie, D.L. (1998). "The Work of Leadership." *Harvard Business Review on Leadership* (pp. 171-197). Massachusetts:

Harvard Business School Press.

Johnson, R.N., Libecap, G.D. (1996). "Reinventing the Federal Civil Service." In G.D. Libecap (Ed.), *Advances in the Study of Entrepreneurship, Innovation, and Economic Growth* (pp. 1-29). Greenwich, Connecticut: JAI Press.

Kenagy, J.W., Berwick, D.M., Shore, M.F. (1999). "Service Quality in Health Care." *Journal of the American Medical Association*, 281(7), 661-665.

Kimberly, J.R., Miles, R.H. (Eds.) (1980). *The Organizational Life Cycle: New Perspectives for Organizational Theory and Research*. San Francisco: Jossey-Bass.

Kotter, J.P. (1998). "What Leaders Really Do." *Harvard Business Review of Leadership* (pp. 37-60). Massachusetts: Harvard Business School Press.

Kroenke, K., Mangelsdorff, A. (1989). "Common Symptoms in Primary Care: Incidence, Evaluation, Therapy, and Outcome." *American Journal of Medicine*, 86, 262-266.

McGregor, D.M. (1989). "The Human Side of Enterprise." In J.S. Gilberg & W.E. Natenmeyer (Eds.), *Classics of Organizational Behavior* (pp. 14-20). Danville, Illinois: The Interstate Printers and Publishers.

National Performance Review (1993). "From Red Tape to Results: Creating a Government That Works Better and Costs Less." Washington D.C.: Government Printing Office.

Nutt, P. (1999). "Surprising But True: Half the Decisions in Organizations Fail." *Academy of Management Executive*, 13(4), 75-89.

Osborne, D., Gaebler, T. (1992). *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*. Massachusetts: Addison-Wesley Publishing Company, Inc.

Pfeffer, J. (1995). "Producing Sustainable Competitive Advantage Through the Effective Management of People." *Academy of Management Executive*, 9(1), 55-72.

Reichers, A.E., Wanous, J.P., Austin, J.T. (1997). "Understanding and Management Cynicism About Organizational Change." *Academy of Management Executive*, 11(1), 48-59.

Rundall, T.G., Norrish, B.R., Starkweather, D.B. (1998). *After Restructuring: Empowerment Strategies at Work in America's Hospitals*. San Francisco: Jossey-Bass Publishers.

Senge, P. (1990). *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday.

Sitkin, S.B. (1996). "Learning Through Failure: The Strategy of Small Losses." In M.D. Cohen & L.S. Sproull (Eds.), *Organizational Learning* (pp. 541-578). Thousand Oaks, California: Sage Publications.

Strauss, A.L. (1997). *Qualitative Analysis for Social Scientists*. New York: Cambridge University Press.

Tichy, N. (1980). "Problem Cycles in Organizations and the Management of Change." In J.R. Kimberly & R.H. Miles (Eds.), *The Organizational Life Cycle: New Perspectives for Organizational Theory and Research* (pp. 164-183). San Francisco: Jossey-Bass.

Upstate New York Veterans Healthcare Network (2001). Malcolm Baldrige National Quality Award Application.

Upstate New York Veterans Healthcare Network (2001). Network Strategic Plan.

Upstate New York Veterans Healthcare Network (2002). Malcolm Baldrige National Quality Award Application.

Upstate New York Veterans Healthcare Network (2002). Network Strategic Plan.

Watson, R.A., Brown, B. (2001). *The Most Effective Organization in the U.S.: Leadership Secrets of the Salvation Army*. New York: Crown Business Publishing.

Young, G. (2000). *Transforming Government: The Revitalization of the Veterans Health Administration*. Arlington, VA: IBM Center for The Business of Government.

## About the Author

Timothy J. Hoff, Ph.D., is assistant professor of health policy and management at the School of Public Health, University at Albany, State University of New York. Dr. Hoff is a sociologist and organization theorist by training who received his doctorate in public administration and policy from Rockefeller College at the University at Albany in 1997.

He has studied changing roles, attitudes, and behaviors of physicians in response to managed-care work environments. This work has appeared in health services and sociological journals such as *Health Care Management Review*, *Journal of Health Care Management*, *Journal of Health and Social Behavior*, and *Social Science and Medicine*.

Dr. Hoff is currently involved in several federally funded grant projects examining the issue of medical errors in health care. In addition, he studies how organizations navigate change through strategic restructuring. This interest has led him to conduct research for the Department of Veterans Affairs and its Management and Decision Research Center.

Before coming to academia, Dr. Hoff worked for a decade in public and private health management positions such as that of hospital administrator. His teaching experience includes health care systems, health care strategy, leadership, research methods, and health organization management. His research has been recognized nationally with awards from the Academy of Management's Health Care Management Division, the Society for Applied Anthropology, and the American Sociological Association.

To contact the author:

Timothy J. Hoff, Ph.D.  
Assistant Professor  
Department of Health Policy, Management,  
and Behavior  
School of Public Health  
University at Albany, SUNY  
1 University Place, GEC Building, Room 183  
Rensselaer, NY 12144  
(518) 402-6512  
fax: (518) 402-0414  
e-mail: thoff@albany.edu

## IBM Center for Healthcare Management Reports Available

### Healthcare

**The Power of Frontline Workers in Transforming Healthcare Organizations:** The Upstate New York Veterans Healthcare Network (December 2003)  
Timothy J. Hoff

**IT Outsourcing:** A Primer for Healthcare Managers (December 2003)  
Yu-Che Chen and James Perry

### E-Government

**Supercharging the Employment Agency:** An Investigation of the Use of Information and Communication Technology to Improve the Service of State Employment Agencies (December 2000)  
Anthony M. Townsend

**Assessing a State's Readiness for Global Electronic Commerce:** Lessons from the Ohio Experience (January 2001)  
J. Pari Sabety and Steven I. Gordon

**Privacy Strategies for Electronic Government** (January 2001)  
Janine S. Hiller and France Bélanger

**Commerce Comes to Government on the Desktop:** E-Commerce Applications in the Public Sector (February 2001)  
Genie N. L. Stowers

**The Use of the Internet in Government Service Delivery** (February 2001)  
Steven Cohen and William Eimicke

**State Web Portals:** Delivering and Financing E-Service (January 2002)  
Diana Burley Gant, Jon P. Gant and Craig L. Johnson

**Internet Voting:** Bringing Elections to the Desktop (February 2002)  
Robert S. Done

**Leveraging Technology in the Service of Diplomacy:** Innovation in the Department of State (March 2002)  
Barry Fulton

**Federal Intranet Work Sites:** An Interim Assessment (June 2002)  
Julianne G. Mahler and Priscilla M. Regan

**The State of Federal Websites:** The Pursuit of Excellence (August 2002)  
Genie N. L. Stowers

**State Government E-Procurement in the Information Age:** Issues, Practices, and Trends (September 2002)  
M. Jae Moon

**Preparing for Wireless and Mobile Technologies in Government** (October 2002)  
Ai-Mei Chang and P. K. Kannan

**Public-Sector Information Security:** A Call to Action for Public-Sector CIOs (October 2002, 2nd ed.)  
Don Heiman

**The Auction Model:** How the Public Sector Can Leverage the Power of E-Commerce Through Dynamic Pricing (November 2002, 2nd ed.)  
David C. Wylde

**The Promise of E-Learning in Africa:** The Potential for Public-Private Partnerships (January 2003)  
Norman LaRocque and Michael Latham

**Digitally Integrating the Government Supply Chain:** E-Procurement, E-Finance, and E-Logistics (February 2003)  
Jacques S. Gansler, William Lucyshyn and Kimberly M. Ross

**Using Technology to Increase Citizen Participation in Government:** The Use of Models and Simulation (April 2003)  
John O'Looney

To download or order a copy of a report, visit the Center's website at: [www.businessofofgovernment.org](http://www.businessofofgovernment.org)

**Services Acquisition for America's Navy:**

Charting a New Course for SeaPort (June 2003)  
David C. Wyld

**Financial Management**

Credit Scoring and Loan Scoring: Tools for Improved Management of Federal Credit Programs (July 1999)  
Thomas H. Stanton

**Using Activity-Based Costing to Manage More Effectively** (January 2000)

Michael H. Granof and David E. Platt and Igor Vaysman

**Audited Financial Statements:** Getting and Sustaining "Clean" Opinions (July 2001)  
Douglas A. Brook

**An Introduction to Financial Risk Management in Government** (August 2001)

Richard J. Buttimer, Jr.

**Understanding Federal Asset Management:**

An Agenda for Reform (July 2003)  
Thomas H. Stanton

**Efficiency Counts:** Developing the Capacity to Manage Costs at Air Force Materiel Command (August 2003)

Michael Barzelay and Fred Thompson

**Market-Based Government**

**Determining a Level Playing Field for Public-Private Competition** (November 1999)

Lawrence L. Martin

**Implementing State Contracts for Social**

**Services:** An Assessment of the Kansas Experience (May 2000)

Jocelyn M. Johnston and Barbara S. Romzek

**A Vision of the Government as a World-Class**

**Buyer:** Major Procurement Issues for the Coming Decade (January 2002)

Jacques S. Gansler

**Contracting for the 21st Century:** A Partnership Model (January 2002)

Wendell C. Lawther

**Franchise Funds in the Federal Government:**

Ending the Monopoly in Service Provision (February 2002)  
John J. Callahan

**Making Performance-Based Contracting Perform:**

What the Federal Government Can Learn from State and Local Governments (November 2002, 2nd ed.)  
Lawrence L. Martin

**Moving to Public-Private Partnerships:** Learning from Experience around the World (February 2003)

Trefor P. Williams

**IT Outsourcing:** A Primer for Public Managers (February 2003)

Yu-Che Chen and James Perry

**The Procurement Partnership Model:** Moving to a Team-Based Approach (February 2003)

Kathryn G. Denhardt

**Moving Toward Market-Based Government:**

The Changing Role of Government as the Provider (June 2003)  
Jacques S. Gansler

**Human Capital Management**

**Profiles in Excellence:** Conversations with the Best of America's Career Executive Service (November 1999)

Mark W. Huddleston

**Reflections on Mobility:** Case Studies of Six Federal Executives (May 2000)

Michael D. Serlin

**Managing Telecommuting in the Federal Government:** An Interim Report (June 2000)

Gina Vega and Louis Brennan

**Using Virtual Teams to Manage Complex Projects:**

A Case Study of the Radioactive Waste Management Project (August 2000)

Samuel M. DeMarie

**A Learning-Based Approach to Leading Change** (December 2000)

Barry Sugarman

**Labor-Management Partnerships: A New Approach to Collaborative Management** (July 2001)  
Barry Rubin and Richard Rubin

**Winning the Best and Brightest: Increasing the Attraction of Public Service** (July 2001)  
Carol Chetkovich

**A Weapon in the War for Talent: Using Special Authorities to Recruit Crucial Personnel** (December 2001)  
Hal G. Rainey

**A Changing Workforce: Understanding Diversity Programs in the Federal Government** (December 2001)  
Katherine C. Naff and J. Edward Kellough

**Life after Civil Service Reform: The Texas, Georgia, and Florida Experiences** (October 2002)  
Jonathan Walters

**The Defense Leadership and Management Program: Taking Career Development Seriously** (December 2002)  
Joseph A. Ferrara and Mark C. Rom

**The Influence of Organizational Commitment on Officer Retention: A 12-Year Study of U.S. Army Officers** (December 2002)  
Stephanie C. Payne, Ann H. Huffman and Trueman R. Tremble, Jr.

**Human Capital Reform: 21st Century Requirements for the United States Agency for International Development** (March 2003)  
Anthony C. E. Quainton and Amanda M. Fulmer

**Modernizing Human Resource Management in the Federal Government: The IRS Model** (April 2003)  
James R. Thompson and Hal G. Rainey

**Mediation at Work: Transforming Workplace Conflict at the United States Postal Service** (October 2003)  
Lisa B. Bingham

**Growing Leaders for Public Service** (November 2003)  
Ray Blunt

Managing for Performance and Results  
**Corporate Strategic Planning in Government: Lessons from the United States Air Force** (November 2000)  
Colin Campbell

**Using Evaluation to Support Performance Management:**  
A Guide for Federal Executives (January 2001)  
Kathryn Newcomer and Mary Ann Scheirer

**Managing for Outcomes: Milestone Contracting in Oklahoma** (January 2001)  
Peter Frumkin

**The Challenge of Developing Cross-Agency Measures:**  
A Case Study of the Office of National Drug Control Policy (August 2001)  
Patrick J. Murphy and John Carnevale

**The Potential of the Government Performance and Results Act as a Tool to Manage Third-Party Government** (August 2001)  
David G. Frederickson

**Using Performance Data for Accountability: The New York City Police Department's CompStat Model of Police Management** (August 2001)  
Paul E. O'Connell

**Moving Toward More Capable Government: A Guide to Organizational Design** (June 2002)  
Thomas H. Stanton

**Performance Management: A "Start Where You Are, Use What You Have" Guide** (October 2002)  
Chris Wye

**The Baltimore CitiStat Program: Performance and Accountability** (May 2003)  
Lenneal J. Henderson

**How Federal Programs Use Outcome**

**Information:** Opportunities for Federal Managers  
(May 2003)

Harry P. Hatry, Elaine Morley, Shelli B. Rossman and  
Joseph S. Wholey

**Linking Performance and Budgeting:**

Opportunities in the Federal Budget Process  
(October 2003)

Philip G. Joyce

**Strategies for Using State Information:**

Measuring and Improving Program Performance  
(December 2003)

Shelley H. Metzenbaum

**Innovation**

**Managing Workfare:** The Case of the Work  
Experience Program in the New York City Parks  
Department (June 1999)  
Steven Cohen

**New Tools for Improving Government**

**Regulation:** An Assessment of Emissions Trading  
and Other Market-Based Regulatory Tools  
(October 1999)

Gary C. Bryner

**Religious Organizations, Anti-Poverty Relief,  
and Charitable Choice:** A Feasibility Study of

Faith-Based Welfare Reform in Mississippi  
(November 1999)

John P. Bartkowski and Helen A. Regis

**Business Improvement Districts and Innovative  
Service Delivery** (November 1999)

Jerry Mitchell

**An Assessment of Brownfield Redevelopment  
Policies:**

The Michigan Experience (November 1999)  
Richard C. Hula

**San Diego County's Innovation Program:** Using  
Competition and a Whole Lot More to Improve Public  
Services (January 2000)

William B. Eimicke

**Innovation in the Administration of Public  
Airports** (March 2000)

Scott E. Tarry

**Entrepreneurial Government:** Bureaucrats as  
Businesspeople (May 2000)

Anne Laurent

**Rethinking U.S. Environmental Protection Policy:**

Management Challenges for a New Administration  
(November 2000)

Dennis A. Rondinelli

**The Challenge of Innovating in Government**

(February 2001)

Sandford Borins

**Understanding Innovation:**What Inspires It? What  
Makes It Successful? (December 2001)

Jonathan Walters

**Government Management of Information Mega-  
Technology:** Lessons from the Internal Revenue

Service's Tax Systems Modernization (March 2002)

Barry Bozeman

**Advancing High End Computing:** Linking to  
National Goals (September 2003)

Juan D. Rogers and Barry Bozeman

Networks, Collaboration, and Partnerships

**Leveraging Networks to Meet National Goals:**

FEMA and the Safe Construction Networks  
(March 2002)

William L. Waugh, Jr.

**21st-Century Government and the Challenge of  
Homeland Defense** (June 2002)

Elaine C. Kamarck

**Assessing Partnerships:** New Forms of  
Collaboration (March 2003)

Robert Klitgaard and Gregory F. Treverton

**Leveraging Networks:** A Guide for Public  
Managers Working across Organizations  
(March 2003)

Robert Agranoff

**Extraordinary Results on National Goals:**  
Networks and Partnerships in the Bureau of Primary Health Care's 100%/0 Campaign (March 2003)  
John Scanlon

**Public-Private Strategic Partnerships:** The U.S. Postal Service-Federal Express Alliance (May 2003)  
Oded Shenkar

**The Challenge of Coordinating "Big Science"**  
(July 2003)  
W. Henry Lambright

**Communities of Practice:** A New Tool for Government Managers (November 2003)  
William M. Snyder and Xavier de Souza Briggs

### **Transforming Organizations**

**The Importance of Leadership:** The Role of School Principals (September 1999)  
Paul Teske and Mark Schneider

**Leadership for Change:** Case Studies in American Local Government (September 1999)  
Robert B. Denhardt and Janet Vinzant Denhardt

**Managing Decentralized Departments:** The Case of the U.S. Department of Health and Human Services (October 1999)  
Beryl A. Radin

**Transforming Government:** The Renewal and Revitalization of the Federal Emergency Management Agency (April 2000)  
R. Steven Daniels and Carolyn L. Clark-Daniels

**Transforming Government:** Creating the New Defense Procurement System (April 2000)  
Kimberly A. Harokopus

**Trans-Atlantic Experiences in Health Reform:** The United Kingdom's National Health Service and the United States Veterans Health Administration (May 2000)  
Marilyn A. DeLuca

**Transforming Government:** The Revitalization of the Veterans Health Administration (June 2000)  
Gary J. Young

**The Challenge of Managing Across Boundaries:** The Case of the Office of the Secretary in the U.S. Department of Health and Human Services (November 2000)  
Beryl A. Radin

**Creating a Culture of Innovation:** 10 Lessons from America's Best Run City (January 2001)  
Janet Vinzant Denhardt and Robert B. Denhardt  
**Transforming Government:** Dan Goldin and the Remaking of NASA (March 2001)  
W. Henry Lambright

**Managing Across Boundaries:** A Case Study of Dr. Helene Gayle and the AIDS Epidemic (January 2002)  
Norma M. Riccucci

**Managing "Big Science":** A Case Study of the Human Genome Project (March 2002)  
W. Henry Lambright

**The Power of Frontline Workers in Transforming Government:** The Upstate New York Veterans Healthcare Network (April 2003)  
Timothy J. Hoff

**Making Public Sector Mergers Work:** Lessons Learned (August 2003)  
Peter Frumkin

**Efficiency Counts:** Developing the Capacity to Manage Costs at Air Force Materiel Command (August 2003)  
Michael Barzelay and Fred Thompson

**Managing the New Multipurpose, Multidiscipline University Research Centers:** Institutional Innovation in the Academic Community (November 2003)  
Barry Bozeman and P. Craig Boardman

## Books\*

E-Government 2001

(Rowman & Littlefield Publishers, Inc., 2001)

Mark A. Abramson and Grady E. Means, editors

E-Government 2003

(Rowman & Littlefield Publishers, Inc., 2002)

Mark A. Abramson and Therese L. Morin, editors

Human Capital 2002

(Rowman & Littlefield Publishers, Inc., 2002)

Mark A. Abramson and Nicole Willenz Gardner,  
editors

Innovation

(Rowman & Littlefield Publishers, Inc., 2002)

Mark A. Abramson and Ian Littman, editors

Leaders

(Rowman & Littlefield Publishers, Inc., 2002)

Mark A. Abramson and Kevin M. Bacon, editors

Managing for Results 2002

(Rowman & Littlefield Publishers, Inc., 2001)

Mark A. Abramson and John Kamensky, editors

New Ways of Doing Business

(Rowman & Littlefield Publishers, Inc., 2003)

Mark A. Abramson and Ann M. Kieffaber, editors

Memos to the President: Management Advice from  
the Nation's Top Public Administrators

(Rowman & Littlefield Publishers, Inc., 2001)

Mark A. Abramson, editor

The Procurement Revolution

(Rowman & Littlefield Publishers, Inc., 2003)

Mark A. Abramson and Roland S. Harris III, editors

Transforming Government Supply Chain

Management (Rowman & Littlefield Publishers, Inc.,  
2003)

Jacques S. Gansler and Robert E. Luby, Jr., editors

Transforming Organizations

(Rowman & Littlefield Publishers, Inc., 2001)

Mark A. Abramson and Paul R. Lawrence, editors

\* Available at bookstores, online booksellers, and from the publisher ([www.rowmanlittlefield.com](http://www.rowmanlittlefield.com) or 800-462-6420)

© Copyright IBM Corporation 2004  
Printed in the United States of America  
01-04  
All Rights Reserved

IBM is a trademark or registered trademark of International Business Machines Corporation in the United States, other countries, or both.

Other company, product and service names may be trademarks or service marks of IBM or of others.

References in this publication to IBM products or services do not imply that IBM intends to make them available in awwhyIBM operates.

The opinions and conclusions expressed herein are entirely the views of the author and may not reflect the views of IBM.