2022

Barriers in Quality Healthcare Delivery in the Veterans Healthcare Systems

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MA, University of Cincinnati, 2008

BS, Grand View University, 2004

Dissertation Submitted in Partial Fulfillment

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Abstract

The VHA and Department of Veterans Affairs (DVA) have been labeled negligent in providing healthcare for U.S. veterans. Strategies to resolve the problems included legislative changes, watchdog responsibilities, and removal of top officials within the VA. The case studies presented underscore reported problems within Veterans Healthcare Systems. The present research was conducted to determine if the negligence was the result of a toxic work environment and whether the problems continue to affect healthcare delivery to U.S. veterans. Beccaria's Rational Choice Theory served as the theoretical basis of the research. A mixed method, transformative design was used to conduct the study. Quantitative data were gleaned from the OPM Federal Viewpoint Survey Database. Qualitative data were extracted from prior surveys from VHA employees and U.S. veterans. The data revealed the workloads of employees were not excessive, but healthcare delivery problems continued to exist. The data also revealed 30% of the employees harbored fear of reprisals if they reported negligent service. The research results indicated the VHA healthcare delivery problems are the result of poor training, poor supervision, and fear of reprisals for reporting possible healthcare delivery errors. Regardless of these issues, U.S. veterans remained hopeful. The three factors constituted a toxic work environment which affects healthcare delivery to U.S. veterans. Providing VHA employees avenues to observe and report healthcare delivery anomalies without fear of reprisals will produce positive social change by improving the toxic work environment and promoting quality healthcare delivery to U.S. veterans.

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Dedication

This is dedicated to my parents, DeWayne F. Walker, and Mary K. Walker.

Acknowledgments

First, I would like to thank Dr. James Mosko and Dr. Kent Sieg. Your expertise and patience during my journey is most appreciated. Also, I would like to thank my family and friends who suffered with me during this journey. I have learned a great deal about a topic I am most enthusiastic about, but also, I learned more about who I have become since embarking on this journey.

Table of Contents

List of Figures

Chapter 1: Introduction to the Study

An advantage of joining the United States military is the benefits package. One of the benefits is healthcare during military service and after separation from military service. Veteran healthcare has been a federal responsibility since World War I (VA, n.d.a.). The Veterans Health Administration prides itself as the largest medical service provider in the world, serving around nine million enrolled U.S. veterans annually (VA, n.d.a.). With constant veteran influx, the Veterans Healthcare Systems are expected to be appropriately equipped and staffed.

Reported negligent VHA actions share plentiful similarities. These similarities include, but are not limited to, inconsistent processes, willful blindness, and lack of sufficient training. The negligence goes deeper and is more than a random occurrence.

By understanding the scope of the purported negligence, emphasis will be placed on the following. First, what opportunities of tacit knowledge, if any, contributed toward the purported negligence. Secondly, the weak enforcement style of the disciplinary policies practiced within Veterans Healthcare Systems. Thirdly, has the professional culture been shaped by inferior performance measures and poor decision delegation? Investigating these areas aim to reveal the root cause of this problem.

Background

Delayed healthcare and access to healthcare have been problematic since the ending days of the Civil War. During that time, the number of war veterans increased to nearly two million (VA, n.d.a.). The number would further increase due to conflicts that occurred after the Civil War up to World War I. In hopes of establishing guaranteed healthcare, in 1930, the Veterans Administration (VA) was established, making it the sole government entity responsible for U.S. veteran healthcare (Molina, 2018). In addition to the surge of U.S veterans, there was a significant increase in combat-related injuries and illnesses suffered by U.S. veterans.

In 2011, the United States Congress pressured the Veterans Healthcare Administration to ensure U.S. veterans were being seen on a prompt basis. The policy buttressed the standard for any U.S. veteran to see their primary care physician within 14 days of inquiry (Molina, 2018). This goal was significant as it was incorporated into employee performance evaluations. The Veterans Healthcare Systems struggled to maintain this initiative.

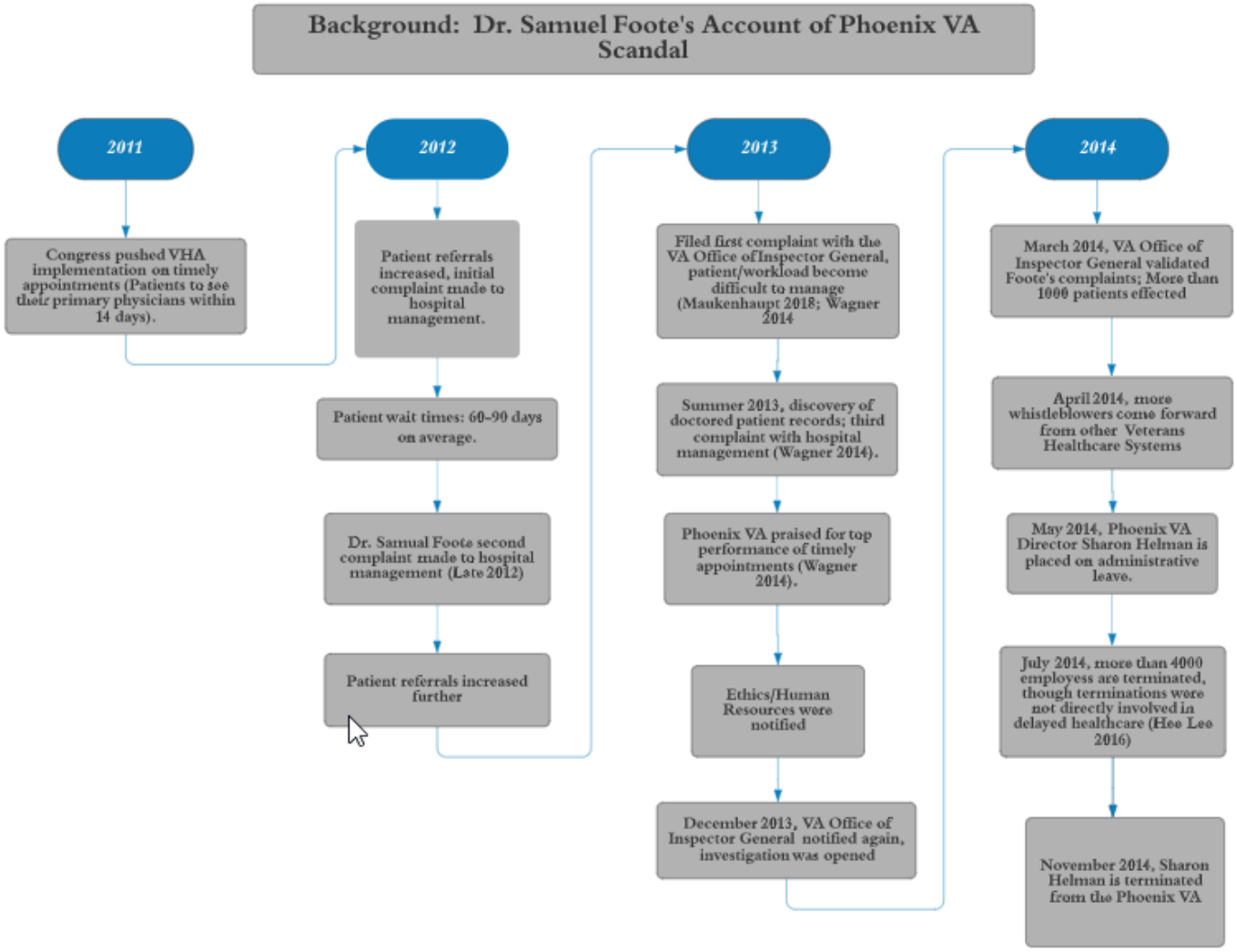
In April 2014, the Phoenix VA Healthcare System (PVA) became a central focus of medical access delays. Sharon Helman, Director of the Phoenix VA Healthcare System, implemented a goal to show improvement toward primary care access (VA, OIG 2017). Patients were shuffled around from one doctor to another. Delayed medical access escalated due to constant veteran surge and vacant physician roles left unfilled at PVA (VA OIG, 2017; Maukenhaupt, 2018). Dr. Samuel Foote, a former VA medical doctor at

PVA, documented the problem over a period of years (Wagner, 2014; Andrzejewski, 2019; ***Figure 1***).

Serious cases involving emergent ailments were wait-listed (Wagner, 2014). Patient referrals continued to rise, making daily patient care coverage difficult to manage. Dr. Foote reported his concerns to hospital management, VHA Employee Ethics, and Human Resources multiple times. All three departments agreed to investigate Dr. Foote's complaints, but no resolution followed (Wagner, 2014). Dr. Foote elevated the concerns to the VA Office of Inspector General.

The VA Office of Inspector General determined the following. Firstly, more than 4000 U.S. veterans on official and unofficial waitlists had waited three months or longer to see their primary care physicians. Secondly, the goal implemented by Sharon Helman played a significant role in the delayed healthcare access reported. According to Molina (2018), a mass cover-up took place by omitting patient records of elongated wait times. The findings prompted additional whistleblowers to come forward with similar incidents at other Veterans Healthcare Systems (Maukenhaupt,2018).

Figure 1



*Note***.** Sources:

Andrzejewski, A. (2015): The VA Scandal One Year Later. Forbes Media LLC, *Policy*. 1-5. Website. Retrieved From: https://www.forbes.com/sites/adamandrzejewski/2015/05/24/the-va-scandal-one-year- later/#174fc76d4cb8

Wagner, D. (2018): The doctor who launched the VA scandal. AZ Central. Website. Retrieved from: https://www.azcentral.com/story/news/arizona/investigations/2014/05/31/va-scandal-whistleblower-sam-foote/9830057/

Proposed Study

Previous research studies acknowledge the existence of inferior healthcare delivery by the Veterans Healthcare Systems. Hayward (2016) placed emphasis on poorly designed performance measures and poor decision delegation. Mannion and Davies (2018) posed inferior healthcare is a consequence of professional cultural frailty. By understanding the scope of the purported negligence, emphasis was placed on the following. First, analysis of opportunities, if any, of tacit knowledge that contributed toward the purported negligence. Tacit knowledge is defined as a social tenure that applies to skills, experience, values, and practice (Mohajan, 2016). Tacit knowledge is difficult to measure, but when applied to self-fulfillment, it reveals rewards or consequences. Secondly, analysis of the enforcement of disciplinary policies practiced at Veterans Healthcare Systems. Understanding both areas can provide insight on how the professional culture has affected healthcare delivery to U.S. veterans.

A mixed methods approach was the pillar of the research. A sequential transformative method was used to design the research plan. Cesare Beccaria's Rational Choice Theory guided the data analysis. The quantitative data were extracted and organized from the Office of Personnel Management Federal Employee Viewpoint Survey Database (OPM). The extracted OPM data were from VHA employees. The qualitative data were extracted from surveyed U.S. veterans. All data gathered were secondary.

The Veterans Healthcare Systems and the VHA can benefit from this study for the following reasons. Firstly, the research will supply information on why healthcare problems continue to occur in VHA facilities. Secondly, the information will provide positive improvement toward policy adherence.

Chapter 2: Literature Review

The practices engaged at the Phoenix VA Healthcare System Scandal are believed to be solely subservient. Theoretically, the actions discovered during the scandal were autonomous. Research suggested that since the scandal, inferior healthcare delivery at Veterans Healthcare Systems shared both characteristics.

Understanding the complexity of the problem involved a review on following areas. Firstly, a visual representation of cases within Veterans Healthcare Systems that were investigated by the VA Office of Inspector General. Secondly, an analysis was completed of the VA General Rules of Behavior and the Application of the VHA's Disciplinary Policy. Thirdly, an analysis of the VA Office of Accountability and Whistleblower Protection Act of 2017. Analysis into all three areas may provide understanding on inferior healthcare delivery within Veterans Healthcare Systems.

Case Presentations

Case #1: Oklahoma City VA Healthcare System (OKVHS): Misuse of Official Time and Failure to Properly Supervise

Between April 2014 and September 2016, an employee did not physically show up for work at the OKVHS. The employee was found to have been working at Johns Hopkins University (JHU) during his scheduled hours at the OKVHS. This employee traveled extensively, for lectures and medical conferences, not sponsored by the VA (Department of Veterans Affairs Office of Inspector General, 2018a). The employee's

supervisor did not physically acknowledge this employee's presence, nor did he verify the hours this employee reported.

With the findings, the following occurred. First, the employee teleworked without authorization. Secondly, the employee collected combined compensation from the OKVHS and JHU. Thirdly, the employee misused his official time while traveling and lecturing during his VA scheduled hours. (Department of Veterans Affairs Office of Inspector General, 2018a). Fourth, of the employee's tenure with the OKVHS, he was only present 30 of the 409 days for which he was compensated. Finally, the employee's supervisor did not exercise appropriate diligence managing him.

The financial damages reported were more than $72,000 (Department of Veterans Affairs Office of Inspector General, 2018a). The matter was referred to the U.S. Attorney's Office for the Western District of Oklahoma (Department of Veterans Affairs Office of Inspector General, 2018a). Prosecutors did not pursue criminal charges in the matter. According to Wagner (2017), the employee was terminated, and the supervisor resigned in March 2017. The OKVHS was working with the offices of VA General Counsel and OKVHS Human Resources on debt collection efforts (Wagner 2017). It is unknown whether debt collection efforts were successful, or if the employee is still active in the medical profession.

Theme Words: Poor Decision Delegation, Tacit Knowledge, Financial Gain

Case #2: Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky

In late December 2017, multiple complaints were generated against a primary care provider for falsifying blood pressure readings. An investigation determined the primary care provider repeatedly documented normal blood pressure readings of 128/78 for numerous high-risk patients. A random review of 5,000 patient records was conducted between October 1, 2015, to December 26th, 2017. The review revealed more than 1,300 patients were diagnosed previously with elevated risks, but blood pressure readings of 128/78 were documented. Not only did the primary care provider falsify blood pressure readings but did not provide the appropriate healthcare management for the patients (Department of Veterans Affairs Office of Inspector General, 2018b).

When inquired of these actions, the primary care provider given absurd explanations such as to restrain repetitive clinical reminders and to control excessive workload. Regardless of the reasons provided, the actions were of personal benefit. The primary care provider received a performance reward in the amount of $4,500 for successful hypertension management. Secondly, the facility did not have a documented oversight process in place for performance validation. Thirdly, a nurse practitioner and the primary care provider both were willfully ignorant to each other's errors (Department of Veterans Affairs Office of Inspector General, 2018b). Finally, the workload of the primary care provider was not higher than any other primary care provider at the clinic.

This case was referred to the United States Attorney for the Eastern District of Kentucky for criminal prosecution. At the conclusion of the investigation, the primary

care provider was terminated from duty. No criminal charges were filed. In addition to updated staff training, management updated procedures regarding blood pressure measurement and documentation requirements. The patients that were affected by primary care provider's actions were notified and referred to new primary care providers.

Between January and June 2018, a nationwide search of VHA providers was conducted who used the same blood pressure reading more than 150 times in multiple patients. Search results yielded additional occurrences at an outpatient clinic in Salem, Virginia. A primary care provider used repeated hypertension readings for previously identified at-risk patients. The VA Office of Inspector General determined the provider did not implement adequate hypertension management. Further, the clinic did not have a process in place to verify performance measurements. As of August 2018, the provider was terminated from duty. It is not known whether criminal charges were filed in this case.

Theme Words: Complaints, Tacit Knowledge, Financial Gain, Willful Blindness

Case #3: Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia

Between January 1, 2018, and June 26th, 2018, a primary healthcare provider falsified blood pressure readings for more than 150 patients. During an analytic data pull using this measurement, the measurement of 139/89 occurred multiple times during this period department of Veterans Affairs Office of Inspector General, 2019a). The affected patients were diagnosed with hypertension, diabetes, or cardiovascular disease.

According to the investigative notes, the readings recorded would have been impossible for such patients to exhibit.

Additionally, the provider documented the reading more than 30% of the time. Of the 150 patients affected, no hypertension management effort was provided in nearly one-third of the patients. There was little evidence to support close patient monitoring, medication changes, etc. (Department of Veterans Affairs Office of Inspector General, 2019a).

During investigative efforts, the justifications provided by the provider were not credible. The provider reportedly advised other employees that this “lazy effort” to improve metric scores. Unlike in Case #2, no performance related incentives were reported being received by the provider. The VA Office of Inspector General interviewed the Chief of Staff and Chief of Primary Care regarding the initial response to this matter. They posited what data they had was insufficient and that complete data was inaccessible. These explanations as provided were discredited (Department of Veterans Affairs Office of Inspector General, 2019a).

Another concern was the sluggish response of management when approached about this issue. OIG interviewed several employees who collaborated with his provider. These employees were aware of this issue stemming back to 2017, but did nothing to report their concerns (Department of Veterans Affairs Office of Inspector General, 2019a). It was later learned this facility did not implement a validation process for hypertension management. The VA Office of Inspector General believed if validation

efforts were in place, this issue likely would have been discovered sooner (Department of Veterans Affairs Office of Inspector General, 2019a).

Theme Words: Lazy Effort, Falsified Documentation, Willful Blindness, Tacit Knowledge, No Verification Policy

Case #4: Factors Contributing to the Death of a Ventilator-Dependent Patient at the San Diego VA Healthcare System (SDVHS)

During the summer of 2018, the VA Office of Inspector General was made aware of the death of a patient whose breathing was supported by a ventilator. The death was considered unusual. When the patient was found, the ventilator tube was disconnected and there was nothing indicative of a triggered alarm. Documented visitors of the patient were a family member and a respiratory therapist. The respiratory therapist added a Passy-Muir Valve (PMV) on the ventilator, which allowed the patient to communicate (Department of Veterans Affairs Office of Inspector General, 2019b).

Records revealed the therapist did lower the alarm's sensitivity to not trigger repeatedly while the PMV was active (Department of Veterans Affairs Office of Inspector General, 2019b). Staff checked on the patient at least three times between 7:00 am and noon. At 12:07 pm, the patient was found unresponsive. Purposeful disconnection of the breathing tube was investigated. The hospital staff informed the Office of Inspector General that the tubing can disconnect with patient movement.

During the investigation, the VA Office of Inspector General was not able to determine the settings of the ventilator prior to the patient dying. After the patient's death, it was determined the settings were adjusted to measure if an alarm failure

occurred. The facility did not have any risk strategies in place regarding patient safety while the PMV was operational. There was no backup plan in place in the event if the alarm did fail.

Additionally, the VA Office of Inspector General determined there were no policies in place regarding the education of PMV use. Secondly, there were no procedures of observance during PMV use. Thirdly, there was no documentation (i.e., VHA reports, reported advisories, etc. covering PMV issues), of whether there were instances of spontaneous removal of ventilator tubing (i.e., pop-offs). Since the patient was immobile, spontaneous removal is unlikely.

After the investigation concluded, the VA Office of Inspector General determined the respiratory staff had limited training regarding the use of the PMV, along with the use of an outdated nurse call system. The VHA did not implement a policy regarding the use of anti-disconnect devices (Department of Veterans Affairs Office of Inspector General, 2019b). It was reported the respiratory staff had no training on the use of anti-disconnect devices. In the event of spontaneous removal of the tubing, the staff did not submit reports of such events.

The VA Office of Inspector General determined leadership failed the standard in clinical alarm management (Department of Veteran Affairs Office of Inspector General, 2019b). These, along with other inconsistencies, were indicative of patient harm. As a result, the patient's death could have been prevented. As a response, the respiratory unit and leadership did have additional training, staff incident debriefings, and emotional

support. The VA Office of Inspector General recommended the SDVHS Director ensure such changes to be implemented and regularly monitored by compliance.

Theme Words: Inconsistencies, Lack of Training, Lack of Documentation, Tacit Knowledge, Negligence.

Case Conclusion

The cases were presented to support the purpose of why this research is needed. These cases revealed the actions of staff that resulted from the toxicity because of inadequate oversight, training, and fear. The basic tenets of healthcare were grossly violated, and U.S. veterans were put through unnecessary risk.

Individual praxis can be improved or shadowed by experience, but dependent on overall intention. Cases such as those cited shared a common theme: Tacit Knowledge. Risk is difficult to measure because of what occurred at the Phoenix VA appeared to be circumstantial (Donaldson, 2017). These cases are a handful of examples of the seriousness of this problem. Additional cases continue to be reported, but it is crucial to recognize the power is in the hands of the employees.

VA General Rules of Behavior and the Application of the VHA's Disciplinary Policy

As part of new hire orientation, VHA employees must acknowledge a seven-page employment addendum defined as the VA National Rules of Behavior (ROB) (Department of Veterans Affairs, n.d.b). The VA ROB states:

> I understand that I have a duty to report information about actual or possible criminal violations involving VA programs, operations, facilities, contracts, or information systems to my VA supervisor; Information System Owner, local Chief Information Officer (CIO), or designee; and ISO, any management official or directly to the OFFICE OF INSPECTOR GENERAL, including reporting to the OFFICE OF INSPECTOR GENERAL Hotline. I understand that I have a duty to immediately report to the OFFICE OF INSPECTOR GENERAL any possible criminal matters involving felonies, including crimes involving information systems.

The addendum has two performance categories. Firstly, the rules of behavior covering the basic requirements of due diligence as a VA employee. Secondly, an emphasis on privacy and security (Department of Veterans Affairs, n.d.b). The addendum provides minimal standards that must be followed. Failure to acknowledge the addendum will adversely affect overall employment (Department of Veterans Affairs, n.d.b). The clarity of this expectation is transparent. The language within this statement empowers all VA employees to do what is right.

The caveat of the VHA's Disciplinary Policy place emphasis on discretionary measures, depending on the seriousness of the misconduct. The VA defines discipline as a progressive measure assessed in four ways. Firstly, determination of what occurred (i.e., basic fact-finding). Secondly, the degree of willfulness of the misconduct. Thirdly, the seriousness of the conduct or determination of leveled competence. Finally, the overall impact on VA operations (Department of Veterans Affairs, n.d.b). The disciplinary actions include reprimands and termination of employment.

VA Office of Accountability and Whistleblower Protection of 2017 (OAWP)

To improve the VA's ability to strengthen accountability measures and the empowerment of whistleblowers, OAWP was created (Department of Veterans Affairs Office of Inspector General, 2019b). In addition, this measure focused to hold senior executives accountable for misconduct but additionally hold management responsible for retaliation efforts toward whistleblowers. As part of performance reviews of senior executives, this measure was woven to address inferior performance.

Comparing the OAWP, the ROB and the disciplinary policies in place, there is trivial difference between the three. Between June 2018 and December 2018, the VA Office of Inspector General investigated allegations of unfairness, accountability issues, and whether the full legal scope was exercised in protections of whistleblowers (Katz, 2019). The VA Office of Inspector General determined the OAWP did not protect whistleblowers. According to the report released by the Office of Inspector General (2019b), investigators had whistleblowers sign disclosures releasing their names and

referring them back to the originating facilities or to other offices. Additionally, it was determined the OAWP had misinterpreted its own legal mandate which resulted in poor implementation of investigative authority (Department of Veterans Affairs Office of Inspector General, 2019b).

Re-examining the events of the PVA Scandal in 2014, the basic tenet of the ROB was followed by Dr. Foote. The PVA Scandal emphasized deficient management and fear of retaliation toward those that opposed management direction. If retaliatory threats are drivers of the purported negligence observed thus far, consider the following: Are retaliation fears a driver of a toxic workplace culture exhibited within the Veterans Healthcare Systems? Written policy makes trivial difference unless enforced as designed.

Organizational Culture and Workplace Culture Within a Healthcare Setting

Azzolini et al (2018) affirms an organization's culture will define the behavior more than the organization's implemented structure. Additionally, Azzolini et al (2018) stated that the structure of a healthcare organization is the simplest to change. The enigma is if healthcare structure is easy to change, healthcare is not. This statement explains the pattern of unrealistic approaches currently adopted by the VA. Mannion and Davies (2018) emphasized organizational culture is primarily responsible for healthcare scandals.

According to Braithwaite et al (2017), the effects of a negative workplace culture within a healthcare setting are extremely critical. Braithwaite et al. (2017) explains there is little evidentiary support that reveals a negative workplace culture as a sole driver for

inferior healthcare. A constructive workplace culture is believed to be more productive, while a toxic workplace culture is counter-productive (Braithwaite et al 2017). Ideally, understanding the dynamics in each is key to the design of improvement initiatives, but challenging due to subjectivity. This presents an excellent research opportunity as there are no known connections as to whether organizational culture and workplace culture affect healthcare delivery simultaneously (Braithwaite et al., 2017).

Mannion and Davies (2018) identify healthcare organizational culture as an obscure aspect of healthcare service organizations and their associated patterns of care. Generally, organizational culture falls back on a pre-designed setting (Braithwaite et al., 2017). According to Azzolini et al (2018) organizational culture (i.e., healthcare, or other professions) is a crucial element in organizational strategy, goals and operational processes that effect morale, turnover, and quality of care issues.

There are three levels of healthcare organizational culture. First, there are visible demonstrations (Mannion and Davies, 2018). These demonstrations are visual roles within healthcare and the physical activity or layout associated with each role. Examples include staffing practices, reward systems, risk management, the response of staff concerns and patient feedback (Mannion and Davies, 2018). Secondly, mutual ways of thinking (Mannion and Davies, 2018). This typically includes a value or belief system that justifies behavior and the manifestations associated. Common examples of values include whistleblower action, improvement of service, dignity, and respect. Finally, Mannion and Davies (2018) explains there are shared assumptions. Shared assumptions are commonly viewed as professional attributes in a medical setting. Examples include

the dialogue spoken between nurses and doctors and the dialogue between patients and staff. These assumptions are molded from various macro policies, such as merit systems (Mannion and Davies, 2018; Minseo and Behr, 2017). These three levels are flawed due to management practices, daily demand, and current work conditions (Gauthier and Marchand, 2016).

Healthcare workplace culture does not follow any healthcare organizational cultural model. Healthcare workplace culture is a mixture of subcultures and counter cultures (Mannion and Davies, 2018). This is due to extensive involvement of complex social constructs, such as decision-making abilities or stressors (Braithwaite et al., 2017). Azzolini et al (2018) emphasizes the success for any healthcare organization, it is critical to shape a culture which welcomes engagement strategies along with continuous improvement. According to the VA's National Center for Organization Development, there is a strong correlation between successful employee engagement and patient satisfaction (Orgrysko, 2019). However, little investigative effort has been made (Azzolini et al., 2018).

Chapter 3: Research Method

Methodology

A major purpose of this study was to understand the toxicity of the professional environment within Veterans Healthcare Systems and whether the toxicity affects healthcare delivery to U.S. veterans. A mixed methods design was the backbone of the research. A sequential transformative design was selected for its transparency and focus on transformational research for marginalized populations.

Cesare Beccaria's Rational Choice Theory (RCT) formed the basis on data analysis. RCT was selected for its simplistic approach on why immoral behavior occurs. Extraction of quantitative data was from the Office of Personnel Management Federal Employee Viewpoint Survey Database (OPM). The quantitative data were sampled directly from results provided by Veterans Healthcare System employees. The qualitative data were obtained from surveyed U.S. veterans. Both data sources are secondary and were examined for attributable themes related to this problem.

Framework: Rational Choice Theory (RCT)

RCT focuses on formal and informal sanctions of egregious utility but emphasized on a secondary concept called the false idea of utility. Cesare Beccaria promoted the concept as a dividing factor of the public good from individuals and unnecessarily sacrifices agenda (i.e., set rules) for recognition or convenience (Freilich, 2015). The false idea of utility concept appears to be an extensive factor of this problem. Egregious utility is a driver of decision making and of tacit knowledge.

This framework was selected for the following reasons. Firstly, it directs the analysis of the costs and benefits of egregious behavior (Freilich, 2015). Secondly, the RCT testable easily compared to other similar theoretical approaches, such as the General Theory of Crime. Examination of the case examples from the VA OIG, along with the combined survey responses will explain the drivers of this behavior, but also why this behavior still occurs.

Theory Considered: General Theory of Crime (Low Self-Control Theory)

A theory considered for this study was Gottfredson's and Hirschi's General Theory of Crime (1990) (Meldrum 2016). This theory heavily leaned on the low self-control concept. While this theory offered a simple explanation toward deviance, its limitation overshadowed the overall purpose of this research (Reisig and Pratt 2011). Additionally, Gottfredson and Hirschi viewed low self-control as adequate in explaining criminal behavior, but on a pre-conditional stance (Meldrum 2016). In other words, a person who would meet such criteria would need to be labeled as impulsive, self-indulgent, or criminally deviant. Due to this limitation and high biased approach, this theory was not selected for this research.

Research Method: Sequential Transformative Design

This method provides simple guidance toward any chosen theory, framework, or idea. Collaboration with this method allows the following. Firstly, it offers insight that is not standardized. Standardized insight reveals on "Who is to blame?" versus "What is the root cause?" Standardized insight has been the route long followed on current policy

design for the VHA and Veterans Healthcare Systems. Secondly, this design provides holistic, transformative thought toward a phenomenon, issue, or process (Plano Clark and Creswell, 2008). Thirdly, the sequential transformative design is root-cause specific. Ultimately, this design helps deter away from the "It is complicated" mode of thinking and reasoning. With these advantages, there are limitations. Firstly, this method can be time extensive. Secondly, there has been little insight on a noted process on how to employ this method. The design breakdown will be as follows:

Figure 2 – Design Breakdown

QUALITATIVE DATA + QUANTITATIVE DATA = RESULT
Or
QUANTITATIVE DATA + QUALITATIVE DATA = RESULT

The Sequential Transformative Design focuses on a marginalized population. In this study, there are two populations involved: U.S. veterans and Veteran Healthcare System employees. This design is researcher driven and promotes a transformational research effort (Plano Clark and Creswell, 2008). Importantly, this method steers away from status quo ideology (i.e., "It is complicated").

Research Questions Restated

The research focused on the following two research questions.

RQ1: Is the healthcare delivery problem the result of individual praxis or systemic malfeasance?

RQ2: Is the power truly delegated to VHA employees to improve healthcare delivery for U.S. veterans?

Through the exploration of a mixed methods design, further clarity will help determine the root cause of this problem and promote flexibility on other ideas toward a resolution.

Role of Researcher

There were no professional nor personal relationships with any participants. The role remained unchanged throughout the study. Determination was made to reduce subjectivity and promote objectivity during analysis. The committee was immediately notified in cases involving bias. A plan of action was determined based on feedback received from the committee.

Ethical Concerns

Ethical issues were minimal as the researcher was not employed at the VA nor shared any affiliation of the VA or VHA respectfully. The data analyzed was secondary and of public access.

Methodology Procedures

The populations studied were U.S. veterans and Veterans Healthcare employees. Through a data mining process, the quantitative and qualitative data were pulled from two sources. Firstly, the Office of Personnel Management Federal Employee Viewpoint Survey Database (OPM). Secondly, the Department of Veteran Affairs. The timeframe analysis focused from the years of 2018 to 2021. Up until 2017, the Department of Veterans Affairs utilized the Federal Employee Viewpoint Survey (FEVS) for their employees. The FEVS utilized was extensive to VA employees, which created potential survey fatigue (VA 2020). Presently, the Department of Veterans Affairs created their own survey that is specific to only their employees (Ogrysko, 2018). Both data sources were examined for attributable themes related to this problem. Qualitative and quantitative data were organized and presented through Microsoft Excel ™ software.

Threats to Validity

The threats to validity of data were slight. Such instances include availability of the employee survey data, which could have been changed at any given time (i.e... no longer available or invalidation). Secondly, internal error of analysis by researcher (i.e... clerical or procedural errors). The likelihood of these threats to occur were small. If such threats were encountered, the dissertation committee would have been notified immediately.

Trustworthiness

Information gathered was held in the strictest of confidence. The detail of data was only discussed between researcher, dissertation committee and Walden University IRB. Collected data was secured through a scan disk that is password-protected, only accessible to researcher and committee members, if solicited. Any hard copies were kept in a locked secure office drawer. All collected data will be kept during the lifetime of the researcher.

In the event of an end-of-life issue with the researcher, all data will be surrendered to Walden University. If collected data becomes lost, Walden University IRB and Committee will be immediately notified. Any remediation efforts will be discussed and carried upon recommendation of committee and Walden University.

Ethical Procedures

In order eliminate any unethical concerns about the data accessed and analyzed, communication will be immediate to the dissertation committee and Walden University. Remedy efforts will be discussed and applied as necessary, including and/or up to termination of the study. An agreement will be drawn up between Walden University and the researcher.

Chapter 4: Results

Data

The data gathered for this study was completely secondary. Search efforts involved queries into the Office of Personnel Management Federal Employee Viewpoint Survey Database, the Department of Veteran Affairs, and Data.gov websites. The queries centralized on survey responses gathered from 2018-2021. The survey responses were organized and presented visually through Microsoft Excel ™ software.

The data reviewed included the following areas. Firstly, survey years of 2018-2020, the responses of the VHA Employee surveys focused on selected themes as acknowledged from the OIG case examples. The survey taken in 2021 was further expanded to include areas such as skill development and supervisor trust. Secondly, the survey responses from U.S. veterans focused on their ratings of their VA health experience and primary care patient experience as of 2019 and 2021. Finally, Servant Leader Index responses extracted from the VHA All Employee Survey from 2020-2021. The Servant Leader Index responses covered areas such as supervisory listening, respect, trust, display of favoritism, and how concerns are addressed. For the purposes of this study, only six random locations were used.

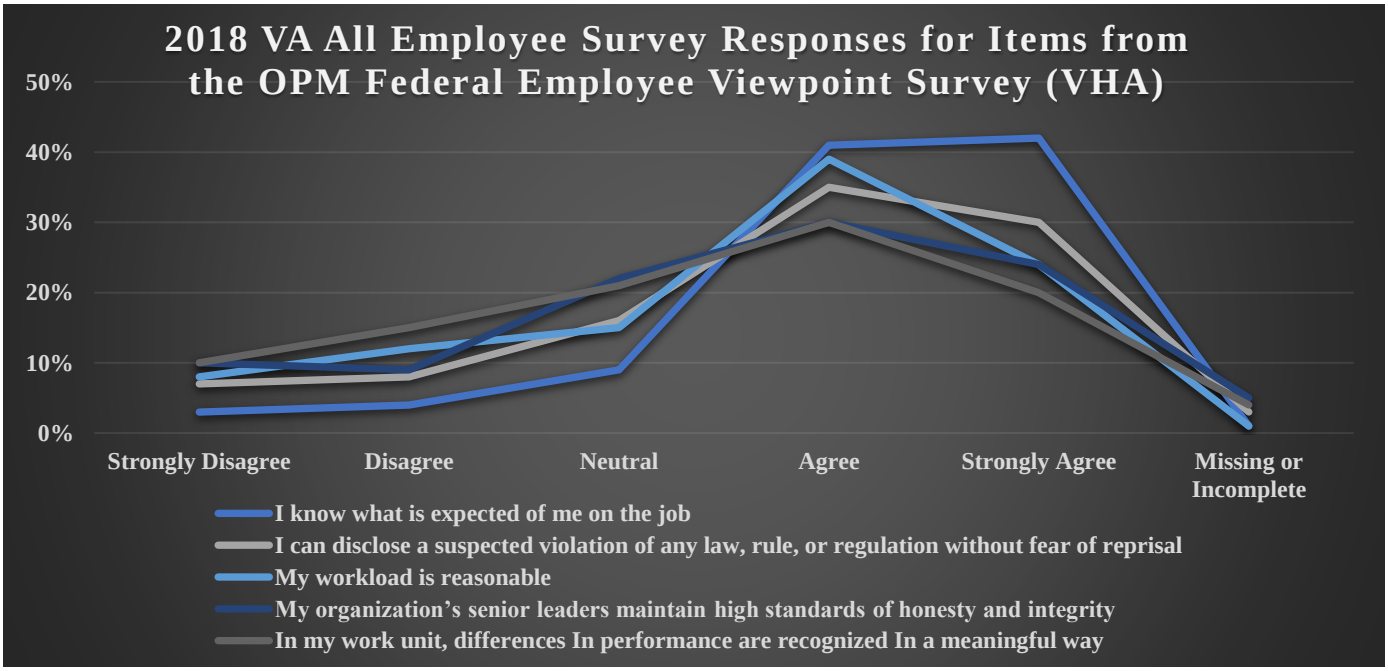
Presentation of the Findings – VHA employees

The data are organized on a percentage measurement between 0-50%. The responses recorded are through a Likert Scale (Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree, and Missing or Incomplete). The survey items as selected are:

(1) I know what is expected of me on the job.
(2) I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.
(3) My workload is reasonable
(4) My organization's senior leaders maintain high standards of honesty and integrity.
(5) In my work unit, differences in work performances are recognized in a meaningful way.

Figure 3

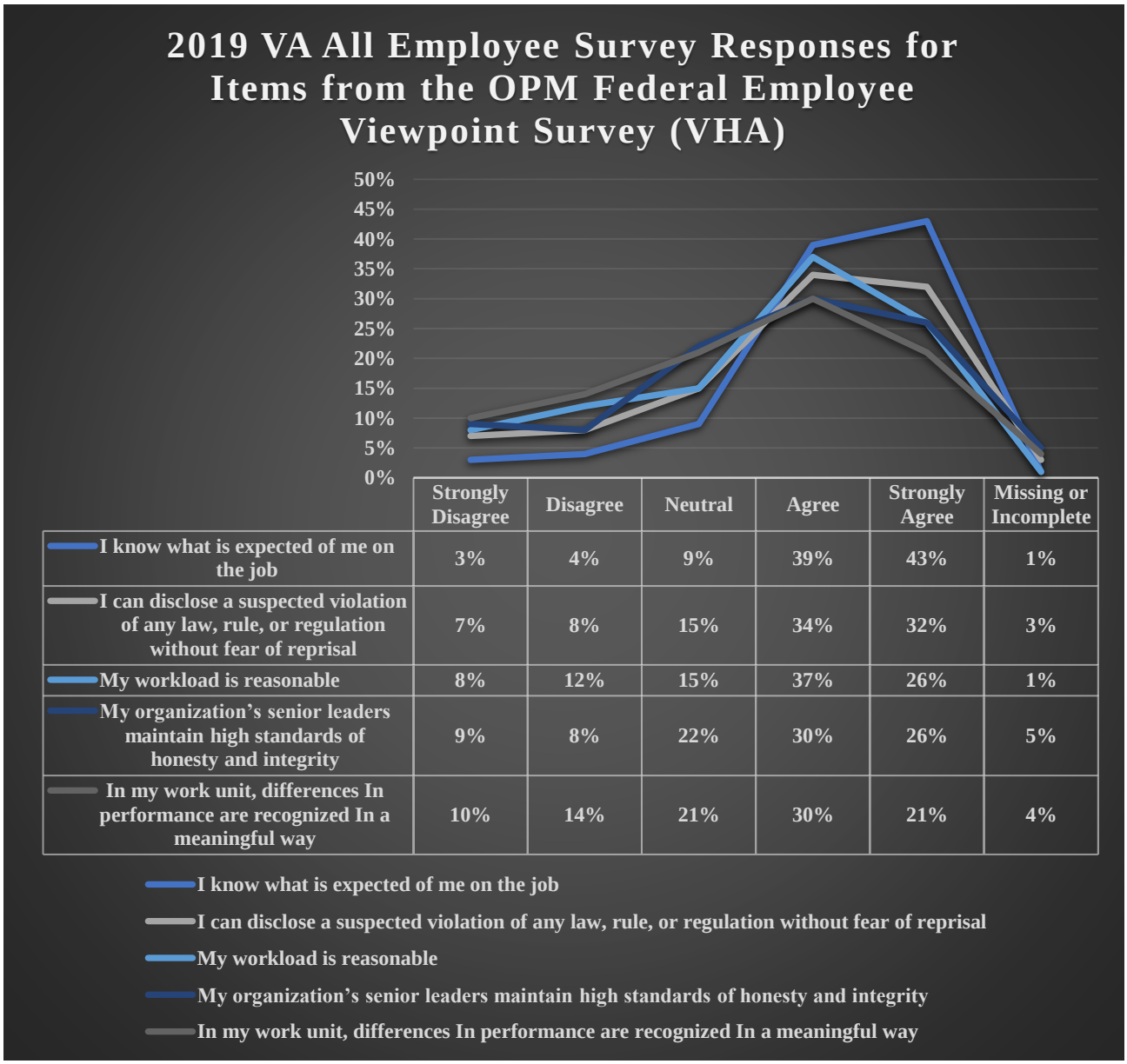
VA All Employee Survey - 2018



Note. Source: Department of Veteran Affairs (2021a). National Center for Organization Development: VA All Employee Survey. Website. Retrieved from: https://www.va.gov/NCOD/VAworkforcesurveys.asp

Figure 4

VA All Employee Survey – 2019

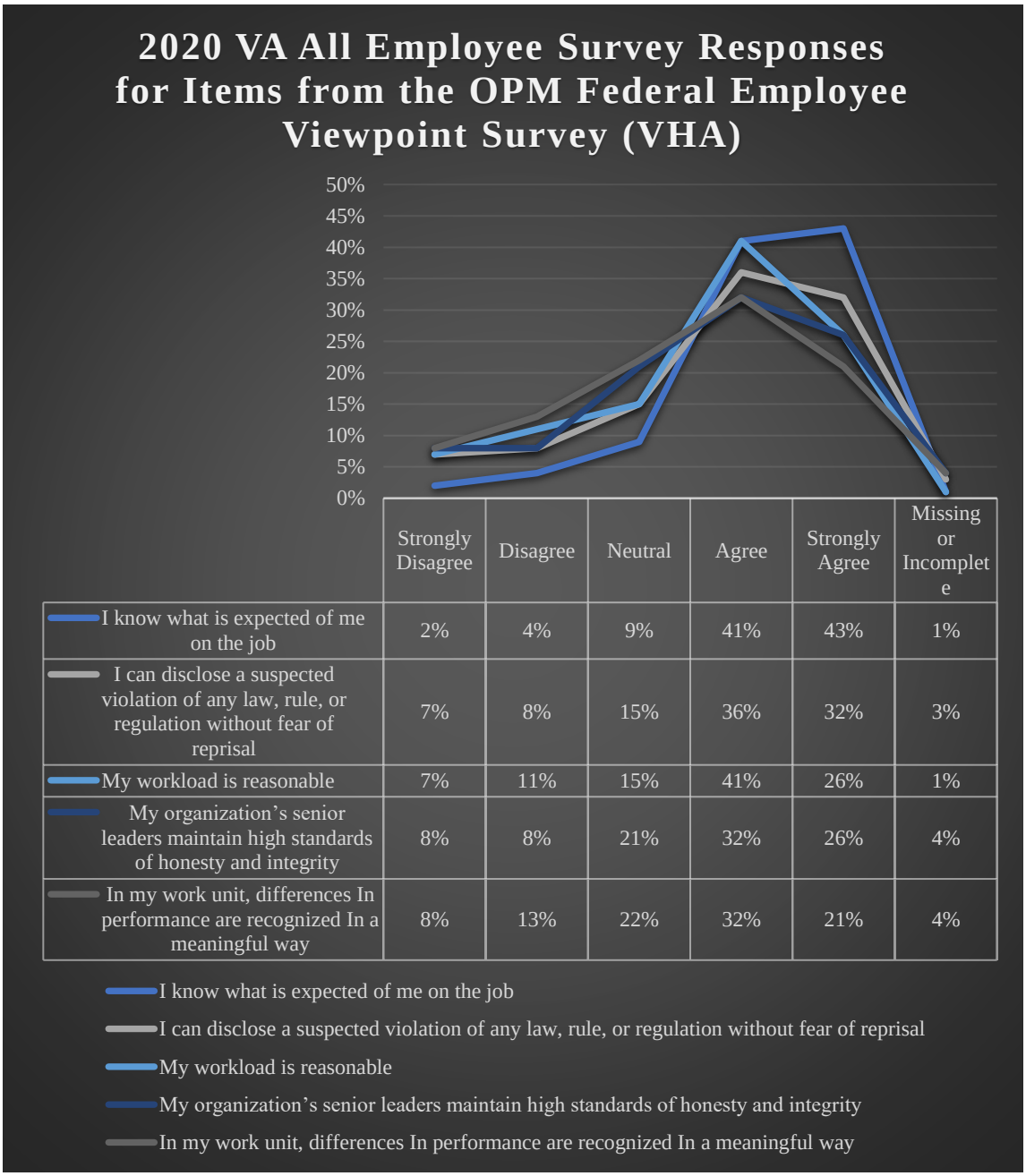


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Missing or Incomplete
I know what is expected of me on the job	3%	4%	9%	39%	43%	1%
I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal	7%	8%	15%	34%	32%	3%
My workload is reasonable	8%	12%	15%	37%	26%	1%
My organization's senior leaders maintain high standards of honesty and integrity	9%	8%	22%	30%	26%	5%
In my work unit, differences In performance are recognized In a meaningful way	10%	14%	21%	30%	21%	4%

Note. Source: Department of Veteran Affairs (2021b). National Center for Organization Development: VA All Employee Survey. Website. Retrieved from: https://www.va.gov/NCOD/VAworkforcesurveys.asp

Figure 5

VA All Employee Survey – 2020

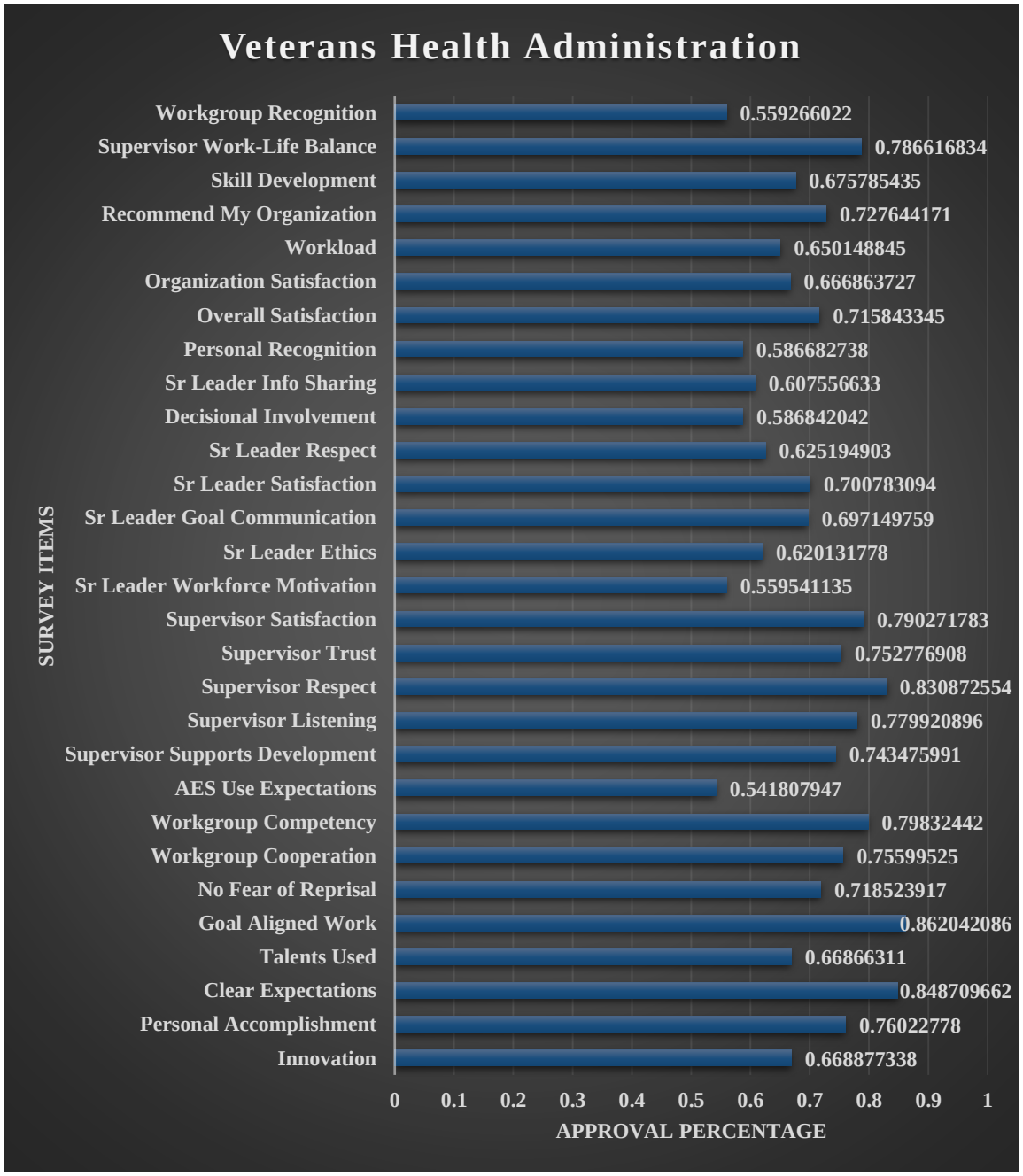


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Missing or Incomplete
I know what is expected of me on the job	2%	4%	9%	41%	43%	1%
I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal	7%	8%	15%	36%	32%	3%
My workload is reasonable	7%	11%	15%	41%	26%	1%
My organization's senior leaders maintain high standards of honesty and integrity	8%	8%	21%	32%	26%	4%
In my work unit, differences In performance are recognized In a meaningful way	8%	13%	22%	32%	21%	4%

Note. Source: Department of Veteran Affairs (2021c). National Center for Organization Development: VA All Employee Survey. Website. Retrieved from: https://www.va.gov/NCOD/VAworkforcesurveys.asp

Figure 6

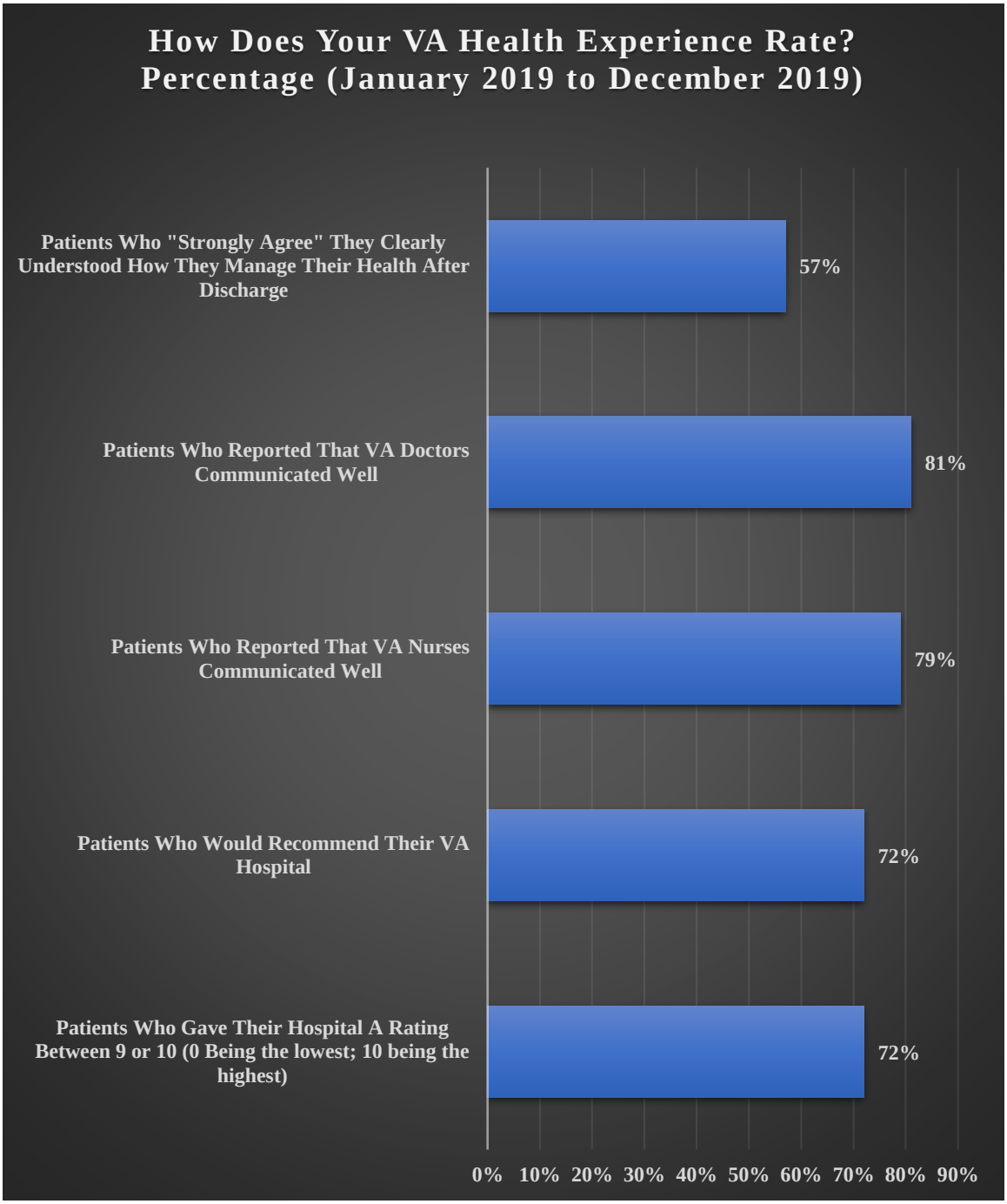
2021 All Employee Survey (AES)



Note. Source: Department of Veteran Affairs (2021c). VA All Employee Survey: Federal Comparisons. Website. Retrieved from: https://www.data.va.gov/stories/s/r32e-j4vj

Figure 7

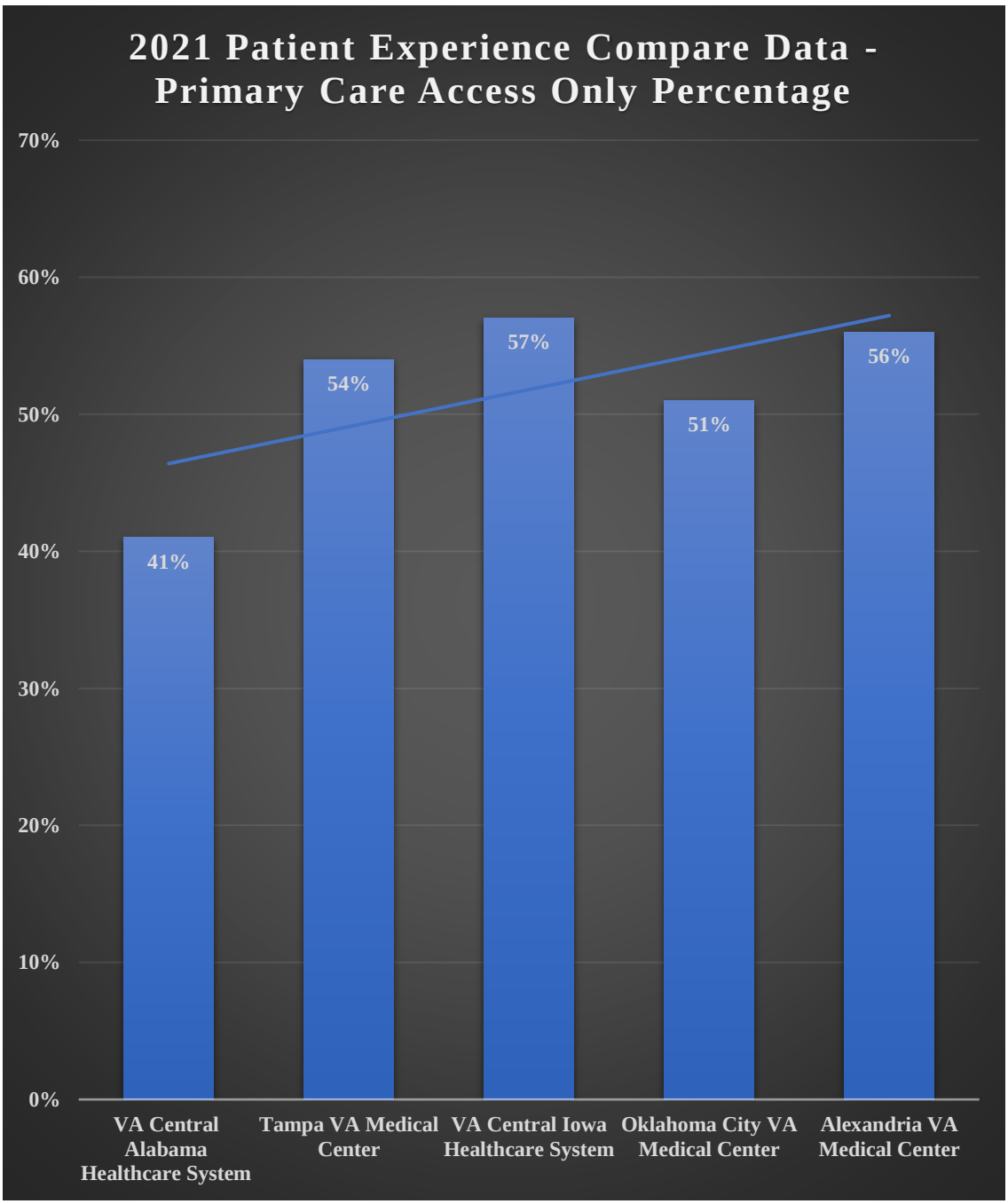
U.S. Veteran Input – 2019 and 2021



Note. Source: Department of Veteran Affairs (2021d). Quality of Care. Website. Retrieved from: https://www.va.gov/QUALITYOFCARE/apps/shep/barchart.asp

Figure 8

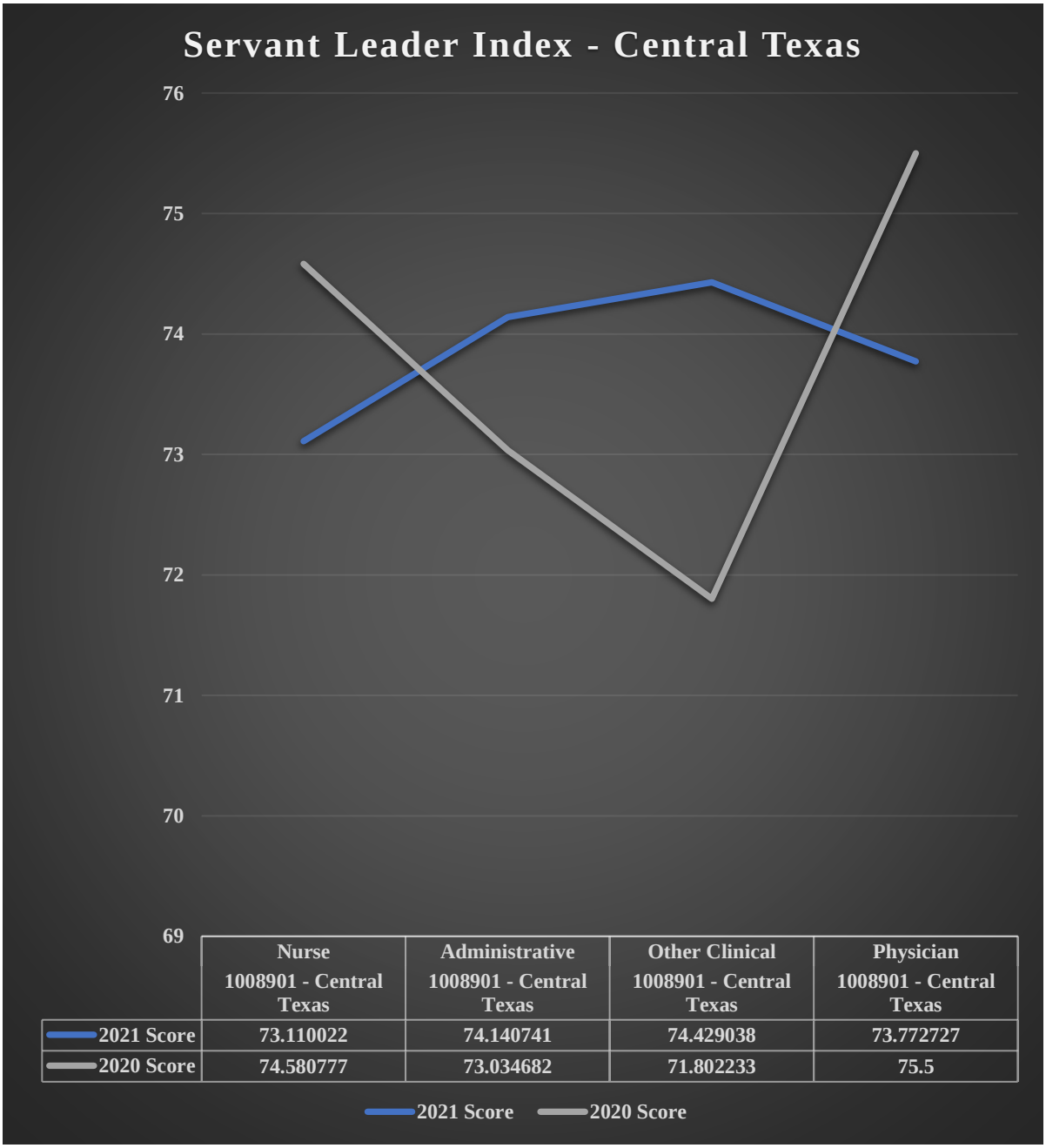
2021 Veteran Input (Randomized Location Selection, As of April 30th, 2021)



Note. Source: Department of Veteran Affairs (2021d) Access to Care. Website. Retrieved from: https://www.accesstocare.va.gov/Healthcare/PatientExperienceCompareData?s=AL&f=521&t=Access

Figure 9

Servant Leader Index: 2020-2021 (Central Texas)

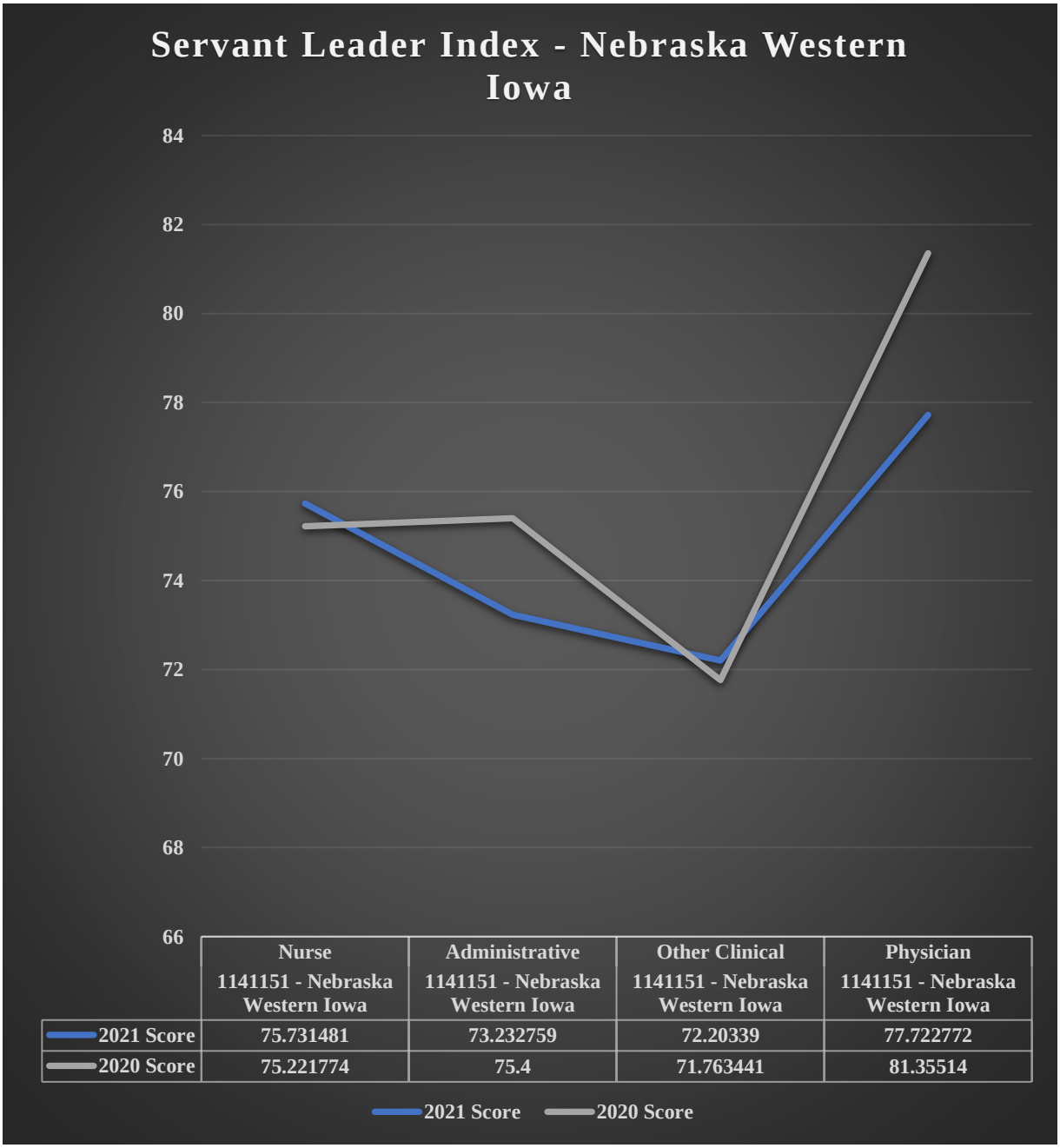


	Nurse 1008901 - Central Texas	Administrative 1008901 - Central Texas	Other Clinical 1008901 - Central Texas	Physician 1008901 - Central Texas
2021 Score	73.110022	74.140741	74.429038	73.772727
2020 Score	74.580777	73.034682	71.802233	75.5

Note. Source: Department of Veteran Affairs (2021e): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

Figure 10

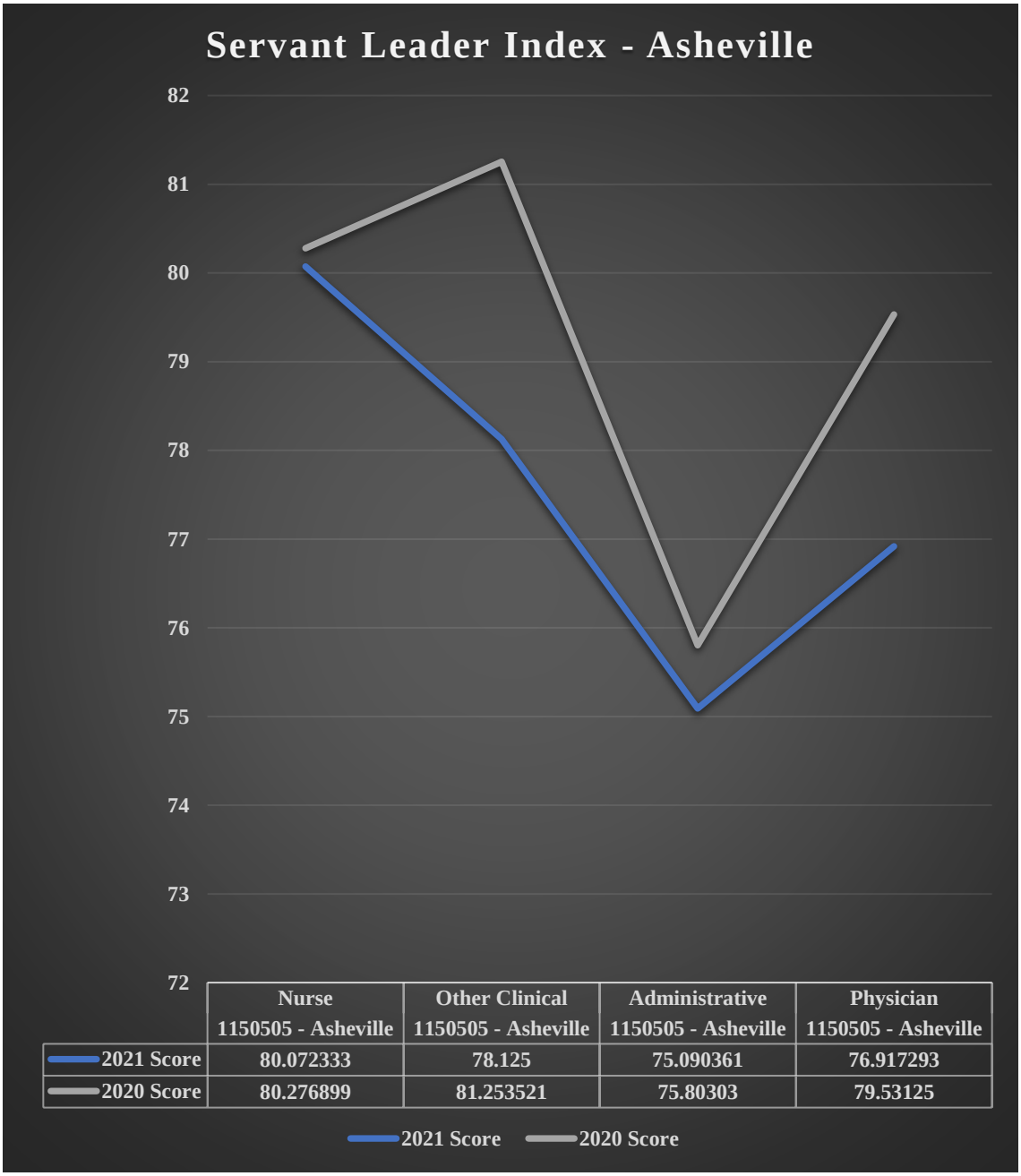
Servant Leader Index: 2020-2021 (Nebraska Western Iowa)



Note. Source: Department of Veteran Affairs (2021e): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

Figure 11

Servant Leader Index: 2020-2021 (Asheville)

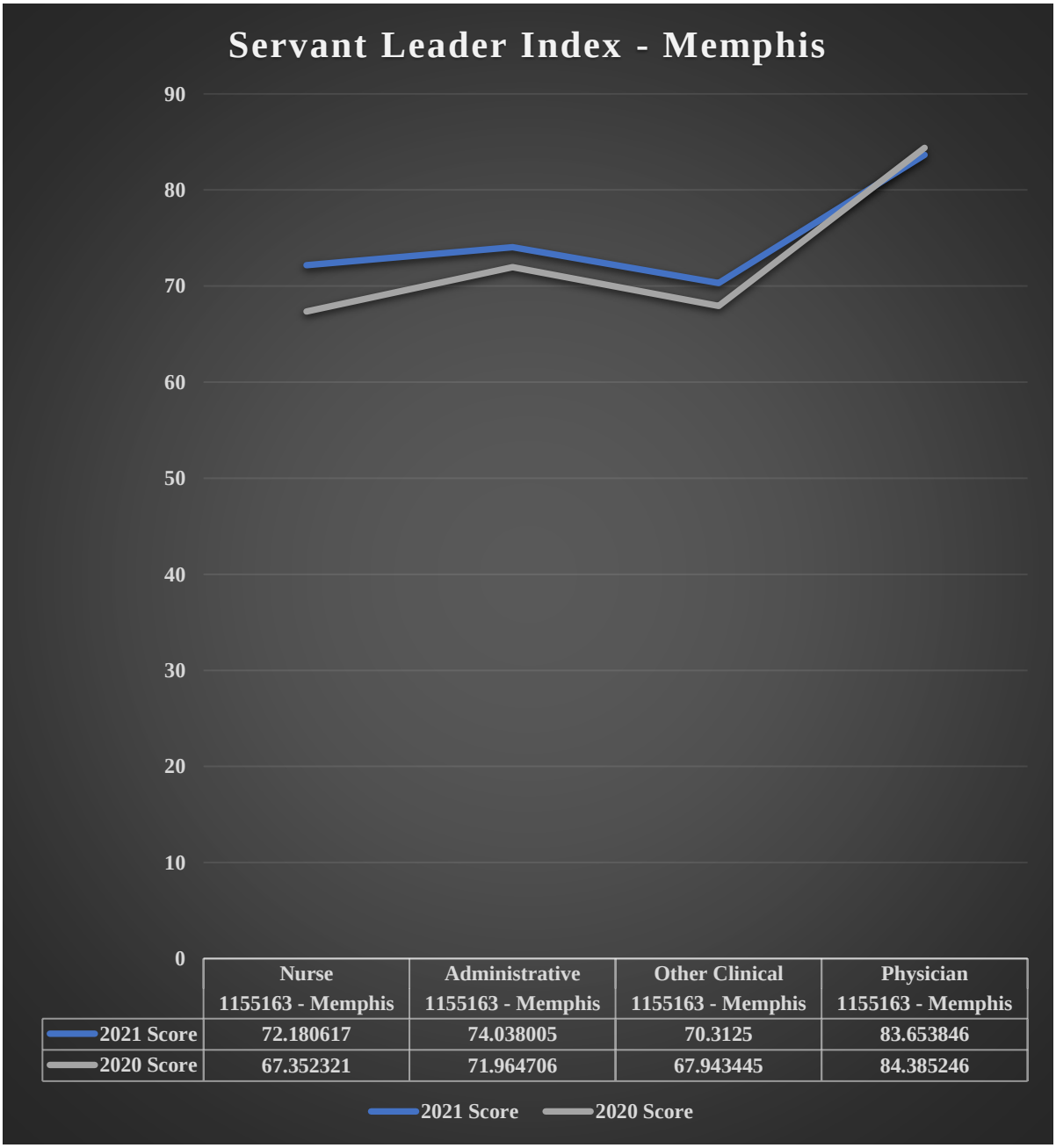


	Nurse 1150505 - Asheville	Other Clinical 1150505 - Asheville	Administrative 1150505 - Asheville	Physician 1150505 - Asheville
2021 Score	80.072333	78.125	75.090361	76.917293
2020 Score	80.276899	81.253521	75.80303	79.53125

Note. Source: Department of Veteran Affairs (2021): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

Figure 12

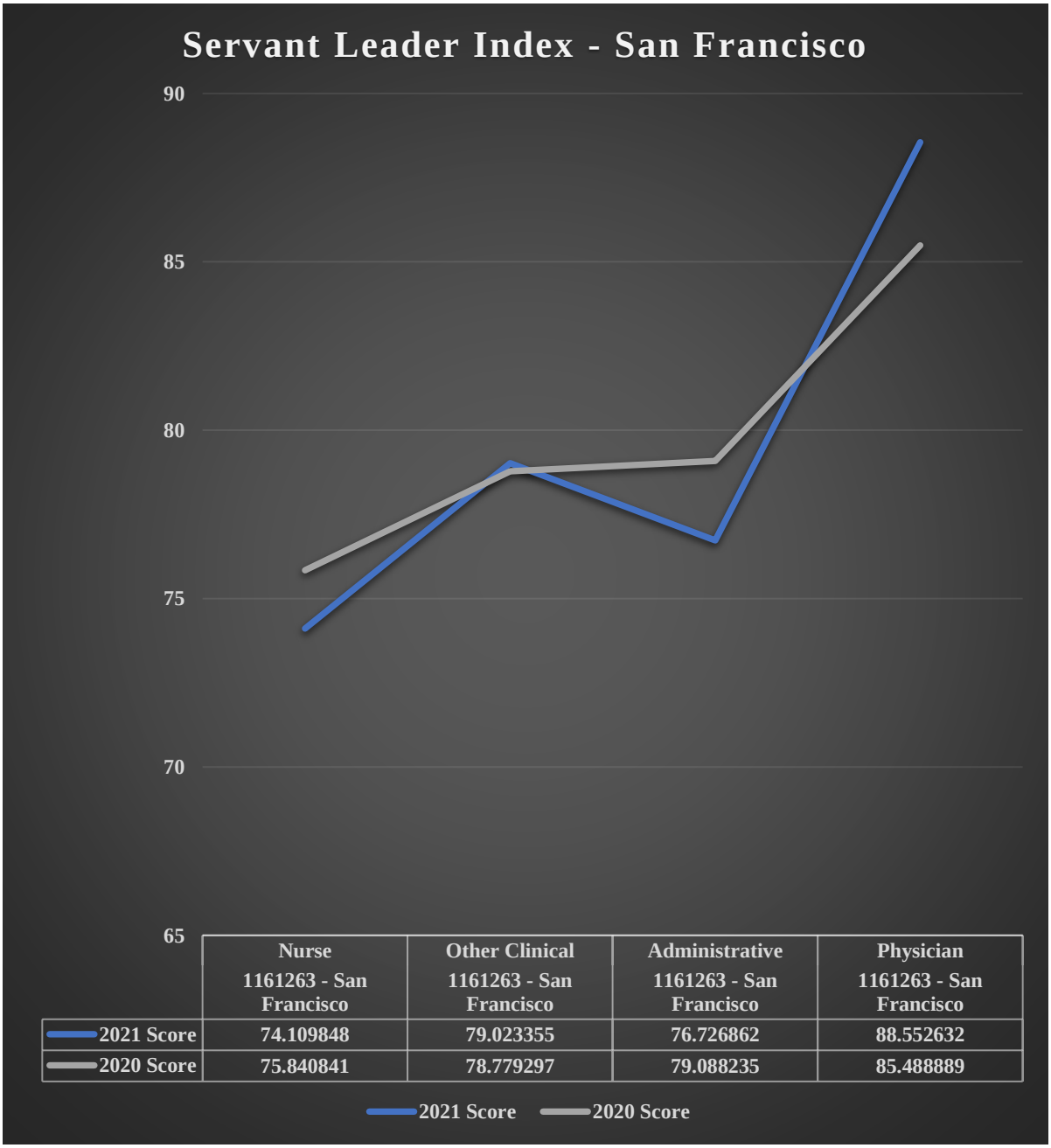
Servant Leader Index: 2020-2021 (Memphis)



Note. Source: Department of Veteran Affairs (2021e): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

Figure 13

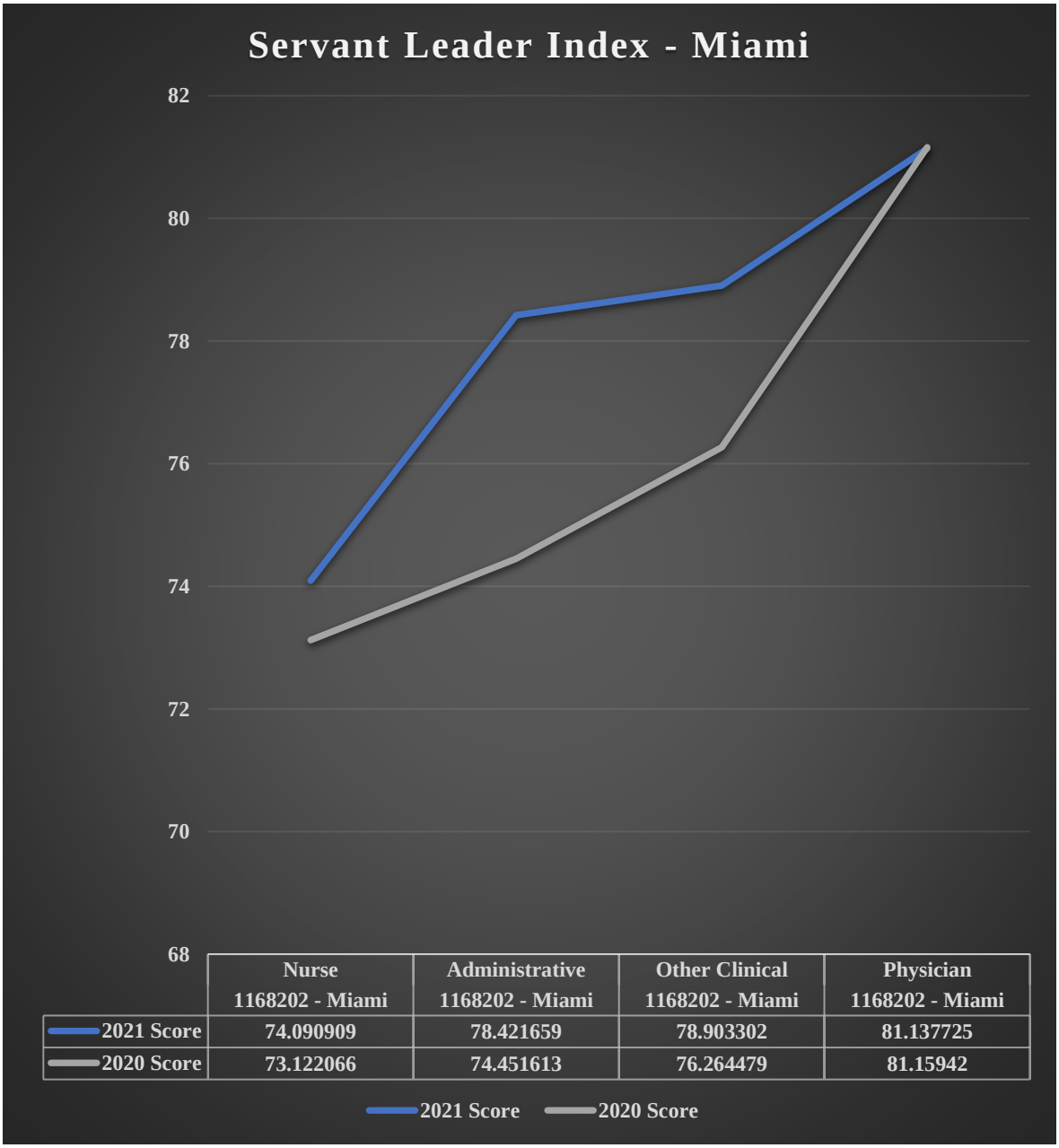
Servant Leader Index: 2020-2021 (San Francisco)



Note. Source: Department of Veteran Affairs (2021e): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

Figure 14

Servant Leader Index: 2020-2021 (Miami)



Note. Source: Department of Veteran Affairs (2021e): All Employee Survey 2020-2021. Website. Retrieved from: https://www.data.va.gov/browse?q=All%20Employee%20Survey%20(AES)%202020%20-%202021&sortBy=relevance

I know what is expected of me on the job.

2018-2020 revealed roughly 41% of VHA employees agreed they know what is expected of them on the job, and those that strongly agreed were at roughly 43%. Throughout that time, only 9% of those surveyed were neutral in this area. Those whom either strongly disagreed or disagreed on this item were between 2-4%. However, responses gathered that were missing or incomplete for all three years was 1%.

I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

2018-2020 revealed roughly 35% of VHA employees agreed they can disclose a suspected violation of any law, rule, or regulation without fear of reprisal. Those that strongly agreed were slightly above 30% and 15% were neutral in this area. Those whom either strongly disagreed or disagreed on this item were on the low side, ranged between 7-8%. However, responses gathered that were missing or incomplete for all three years was at 3%.

My workload is reasonable

2018-2020 revealed roughly 40% of VHA employees agreed their workload is reasonable. Those that strongly agreed were around 25%. Throughout that time, 15% of those surveyed were in the middle or considered they were neutral in this area. Those whom either strongly disagreed or disagreed on this item roughly ranged between 7-12%. However, responses gathered that were missing or incomplete for all three years remained at 1%.

My organization's senior leaders maintain high standards of honesty and integrity.

2018-2020 revealed roughly 40% of VHA employees agreed senior leaders maintained high standards of honesty and integrity. Those that strongly agreed were around 25%. Throughout that time, 15% were neutral in this area. Those whom either strongly disagreed or disagreed on this item roughly ranged between 7-12%. However, responses gathered that were missing or incomplete for all three years remained at 1%.

In my work unit, differences in work performances are recognized in a meaningful way.

2018-2020 revealed roughly 30% of VHA employees agreed that differences in work performances were recognized in a meaningful way. Those that strongly agreed were around 20%. Throughout that time, roughly 22% of those surveyed were in the middle or considered they were neutral in this area. Those whom either strongly disagreed or disagreed on this item roughly ranged between 9- 15%. However, responses gathered that were missing or incomplete for all three years remained at 4%.

2021 All Employee Survey (AES)

The data shows approval percentage measurements ranging between 54-90%. Looking at the pre-selected survey items from 2018-2020 or items of similarity. 2021 AES results showed the following:

(1) No Fear of Reprisal - 71%
(2) Clear Expectations - 84%
(3) Senior Leader Ethics - 62%
(4) Workload - 65%

(5) Workgroup Recognition - 55%
(6) Workgroup Competency - 79%
(7) Workgroup Cooperation – 75%

Presentation of the Findings – U.S. veterans

During 2019 and 2021, the VA conducted surveys to U.S. veterans that focused on multiple areas involved with their healthcare. For the purposes of this study, their ratings of their VA health experience (at their VA hospital) and primary care patient experience were only gathered and analyzed. From January 2019 to December 2019, health experience was surveyed on the following items:

(1) Patients who "Strongly Agree" they clearly understood how they manage their health after discharge. – 57%
(2) Patients who reported that VA doctors communicated well. – 81%
(3) Patients who reported that VA nurses communicated well. – 79%
(4) Patients who would recommend their VA hospital. – 72%
(5) Patients who gave their hospital a rating between 9 and 10 (0 being the lowest; 10 being the highest). – 72%

In early 2021, the VA surveyed U.S. veterans on how they measured their experience at their VA Medical Center or Healthcare System. This data was presented online and covered most VA Healthcare Systems locations nationally. The presentation of this data was to provide the public a general idea of how U.S. veterans of a selected area rated their experience. This could be comprehended as a guiding source for U.S. veterans when looking for their VA Medical Center or Healthcare System.

This survey covered areas such as primary care access, specialty care access, care coordination and provider rating (Department of Veteran Affairs, 2021b). Only five

locations were selected, and area of measurement covered primary care access. The scale of measurement between these selected locations, U.S. veterans rated their experience between 41-57%. This was only a snapshot of how U.S. veterans rated their primary care access.

2020-2021 Servant Leader Index: How a Supervisor/Manager is Rated

The Servant Leader Index is a measurement of the respondent's supervisor. This area was analyzed specifically to understand how a VHA employee describes their supervisor or manager. This area can be informative, but inaccurate at the same time. This is due to subjectivity of the occupation held.

Six random locations were selected and measured from the stance of occupation. Those occupations were Administration, Other Clinical, Nurse and Physician. These occupations were selected as they are central components in veteran healthcare delivery. The only occupations that were not included were those classified as Wage, as those cover areas not as significant in healthcare such as retail. The scores measured approval percentages, which ranged from 67% to 88%.

Chapter 5: Discussion, Conclusions, and Recommendations

Interpretation of the Findings – VHA employees

In 2018, the VA incorporated their All-Employee Survey (AES) and Federal Employee Viewpoint Survey (FEVS) together (Department of Veteran Affairs, 2021c). This change was necessary so participation would increase and survey fatigue reduced. Prior survey years shown a steady decline in participation as the survey makeup itself was extensive. As of now, this survey is considered a living document subjected to annual changes to the survey items (Department of Veteran Affairs, 2021c). This is considered important as employee feedback does change, but there is an area that is concerning. Even though the response percentages are presented on either "Agreed/Strongly Agreed" or "Disagreed/Strongly Disagreed," no significant difference is presented due to respondent subtlety.

2018-2020

During 2018-2020, around 40% of VHA employees understood their core responsibilities. More than 30% of VHA employees agreed they could disclose violations without fear of reprisal. This is concerning as this fear appeared to have shadowed VHA employees significantly, potentially affecting work performance. VHA employees acknowledged their workload as somewhat reasonable, but those that were in the middle or did not agree on this was around 10%. This means the responsibilities could have evolved to meet demand, shift in immediate management, etc.

VHA employees significantly agreed senior leaders held high standards of honesty and integrity, which could be seen as an improvement from prior years. Those that either disagreed or remained neutral may not view this as an improvement, but as in no meaningful change. This can be inaccurate due to the Servant Leader Index. VHA employees agreed work performance differences are recognized meaningfully, which could be acknowledged as praise or constructive feedback. Those in disagreement or in the middle may have seen this question as not experiencing what those respondents consider as praise or constructive feedback. Both areas are open to interpretation.

2021 All Employee Survey (AES): How Much has Changed?

Comparing 2018-2020 and 2021, there was significant improvement on the pre-selected survey items or items of similarity. The data showed additional areas presenting employee engagement. 2021 AES results showed the following:

No Fear of Reprisal - 71%
Clear Expectation - 84%
Senior Leader Ethics - 62%
Workgroup Recognition - 55%
Workgroup Competency - 79%
Workgroup Cooperation – 75%

VHA employees are less afraid of reprisal and exhibited no fluctuation in core expectations of their role. Additionally, the items of Senior Leader Ethics and Workload showed little to no fluctuation. Workgroup Recognition could be improved (and continuously acknowledged as such). Workgroup Competency demonstrates VHA

employees are not only empowered to do their job, but also empowered to do it correctly within their workgroup. Lastly, VHA employees show successful collaboration with other work groups.

Presentation of the Findings – U.S. veterans

During the years of 2019 and 2021, the VA conducted surveys to U.S. veterans that focused on multiple areas involved with their healthcare. 2020 was not included in this study due to the 2020 COVID-19 pandemic, which would have presented a detrimental difference.

2019

From January 2019 to December 2019, US Veterans were surveyed on their health experience at VA Medical Centers or VA Hospitals. These items include, but not limited to:

(1) Patients who "Strongly Agree" they clearly understood how they manage their health after discharge. – 57%

(2) Patients who reported that VA doctors communicated well. – 81%

(3) Patients who reported that VA nurses communicated well. – 79%

(4) Patients who would recommend their VA hospital. – 72%

(5) Patients who gave their hospital a rating between 9 and 10 (0 being the lowest; 10 being the highest). – 72%

U.S. veterans agreed that VA doctors and nurses communicated well with them. Items 1 and 5 are concerning items, as the VA only projected either a "Strongly Agree" or high numerical rating. This measurement does present a skewed view that is highly

subjective to the public. Additionally, it is concerning that items 4 and 5 could be from the same question posited to U.S. veterans. Even though this was from 2019, the data is problematic and does not accurately present overall health experience of U.S. veterans.

2021

In early 2021, the VA surveyed U.S. veterans on how they measured their experience at their VA Medical Center or Healthcare System. This data was presented online and covered most VA Healthcare Systems locations nationally. The scale of measurement between these selected locations, U.S. veterans rated their experience between 41-57%. This survey covered areas such as primary care access, specialty care access, care coordination and provider rating (Department of Veteran Affairs, 2021d). For the purposes of this study, five locations were selected and area of measurement covered primary care access:

(1) VA Central Alabama Healthcare System - 41%
(2) Tampa VA Medical Center - 54%
(3) VA Central Iowa Healthcare System - 57%
(4) Oklahoma City VA Medical Center - 51%
(5) Alexandria (LA) VA Medical Center - 56%

The online data fluctuated, as based on location. This data can be used for a U.S. Veteran in determining the establishment of their healthcare or how the location is rated in healthcare access. This area requires additional exploration on driving factors of these measurements.

2020-2021 Servant Leader Index

As a critical component toward professional culture, this measurement covers areas such as listening, respect, trust, display of favoritism and addressing concerns (Department of Veteran Affairs, 2021e). The scores measured approval percentages, which ranged from 67% to 88%. The measurements are significant but represented bias, due to location and occupation held.

What Does the Data Mean for VHA Employees and U.S. veterans?

VHA employees are capable of their duties as well as what is required to thrive at their jobs. There could be instances where employees do fear reprisal, but it should not stop them from doing what is right. Workload could vary, depending on a variety of factors, but if workload is excessive or problematic, VHA employees can make their voices heard. Confidence in senior leadership integrity has stayed the same, but this area is biased. This sensitivity would be how the respondent views their own supervisor/manager (negative or positive) and the results can be skewed because of it. Even though improvement is evident, further investigation is needed.

U.S. veterans are making it known to the VHA where improvements are needed and they are not losing hope in the VHA. Primary care access must improve significantly, along with how U.S. veterans can manage their health successfully. Communication from VA doctors and VA nurses, along with VA hospitals need to continuously seek ways to improve their areas.

Limitations of the Study

The main limitation present in this study was lack of additional time to explore other areas that may have been contributory to this problem. The survey data gathered from VHA employees and U.S Veterans only provided a glimpse of what may or may not be contributory to this problem. Secondly, no live surveys or interviews were conducted due to privacy reasons, which would have given a more refreshed outlook. Thirdly, the VA health experience at a VA Medical Center or VA Hospital as recorded covered only the year of 2019 and there had been no updates made to this data. Finally, data captured in all areas for the year 2020 could have been influenced by the COVID-19 Pandemic.

Recommendations

Healthcare delivery can continuously improve and change as based on patient needs. It is crucial that if there are problems VHA employees encounter, VHA employees must not be silent or oblivious to it. Being silent or oblivious to problems contributes and intensifies the problem. Also, if VHA employees are in the wrong, it is important for the VA to set an example every time. Not doing so will exemplify the toxicity of the professional environment within Veterans Healthcare Systems and ultimately continue affecting healthcare delivery to U.S. veterans.

The VA must listen and respond proactively to all concerns expressed by U.S. veterans. VHA employees and U.S. veterans are important clientele of the VA. Subjectivity could be reduced if survey delivery were promoted randomly versus being specifically set annually.

Social Implications

This research provided a simplified analysis of this problem. The social implication of this study is to enhance the knowledge of why healthcare delivery continues to be problematic. First, areas promoting egregious utility and false idea of utility need to be closely watched. Secondly, oversight can and should be further enhanced. Thirdly, Veterans Healthcare Systems have made strides in technology on how to combat this problem. Finally, it gives some insight on common barriers on healthcare delivery and direction on where improvement is needed. Since the scandal in 2014, action and positive change are evident within the Veteran Healthcare Systems.

Conclusion

VHA employees have the power to improve healthcare delivery for U.S. veterans. U.S. veterans also have the power to improve their healthcare delivery. Their voices must be heard and not silenced. The VA must recognize that their employees and U.S. veterans are the clientele and not a burden.

Healthcare in general, is a growing and changing entity. Since inception, the VA has experienced considerable highs and lows of healthcare delivery. The problem with healthcare delivery for US. Veterans is not as complicated as society has been led to believe. The healthcare delivery problem is not a result of systemic malfeasance or individual praxis but a combination of both. Society has been led to understand that inferior healthcare delivery within Veterans Healthcare Systems is a result of erroneous measures in place. Another misconception is that with more financial resources poured into this entity, these erroneous measures will be appropriately overseen. Unfortunately, this problem goes beyond erroneous measures.

Recent cases within the VA OIG show not only erroneous measures, but also practices that are aligned with the characteristics of egregious utility. It is also evident with how the VA responds to these reported issues and they are not as strict with the outcome. Whether such actions are of convenience or financial gain, these practices promote the false idea of utility. If egregious utility and false idea of utility are present as motivators, inferior healthcare delivery will be a constant barrier in Veterans Healthcare Systems.

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