Dynamic Analysis of Healthcare Service Delivery: Application of Lean and Agile Concepts

by

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A Dissertation
Submitted to the Faculty
of the

WORCESTER POLYTECHNIC INSTITUTE

in partial fulfillment of the requirements for the
Degree of Doctor of Philosophy
in
System Dynamics
May 2013

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Abstract
Hospitals are looking to industry for proven tools to manage increasingly complex operations and reduce costs simultaneously with improving quality of care. Currently, ‘lean’ is the preferred system redesign paradigm, which focuses on removing process waste and variation. However, the high level of complexity and uncertainty inherent to healthcare make it incredibly challenging to remove variability and achieve the stable process rates necessary for lean redesign efforts to be effective. This research explores the use of an alternative redesign paradigm – ‘agile’ – which was developed in manufacturing to optimize product delivery in volatile demand environments with highly variable customer requirements. ‘Agile’ redesign focuses on increasing system responsiveness to customers through improved resource coordination and flexibility. System dynamics simulation and empirical case study are used to explore the impact of following an agile redesign approach in healthcare on service access, care quality, and cost; determine the comparative effectiveness of individual agile redesign strategies; and identify opportunities where lean methods can contribute to the creation of responsive, agile enterprises by analyzing hybrid lean-agile approaches. This dissertation contributes to the emerging literature on applying supply chain management concepts in healthcare, and opens a new path for designing healthcare systems that provide the right care, at the right time, to the right patient, at the lowest price.
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0-1. Introduction

Providing the right care, to the right patient, at the right time is not only the definition of providing quality healthcare, but also the key to the long-run viability of our healthcare system. However, our healthcare delivery system is often unable to match the supply of healthcare services with the demand for that care. Intense, inherent demand variability renders this synchronization almost impossible to maintain for any significant period of time. The mismatch between patients and providers has been shown to lead to significant adverse effects: demand variability has been suggested as a main driver for increasing healthcare delivery costs (Litvak, 2005), unexpected surges in admission rates have been linked to increased likelihoods of unplanned patient readmission (Baker et al, 2009), and the inability to maintain a desired patient:provider ratio has been correlated to increased patient mortality (Needleman et al, 2011; Aiken, 2002). Demand variability may be the most pressing problem facing healthcare delivery today.

Furthermore, present day healthcare delivery is defined by the idea that networks of clinicians, rather than individual clinicians, provide patient care, and that the success or failure of healthcare delivery is ultimately determined by the ability of those clinicians to coordinate their activities. As healthcare increases in complexity, these previously disparate care processes and clinicians become even harder to manage and align, resulting in further increased risk to patients and inefficient use of system resources. Analysis from supply chain management research indicates that linking locally controlled service delivery processes (i.e., individual healthcare clinics or hospital departments) into continuous chains of service provision creates internal demand variability that amplifies already problematic external variability. This ‘bullwhip effect’ of systemic demand variability amplification has been shown to be inherent to both manufacturing and service delivery chains (Anderson et al, 2005), and to be the suggested leading cause of supply stock-outs and product distribution costs (Lee et al, 1997). Recent research has found a similar phenomenon of demand variability amplification in multiple healthcare delivery settings, from elective surgery, to in-patient recovery wards, to emergency departments (Sameul et al, 2010; Walley, 2007; Sethuraman & Tirupati, 2005), where it has led to performance degradation, reduced resource availability and greater probability of exceeding desired provider utilization and occupancy rates. Increasing demand variability inside the patient care chain generally results in greater stress on employees, higher operating costs, and lower hospital revenues.

Combining these two analyses leads to the conclusion that healthcare delivery is facing a ‘perfect storm’ of demand variability, stemming from the combination of exogenous and endogenous demand variation. As our delivery systems become more interconnected and dependent upon each other, the problems currently caused by demand variation will undoubtedly be further magnified. Hence, being able to quickly adapt to ever-changing rates of patient arrivals and flow through healthcare systems is crucial to the overall success of healthcare delivery. Creating new management structures and decision heuristics to better respond to both internally and externally
driven demand variation is essential to ensure that the supply of care can be synchronized to meet the peaks and troughs of patient demand. Defining, evaluating, and implementing new healthcare service delivery management methods, at the operations level, is clearly of critical importance to providing effective, high-quality healthcare.

The objective of this research is to improve how our healthcare delivery system responds to variation in initial demand for care and in subsequent patient flow through the care delivery chain. In the subsequent chapters we explore the effects of increasing resource flexibility and/or efficiency in a real world healthcare delivery system subject to intense, unpredictable demand variation; show how current dominant healthcare delivery system redesign methods may actually increase internal variation to the detriment of patient health and safety; discuss an alternative approach to improving system behavior; and propose, test, and validate concrete operational changes to improve performance based on that new approach.

This introduction is organized as follows. First, we discuss and justify the use of system dynamics as an appropriate methodology for understanding behavior of healthcare delivery systems. Second, we present our motivation for this research, which stems from our experiences improving service delivery at one Boston-area VA hospital. Third, we discuss the development of a generalizable healthcare service delivery model, its underlying logic, and its limitations. Fourth, we present our simulation experiments, which explore the intended and unintended effects of multiple system improvement paradigms applied to that generic model. The penultimate section discusses the implications of our findings; our contributions to the fields of service supply chain management, healthcare service delivery, lean methods, and healthcare service simulation; our research shortcomings; and possible future work. The concluding section of this introduction presents the organizational structure of the dissertation.

0-2. Methodology
This research is founded on the pillars of supply chain management, healthcare delivery improvement, and patient safety literatures. Our research and conclusions are based on a mixture of direct observation, semi-structured interviews, system dynamics simulations, and empirical analysis. We had direct access to stakeholders and participants of a Veterans Affairs (VA) healthcare delivery system, and years’ worth of clinical process data from that system. The use of system dynamics as a method for analyzing the behavior of complex systems over time is well established.

System dynamics modeling has been used to address many healthcare related problems and has resulted in about 1500 publications since 1991 (Brailsford 2008). Dangerfield (1999) reviews system dynamics modeling in healthcare and concludes that the method can be used effectively in a qualitative way when influence (or causal) diagrams are the main analytic tool, and in
quantitative ways when based on simulation models. This research extends previous dynamic analyses of healthcare management: Specifically, Taylor and Dangerfield’s (2005) use of quantitative system dynamics analysis of the reasons for failed management interventions in cardiac catheterization services, and Lane and Husemann’s (2008) use of qualitative modeling to elicit proposals for improvement of acute patient flows in the UK National Health Service. Similarly, Wolstenholme et al (2006) use both qualitative and quantitative system dynamics to analyze the effects of care delivery redesign on mental healthcare performance. A general discussion of the role of system dynamics in analyzing healthcare delivery systems can be found in Taylor and Lane (1998).

We chose system dynamics simulation because the method encourages both a systemic view of the interactions of patient flows and information, and a more strategic perspective on the management of the system. It is widely accepted by healthcare professionals that healthcare delivery cannot be understood by looking at factors in isolation (Lane, 1999). By encouraging the study of how different processes interact to produce observed effects, system dynamics offers a rigorous approach for bringing that interconnectedness insight into focus. We choose system dynamics specifically for its ability to 1) clearly relate patterns of behavior to system structure, 2) quantify the causal links between demand and patient wait times, and 3) assess potential changes to system structure and management decision heuristics that will improve system performance in the long term. This necessitates the consideration of a broad range of interactions across physical and information flows.

Throughout these chapters, the service chain and governing decision heuristics are modeled through first-order nonlinear differential equations. The formal mathematical expressions use to represent the systems studied are reported throughout the paper and the specific model code for each is included in individual appendices. We have not used discrete-event simulation (DES) or stochastic modeling (of variables like ‘patient inflow’ or ‘treatment time’) because our primary objective is not to quantify numerical results for one specific healthcare delivery chain, but to understand and illustrate to healthcare managers the deterministic behaviors of healthcare delivery systems in general. The use of continuous, as opposed to discrete, flows in the model is a reasonable approximation of the perpetual adjustments (hiring and firing) necessary in the management of service organizations, and is a common method for abstracting these systems in both operations management and supply chain management research (Sethi & Thompson, 2000). For an in-depth discussion of the trade-offs and appropriate problems for using system dynamics or DES see Tako and Robinson (2009) and Kleijnen (2005).

0-3. Research Motivation
The motivation for this research arises from the experiences at one representative Veterans Affairs (VA) hospital, which was beset by problems stemming from increasing demand variation
for one of its key services: the administration of Compensation and Pension (C&P) exams. These exams determine the level of veterans’ service-connected medical disability, a key factor governing veterans’ access to free medical coverage at the VA and their life-time disability benefits. Providing timely and accurate disability exams is a critical service provided by the VA. All returning service members must navigate this process, as must all current VA patients seeking to change their recognized level of service-connected disability and subsequent benefits. Specifically, at our study site, demand for C&P exams and average wait times for those exams nearly doubled from June to November 2010, when this research project began, effectively amounting to a denial of services for some veterans.

Many other VA facilities nation-wide experience similar demand variation and subsequent increases in service delays for C&P exams, along with reductions in exam quality and patient satisfaction. The backlog of veterans waiting for disability assessments has risen dramatically in recent years, from less than 389,000 in 2009 to over 809,000 by 2011. Of this amount, over 60 percent are currently waiting for over 125 days. These delays prompted a series of Office of Inspector General investigations in 2008-9, in which they found inefficient, poorly coordinated services; scant resources; and low quality, as measured by the number of incomplete exams (Finn, 2010). More recently, the spectacle of veterans committing suicide because of delayed treatment for PTSD caused, in part, by delays in the Compensation and Pension process, has brought widespread criticism upon the VA (New York Times, 5/6/2011). Finding a solution to this problem, even at only one pilot site, could lead to significant improvement in veterans’ access to healthcare services.

0-3.1. Model development
We sought to address this declining performance through an analysis of demand variability, the factors governing patient flow through the service delivery system, and clinic managers’ service capacity decision heuristics. In order to identify and test operation-level changes that the C&P clinic could implement quickly to increase their ability to respond to severe fluctuations in demand, we built a dynamic simulation of the C&P clinic. Simulation was a necessary first step in redesigning the clinic, as the large scale changes necessary to both system structure and management were deemed too risky to implement without a well-developed understanding of both their intended and unintended effects. In the dynamically complex healthcare environment, structure and management changes often result in both intended and unintended consequences that cannot be easily foreseen without the help of a computer model (Kleijen, 2005).

To build a representative dynamic model of the C&P clinic, we worked with system stakeholders, conducting interviews with managers, providers, and administrative staff; developing causal loop diagrams in group meetings; iteratively refining and adding the details they deemed important. Stakeholders then identified the relative influences between system components and explained and quantified their own decision heuristics. We presented initial
simulations, then revised the model until both model structure and outcomes fit the existing historical data.

The primary elements identified for this model include the demand rate for C&P exams, exam scheduling, the backlog of exams waiting to be conducted, C&P staffing adjustments, and measures of quality and rework. The model includes many feedbacks between these causal elements. We capture the balancing feedback between patient backlog and the recruitment of personnel by clinic managers; we include the ability of clinic managers to adjust providers’ hours worked per week. Also included are the reinforcing feedback effects that sustained increases in hours/week have on clinician fatigue, and subsequent effects of fatigue on exam quality and backlog through re-work, as well as feedback to clinician burnout and quit rates. We also relate that quit rate and subsequent replacement hiring with exam quality through the process of staff building practical experience over time. Each of these feedback effects and how they interrelate are explained in detail in the model design section (section 6) of Chapter 1. A simplified diagram of the full model, which effectively presents all key systemic interactions, is shown in Figure 1.

![Figure 1. Stock and flow diagram of the C&P system dynamics model.](image)

Only the high level map is shown; the full model consists of 143 equations, 9 levels, and 11 rates, and is included in Appendix C.

We supported this model building with quantitative information held by hospital staff, internal management reports, and the hospital’s electronic medical record system. All model parameters were generated by analyzing hospital records and model behavior was validated against historical demand and performance data. By working with those who had direct knowledge of the system, we were able to access their ‘mental models,’ as well as more quantitative sources,
and were able to build a transparent model that was accepted as realistic in its formulation and level of detail.

This level of interaction and collaboration was necessary for the creation of a useful, meaningful simulation model that was suited to their unique context. Also, there are no other simulation models or empirical evidence extant to assist healthcare managers with modifying management heuristics or decision structures to better respond to demand variation, nor does the current service management research literature provide practical advice to improve the ability to synchronize the supply of care with patient demand (Vries & Huijsman, 2011). In the larger field of supply chain management, the study of healthcare service delivery and patient logistics is very new, and while it has a few exemplary initiatives, still lacks much academic research (Shah et al, 2008). Furthermore, C&P clinic managers were skeptical of the need to change their own decision-making heuristics, even if it was clear in the abstract that the root cause to their current performance problems was demand variation. Collaborative model building not only helped validate the model, it also provided powerful evidence to support their subsequent management change efforts.

Our dynamic analysis found that, though prevalent, other forms of variation were not a significant cause of the patient access and exam quality problems being experienced in the C&P clinic. Process variation, variation in patient characteristics, variation in provider practices and opinions certainly occur in the C&P clinic, as in almost all healthcare service settings, but do not appear to be significant contributors to the main performance problems. The unacceptable increase in average service time and reduction in exam quality were clearly generated by patient demand variation.

Demand variation led to this performance degradation because system structure and delays inherent to managers’ decision process and subsequent resource allocation insured that the clinic could not keep the supply of services adequately synchronized with extreme changes in demand. The resultant increase in patient backlog and pressure on C&P clinicians created further adverse effects that compounded the original increase in demand. Bringing new clinicians into the clinic as a response to the growing backlog reduced staff’s average experience level with C&P disability examinations. This unintentional, but unavoidable, decrease in experience led to decreases in average exam quality, which increased re-work precisely at the least opportune time to enlarging a second stream of demand for C&P services. Given the re-work discovery and correction times of this particular C&P clinic, the delivery system structures and management’s capacity adjustment decisions unintentionally amplified external demand variation, exacerbating the patient access problem. This insight further established the need for management to be able to respond quickly to any significant increase or decrease in patient demand, to prevent any significant buildup of patient backlog and subsequent additional variation.
Simulation of operations-level changes to management decisions and system structures suggested that increasing resource flexibility, defined as the ability to respond both quickly and sufficiently to changes in patient demand, was most impactful. The specific operational changes suggested resulted in expanding management’s control over setting the number of hours worked per clinician per week, which simulations indicated would mitigate the demand amplification effect of increasing re-work, and also render the system able to prevent future demand ‘shocks’ or severe variation from creating the patient access and exam quality problems experienced in 2010. A complete discussion and evaluation of the improvement scenarios proposed for the C&P clinic, both to provider type and management decision heuristics is presented in section 6.4 of Chapter 1. Addressing other sources of variation was deemed to be of minimal importance, as they were not significant contributors to the observed performance problems, when compared against the effects of external demand variation.

0-3.2. Impact of recommendations

Changes to C&P management and organization were implemented in early through mid-2011, and lead to significant improvement in patient service time (see Figure 2). Over the 12 months following implementation, average patient wait time dropped from over 48 days down to 9 days. A simplistic calculation of the benefits generated by implementing our recommendations (defined as $\sum$ (reduction in average service time * patients seen per month) over the post-implementation period (i.e., from July2011 to March2013), where “reduction in service time” = [average service time pre-implementation (i.e., average over March2009 to Feb2011) – service time in a specific post-implementation month (i.e., any month after July2011)]) finds a total of ~550 years of avoided patient delay. While this calculation and resultant estimated impact could certainly be refined, the sheer scale of the improvement must be recognized.

Moreover, the implementation of our recommendations appears to prevent extreme variation in demand from degrading service performance. Six months following the implementation period, the C&P clinic experienced a sudden, sharp increase in demand, which was even larger than the surge in demand in 2010 that triggered the initial patient access crisis. With the more responsive system structure in place, this level of variation in demand had almost no affect average patient wait time. The operational shift from moderately flexible personnel resources to highly flexible personnel appears to have secured clinic access over the long-term and made the C&P clinic resilient to a high level of demand volatility. Patient access to C&P clinic appears to have stabilized at the previously inconceivable performance level of an average service time of ~10 days, despite an increasingly volatile demand rate. The details of implementation and the organizational changes made to the C&P clinic are presented in section 8.4 of Chapter 1.
0-3.3. Model limitations

Despite the clear success of our recommendations in creating a healthcare delivery system that is able to better synchronize supply of service with its demand, these results should not be used to draw general conclusion about the importance of management response to demand variation as a means for improving healthcare delivery. This model is not representative of most healthcare processes, as model structures were based on analysis of one specific healthcare service only, and model parameters were calibrated to recreate a specific set of historical data. This dynamic model was not build to generate generalizable conclusions on the management of healthcare delivery systems, but to represent and solve a specific problem.

Even to that end, our model has serious limitations. While model parameters were precise enough to assist C&P managers in forming perceptions of system behavior and feedbacks that led to selecting operational changes that did increased performance, the sustainability of those new operations and management structures could be undone if we underestimated the magnitude of effect of overtime on fatigue and of that fatigue on quality and clinician turnover. Our interviews with C&P clinicians could only result in a basic understanding of the strength and timing of those feedback effects; no literature could provide insight to the specific characteristics of the C&P clinic, nor were VA human resources data made available to our investigation. The solution implemented in the C&P clinic requires the frequent use of overtime (as well as the ability to schedule fewer than normal hours per week) to maintain service supply and demand synchronization. If we underestimated the effect overtime has on fatigue, then this would
results in an unintended buildup of fatigue, leading to decreased exam quality, average experience levels (due to higher clinician turnover) and a reinforcing increase in re-work that could eventually outweigh and overwhelm the performance gains experienced to date.

Also, our model does not explain the change in service standards shown in the months following implementation. Our model boundaries did not include feedback between performance and desired performance, nor any other structures governing how the level of desired performance is selected. We can only offer conjecture as to the reasons the performance of the C&P clinic has not returned to the previous level of an average service time of ~26 days. Perhaps the significant honors received by the C&P management team for their improved performance provided them with a level of notoriety that they did not wish to relinquish. The ability to keep patient service times close to 10 days does place the hospital among the top performers in the nation. Perhaps the C&P managers had reasons for hiring additional, unnecessary clinicians that they did not reveal to us in our model building sessions, which led to the observed reduction in patient backlog and subsequent lower average service time. While both theories are plausible, the consistency of performance would suggest the former is closer to the truth, but without further investigation, it is impossible to know with certainty. These limitations, and others, are discussed in detail in the model description and analysis sections of Chapter 1.

However, the most important limitation of this model does not stem from its parameter estimation or model boundaries, but from its level of abstraction. The most important abstraction was the aggregation of steps in the pre-exam scheduling process and the post-exam results reporting process into a single backlog of services waiting for completion. These steps in the overall service delivery process were found not to contribute to the dynamic behavior of the system, as no relation was found between those process steps, their own service capacities - as these steps are completed by clerks or other non-clinical staff, and other system components or performance measures. This reduction in model detail allows for a clearer interpretation of the causal factors producing the behavior observed in simulation, but excludes potential demand variation amplification effects generated by linking locally controlled steps in a service chain (i.e., the ‘bullwhip effect’). The target service times and service backlogs for these other stages in the C&P service delivery process are between $1/3$ to an entire order of magnitude smaller than the clinical steps of the care delivery process, as are the costs associated with those steps. The C&P managers felt that the clarity offered by such an abstract representation was more useful than the insights generated by including details on the actions of clerks, transcribers, and other seemingly ancillary staff.

This abstraction fundamentally limits the ability to draw generalizable conclusions from this initial work improving healthcare delivery. As discussed previously, most healthcare services do not consist of only one stage or clinic, but multiple, discrete stages linked in series in a chain of activities, all of which perform a necessary action to facilitate patient care in subsequent stages.
As healthcare becomes more advanced, these multiple, independent stages are linked in ever more complex chains of care delivery. A different dynamic model is required to assess the impact of this complexity on performance.

**0-4. Healthcare Delivery as Service Chain**

With the growing complexity of healthcare services, providers are increasingly dependent on sharing care delivery activities with other, specialized healthcare professionals to provide adequate patient care. Patients are now treated in service chains that combine interventions into serial encounters with specialized providers and link these encounters into clinical pathways. Moreover, the implementation of more integrated care programs are frequently cited as common operational change used to decrease resource utilization and improve healthcare quality (Apetel and Pourjalali, 2001). Clearly, from both a theoretical and practical point of view, the healthcare service delivery is changing significantly.

However, the variability and unpredictability inherent to healthcare demand renders this network approach to care delivery difficult to manage (Li et al, 2002). Supply chain management literature suggests that this trend of increasing complexity and interdependence of stages in the healthcare delivery system has the effect of generating internal demand variability. Similar to the ‘bullwhip effect’ in manufacturing (Forrester, 1958, 1961; Lee et al, 1997), research on healthcare service chains has identified structural tendencies toward internal demand variation amplification as a key cause of supply chain stress, reducing access to services (as measured by the distribution of service delivery time), and subsequent degradations in service quality and increasing employee stress and fatigue. The most recent case study of internally-created demand variability was conducted in a 127 bed hospital in Uttar Pradesh, India, which revealed dynamic system behavior equivalent to the bullwhip effect (Sameul et al, 2010). The bullwhip effect was similarly identified in a study of one UK hospital: Based on interviews with hospital staff and data from hospital’s EHR system, analysis of emergency patient arrivals and discharges revealed amplification of demand variability downstream in the service chain (Walley, 2007; for a graphical representation, see Figure 3). In this case, distortions in demand clearly led to performance degradation, as downstream services reported reduced resource availability and greater probability of exceeding desired utilization and occupancy rates. These are similar consequence to the effects seen in manufacturing systems, where the bullwhip effect has been a suggested cause for increasing stock-outs and higher costs.
A study of a large hospital in Australia also directly identifies the bullwhip effect in the patient care chain for elective surgeries (Sethuraman & Tirupati, 2005). The increasing variation in demand for services as elective patients move to downstream departments inside the hospital creates the need to make more beds available in post-operative care wards than indicated by the initial demand. On peak days, when the bullwhip effect causes the number of elective surgery recovery patients to be artificially high, there is a shortage of beds in the in-patient wards, which restricts the number of surgeries and reducing the theater utilization and hospital throughput on subsequent days. Demand for nursing services is directly affected by higher variability, resulting in higher labor costs. Demand variation amplification is also associated with increased dependence on less experienced part-time or temp agency staff. Increasing demand variability inside the patient care chain generally results in greater stress on employees, higher operating costs, and lower hospital revenues. The growing interdependence of healthcare delivery leading to demand variation amplification, coupled with pressure to reduce costs and serve greater numbers of patients, makes healthcare service delivery chains increasingly difficult to manage and coordinate.

However, despite the clear conclusion that system structures and management practices are the cause of these demand variation amplification problems, research into the effective management of increasingly interconnected healthcare delivery chains faced with highly variable demand is practically nil. Service chain management in a healthcare context is very much an emerging field, with only limited academic studies addressing the challenges unique to the healthcare setting (Vries & Huijsman, 2011). Subsequent questions of how service delivery integration and coordination of care systems regarding patient flows and resource management can be best
achieved operationally still are a relatively unexplored area of service supply chain management. Most service supply chain management research is still theoretical or conceptually-focused as opposed to operational in nature (Sampson & Froelhe, 2006), currently providing little to aid healthcare managers facing the combination of demand volatility and increasingly integrated care delivery chains. Furthermore, to date there has been limited success in improving system-wide service chain management in real-world healthcare delivery systems (McKone-Sweet et al, 2005; Vries & Huijsman, 2011). There are very limited practical guidelines or sets of identified best-practices for designing and implementing cost-effective, and at the same time, demand responsive, healthcare delivery systems. Healthcare managers face a significant gap in knowledge around the optimal design and management of complex care delivery systems to ensure effective patient care.

0-4.1. Developing a generalizable model
We address this gap in knowledge by extending our original analysis of the dynamic interplay between external demand variability, clinic manager’s decision heuristics, and resource allocation structures from one specific clinic to an entire healthcare service chain. The purpose of this model is to draw generalizable conclusions on the effectiveness of our proposed strategy to improve healthcare delivery through changing management response to demand variation. The dynamic simulation model we create captures the essential elements of reality common to most healthcare delivery chains rather than perfectly simulating one specific service. The healthcare service chain depicted is thus an abstract representation of a broad spectrum of possible healthcare services. The limitations inherent to this approach, both to analyzing model behavior and to the applicability of our conclusions, are discussed in the next section.

This new model is both a simplification of the original and an extension. Like the initial model, this new, more generic healthcare service chain contains no variability in clinical care itself or provider preferences, and also excludes variation in the characteristics of individual patients. We further simplify the original model by removing the complex feedbacks related to overtime, fatigue, quality, and rework. Not all healthcare service managers have ability to schedule overtime. This additional system structure to change service capacity is subsumed into a general representation of adding or removing staff from the stock of employees.

This abstraction that employees can only work a fixed number of hours per week severs causal connections to fatigue, exam quality, and rework creation. While this simplifying assumption certainly cannot be said to be the norm in healthcare services, we believe excluding these feedbacks from the generic model is appropriate, and should not alter our model behavior significantly. The effect of fatigue on service quality and the creation of internal demand variability has been studied before in detail. In their simulation case study of a European telecom firm, Akkermans and Vos (2003) use a similar model to our generic healthcare service
chain to explore the effect of rework on service chain performance and the ‘bullwhip effect.’
They develop insight into the interdependence between employee stress, work quality, rework,
and demand variation amplification, concluding that the addition of these feedbacks amplifies
internal demand variation, and that the magnitude of demand amplification is directly governed
by model parameters for error creation and rework discovery and correction.

Simply from the model’s structure, we can infer that removing these links in the generic model
eliminates a potentially significant, self-reinforcing in-flow into clinics’ backlogs, which will
result in the model generating a reduced ‘bullwhip effect’ than would occur with these links in
place. However, the magnitude of the impact of this assumption of no fatigue and perfect quality
depends on how divergent these parameters are from the real-world healthcare delivery chain it
is being used to represent. The more divergence, either in error creation or in discovery and
correction times, the less the recommendations and conclusions gleaned from our simplified
model should be used to improve any real-world healthcare delivery system.

We extend the original model to include multiple, serial stages in the service chain. These stages
can represent individual clinics, as in our C&P case study, or individual hospital departments.
They represent any discrete stage of a patient care process with its own locally controlled staff
that is linked in series to provide patient care. For consistency, we will refer to these patient care
stages as ‘clinics’ from here on. Each clinic in our model operates in an identical manner, has
identical performance standards and parameters, and is autonomous, with capacity decisions
based only on the information available at each clinic. Each clinic is linked, as the output of
clinic, forms the demand to clinic, but each clinic requires a separate resource to serve its
patient backlog, which could either be from requiring a different set of skills to complete the
tasks in each clinic, or that an organizational structure prevents sharing resources between
clinics.

Just as in the original model, each clinic has sole responsibility for operational performance and
control over the finite service capacity in the clinic. Each clinic’s implicit goal is to keep service
performance at a desired level (measured in average days wait time), while keeping service
capacity costs to a minimum. Management decision-making is represented by the model’s main
feedback loop (highlighted in Figure 4, below), which uses the local information available on the
order backlog and current service capacity to determine any changes to that service capacity.
While this structure is far from optimal, it is a realistic representation of how real managers make
decisions in similar settings (Sterman, 1989). This structure follows the common ‘staff to
demand’ heuristic found currently in most hospitals and healthcare centers (Litvak et al, 2005).
The mathematical formulation of this decision heuristic is discussed in detail in section 6.1 of
Chapter 2, on the service delivery chain structure.
Figure 4. A generic, multi-stage healthcare service delivery model, with the feedback structure of a single representative stage (i.e., clinic or hospital department) shown.

The main capacity adjustment loop is highlighted. This healthcare delivery chain could contain any number of individual stages, here we have arbitrarily shown a three stage chain.

This simplified, serial clinic model is more in line with the service supply chain management literature and previous service chain simulation studies than our initial model. The important concepts that differentiate a service chain from a manufacturing or product supply chain are captured in this model’s structure. They are 1) a customer order backlog in place of a tangible finished goods inventory, 2) service provision is intangible and non-storable (portrayed as an instantaneous rate rather than a tangible stock), 3) service provision is determined by the simultaneous availability of customers and service providers, and 4) order backlogs can only be managed by adjusting service capacity (Giannakis, 2011; Baltacioglu et al, 2007). There is no finished goods inventory to act as a buffer to demand variation; instead, backlogs can only be managed by adjusting service capacity. This generic simulation model integrates well with the recent conceptual service supply chain literature, subsuming both Sampson’s (2000) proposed 'dyad' and Christopher and Peck’s (2004) proposed 'network' structures. Each clinic in the chain of service delivery is composed of the same basic participants and tangible and information
flows as Sampson's model, but each of these clinics is in turn linked through the exchange of information and customers. We believe our model structure represents an operationalized synthesis of current service supply chain concepts.

This new model builds on a thread started by Anderson and Morrice (1999, 2000), who were the first to use system dynamics to simulate a multi-stage service system with their model of the mortgage service industry. Other dynamic serial service models have followed, including publications by Akkermans and Vos (2003) and Anderson et al. (2005, 2006). The models used in all of these studies are based on the same underlying assumptions and no clear criticism or alternative structure has emerged in the system dynamics or service supply chain literatures. Indeed, Sampson and Froehle cite these models as "clear exceptions" to what they describe as the normally "forced and unclear" application of supply chain management principles and models to services (2006, p.337).

0-4.2 Limitations and applicability of the generic model

The main abstraction that permits clear analysis of the bullwhip effect and the effect changing management structures has on healthcare service delivery is also the abstraction that limits the direct applicability of this model to any one healthcare service delivery chain. Chains of identical clinics, where desired service times, capacity adjustment practices, and service quality are all equivalent, are simply not a realistic representation of almost any healthcare delivery system. The stages, clinics, or departments in any healthcare service chain are much more likely to be different in all of these characteristics than they are to be the same. It is heroic to assume that the conclusions generated by this model apply to all healthcare service system.

However, while not universally applicable, there are many healthcare services where the differences in these parameters and structures are minimal, and thus could benefit from the knowledge generate by a dynamic analysis of this abstract model. The applicability of our conclusions depends on how closely a real-world healthcare service chain’s stages are to having similar properties. We discuss each parameter in detail, citing examples where we believe these factors are similar enough to warrant the consideration of our conclusions and recommendations.

Desired service times: The distinct clinics in our abstract healthcare service could portray a care chain that takes a patient across multiple organizations and locations, where each clinic has a desired service time measured in months; for example, an elective surgery chain, that starts with a visit to a primary care provider, then next to a specialist, then to an out-patient surgery clinic. Each of these stages in our change could conceivably have a desired average patient wait time of two months (i.e., two months to get an appointment with a primary care physician, two months to get an appointment with a specialist, and two months to schedule the out-patient procedure). Our model could also apply to patient care chains where each stage lasts only an
hour; for example, a trip to the emergency department might last a total of four hours, with each stage patient intake, triage, clinical interview, and discharge with prescription taking one hour each.

Our conclusions and recommendations should not be applied to a patient care chain with stages with very dissimilar desired service times; for example, it is not an accurate representation of the care process for patients suffering heart attacks. This patient care chain starts in the emergency department (where desired service time is measured in minutes), then proceeds to the in-patient recovery wards (where the desired service time is measured in days), and finally to physical therapy (where the desired time is measured in months). Sensitivity analysis on the variation in desired service times across clinics in our abstract healthcare delivery chain is conducted in section 8 of Chapter 2, where we test the effects altering the distribution of service times has on resultant demand variation amplification and total patient service time. We find that varying these parameters significantly affects the magnitude of the amplification inherent to the service chain, with an even distribution resulting in the most downstream demand variation amplification. A detailed explanation for why changing these parameters produces this behavior is included in section 8 of Chapter 2. Thus, this assumption of identical desired service delivery times in our abstract model results in an over-estimation of the ‘bullwhip effect’ compared to that created by most real-world healthcare delivery chains, with the magnitude of this error increasing the more the parameters diverge. However, this ‘bullwhip magnifying’ assumption counteracts the previously stated ‘bullwhip diminishing’ assumptions discussed in section 4.1 of this introduction. Testing the effects of relaxing these assumptions to represent more specific, real-world healthcare delivery chains is the subject of future work.

Capacity adjustment processes: Similar to the examples above, there are many patient care chains where each stage has a similar process, and overall delay time, for adjusting its service capacity. For example, inside the emergency department, most stages have an ‘on-call’ clinician ready to support the current staff if demand increases at any stage in the emergency care process, resulting in an equivalent reaction no matter the specific type of staff needed. There are other patient care chains where each stage takes many months to add capacity. In the previous out-patient specialty surgery example, for any one of those clinics to change its service capacity, they must go through the same process of posting a position for, interviewing, credentialing, and finally hiring a new clinician, which, when summed together, are probably equivalent no matter the type of clinician, whether general practitioner, specialists, or specialty surgeon.

The importance of variation in these two parameters is evaluated through simulation experiments in subsequent chapters. We find that large differences in capacity adjustment times affect the behavior of the service chain, as do the combination of differences in these two parameters between clinics in our model. We explore the interaction effects of these two distributions in section 8.3 of Chapter 3 on ‘Coordinated planning.’ We find that, similar to varying the
distribution of parameters governing individual clinics’ desired service times, altering the
distribution of capacity adjustment times away from our simplifying assumption of uniformity
reduces the bullwhip effect. However, we find that varying the distribution of these two
parameters together results in even more complex behavior and significant impact on inherent
downstream variation amplification. Causal explanations for these interaction effects is
discussed in section 8.3 of Chapter 3. Given the impact of the assumption of uniformity in these
model parameters on overall model behavior, we recommend against applying our conclusions to
real-world healthcare chains with differing parameters without serious consideration, and
propose this as the subject for future research, both in simulation and especially in quantitative
analysis of real-world healthcare service chains.

Service quality: In our generic model, we assume that each stage makes an equivalent
number of mistakes and that the creation of mistakes is not dynamically related to any other
element in the model. As discussed previously, this is obviously not the case in most healthcare
service systems. It is highly unlikely that the quality of care provided in each clinic in a
healthcare service chain are the same, it also unlikely that any individual real-world service chain
would even know the relative quality of each of its clinics. While much research has been
conducted on understanding the root causes of errors made in healthcare services, little research
has been done comparing the relative magnitude of these causes between stages in a care
delivery chain, or general conclusions about the dynamic interaction of these causes and other
elements in our generic model. More precise estimation of the effects of relation of the
patient:provider ratio to service quality in diverse clinical settings would increase the
significance of our results. Our model excludes dynamic effects related to service quality, as
there is little generic analysis in the literature to guide model design on this issue. Without
reliable, generalizable correlations or parameter estimates from the field, it is difficult to produce
a direct measure of the impact of the bullwhip effect on risks to patient health. See section 7.1 of
chapter 2 on ‘Performance measures’ for further discussion.

There are other limitations and potential bias inherent to the structure of our generic model. By
excluding, 1) the dynamic effects of increased patient service time on patient health, 2) the effect
of service quality on clinic rework rates, and 3) variation in both individual patient and provider
characteristics, we limit both the complexity of model behavior and the scope of our subsequent
policy analysis. These elements should be included in future simulation studies, but, to provide
value, must be calibrated to a specific service delivery chain. As discussed in the limitations of
the initial model, past service supply chain research suggests that these additional feedbacks may
magnify the variation amplification effect (Akkermans & Vos, 2003), thus our model potentially
under-estimates the bullwhip effect and its effects clinic performance.
0-5. Simulation Experiments

Given these constraints and limitations, we use this generic model to conduct two sets of experiments. Both of these explore the impacts of demand variability and changing the structures and parameters governing management decision-making on the performance of healthcare service delivery systems.

The first set addresses the current focus in healthcare delivery on improving efficiency and reducing cost, rather than directly targeting demand variability. Specifically, in this first set of experiments, we explore the intended, and unintended, effects of the dominant healthcare service improvement paradigm, ‘lean,’ which aims to redesign healthcare service delivery chains to be able to serve more patients with fewer resources. This set of experiments fills a crucial gap in knowledge, as, to date, there has been minimal research on the effect of unpredictable demand variability on the outcomes of lean redesign efforts, in either service or manufacturing contexts, nor any work firmly criticizing the use of lean in healthcare delivery in the literature (Brandao de Souza, 2009).

The second set of experiments is designed to expand understanding of the use of a contrasting management paradigm, ‘agile,’ in the realm of healthcare delivery. First coined by researchers at the Iacocca Institute at Lehigh University in 1991, ‘agile’ focuses on increasing system responsiveness to demand through changing all parts of a product or service system, from organizational structures, to information systems, to logistics processes, to management decision heuristics. Agile has recently been suggested as a means to improve healthcare service delivery (Vries & Huijsman, 2011), but specific practices or operational plans to increase 'agility' have not been developed for service chains, including healthcare. This experiment set starts to fill this significant gap in knowledge, exploring how agile strategies can be translated into operational plans in healthcare service delivery; understanding the trade-offs created by individual agile practices in healthcare delivery systems on patient access, service quality, and cost control; and gauging the comparative effectiveness of individual agile practices at improving performance along those dimensions. Each set of experiments is discussed in detail in the following sections.

These two experiment sets were also chosen because ‘lean’ and ‘agile’ are often presented as contrasting performance improvement strategies in the supply chain management literature, with their effectiveness determined by the context characteristics in which they are applied. The use of the two strategies is usually separated by characteristics of both customer demand and production methods for a given product or service. Bruce et al. (2004) find that agile is most applied to products that have short life cycles and require low or no finished inventory, while lean is more applied to durable goods. Christopher (2000) suggests that agile is the preferred improvement strategy in contexts where demand volatility is high, the products or services demanded are highly variable, and production volumes are low; while lean is the preferred strategy when demand is predictable and the volume is high (see Figure 5). Other researchers
separate the two strategies by the main competitive criteria in a market, with lean seen as most appropriate when the competitive criteria is cost, and agile being the more effective strategy when service and customer value enhancement are the determining factors of success (Christopher & Towill, 2001). In most service or manufacturing systems, these selection criteria overlap to a large degree, resulting in clearly separate spheres were either lean or agile would be the more effective strategy.

![System re-design classification matrix](adapted-from-Christopher-2000)

Figure 5. System re-design classification matrix (adapted from Christopher, 2000).

Seen through this lens, it is evident that commodities or mass-production industries are suited for following a lean strategy, as demand is relatively predictable and therefore facilitates the level schedule requirements necessary for a lean supply chain (Suzaki, 1987; Naylor et al, 1999, Childerhouse & Towill, 2000). Conversely, both the production methods and demand attributes of healthcare service delivery seem to be more suited to the agile paradigm, where the unpredictability of the demand is impossible to eliminate and the service volumes are relatively low. This also suggests that, although lean is currently the dominant strategy in healthcare service delivery, using lean in that context is potentially counter-productive, as healthcare does not appear to meet the conditions where following a lean strategy is most appropriate.

**0-5.1. Experiment 1: Lean concepts applied in healthcare**

'Lean' is currently the most popular strategy for improving healthcare delivery systems, with a significant number of hospitals and medical groups in the US adopting a version of lean production as their approach to improving quality and efficiency (Robinson et al, 2012; Joosten et al, 2009; Shah et al, 2008). Implemented in the healthcare setting, lean is commonly used to minimize patient delays in the emergency department, reduce the number of return visits, eliminate medication and medical errors, and prevent inappropriate procedures. The lean
approach in healthcare is adapted from the Toyota Production System, and focuses on improving process efficiency through the elimination of waste, or *muda*, which is defined as any activity that consumes resources but generates no redeeming value for the patient (Womack & Jones, 1996).

Previous research in supply chain management finds that, in markets with significant demand variability, increasing efficiency in service delivery chains without regard to either the context or an understanding of how those changes would affect the entire delivery chain can reduce the ability of that system to synchronize production with customer demand. This inverse relationship between efficiency and the ability to meet a changes in demand volume is found in theoretical research (Slack, 1983; Easton & Rothschild, 1987; Carlsson, 1989), industry case studies (Wheelwright, 1995), and large, cross-sectional industry surveys (Suarez et al, 1996; Sanchez & Perez, 2005). Even at Toyota, the incubator of lean, Adler et al. (1999), find evidence for a trade-off between production efficiency and the ability to change production to synchronize production with demand. If this trade-off exists in healthcare service delivery as well, then this would mean that the more ‘lean’ a system becomes, the less that system will be able to meet its patients’ needs and the lower overall quality of care it will provide.

This trade-off may be acceptable in manufacturing or service systems where the cost of temporarily not meeting demand is relatively low. However, this capability is critical for healthcare service delivery chains, as patient volumes are constantly changing and measures of quality in almost all healthcare service delivery systems have time sensitive components (Aronsson et al, 2011). The longer patients wait for care in any stage in a service delivery chain, the more likely their condition will deteriorate in the interim. Since being able to respond in an appropriate and timely fashion is critical to providing effective care, the potential for life-threatening consequences of ‘lean’ diminishing the ability to match supply of services to demand is worth investigating.

The aim of this research is to better understand the complex effects of lean improvement in healthcare delivery systems on overall service delivery, quality, and cost in a service chain with unknown, variable demand. We investigate the structural causes for the existence of a significant trade-off between increased efficiency and they ability to synchronize service capacities with demand in the healthcare delivery chain. Our hypothesis is that ‘lean,’ in its current state of affecting single, isolated improvements in clinic efficiency without regard to the complex dynamics of the healthcare setting, is detrimental to the responsiveness of healthcare services to patient demand, leading to reduced access to services, and further possible subsequent consequences in service quality and cost. We test for these feedback effects in simulation in our generic model, and in turn, evaluate the importance of matching improvement strategy to context.
This set of experiments answers the specific research questions:

1. What are the adverse effects or increased risks generated by following a lean improvement strategy in a service delivery chain facing unpredictable, highly variable demand (such as healthcare service delivery)?
2. Does a following a lean strategy without addressing demand volatility reduce the effectiveness of healthcare improvement efforts in the long-term?
3. How can agile concepts be incorporated with efforts to improve individual stage (i.e., clinic or hospital department) efficiency to mitigate these risks?

0-5.1. Experiment 2: Agile concepts applied in healthcare

The second set of experiments focuses on the alternative improvement paradigm of ‘agile,’ which has recently been suggested as a means to improve healthcare service delivery (Vries & Huijsman, 2011). Many manufacturing companies have followed agile principles to improve their supply chain’s ability to better accommodate and synchronize production and delivery with volatile demand, resulting in increased revenues and market share (see Lee, 2004 for discussion). The core agile strategies – increasing market sensitivity, incorporating real-time demand information in management decisions, coordinating planning over the entire service chain, and integrating processes and performance management are across all stages in the chain – seem perfectly suited for improving the management of complex healthcare organizations faced with inherently variable demand.

However, even if manufacturing case studies and conceptual models of agility are available, the extant literature fails to clearly delineate how agile concepts can be applied to aid healthcare service delivery. The question how to best integrate agile strategies into healthcare is an uncovered field in the area of supply chain management, and has only most recently been a suggested topic of research (Vries & Huijsman, 2011). Specific practices or operational plans to increase 'agility' have not been developed for service chains, including healthcare. To our knowledge, there are no agile case studies addressing the challenges unique to the healthcare setting. This is a clear gap in knowledge that limits the improvement of healthcare service delivery chains. Moreover, the comparative effectiveness of individual agile operational plans is also unknown, as are the trade-offs created by individual agile practices on cost, service access, and service quality. Given the resource constraints in most hospitals, it is useful, if not critical, to develop an understanding of how, and to what effect, specific agile-derived operational plans can be used to improve healthcare service delivery.

We seek to address these gaps by determining how agile principles can be operationalized in healthcare service chains to address issues of patient access, service quality, and cost control. From the literature, we define specific operational practices based on core agile strategies, then test these operations-level changes in our generic healthcare delivery model. We establish the
comparative effectiveness of changes to system structures that promote market sensitivity, demand information sharing, and centralized planning. This study provides healthcare managers and policy makers with concrete guidance to improve system performance through adopting agile practices, and opens a new area for service supply chain management research.

This set of experiments answers the specific research questions:
1. What are key agile operational plans or practices (structural changes to process or information flows or management decision-making) that can be applied or adapted to improve performance of healthcare service delivery chains?
2. How do these different agile-derived practices impact cost, quality, and access to services under unpredictable, variable demand?

0-6. Contributions
This research presents a collection of studies that explores the complexity of healthcare service delivery, forming significant contributions to the lean healthcare, service supply chain management, and patient safety literatures. Centered on the importance of patient demand volatility and designing how healthcare service chains respond to that volatility, we develop a new understanding of how to improve service performance in healthcare; specifically, the counter-intuitive conclusion that, when facing volatile demand for services, increasing the ability to synchronize service capacity to demand can yield more improvement to patient access and cost than increasing personnel or resource efficiency. This research and insight contributes directly to solving a national patient access problem for Compensation and Pension exams in VA hospitals. The gains made from applying this concept in a real-world healthcare service chain led us to use simulation to uncover new, easily implementable operational plans for improving performance in healthcare chains. Our contributions can be grouped into the categories of service supply chain management, healthcare service delivery, lean methods, and healthcare service simulation.

Our main contribution to the service supply chain management literature is drawing new conclusions about the importance of agile practices for improving healthcare delivery, specifically around the core strategy of improving market sensitivity, and the operation plan of adding derivative control to the management of capacity at each stage (i.e., clinic or hospital department) in a service chain. This research is the first, to our knowledge, to identify and define a set of operational plans for the core set of agile strategies, and the first to evaluate their comparative effectiveness in simulation.

This research is a first step toward understanding the full impact the agile paradigm can have on healthcare services. Our research is a catalyst for further study into defining and testing agile concepts at the operations level in service supply chains. We encourage others to extend this line
of investigation through defining other operational plans for each core agile strategy and evaluating their effectiveness in simulation, assessing the impact of our model’s simplifying assumptions on the effectiveness of the agile-based operational plans, and through direct empirical evaluation in real-world case studies. Research of this type will lead to a more complete theory of agile service delivery and its value for improving the performance of healthcare delivery systems.

Our main contribution to the field of healthcare service delivery comes from our applied work in one VA hospital’s C&P clinic, where we formed a new conclusion about the strategies for improving healthcare service delivery, one that deviates from standard understanding that dominates healthcare improvement today. Both our implementation outcomes and subsequent simulation analysis suggest that problems with patient access are generally better alleviated by modifying management decision-making processes than simply increasing the effective service capacity through lean-based initiatives. This applied work in the C&P clinic is first application of operational changes derived from an agile strategy (e.g., increasing market sensitivity) in empirical study in healthcare. We estimate that the operational changes we prescribed for our study site have saved over 550 years of delay for veterans to date. At a practical management level, this work yields specific lessons and proven operation changes that could be implemented quickly in C&P clinics across the country.

Our main contribution to the understanding of lean methods comes in the form of critique. We offer the first clear critique of the use of lean in healthcare service systems, based on a synthesis of concepts from lean, service supply chain simulation, and patient safety. Our dynamic analysis is the first to describe the direct structural links that cause successful lean implementation projects to increase system-wide internal demand variability (through the service chain equivalent of the ‘bullwhip effect’) and provider fatigue. Through the simulation of these causal feedbacks, we are the first to open the possibility that hospitals have exposed patients to unnecessary risk of mortality and readmissions through their attempts to adopt lean methods. This work clearly prompts the need for future research at the intersection of lean and patient safety, specifically to confirm our findings through empirical analysis in the field and through studies of the quality elasticity of providers in different healthcare service chains (i.e., the effect of variability in the patient:provider ratio on quality of care and patient health outcomes).

Finally, within the field of healthcare service simulation, our generic model represents one of the few bridges between abstract service supply chain research and models of specific healthcare service chains. The translation of myriad situation-specific healthcare management decision heuristics (gleaned from years of observation and tens of interviews) into abstract, generalizable equations is a contribution to the healthcare management simulation literature. This model, given its simplicity and ability to produce complex behavior, is a sound base for future healthcare service simulation studies.
Taken all together, this research suggests a clear shift is necessary in both the guiding theory and practice of healthcare delivery improvement efforts. Our hope is that this research will successfully highlight the importance of designing care systems that respond effectively to variability in patient demand; how improving demand responsiveness can also lead to reduced costs, as resources are matched more effectively to demand; and provide healthcare practitioners and leaders with practical insights for applying simple, effective operational plans to improve performance in their own healthcare delivery systems.

0-7. Dissertation structure
This dissertation is organized as follows. The first chapter, titled “A New Approach to Improving Healthcare Delivery: the importance of resource flexibility,” presents a detailed narrative of our work with the Compensation and Pension clinic, including model development, scenario tests, implementation efforts, and overall conclusions drawn from the experience.

The second chapter, titled “The Unintended, Adverse Effects of ‘Leaner’ Healthcare,” encompasses our first experiments conducted with our generic healthcare delivery model. The experiments in this chapter focus on the effects of the application of lean-based improvement methods on demand variation amplification and the subsequent unintended consequences of wider distribution of service delays, increased provider fatigue, reduced quality of care, and the possibility of increased patient mortality. This chapter highlights the importance of collaborative planning and performance measurement in healthcare and offers critical managerial insights for hospital systems considering applying lean methods to their service delivery chains.

The third chapter, titled “Adapting Agile Strategies to Healthcare Service Delivery,” is the collection of our analysis of the applicability of agile strategies to the context of healthcare service delivery, our development of specific operational plans for these agile strategies, and our test of their comparative effectiveness. This study provides healthcare managers and policy makers with concrete guidance to improve system performance through adopting agile practices, and opens a new area for service supply chain management research.

The final chapter presents our conclusions, namely the implications of our work; our contributions to the fields of service supply chain management, healthcare service delivery, and lean methods; our research shortcomings; and possible future work. The concluding sections of this dissertation contain appendices and references.
Chapter 1. A New Approach to Improving Healthcare Delivery: the importance of resource flexibility

1-1. Abstract
Nation-wide, the Veterans Health Administration faces growing dissatisfaction with the delivery of one of its key services, conducting Compensation and Pension (C&P) exams, which determine the extent of a veteran’s service-related medical coverage and disability pension. Many VHA facilities are experiencing increasing service delays, along with reductions in exam quality and patient satisfaction. To address this issue, our study site proposed a lean-based redesign of the service chain, which we compared against an alternative 'agile'-based redesign in simulation. Based on the estimated improved performance under the agile strategy, hospital leadership adopted an alternative redesign plan, which focused on improving market sensitivity instead of increasing clinician productivity as a means to increase access to C&P exam services. We evaluate the impact of these redesign efforts 24 months after implementation, finding a sustained reduction in average wait time for C&P appointments by over 80% from peak wait time. However, analysis of system performance under various demand scenarios reveals implicit trade-offs between resource flexibility, clinic utilization rates, patient wait-times, and clinician fatigue that could undo these gains. This work contains insights for both service supply chain researchers and healthcare managers on benefits and challenges of implementing agile-based redesign in healthcare systems.

1-2. Introduction
The purpose of this study is to conduct a practical evaluation of ‘agile’-based redesign strategies applied in healthcare services. Agile system design, which focuses on increasing resource flexibility to accommodate demand volatility and uncertainty, has recently been suggested as a means to improve healthcare service delivery (Vries & Huijsman, 2011). However, specific practices or operational plans to increase 'agility' have not yet been developed for services in general, or for healthcare in particular. Moreover, the trade-offs created by implementation of individual agile practices on cost, service access, and service quality are unknown. While theoretical agile concepts seem perfectly suited for improving the management of complex healthcare services, implementation remains untested in the field. As such, current supply chain management research into ‘agility’ neither provides practical guidance to healthcare managers in the use of agile strategies in real-world system redesign, nor evidence to support its use over other, more standard redesign methods.

We address this gap by clearly outlining how resource flexibility, a key component of the agile paradigm, leads to improved service delivery in healthcare, and then testing specific agile and lean practices both in simulation and in practice. Our work focuses on improving service delivery in the Compensation and Pension (C&P) clinic inside one Veterans Health
Administration (VHA) hospital, which administers medical disability examinations, a key factor governing a veteran’s level of medical coverage at the VHA and their life-time disability benefits. Providing timely and accurate disability exams is a critical service provided by the VHA. Many other VHA facilities nation-wide experience increasing service delays for C&P exams, along with reductions in exam quality and patient satisfaction. At our study site, average wait times for C&P exams nearly doubled from August to November 2010, when this research project began, effectively leading to a denial of services for some veterans.

With the complexity of service delivery and the high costs incurred if redesign efforts failed, there was a clear need to assess the impact of proposed system changes and improvement strategies on cost effectiveness and operational performance prior to implementation. The aim of this research is twofold: to use system dynamics simulation support hospital management decision making on the redesign of service delivery by assessing the impact of multiple proposed redesign initiatives, and to use this case study to build knowledge of the effectiveness of ‘agility’ in improving healthcare delivery. Our specific research questions are:

- What are the benefits realized from following an agile system redesign paradigm focusing on flexibility in healthcare?
- How do these improvements compare to following a lean strategy of increasing process efficiency?
- How effective are specific operational plans for promoting market sensitivity, a key characteristic of agility, at reducing cost and increasing access to services in real healthcare systems?

To answer these questions, we develop a system dynamics model of the C&P clinic based on a series of semi-structured stakeholder interviews to determine the relationships between operational policies, management decisions, and process outcomes, and then calibrate that model with data available from the hospital’s electronic medical record and site observations. This model was used with clinic managers to test the impact of system redesign based on standard lean improvement methods, which focused on increasing clinic efficiency; and agile-based redesign, which focused on increasing resource flexibility as a response to rising service delays.

Following simulation analysis under multiple demand scenarios, hospital leadership selected a combined ‘lean + agile’ operational plan, instituting management changes to increase resource flexibility to control patient wait times, and operational changes to increase clinic efficiency to reduce costs. C&P clinic redesign commenced in February 2011, with most changes coming online during the summer of 2011. We evaluate the impact of the redesign on system performance after 24 months, finding the combined strategy led to sustained improved performance. This work reveals previously implicit trade-offs between resource flexibility, clinic utilization rates, and patient wait-times. This work clearly identifies increasing resource flexibility as a successful means to accomplish both cost reduction and improve access to
services, and highlights a few of the potential pitfalls of implementing agile-based redesign in real-world healthcare systems.

The paper is organized as follows. First, we present the origins of the present study, provide background on the patient access problem and discuss the role of both lean and agile paradigms in improving healthcare services. Next, we discuss the choice of system dynamics, and provide an overview of our model development process. Then, we present an overview of the existing intake and disability assessment process in the C&P clinic (the base case scenario) and define alternative scenarios representing lean- and agile-based clinic redesign plans. We end with scenario testing, model results, post-implementation evaluation, and conclusions.

1-3. Problem Description

The Veterans Administration faces growing dissatisfaction with the delivery of one of its key services, Compensation and Pension (C&P). C&P is the clinical segment of a longer process through which Veterans petition for official recognition of a service connected disability, which if found, grants them access to free healthcare services for that disability at a VA hospital and potential pension payments for lost employment. Simply put, C&P is the gateway to VA health services and benefits. All returning service members must navigate this process, as must all current VA patients seeking to change their recognized level of service-connected disability and subsequent benefits.

Many VHA facilities nation-wide are experiencing increasing service delays for C&P exams, along with reductions in exam quality and patient satisfaction. The backlog of people waiting for disability assessment by the VA has risen dramatically in recent years, from less than 389,000 in 2009 to over 809,000 by 2011. Of this amount, over 60 percent are currently waiting for over 125 days. The VA’s FY2012 national budget projects that the average days to complete a claim to rise to 230 days in FY2012 (U.S. Department of Veterans Affairs, 2011).

Long wait times for medical disability exams and a growing backlog of C&P claims have led to C&P becoming an important political issue, as veterans report dissatisfaction with lengthy processing times (Luk et al, 2010). More recently, the spectacle of Veterans committing suicide because of delayed treatment for PTSD has brought widespread criticism upon the VA (New York Times, 5/6/2011). These actions and others prompted a series of Office of Inspector General investigations in 2008-9, in which they found inefficient, poorly coordinated services; scant resources; and low quality, as measured by the number of incomplete exams (Finn, 2010). These critiques have forced the VA in general and C&P clinic managers in particular to initiate service delivery redesign efforts focused on improving efficiency and patient access.
This paper focuses on the C&P clinic at one VA hospital in the Northeast, which, for confidentiality, will be referred to simply as ‘the hospital’. This hospital is a large, integrated care organization with a service area of around 470,000 people, treating 63,000 patients annually, with a staff of approximately 3,700 FTE, including primary care doctors, specialists, lab services, administrators and support staff. The organization provides primary and intensive care, specialty surgical services, emergency and urgent care, and both in- and out-patient mental health treatment.

At the end of 2010, the C&P management team was confronted with what they described as a ‘perfect storm’ of rapidly growing waiting lists, long waiting times, fatigued personnel, and changing clinical and legal guidelines. Wait-times for C&P exams, which had always been somewhat variable, almost doubled over the period of two months, from an average of 27 days to over 49 days, as shown in Figure 6. A review of demand data showed an equally large increase in demand a few months prior. While such a dramatic increase is not the norm, interviews with C&P managers confirmed that similar ‘spikes’ in demand have occurred previously as regulations governing Veteran eligibility for specific diseases and conditions are re-written by Congress, or the VA changes national policies, guidelines, or staffing at upstream stages in the disability assessment process.

This increase in patient wait times, and thus reduced access to C&P services, was unacceptable to both C&P managers and to hospital leadership. Patient wait times are a key performance indicator for C&P services. All VA hospitals are judged against a national standard of 30 days average patient wait time. However, this measure is calculated monthly, as opposed to weekly or daily, so reporting of possible problems are delayed by up to one month before clinic managers have substantive data proving there is a patient access issue, which is crucial to facilitating their requests for changes in resources and personnel. Anecdotal evidence is reported faster, as it comes directly from C&P clinic providers and administrative staff, but these qualitative data are not enough to trigger changes in resource or personnel allocation. Managers do have access to information on the distribution of individual patient wait times, specifically the number of patients waiting for greater than 60, 90 and 120 days, but these data are not officially part of the VA's evaluation of C&P performance, are not linked to routine performance evaluation or process management, and are thus not easily collected or frequently examined.

Not only is official average patient wait time calculated monthly, but so are any data on demand rates. Under the current system, C&P clinic managers at our study site only access aggregate data on demand: total requests summed over each month. These few, aggregate measures do not provide enough detail to effectively manage C&P clinics. Discussion with C&P managers revealed that they recognize this fact, and instead make management decisions based on clinic backlog level, which is reported to them daily by C&P clinic scheduling clerks. This practice has led to adequate performance under previous demand conditions, and is similar the decision
heuristic reported in most service settings. For example, Anderson (1997) finds an identical ‘stock-correction’ type decision heuristic in the custom machine tool industry, Anderson and Morrice (2000, 2001) in a mortgage services company, Akkerman and Vos (2003) in a telecom company, and Anderson et al (2005) in the service supply chain management of an oil field development firm. While not an optimal decision heuristic or control mechanism by any means, it appears to be the rule most often used in practice in service management.

Despite the ubiquity of this kind of management heuristic, when faced with a rapid increase in demand, such as seen in June, July and August of 2010, C&P managers were not able to maintain system performance within desired boundaries. System structure and delays inherent to their decision process and subsequent resource reallocation insured that managers could not keep the supply of services adequately synchronized with extreme changes in demand. They did not have enough quantitative data to justify the resource additions needed until problem was well out of control. Additional personnel transfers to the C&P clinic were only authorized after patient wait times increased to being the worst in the region. The hospital needed a new system structure to allow for an effective and prompt respond to a wider range of demand rates.

1-4. Literature Review and Dynamic Hypothesis
To respond to the sever decline in system performance, hospital leadership ordered a redesign of the C&P clinic, including care processes, patient scheduling, and management. The proposed clinic redesign was based on a ‘lean’ approach, and thus focused on the fundamental lean goal of accomplishing perfect quality with minimal waste due to unneeded operations, inefficient processes, or excessive buffering in operations (Narasimhan et al, 2006). The lean approach in
healthcare is essentially focused on the elimination of waste or *muda*, which is defined as any activity that consumes resources but generates no redeeming value in the eyes of the ‘customer’ (Womack & Jones, 1996). Reinforcing this definition, Naylor et al. (1999) describe lean as developing a value stream to eliminate all waste, including time, and to ensure a level schedule. A level schedule means that the service delivery process must be protected from uncertainty and variation. This ‘level-loading’ makes high-capacity utilization possible, thus leading to lower total costs. Also for healthcare, lean applications usually include such elements as creating strong collaborations between providers, reducing the number of suppliers, moving toward just-in-time service delivery and continuously striving to improve quality (Aronsson et al, 2011). Lean, in this sense, is a redesign effort aimed mainly at increasing the efficiency of operations.

Lean is currently the most common set of tools and guiding management strategy for healthcare delivery redesign (Shah et al, 2008). Lean organization strategy is most associated with the success of Toyota, but the upsurge of interest in lean healthcare can be traced to the widely-publicized successes of lean improvement projects at Virginia Mason, ThedaCare, Pittsburg General hospitals in the early 2000s. Each facility achieved significant reduction and elimination of waste through the redesign of patient logistics, clinical pathways, data interchange, and care integration (Miller, 2005). Lean methods and strategies are currently promoted in VA hospitals nation-wide, and are the basis for most VA redesign and improvement initiatives.

After conducting a thorough process analysis, C&P management opted to change the design of its service provision process by transitioning from a specialty-driven practice to using more mid-level, generalist providers (physician assistants, PAs, and nurse practitioners, NPs). Their hypothesis is that PAs and NPs would be more productive than specialists, as they are able to conduct more types of medical exams and potentially conduct multiple examinations during the same appointment; resulting in faster, more efficiency service, and thus lower average service times. Service quality would not be affected by this shift, as C&P medical disability examinations are highly routinized, with clear exam templates and mandatory question sets provided for all possible claimed disabilities. However, C&P management could not evaluate this assumption, as there are currently no measures for the diagnostic quality of C&P exams (i.e., no peer review or medical oversight).

Transitioning to mid-level providers would increase clinic process efficiency, allowing the C&P clinic to work down the backlog of patients that had accumulated during the summer. This solution also complemented a general trend of improving VA clinic efficiency by keeping clinicians ‘working at the top of their licenses,’ and had the positive secondary impact of reducing costs, as the salaries of these mid-level staff are significantly lower than those of specialists.
**1-4.1 Alternative analysis**

However, we posit that a ‘lean’ approach will not yield a long-term solution for maintaining adequate access to C&P services. The lean strategy and redesign methodology was developed for optimizing production and supply chains, and thus functions best in those environments (Lewis, 2000). However, fundamental differences exist between the native context of lean, and healthcare, which reduce the effectiveness of lean-based redesign in that context. Effective lean redesign requires that uncertainty within the product or service supply chain be reduced as much as practicable to ensure that resources are being deployed efficiently (Mason-Jones et al., 1999). Operationally, lean synchronizes supply with demand by leveling demand inside production processes, and working with suppliers to reduce lead-times toward just-in-time supply delivery. This goal, called *heijunka*, or load-leveling, is the foundation of the Toyota Production System and all lean manufacturing (see Figure 7). One of the most basic tenants of lean is that standard work processes and level production are necessary to support all subsequent process redesign work in waste reduction, quality and reliability improvement, inventory reduction, etc. (Aronsson et al, 2011). Thus, a lean approach makes the most sense in contexts where load-leveling is possible, i.e., when demand is predictable, the requirement for variety is low, and volume is high (Christopher, 2000).

![Figure 7. ‘House of Lean’ visualization of lean enterprise redesign strategy (adapted from Liker, 2004).](image-url)
This is not the case for demand in C&P services. The attributes of demand and production requirements in the C&P clinic, and healthcare systems in general, are radically different from manufacturing systems. Demand for C&P services is neither constant nor predictable to any useful degree, as it depends on many factors, from the health of individual Veterans, to advances of medical science, to the writing and rewriting of national regulations on the service connection of disabilities. Demand for C&P services inherently includes individual customer inputs – e.g., an individual’s acute symptoms, chronic conditions, medical history, etc. – which create significant demand variety. This variety ensures that each service delivery event subsumes a unique set of clinicians and resources. This, in turn, creates a high degree of variability inside the process, both in terms of the degree of complexity, which can vary from a single appointment to multiple examinations that involve several care providers, and in process times and durations. Finally, intrinsically, C&P volumes are relatively minuscule when compared to those of manufacturing.

These combined differences along dimensions of volume, variety, and variability, render the optimization of C&P clinic service delivery a fundamentally different problem than optimizing a production or manufacturing operation. The high level of complexity and uncertainty make it incredibly challenging to remove variability and achieve the level-loading foundation necessary for lean redesign efforts to be successful. Thus, the C&P service is faced with a situation where demand uncertainty is impossible to remove, yet they still need to redesign their clinic structures and decision heuristics in a manner that enables them to synchronize supply and demand to facilitate their efforts to improve efficiency, increase quality, and reduce total costs.

### 4.2 Agile-based redesign

Based on this synthesis of the service supply chain and lean healthcare literature, we proposed shifting to an alternative redesign strategy, one that focuses specifically on contexts defined by volatile demand and highly variable customer inputs and requirements. ‘Agile’ is a strategy that emphasizes organization-wide flexibility as the method for meeting demand at the lowest total cost (Lee, 2004). It encompasses redesign of organizational structures, information systems, logistics processes, and management decision heuristics, all to achieve timely and effective response to rapidly changing demand environments (Christopher & Towill, 2002). Sarkis (2001) defines an ‘agile’ organization as one that able to compete successfully within a state of dynamic and continuous change. Complementing that definition, Narasimhan et al (2006) define an agile organization as one that “efficiently changes operating states in response to uncertain and changing demands placed upon it” (p. 443).

The agile strategy to adopt flexible capacity, specifically increasing flexibility along the dimensions of service volume, variety of customer inputs and requirements, and the capability to execute unplanned, new activities in response to unforeseen shifts in market demands or external supply disruptions, differs considerably from the traditional lean approach (Brown & Bessant,
The lean approach of using fixed (or planned) capacity is built on the logic of maintaining high utilization of resources, e.g. personnel and equipment, to achieve the lowest possible costs. In industries where external variability is difficult to control, lean firms protect production processes from demand variation by maintaining buffer stocks of finished inventory, which they subsequently try to reduce through increasing production efficiency (Aronsson et al, 2011). While reducing these inventories to zero, to create ‘just in time’ production, is the end goal; in reality, firms always need some buffer against changes in demand, or they must allow variation in product delivery times.

In the healthcare context, this ‘inventory buffer’ would translate to patient queues. Consequently, stringently following a lean approach, through the use of fixed (or planned) resources to maintain high utilization rates and minimizing the use of a constant ‘patient buffer,’ ensures that service times vary over time, depending on demand volume. Large volumes of patients, in excess of the planned capacity, will result in longer service times and patient queues, as described on the left side of Figure 8. Thus, focusing on making improvements to process efficiency will not actually result in improvements to patient access to services in the long term, as the root cause of demand variation itself has not been addressed.

Our alternative, agile-derived approach to the problem faced by the C&P clinic is to increase the flexibility of service capacity to ensure a fixed lead-time, shown on the right side in Figure 8. This more flexible service delivery system requires high availability of extra personnel or other resources needed to perform the process on time, independent of the actual demand volume. The advantage with this approach is that patients will receive reliable access to C&P services, and it will considerably shorten average throughput times in the system as a whole. Shifting the C&P clinic to a more agile structure will provide the ability to maintain desired performance levels over the long term, regardless of future equivalent ‘spikes’ in demand.

Figure 8. Response to an increase in demand for services under fixed or flexible capacity production systems (adapted from Aronsson et al, 2011).
1-5. Methodology/Approach
The specific modifications to system structure and operations necessary to support a more flexible and timely reallocation of resources and personnel in response to changes in demand is difficult to determine, and even more difficult to justify. To date, there is no simulation or empirical evidence to shed light on to what extent health care providers can benefit from following an agile redesign strategy in practice (Vries & Huijsman, 2011). C&P clinic managers were skeptical of the need to change their own decision making heuristics, even if the abstract logic of demand variation as the root cause to their current trouble was clear. Managers were quick to point out that shifting to a more agile service delivery system would probably require more resources, which would which persistently remain at lower average utilization rates.

Transitioning to an agile service delivery system can lead to this possible downside, if the new process for resource allocation is not sufficiently flexible. If significant delays persist in resource reallocation, then synchronizing service supply with demand will not occur, and a resource buffer will be necessary to replace the missing patient buffer. For an agile strategy to be effective, resource gap identification, reallocation decisions, and actual C&P clinic schedule changes will all have to be made quickly enough to accommodate the demand volatility demonstrated in 2010.

In order to identify and test operation-level agile policies that increase flexibility to a level adequate for probable future fluctuations in demand, we first built a dynamic simulation of the C&P clinic. Simulation was a necessary first step in clinic redesign, as such large scale changes to both system structure and management were deemed too risky to implement without a well-developed understanding of both their intended and unintended effects (Smits, 2010; Young et al, 2004; Bower and Gilbody, 2005). In the dynamically complex healthcare environment, process and policy changes often result in intended and unintended consequences which cannot be easily foreseen without the help of a computer model (Kleijen, 2005).

This kind of exploratory simulation is also necessary because little is known about how ‘agility’ can be operationalized with patient care systems. There are no agile redesign case studies addressing the challenges unique to the healthcare setting to aid in the targeting specific operational improvements to system flexibility. In the larger field of supply chain management, the study of healthcare service delivery and patient logistics is very new, and while it has a few exemplary initiatives, still lacks much academic research (Shah et al, 2008). Furthermore, the problem of maintaining patient access in the face of volatile demand is a ‘long term problem’, where the effects of redesign decisions do not appear immediately, but would only appear after months or even years (Vennix, 1996). Any evidence required to support system modifications that stem from our hypothesis that increasing system flexibility would provide the level of patient access desired must necessarily come first from simulation.
We use system dynamics simulation because the method encourages both a systemic view of the interactions of patient flows and information, and a more strategic perspective on the management of the system. It is widely accepted by healthcare professionals that healthcare delivery cannot be understood by looking at factors in isolation (Lane, 1999). By encouraging the study of how different processes interact to produce effects, system dynamics offers a rigorous approach for bringing that interconnectedness insight into focus. We choose system dynamics specifically for its ability to 1) clearly relate patterns of behavior to system structure, 2) quantify the causal links between demand and patient wait times, and 3) assess potential changes to system structure and management decision heuristics that will improve system performance in the long term. This necessitates the consideration of a broad range of interactions across physical and information flows.

System dynamics modeling has been used to address many healthcare related problems and has resulted in about 1500 publications since 1991 (Brailsford 2008). Dangerfield (1999) reviews system dynamics modeling in healthcare and concludes that the method can be used effectively in a qualitative way when influence (or causal) diagrams are the main analytic tool, and in quantitative ways when based on simulation models. We build off of previous work in healthcare management: Specifically, Taylor and Dangerfield’s (2005) use of quantitative system dynamics analysis of the reasons for failed management interventions in cardiac catheterization services, and Lane and Husemann’s (2008) use of qualitative modeling to elicit proposals for improvement of acute patient flows in the UK National Health Service. Similar Wolstenholme et al. (2006) use both qualitative and quantitative SD to analyze the effects of process redesign on mental healthcare performance. A general discussion of the role of system dynamics in analyzing healthcare systems can be found in Taylor and Lane (1998).

As with all modeling approaches, the application of system dynamics produces gains as well as losses. Examples of the latter are the loss of the stochastic variation and resolution down to the individual patient, or condition level. We have not used modeling methods capable of these features, such as discrete-event simulation (DES) or stochastic modeling (of variables like 'client inflow' or 'assessment time'), because our primary objective is not to quantify numerical results but to understand and illustrate to C&P managers the deterministic behavior of their system and understanding what causes poor system performance. For an in-depth discussion of the trade-offs and appropriate problems for using SD or DES see Tako and Robinson (2009) and Kleijnen (2005).

We choose system dynamics for its ability to generate buy-in for our alternative proposal and to involve the C&P management team in the model building process. The combination of modeling software and group model building produces results that are both technically representative and persuasive to system participants. In this study, we worked closely with those who had direct knowledge of the system. By accessing their 'mental models' as well as formal
sources (Forrester 1961), we were able to build a transparent model which was accepted as realistic in its formulation. The model became a 'visual learning environment' (Lane 1997), helping C&P management to understand why system structure produced the behaviors they had experienced (the Base Case) and how behavior would vary under different management policies (the Simulation Analysis). Using system dynamics made the complex and compelling mathematical model accessible to our group of healthcare professionals.

First, we used system dynamics qualitatively to develop influence diagrams that specify relationships between management decision and their effects, and quantitatively through computer simulation. We develop the simulation model for the C&P patient access problem following the method adapted from Forrester (1994) and Sterman (2000):

1) Describe the system, including its parts and boundaries. We develop influence diagrams based on the internal reports, interviews with hospital staff, and the literature.

2) Convert these descriptions to level and rate equations, using Vensim® software.

3) Revise the model, until both model structure and outcomes fit the existing (base case) performance.

4) Design alternative policies and process structures, based on interviews with C&P managers, which are then simulated and compared to the base scenario.

5) Discuss the Base Case and alternative scenarios with the C&P management team.

6) Implement changes to decision policy and system structures

It should be noted that the sequence of steps 1-5 is iterated until the participants were satisfied and agreed that the simulation model sufficiently represented reality. Initial qualitative research into the management of C&P clinics was completed in 2009 (Luk et al, 2010), and the first round of semi-structured interviews began in October 2010. We conducted a total of seventeen semi-structured individual and group interviews with clinicians, clerks, operations and business managers, operating staff, and medical directors. Initial interviews with hospital staff were used to create a basic conceptual map outlining patient, personnel and information flows. In subsequent rounds of interviews, interviewees revised copies of the conceptual map, correcting or adding information so that it best represented their perception of the system. Next, to facilitate step 2, the C&P team identified relative influences between system components and explained and quantified their own decision heuristics. The primary elements identified for this model include the referral rate for C&P exams, exam scheduling, the backlog of exams waiting to be conducted, C&P staffing adjustments, and measures of quality and rework. We supported this subjective analysis with information held by hospital staff, internal management reports, and the electronic medical record system.

Over the course of these interviews and subsequent model revisions, we developed a close working relationship with C&P clinic managers. While initially skeptical, their direct
involvement in the model building process made them more willing to accept the results of our alternative agile-based redesign simulation runs in step 4. We concluded step 5 with a policy recommendations report regarding our findings on the impacts of policy and process structure redesign on C&P performance and efficiency that was signed off by the entire C&P management team. The final step of implementation was undertaken by hospital leadership in a series of transformative changes to the C&P clinic from February 2011 through June 2011.

1-6. Model Design
First, we present a description of C&P patient flow, followed by an influence diagram identifying all significant management decision heuristics and information feedbacks. Combined, these inform the design of the simulation model, which is then presented with three scenarios for policy analysis.

1-6.1 Patient flow
Patients are referred to the C&P clinic solely by the Veterans Benefits Administration, which conducts the initial 'triage' process for assessing disability claims. After referral to the hospital C&P service, patients enter the hospital’s intake process for exam scheduling and medical disability assessment. Conducting disability assessments is the key business process, with about 80% of the staff conducting specialized disability exams (e.g., ischemic heart disease relating to Agent Orange exposure, or PTSD), and the remaining 20% required for administrative and clerical support. The C&P clinic directly employed approximately 14.6 FTE people, 1.4 generalists (MDs, physician assistants and nurse practitioners), 0.8 psychiatrists, 5.4 specialists, and 6 support staff. Actual percentages fluctuate as C&P managers attempt to match clinical resources with changes in demand. The remaining staff needed to conduct disability exams are procured on an ad hoc basis from other departments inside the hospital, and from outside providers on fee-for-service contracts. These 'non-aligned' staff represent the bulk of the capacity used by the C&P clinic.

Figure 1 shows a simplified version of the final map of the C&P process, consisting of the following phases:

- Patients are referred to C&P at an average rate of 153 patients per week (645 per month). After referral, patients enter the first waiting list (W1) to wait for a C&P clerk to contact them to schedule their appointment for a disability assessment. The average waiting time for an appointment is 1.3 days, with over 96% of all patients are scheduled within the 3 day guideline. The scheduling timeliness produced by each C&P support staff is monitored and addressed weekly by C&P management. This management feedback process ensures that adequate clerk time is devoted to scheduling patients. We found no linkage between
scheduling and other wait times or backlogs; the changes in work pressure in other parts of the C&P process do not affect this performance indicator.

- After scheduling, patients enter the second waiting list (backlog W2), waiting for their appointment(s) for disability assessment. On average, 2,543 patients are waiting for their assessment, which consist of an average of 1.6 separate appointments, each with a different specialist provider. One patient may claim multiple disabling conditions, requiring multiple biologic systems to be examined (e.g., a patient may be suffering from joint pain, tunnel vision and depression). Appointments are conducted by a broad range of clinicians with varying specialization and productivity levels. A specialist can complete, on average, 0.63 of a patient's disability assessment in their one hour appointment. A physician’s assistant can complete, on average, 0.87 of a patient’s disability assessment in their one hour appointment. 17% of patients are referred to C&P for three disparate conditions, 6% for four conditions, and only 1.3% for five or more. C&P management has near complete flexibility around assigning patients to specific providers (either to multiple specialists or a single generalist). However, there are a few conditions, such as PTSD exams, where a particular specialist is mandated by law. Approximately 5% of patients fail to report to their appointment, or about 7 per week.

- After the appointment, patient exams enter a third backlog, waiting for their assessment report to be competed and sent to the VBA. This takes clinicians an average of 0.9 days. Some assessments are returned to the hospital as incomplete, unclear, or otherwise insufficient for use by the VBA. Reports with errors are discovered by the VBA after an average of 4.3 weeks, after which they are returned to the originating clinician. Correcting an assessment report requires approximately the same amount of time as the originating patient appointment, but very rarely (<0.1%) are patients required to return to facilitate this correction. The rework rate is reported monthly as a percentage of the entire C&P workload (not by individual clinician) and is between 1 and 2%. It should be noted that this quality measure does not measure the accuracy of the diagnoses, but simply familiarity with work processes, exam templates, and VBA requirements.

In the equilibrium simulation, the outflow rate of complete assessments equals the inflow rate of requests for assessment. Therefore, on average, 146 patients leave the C&P process every week (accounting for the extra work done to correct errors and losses from patient no-shows). We estimate an average total assessment duration of 27.3 days, which compares reasonably to the process time of 26.9 days from calculations based on internal C&P oversight reports.
The intake and assessment process in Figure 1 represents a stable situation, meaning that the available personnel resources in C&P have been allocated in such a way that the patient flows and waiting lists remain stable over long simulation periods. In reality, variations in referral rates, examination rates, and the availability of personnel resources lead to fluctuations in system performance (as measured by patient wait time and rework rate, as well as, unmeasured, in terms of cost and quality). The flows of patients through the C&P process strongly depends on the personnel resources assigned to each rate and the personnel resources needed per patient. These variables are determined directly by C&P management decision heuristics, which can be modeled as responses to available information on process performance. These responses create controlling feedback loops, where a rise in one performance measure (e.g., wait times) triggers a response (increasing personnel resources) that counters the initial change (wait times decline). The structure of these balancing feedbacks between referral rates, backlogs, and service capacity are crucial to the ability of the system to keep patient wait times within the desired range. Explicitly modeling each feedback loop creates a more robust understanding of the system and provides explanations for the observed system behavior. We analyze the linkages between the demand for services, assessment processes, and capacity adjustment decision frameworks in the next section.
1-6.2 Management decision heuristics

Fundamentally, a system dynamics model is a causal theory of how behavior is generated by a system of both material flows and information feedbacks. Although no two C&P departments have the exact same problems, the nature of the main factors reducing access to services is universal. There are four main feedback processes interacting to affect patients’ access to services. The principle interactions created by C&P management decisions and how these decisions influence the provision and availability of C&P services are shown in Figure 2. The C&P process contains the following feedback loops:

- Balancing Loop 1: Recruiting Personnel
  An increase in the number of patients waiting for exams increases the backlog and the expected patient wait time (C&P management uses the proxy measure 'average time until the next available appointment,' which is known continuously by clerks as they schedule patients). As this time increases beyond the target acceptable wait time, work pressure increases, leading C&P managers to hire more personnel. This results in more total personnel available to provide services, increasing the examination rate, which reduces the patient backlog and the proxy metric for expected wait time. Under the initial system design, where C&P examiners are predominantly specialists from outside departments, C&P management increases personnel resources by 'borrowing’ them from other services. Actual hiring of new staff is avoided because of the many delays inherent to the process: posting the position, filling the vacancy, accrediting the new clinician, specific training in disability assessments, takes, on average, 52 weeks.

Mathematically, this balancing loop includes investment in human capital, including hiring, training, and learning-by-doing, and is structured as follows. Desired workforce at any given time is based on C&P manager’s perceptions of clinician effectiveness and the desired service capacity. Desired service capacity is based on the throughput requirements (which are based on the backlog of patients awaiting C&P exams) and perception of effectiveness (which is based on the ratio of service capacity to actual current number of clinicians). The desired workforce does not change instantaneously as it takes time to authorize the changes in the desired workforce, which is captured by parameter $τ_{dwf}$ (all time parameters are denoted by the letter tau, with a subscript identifying the specific constant and use in the model).

This adjustment delay is included in the model as an exponential smooth, or a weighted moving average where the importance of input data decline exponentially with age. This is a common formulation of adaptive expectations, where perceptions adjust gradually over time (Sterman, 2000). Perception of desired workforce changes when the actual desired service capacity (modified by other perception, discussed immediately, below), differs from the
perceived state. As the perception of desired workforce is updated, the error falls, and the subsequent adjustments diminish, until the perception again matches reality.

\[
D_{wf}(t) = \int_{0}^{t} \left( \frac{D_{sc}(t)/P_{ee}(t)}{\tau_{dwf}} - D_{wt}(t) \right) dt + D_{wt0}
\]

where \(D_{wf}(t)\) = desired workforce at time \(t\), measured in units of clinician FTEs (Full Time Equivalents)

\(D_{sc}(t)\) = desired service capacity at time \(t\), measured in units of clinician FTEs

\(P_{ee}(t)\) = perceived clinician effectiveness at time \(t\), defined below

\(D_{wt0}\) = initial desired workforce at \(t = 0\)

\(\tau_{dwf}\) = time to adjust desired workforce level = 2 weeks

Desired service capacity is the required service capacity based on the desired production rate and the standard work intensity and time allocation, represented as:

\[
D_{sc}(t) = R_{dc}(t) / (w(t) \cdot \delta(t))
\]

where \(R_{dc}(t)\) = desired completion rate at \(t\), defined in the section on balancing loop 2

\(w(t)\) = work week at time \(t\) (standard in this model is 40 hours / week, but this parameter is modified by C&P managers as a response to work pressure, which is discussed in the section on balancing loop B2)

\(\delta(t)\) = productivity of experienced clinicians at time \(t\) (standard in this model is 0.63 requests / specialist*hour and 0.87 requests / generalist*hour, but these parameters are modified by the effect of fatigue, which is discussed in detail in the section on reinforcing loop R1). Variation in productivity is based on breadth of skill set and understanding of the purpose of forensic examination: generalists can conduct more aspects of a patient's request than a specialist, who can only examine issues in their area of expertise. An individual generalists can conduct, on average, 0.87 of a patient's total request, while a specialist can complete, on average, 63% (based on skill set and distribution of exams per patient).
Perceived clinician effectiveness is management’s aggregate dimensionless understanding of the effectiveness of their total workforce. It does not distinguish the causes of changing effectiveness, which could be caused by changes in average clinicians experience, changes in productivity, and the effects of fatigue and work intensity. The workforce is divided into two populations: experienced and recently hired “rookie” clinicians. New hires are less productive than experienced clinicians, but gradually gain skills through experience, on-the-job coaching and mentoring. This perception of effectiveness does not change instantaneously as it takes time to recognize the changes in the workforce, which is captured by parameter $\tau_{pp}$. This adjustment delay is included in the model as an exponential smooth, which constantly updates current perception based on the gap between that perception and reality.

$$P_{ee}(t) = \int_0^t \left( \frac{C(t)}{E_e(t)} - P_{ee}(t-1) \right) \frac{dt}{\tau_{pp}} + P_{ee0}$$

where $C(t) =$ service capacity at time $t =$ defined in the section on reinforcing loop R1, “Fatigue Buildup,” below

$E_e(t) =$ total number of clinicians $= E_r(t) + E_e(t)$, measured in units of clinician FTEs

$E_r(t) =$ total number of new (rookie) clinicians at time $t$, measured in units of clinician FTEs

$E_e(t) =$ total number of experienced clinicians at time $t$, measured in units of clinician FTEs

$\tau_{pp} =$ time to perceive productivity $= 13$ weeks, i.e., a quarterly update, which includes time to measure, report, and assess clinician productivity

$P_{ee0} = 1$, which represents a dimensionless ratio, normalized to 1

Desired workforce informs the hiring rate of new clinicians, which contributes to the stock of new clinicians, $E_r$:

$$E_r = \int_0^t (R_h - R_{r,10} - R_{rq} - R_{m}) dt + E_{r0}$$
The hiring rate of new clinicians, $R_h$, both replaces clinicians that have quit working at the hospital and adjusts for changes in the desired workforce.

$$R_h = \left[ \left( \frac{D_{wf}(t) - E_r(t)}{\tau_{wf}} \right) \right] + R_{rq} + R_{eq}$$

where
- $D_{wf}(t) =$ desired workforce (defined above)
- $E_r(t) =$ total number of clinicians in time $t = E_e(t) + E_e(t)$, measured in units of clinician FTEs
- $\tau_{wf} =$ time to adjust workforce = 4 months for “borrowed” staff, which includes negotiation with other service line, internal negotiation within that service, restructuring clinic profiles, and informing C&P clerks. Set to 1 year for permanent staff, which includes creating and filling a vacancy in through human resources and the credentialing processes.
- $R_{rq} =$ new clinician turnover rate (defined below)
- $R_{eq} =$ experienced clinician turnover rate (defined below)

$R_{lo} =$ layoff rate of new clinicians at time $t = \min[R_{dlo}, R_{maxlo}]$, measured in units of clinician FTEs/week

where
- $R_{dlo} =$ desired layoff rate = $\max(0, -R_h)$, remains zero, unless the desired hiring rate falls below zero, measured in units of clinician FTEs/week
- $R_{maxlo} =$ maximum layoff rate = $E_r/\tau_{lo}$, determined by the number of workers and the layoff time, measured in units of clinician FTEs/week
- $\tau_{lo} =$ time to layoff an clinician = 2 weeks for “borrowed” staff, and 8 weeks to layoff permanent staff

$R_{rq} =$ quit rate of new clinicians at time $t = E_r * \text{“Effect of Burnout on Turnover,”}$ measured in units of clinician FTEs/week

where $E_r =$ number of new clinicians a time $t$

“Effect of Burnout on Turnover” = is described in the discussion of reinforcing loop R1, “Fatigue Buildup,” below

$R_m =$ maturation rate of new clinicians at time $t = E_r / \tau_m$, measured in units of clinician FTEs/week

where $\tau_m =$ time for an average new clinician to gain experience = 52 weeks for “borrowed” staff, as they only work on average 20% of their time on C&P; and 16 weeks for permanent staff, who work in the C&P clinic full time.

$E_{r0} =$ initial number of new clinicians at $t = 0$, measured in units of clinician FTEs
As new clinicians gain experience, they flow into the stock of experienced clinicians, $E_e$, represented as:

$$E_e = \int_0^t \left( R_m(t) - R_{elo}(t) - R_{eq}(t) \right) dt + E_{e0}$$

where $R_m(t) = \text{maturation rate of new clinicians at time } t$, measured in units of \textit{clinician FTEs/week}$

$R_{elo}(t) = \text{experienced clinician layoff rate} = \begin{cases} \text{MIN}(R_{dlo}(t), R_{maxlo}(t)), 0, & \text{measured in units of } \text{clinician FTEs/week} \\ \end{cases}$

This ‘if then else” equation ensures that the hospital lays-off new clinicians before experienced clinicians.

$R_{eq}(t) = \text{quit rate of experienced clinicians at time } t = E_e \cdot \omega$ “\textit{Effect of Burnout on Turnover},” measured in units of \textit{clinician FTEs/week}$

$E_e = \text{number of experienced clinicians, measured in units of } \text{clinician FTEs}$

$\omega = \text{the dimensionless fraction of experienced clinicians that leaves the C&P clinic every week = 0.05 for “borrowed” staff who have less affiliation to the C&P clinic and see working in C&P as a secondary duty, and 0.02 for permanent staff}$

“\textit{Effect of Burnout on Turnover}” = is described in the discussion of reinforcing loop R1, “Fatigue Buildup,” below

$E_{e0} = \text{initial number of experienced clinicians at } t = 0, \text{measured in units of } \text{clinician FTEs}$

Taken together, these equations determine the service capacity, $C(t)$, which directly influences the C&P request completion rate and thus patient backlog. This balancing control loop operates in conjunction with the ability managers have to adjust clinicians working hours per week. This, and a full description of equations governing the patient backlog, are discussed in the next section on balancing loop B2 “\textit{Adjusting Hours per Week},” below.

- Balancing Loop 2: Adjusting Hours per Week

Similar to B1, as an increase in work pressure also leads C&P managers to increase the number of hours assigned per clinician per day (usually in the form of overtime). This causes an increase in the examination rate, which reduces the backlog, the average wait time,
and the proxy metric for expected patient wait time. This feedback loop contains almost no
delays, as changes to the number of hours each clinician is assigned to C&P can take effect
the following day. This feedback is constrained by each clinician's willingness to work
overtime. The few clinicians working directly for C&P (mainly PAs and NPs) have worked
up to 20 additional hours per week. However, because most specialists are only temporarily
assigned to C&P, they perceive C&P as secondary to their normal duties and are only willing
to work up to two extra hours weekly for C&P patients. If work pressure declines, both
generalists and specialists will reduce their C&P hours per day. In the Base Case Scenario, a
predominance of specialists ensures that loop B1 dominates B2 in creating the dynamic
tendencies of the system, as it is easier to increase service capacity by 'borrowing' more
specialists than through increasing their C&P clinic hours per day.

Mathematically, the structure of this balancing loop is as follows. This section presents the
structure for the arrival, accumulation and processing of C&P exams and the link to the
service capacity sector, where $B(t)$ is the order backlog, $R_c(t)$ is the exam completion rate in
the clinic at time $t$, and $R_{ed}(t)$ is the error discover rate at time $t$. Note that $R_a(t)$ is the new
C&P request arrival rate, which is determined exogenously.

$$B(t) = \int_0^t (R_a(t) - R_c(t) - R_{ed}(t)) \, dt + B_0$$

where $B(t) =$ patient backlog at $t$, measured in units of C&P patient requests for
exam(s). This is analogous to the number of C&P patients awaiting service.

$R_a(t)= \text{exogenous arrival rate of patients at time } t$, measured in units of C&P
patient requests/week

$R_c(t) =$ completion rate of patients at time $t$, measured in units of C&P patient
requests/week

$R_{ed}(t) = \text{error discovery rate at time } t$, defined in the discussion of reinforcing loop
R2, below

$B_0 = \text{initial backlog (C&P patients in-progress) at } t = 0$

The completion rate is the lesser of the potential completion rate based on the potential
completion rate, $R_{pc}(t)$, or the maximum completion rate, based on the number of exams
in the backlog and the minimum time needed to process each exam, $R_{cmax}(t)$.

$$R_c(t) = \min[R_{pc}(t), R_{cmax}(t)]$$

where $R_{pc}(t) = \text{potential completion rate} = C(t) \ast \delta \ast w(t)$, measured in units of
C&P patient requests/week
where \( w(t) \) = work week at time \( t \) (standard in this model is 40 hours / week, but this parameter is modified by C&P managers as a response to work pressure, which is discussed below)

\( \delta(t) \) = productivity of experienced clinicians at time \( t \) (standard in this model is 0.63 requests / specialist*hour and 0.87 requests / generalist*hour, but these parameters are modified by the effect of fatigue, which is discussed in detail in the section on reinforcing loop R1, “Fatigue Buildup,” below)

\[
R_{\text{cmax}}(t) = \text{maximum completion rate at time } t, \text{ measured in units of C&P patient requests/week}
\]

\[
= B(t) / \text{“minimum delivery delay”}
\]

where the “minimum delivery delay” = 0.5 weeks

The desired completion rate depends, \( R_{dc}(t) \), on the backlog and the organization’s delivery time goal, so

\[
R_{dc}(t) = B(t) / \lambda, \text{ measured in units of C&P patient requests/week}
\]

where \( \lambda \) = target service time = 3.85 weeks (just under the mandate set nationally at 4 weeks)

The decision to adjust service capacity through making changes to the hours of work per clinician to complete C&P exams at the desired rate is dependent on work pressure, which we define as the ratio of desired to actual service capacity. A work pressure greater than one indicates the clinic is under stress as there are more exams in the backlog than the clinic can process within the target service time, given the number and productivity of clinicians, the standard workweek and the current standard for the time that should be allocated to each exam. A work pressure of less than one indicates excess capacity. High work pressure boosts exam completion through greater work intensity, reducing the backlog and work pressure.

**Work Pressure** = \( C_d(t) / C(t) \), measured as a *dimensionless ratio of clinician FTEs to clinician FTEs*

where \( C_d(t) \) = desired capacity at time \( t = C_d(t) = R_{dc}(t) / (\delta \cdot w) \), measured in units of clinician FTEs

where \( R_{dc}(t) \) = desired completion rate at \( t \), measured in units of C&P patient requests/week
$w(t) =$ work week at time $t$ (standard in this model is 40 hours / week)

$\delta(t) =$ productivity of experienced clinicians at time $t$ (standard in this model is 0.63 requests / specialist*hour and 0.87 requests / generalist*hour, but these parameters are modified by the effect of fatigue, which is discussed in detail in the section on reinforcing loop R1)

Workweek, $w$, is an increasing function of work pressure, defined as:

$$w(t) = w_s \ast \text{"Effect of Work Pressure on Workweek,"
measured in units of work hours / week}$$

where $w_s =$ standard workweek = 40 hours / week

"Effect of Work Pressure on Workweek" is defined by the dimensionless graphical function, shown below in Figure 10, which shows the effect of work pressure on workweek estimated from our interviews and observations in the C&P clinic (for details on the estimation process, see Sterman, 2000). Note that workweek saturates at extreme levels of work pressure: work hours cannot be increased beyond some level even when work pressure is very high; similarly, the workweek does not fall to zero even when work pressure is very low.

---

**Figure 10.** C&P management’s responses to work pressure
**Reinforcing Loop 1: Fatigue Buildup**

While higher work intensity boosts output in the short run, extended overtime causes fatigue that eventually undermines the benefit of longer hours through an increase in fatigue. This results in a decrease in the effectiveness of the personnel, reducing the exam completion rate. This reinforcing loop does not pose a problem in the Base Case Scenario, as the use of overtime is limited by the organizational constraints mentioned above. We assume that all staff (both specialists and generalists) experience the same effects of fatigue on productivity for the same accumulated overtime.

Mathematically, the structure of this reinforcing loop, which connects service capacity with the effect of fatigue on clinician productivity, is as follows.

\[ C(t) = \text{service capacity at time } t = E_{et}(t) \times \text{"Effect of Fatigue on Productivity"}, \text{ measured in units of clinician FTEs} \]

where  \( E_{et}(t) = \text{effective total number of clinicians at time } t = E_e(t) + (E_r(t) \times \rho) \), measured in units of clinician FTEs

where  \( E_e(t) = \text{total number of experienced clinicians at time } t, \text{ measured in units of clinician FTEs} \)

\( E_r(t) = \text{total number of new (rookie) clinicians at time } t, \text{ measured in units of clinician FTEs} \)

\( \rho = \text{new clinician (rookie) productivity fraction} = 0.5, \text{ measured as a dimensionless fraction of the productivity of a fully trained clinician} \)

“Effect of Fatigue on Productivity,” defined by the graphical function shown below in Figure 11, is a decreasing function that reduces service capacity when the recent workweek is greater than 40 hours/week, but increases only marginally above its normal operating point when the workweek falls below normal. The effect this equation describes is discussed in the section on feedback loop R2b, “Work Quality.”
Fatigue builds up and dissipates over time; we model fatigue as an exponentially weighted moving average of past work intensity, as measured by the recent workweek. The longer the fatigue onset time the longer it takes for burnout to set in and for clinicians to recover when work intensity falls.

Recent workweek, measured in units of work hours / week, is an exponential smoothing of the workweek over the period for the onset of fatigue. The 'short term' label refers to the fact that the burnout onset time is much longer than the fatigue onset time.

\[
Recent\ Workweek = w_r(t) = \int_0^t \left( \frac{w(t) - Recent\ Workweek\ (t)}{\tau_{fo}} \right) dt + w_s
\]

where \( w(t) \) = workweek at time \( t \), measured in units of work hours / week
\( w_s = \) standard workweek = 40 hours / week
\( \tau_{fo} = \) fatigue onset time = 3 weeks, which the average time for an extended series of workweeks to have an impact on clinician productivity

Extended periods of high work intensity also increase clinician turnover. The effect of fatigue on turnover is an increasing function of burnout, and affects both types of clinicians equally.

\[
R_{q, t} = \text{quit rate of new clinicians at time } t = E_t \times \text{“Effect of Burnout on Turnover,” measured in units of clinician FTEs / week}
\]
where $E_r = \text{number of new clinicians a time } t$

"Effect of Burnout on Turnover" = described below

$R_{eq}(t) = \text{quit rate of experienced clinicians at time } t = E_e \times \omega \times "\text{Effect of Burnout on Turnover},"$ measured in units of clinician FTEs / week

$E_e(t) = \text{number of experienced clinicians, measured in units of clinician FTEs}$

$\omega = \text{the fraction of experienced clinicians that leaves the C&P clinic every week } = 0.05 \text{ for "borrowed" staff who have less affiliation to the C&P clinic and see working in C&P as a secondary duty, and } 0.02 \text{ for permanent staff}$

"Effect of Burnout on Turnover" is defined by the graphical function shown below in Figure 12. Like the effect of fatigue on productivity, extended overtime increases attrition with a delay, but with a longer time constant: long workweeks quickly reduce productivity, but people will tolerate high overtime much longer before quitting.

![Figure 12. Effect of burnout on turnover](chart.png)
Long Term Workweek, measured in units of \( \text{work hours/week} \), is an exponential smoothing of the workweek over the period for the onset of burnout. The 'long term' label refers to the fact that the burnout onset time is much longer than the fatigue onset time.

\[
LongTerm\ Workweek = w_I(t) = \int_0^t \left( \frac{w(t) - w_I(t)}{\tau_{bo}} \right) dt + w_s
\]

where \( w(t) \) = workweek at time \( t \), measured in units of \( \text{work hours/week} \)

\( w_s \) = standard workweek = 40 hours/week

\( \tau_{bo} \) = time for the extended workweek to have an effect on turnover = 52 weeks

These two ‘side effects’ of high work intensity on fatigue and burnout create a pair of reinforcing feedbacks that reduce service capacity (directly and indirectly, as attrition both lowers headcount and increases the rookie fraction), which lowers C&P exam request completion rate, allowing the service backlog to rise, further increasing work pressure and forcing service providers to work even harder.

- **Reinforcing Loop 2 (a and b): Work Quality**

Increasing fatigue creates an increase in the percentage of errors made, increasing the number of exams returned by the VBA for correction. This reinforcing loop causes the unintended consequence of increasing the backlog of exams (as this rework is added to the queue), further increasing work pressure and the need for more hours assigned per clinician per day to C&P. Loop R2b indicates that hiring also adversely affects average quality, as clinicians new to C&P will produce more errors than those with accumulated experience. We found that, on average, specialists take more time to gain experience than generalists, as specialists see fewer C&P patients per week (generalists can see up to 10 patients per day, while most specialists see an average of 4.3 patients per week in the Base Case Scenario).

Mathematically, the structure of this reinforcing loop, which connects the effects of fatigue to service quality and backlog, is as follows. We assume that the probability of errors depends on two factors: fatigue and average clinician experience. Fatigue increases the chance of error and cuts the chance of detecting and correcting it at the time. Inexperienced clinicians simply make more errors than experienced clinicians. For simplicity we assume these sources of error are independent. The probability an exam is done incorrectly is then the complement of the probability that no error was introduced by any of these factors:
The specific effect of recent workweek has on the probability of error-free examination and documentation is defined by the graphical function in Figure 13, defining the effect the dimensionless ratio of recent workweek to standard workweek = \( w_r(t) / w_s \) has on \( f(F_i) \).

The specific effect of average clinician productivity on the probability of error-free examination and documentation is defined by the graphical function in Figure 14, defining the effect the average productivity as the dimensionless ratio of effective workforce to total clinicians = \( E_{ef}(t) / E_t(t) \) has on \( f(F_i) \).
Sensitivity analysis suggests that model behavior is not significantly affected by changes in these graphical functions.

The errors created by these effects are typically not detected immediately: the VBA takes an average of one month to discover an error in either the exam or its documentation. Errors therefore accumulate in a stock of unknown rework until they are discovered (this is a standard model construction for rework, for details see, Lyneis and Ford, 2007).

\[ E(t) = \int_0^t \left( R_{eg}(t) - R_{ed}(t) \right) dt + E_0 \]

where \( E(t) \) = backlog of undiscovered errors at time \( t \), measured in units of C&P patient requests for exam(s)
\( R_{eg}(t) \) = error generation rate at \( t \), measured in units of C&P patient requests for exam(s)/week
\( R_{ed}(t) \) = error discover rate at \( t \), measured in units of C&P patient requests for exam(s)/week
\( E_0 \) = initial backlog of undiscovered errors at \( t = 0 \), measured in units of C&P patient requests for exam(s).

Error generation, \( R_{eg}(t) \), depends on the total completion rate and the probability that each exam contains an error:

\[ R_{eg}(t) = R_c(t) \times P(EG), \text{ measured in units of C&P patient requests for exam(s)/week} \]

where \( R_c(t) \) = completion rate of C&P patient requests at time \( t \) measured in units of C&P patient requests for exam(s)/week
\( P(EG) \) = probability of error generation (dimensionless)

The error discovery rate, \( R_{ed}(t) \), is assumed to be a first-order process with a constant average error discovery time:

\[ R_{ed}(t) = \frac{E(t)}{\tau_{de}}, \text{ measured in units of C&P patient requests/week} \]

where \( E(t) \) = the number of undiscovered errors at time \( t \), measured in units of C&P patient requests for exam(s)
\( \tau_{de} \) = time to discover errors = 4 weeks
When errors are discovered they are added to the service backlog to await reprocessing. Thus, the service backlog is:

\[
B(t) = \int_0^t \left( R_a(t) - R_c(t) - R_{ed}(t) \right) dt + B_0
\]

where \( B(t) \) = patient backlog at \( t \), measured in units of \( C&P \) patient requests for exam(s). This is analogous to the number of \( C&P \) patients awaiting service.

\( R_a(t) \) = exogenous arrival rate of patients at time \( t \), measured in units of \( C&P \) patient requests/week

\( R_c(t) \) = completion rate of patients at time \( t \), measured in units of \( C&P \) patient requests/week

\( R_{ed}(t) \) = error discovery rate at time \( t \), measured in units of \( C&P \) patient requests/week

\( B_0 \) = initial backlog (\( C&P \) patients in-progress) at \( t = 0 \)

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Figure 15. Influence Diagram of the main effects determining waiting time in C&P.
The polarities of the causal links are: '+' = variables move in the same direction, '-' = variables move in the opposite direction.
1-6.3 Simulation model

We use the overview of the current process (Figure 1) and the influence diagram of C&P management decision processes (Figure 2) to clarify thinking and to discuss process redesign, policy decisions, performance indicators, and the items to include in the simulation model. The model has nine stocks and 38 other variables, (plus 26 stocks and variables to calculate performance measures). Although the software has the ability to display the model graphically, we show a simplified map which effectively presents all systemic interactions (Figure 16). The model was constructed using Vensim® modeling software.

![Stock and flow diagram of the C&P system dynamics model.](image)

Based on our discussions with C&P process stakeholders, we employed three main abstractions from the actual C&P process. First, we determined that the backlogs W1 and W3 do not contribute to the dynamic behavior of the system, as no relation was found between them and other system components or performance measures; thus, they were subsumed into the backlog W2. This reduction in model accuracy allows for a more clear interpretation of the causal factors producing the behavior observed in simulation. The second abstraction made was to start each model with the appropriate number of clinicians, regardless of type, for the Base Case Scenario initial referral rate. This prevents model initialization errors from confusing actual dynamic behaviors. Finally, in conjunction with C&P management, we made the decision that analysis of policy and process changes should only compare scenarios where personnel resources consist of all specialists or all generalists. In reality C&P is currently, and must continue to be, composed of a mix of generalists and specialists, and in no case could staffing with only one or the other be
a feasible policy. However, C&P management felt that such abstracted scenarios were more useful for comparison and decision-making purposes, allowing for more clear answers to their questions on process redesign.

### 1.6.4 Clinic redesign proposals

We test both lean and agile-based system redesign proposals in simulation. These different scenarios test the implicit hypothesis underpinning the current process redesign, that improving provider efficiency will improve service timeliness, and the alternate hypothesis, that increasing resource flexibility will instead improve service timeliness and patient access.

The lean proposal generated by C&P managers is to change the type of provider used to deliver C&P medical disability exams. The two types of providers chosen by C&P managers to be of interest were staffing with all specialists and with all mid-level generalists (specifically, physician assistants). Physician assistants show increased efficiency over specialists, as measured by the average number of disability assessments completed per hour. This change is included in our model as an increase in the provider productivity parameter. The parameter governing variable costs due to salary is also modified in this scenario, as PAs earn about half as much as specialists. Based on conversations with C&P managers and other C&P staff, we assume that the quality of exams (as measured by the rework rate) will not be affected by type of clinician. The process for completing C&P disability exams is highly scripted, ensuring that a broad range of provider can accomplish them with little additional training.

Our proposed agile-based system redesign concept is to improve resource flexibility through changing the speed at which resource allocation decisions are manifest, rather than changing specific provider types. There are many possible ways to increase the speed of the decision to adjust resource allocation, ranging from streamlining the hiring process for new C&P clinicians, to reviewing and reacting to patient backlog measures daily instead of weekly, to removing steps in the communication process between C&P managers and their staff’s primary service chiefs. Considering the constraints present in the hospital, in terms of lengthy hiring times for new clinicians, delays in borrowing clinicians from other departments, and the limited ability to schedule over-time, we propose to increase resource flexibility through the counter-intuitive solution of hiring all C&P clinicians directly for the C&P clinic.

In this scenario, C&P clinicians will report directly to the C&P medical director, who will no longer need to ‘borrow’ clinicians from other departments. This staffing shift will increase resource flexibility by increasing individual C&P clinicians’ ability to work overtime when demand increases and the ability of C&P managers to schedule less than 40 hours per week when demand decreases, both of which are currently limited by the organizational structure inherent to ‘borrowing’ providers, as discussed in section 7.2. We believe that increasing the ability to make these types of hours/provider/week decisions will result a net increase in capacity flexibility,
even if management decisions on the total number of providers per week manifest much more slowly than before. Shifting the mechanism by which resource capacity is adjusted, from changing total personnel to changing hours/week, will allow C&P managers to react more quickly to fluctuations in patient backlog, resulting in better synchronization of service capacity with demand.

This proposed policy is included in the model as a change in the capacity adjustment time parameter and the maximum possible workweek per provider. In addition to the effects on resource flexibility, these changes to clinic staff primary location also necessarily affect providers’ learning rates as related to gaining experience, and clinician turn-over rates (for details, see Table 1). Providers who work directly for the C&P clinic gain experience faster when working solely on C&P cases, and are more committed to the C&P clinic, therefore remaining in C&P longer than their ‘borrowed’ counterparts.

C&P clinic managers raised substantive concerns about this proposal during the policy design phase. Their qualms fell into three main categories. The first is that even if flexibility is as important to performance as we believe, hiring new clinicians at the VA takes so long that our proposed policy could never create a more flexible system than their current system of ad hoc borrowing. The lengthy time to hire a new clinician was perceived to completely overwhelm any possible flexibility gains from ability to use overtime. Before explicit investigation of this effect in group simulation sessions, C&P managers discounted the effect overtime adjustments could have on the total service capacity.

The second problem they foresaw is that since the agile-derived operation change allows for no resource buffer for C&P managers, then the continuous use of overtime to adjust service capacity would lead to clinician fatigue and eventual burnout. This would not only have a detrimental impact on service quality in the short term, but reduce average experience level of C&P clinicians in the long term, as the higher turn-over rate would ensure that proportionally more clinician would be new and inexperienced than before. This causal relationship is commonly found in workforce models in the literature, and undoubtedly appears in their real-world system. We explicitly include these feedback loops to allow for overtime to create a buildup of fatigue and subsequent declining service quality in our model.

The third main concern centered on costs: if demand declined significantly (a reverse from the event seen in 2010), then C&P managers will not be able to quickly reduce capacity, which will lead to low utilization rates and unjustifiable higher costs in that period of abnormally low demand. We addressed this concern by explicitly setting ‘time to dismiss’ equally as long as the ‘time to hire.’ Model testing under various demand scenarios, included in section 9.3, address this concern. Working with the C&P management team, we included all of these constraints and feedbacks explicitly in our model to test for these predicted effects.
Table 1. Parameter changes for the three system redesign scenarios tested and base case, developed through interviews and analysis of data obtained from VA CPRS reports.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>unit</th>
<th>Base Case = ‘Borrowing’ specialists (100%)</th>
<th>‘Borrowing’ mid-level providers</th>
<th>Hiring specialists</th>
<th>Hiring mid-level providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Hire</td>
<td>[weeks]</td>
<td>16</td>
<td>16</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>Time to Train</td>
<td>[weeks]</td>
<td>52</td>
<td>52</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Maximum Productivity</td>
<td>[exams/hour]</td>
<td>0.63</td>
<td>0.87</td>
<td>0.63</td>
<td>0.87</td>
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<td>[hours/week]</td>
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<td>42</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>Time to Layoff</td>
<td>[weeks]</td>
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<td>2</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Normal Quit Rate</td>
<td>[dimensionless /week]</td>
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<td>2%</td>
<td>0.05%</td>
<td>0.05%</td>
</tr>
<tr>
<td>Cost</td>
<td>[dollars/year]</td>
<td>$150,000</td>
<td>$75,000</td>
<td>$150,000</td>
<td>$75,000</td>
</tr>
</tbody>
</table>

1-7. Simulation Analysis
In this section, we test for the effects of a sudden increase in demand for C&P services on system performance, finding support for our hypothesis that the ad hoc ‘borrowing’ of providers, which provided the appearance of flexibility, was, in fact, not flexible enough to accommodate the ‘spike’ in demand seen in 2010. These simulations produce system behaviors that closely match historical data, further validating our model. Finally, we discuss how model structure creates these behaviors and the implications for C&P redesign.

1-7.1 System performance under ‘normal’ demand
Calibration of the patient referral rate to C&P was derived from historical data made available by the hospital. These data are simulated as stochastic variation around a mean of 153 patients per week, or the equivalent of 1,025 exams per month. To establish that the model is able to produce the dynamics seen in the real world, this variation around the mean patient referral rate was simulated 1,000 times for the equivalent of three years each. Summary statistics from these runs are shown in Table 2, and compared to historical data. Unless otherwise stated, these performance measures have been calculated from simulations using this ‘normal’ demand and are averages subsuming the variation caused by ‘normal’ variation in the referral rate.
The measures calculated include a weekly average across all patients for the total delay time (from the initial request arriving at the hospital to the assessment report being sent to the VBA); this also includes potential rework delays. The minimum and maximum of this total waiting time are also calculated. Other measures track weekly average figures for error production, total service capacity, and clinician time utilization rates.

In both real C&P historical data and in the outputs of this simulation, average total patient wait time remains below the 30-day guideline more than 91% of the time. The slight variation in average total wait time, from 24.6 to 30.1 days, is caused by the delays and constraints in adjusting service capacity to match changes in demand for services. The management structure present before system redesign efforts began is flexible enough (including both hiring or ‘borrowing’ and clinician’s overtime preferences) to respond adequately when variation in demand for services remains within the bounds of what is considered ‘normal’ demand. Adequate flexibility, in this instance, is defined as responding both quickly and sufficiently to ensure no sustained buildup in the patient backlog. The underlying causal relationships linking these two factors are analyzed below.

<table>
<thead>
<tr>
<th>Performance measures for the base case scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average total patient backlog [patients]</strong></td>
</tr>
<tr>
<td>Base Case Scenario (Avg. referral rate 153 patients/week)</td>
</tr>
</tbody>
</table>

Behavior of exogenously determined demand and resultant average service delivery time (as computed by Little’s Law), average patient backlog, average clinical service capacity, average insufficiency, and average clinician utilization rate. Demand is simulated around a base demand rate of 655 disability assessments per week supplemented with a pink noise process with a standard deviation of 0.075. The time horizon for the simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.

In this base case scenario, the largest contributor to patient wait time arises from delays in the balancing loop B1, which represent management decisions seeking to adjust number of providers available to match demand for C&P services. C&P managers change desired workforce proportionally to match the changes in the expected wait time determined by the average time until the next available appointment. This scenario represents the situation before system redesign, where managers are constantly negotiating with specialty service chiefs to adjust personnel allocations to the C&P clinic. The personnel re-allocation process takes an average of
four months, consisting of negotiations between service chiefs, internal negotiations with clinicians, and updating clinic profiles in the IT system. During this time, service demand has undoubtedly changed, prompting another round of negotiations. Thus, C&P personnel resources are always four months behind what C&P managers believe they should be.

However, this delay leads to limited adverse consequences during normal fluctuations in demand for services. As shown in both simulation and site data, a four month personnel adjustment delay is not enough to allow a buildup of patients waiting for C&P appointments. Under normal conditions, neither the speed nor the volume of the responses generated by this loop is too limited for managers to be able to keep C&P performance close to desired.

C&P managers can also adjust service capacity by directly changing hours per clinician, represented by balancing loop B2. However, this loop has little effect on overall service capacity in this scenario. No large adjustments to C&P hours per week are possible, as 'borrowed' specialists have no incentives to work overtime, and a reduction in clinic utilization (working less than an 8 hour day) would cause their specialty service to re-requisition them to their primary service. While balancing loop B2 is not constrained at all in speed, it is severely constrained in terms of volume of response available.

The pre-redesign organizational structure in which C&P is embedded leads to a dependence on loop B1, the official re-allocation of resources between departments. This lack of an immediate lever to change service capacity, coupled with the delay in resource re-allocation, prevents C&P managers from reacting optimally to changes in demand for services. These two factors combined lead to the observed 9% overage in patient wait times.

1-7.2 System performance under excess demand for services
The reference mode also includes a period of excess demand for C&P services. Clinic managers and data from the hospital’s electronic medical record system indicate that excessive demand overloads the C&P system, creating a massive patient backlog which increases average patient wait time to near 50 days. Figure 17 compares historical data, with a 160% increase in demand for services during July and August 2010, to the base case simulation output (one sample run shown). The model replicates historical behavior, where normal variation in the patient referral rate produces a tolerable variation in total patient waiting time, until a period of excess demand creates a subsequent increase in average patient wait time. The underlying reasons for this behavior are analyzed below.
Figure 17. C&P referral rate and average patient wait time. At right: Historical data from C&P service from March 2009 through July 2011. At left: Output from a representative base case simulation run.

Behavior of exogenously determined demand and resultant average service delivery time (as computed by Little’s Law). Demand is simulated around a base demand rate of 655 disability assessments per week supplemented with a pink noise process with a standard deviation of 0.075; to match the historical data this demand is supplemented with an increasing ramp of slope 0.08 from week 80 to 87.5, then ramp of -0.08 from week 87.5 to 95. The time horizon for the simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.

When demand for services is inside the ‘normal’ range, the system’s management structures contain tolerable delays and constraints, producing limited variation in patient wait time. However, historical data indicate that the system is not robust against a rapid increase in demand for services outside this range. In this situation, the four month delay in personnel resource reallocation in Loop B1 is too long to maintain desired system performance. The delays in C&P system response time, coupled with the constraint on the more immediate service capacity adjustment loop, balancing loop B2, allow a considerable backlog of patients to develop before adequate service capacity is allocated to C&P. The backlog immediately following the period of excess demand in July and August 2010 reached over 5,000 patients, an increase of 250% over the average ‘normal’ backlog.

Moreover, increasing personnel levels creates the additional challenge of temporarily lowering the average productivity (loop R1). Interviews with C&P medical directors and clinicians suggest that clinicians new to C&P exams are only 50% as productive as experienced clinicians. While not a driver of system behavior in the base case, as the proportion of new to experienced providers is relatively static, management responses to this sudden demand increase create productivity reductions which exacerbate the patient access problems. Bringing in new, less
productive clinicians, reduces average productivity just when managers need the most from their staff.

Increasing C&P personnel levels also adversely affects service quality (loop R2b). Just as new clinicians take more time per exam, they also make more mistakes per exam than more experienced clinicians (while not diagnostically less proficient, they have less understanding of reporting terminology and the nuances of the C&P IT system). C&P managers found that new clinicians were twice as likely to make a mistake as experienced clinicians. It takes the VBA, on average, one month to discover these reporting errors, resulting in a secondary surge in total demand as this re-work is returned for completion.

These two reinforcing loops combined simultaneously create an increase in rework, further increasing the backlog of pending exams when it is already above normal, and a decrease in the ability of C&P to (re-)do those exams. The long-lasting effects of these ‘side effects’ to management’s response to the demand surge can be seen in Figure 18, where rework is shown to account for up to 25% of the total C&P workload after the simulated surge in demand.

Delays in balancing loop B1 also lead C&P managers to request more capacity than is actually needed to return patient wait time to within the desired range. Delays between initiating personnel adjustments and the observable effects of those adjustments are not captured by performance measures in the system, or in the decision heuristics of C&P managers. This information gap leads to an overshoot of the optimal personnel adjustments, producing a period of excess capacity. Loop R1 reinforces this effect, as clinicians who were previously new to C&P and, thus, working at below-average productivity, improve their performance over time, further increasing effective capacity only after the demand surge has passed. These management structures create an overshoot which can be seen in both the below-average patient wait time at the end of both the historical data and in the simulation (in Figure 17 from June to July 2011 in site data, and in

![Figure 18. Base case scenario simulation output for patient referral and error rates contributing to patient backlog.](image)

Behavior of exogenous demand, internally created re-work, and total workload over the course of the base case simulation. Demand is simulated around a base demand rate of 655 disability assessments per week supplemented with a pink noise process with a standard deviation of 0.075; to match the historical data this demand is supplemented with an increasing ramp of slope 0.08 from week 80 to 87.5, then ramp of -0.08 from week 87.5 to 95. The time horizon for the simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.
weeks 120-150 in simulation) and in the reduced clinic utilization rates of C&P clinicians over the same period.

We have derived a system structure from iterative interviews and site data that reproduces observed behavior. In analysis of the base case simulation, we have clearly defined the problem facing C&P. Simulations reveal a system robust against what is perceived to be a ‘normal’ level of demand volatility, but not against ‘surges’ in demand, or increased levels of demand volatility. C&P management decision structures reliant on borrowing specialist clinicians are not flexible enough (in terms of response speed) to prevent a buildup of patients waiting for appointments when demand increases suddenly. If demand is subject to recurrent sudden increases, then further patient access problems are inevitable.

1-8. Exploring Agile Clinic Redesign
The initial motivation for this research was to inform system redesign efforts by a VA hospital facing a 'crisis' of patient access to services. Model simulations explore what changes to current system structures or processes could render the system more robust against fluctuation in demand for services, and prevent future sudden increases in demand from recreating the access problem seen in 2010. Exploratory simulation allows us to confidently test lean-derived system redesign proposals, along with the agile-based proposal, before implementation. Simulation also allows us to challenge managers’ assumptions on the causes of the observed behavior in the system, and assess the robustness of new policies under different demand conditions.

We conduct a range of simulation experiments for comparison with the base case. The principle scenarios involve changes in provider type in C&P, changes to the staffing structure of the C&P service, and combined scenarios. Other policy runs explore the effects of increased demand volatility.

1-8.1 Performance measures
Policies were judged against current national guidelines for timeliness (total average patient wait time <30 days) and quality (<2% disability assessment return rate). However, discussion with C&P managers indicated that other performance indicators would be useful for evaluating system performance. Hospital administrators and C&P managers sought to compare clinic (e.g., average provider) utilization, total cost, productivity, and cost per patient across the various system redesign alternatives.

The resulting total of seven key performance indicators are listed in Table 3, left column (equations for performance measure calculation are shown in Appendix C). The first two indicators are the national performance indicators currently tracked by the hospital. The next indicator is total cost per year, which is based on number of providers and hours worked per
week (this measure includes the extra costs of overtime and under-time, but excludes fixed costs, tests, labs, administrative and support staff, etc.). The next three indicators are measures of productivity: Clinic utilization is the ratio of actual time spent in C&P to a standard 40 hour workweek; average productivity is measured as exams/hour (which is affected by ratio of new to experienced providers and fatigue from excess periods of overtime), and cost per patient.

Finally, we present our own measure of timeliness: the average absolute difference between the target wait time and the actual wait time (i.e., the accumulation of all wait time error, averaged over the duration of the simulation). This is a more descriptive measure of the C&P system's response to fluctuations in demand for services than average total wait time. Average total wait time can be a misleading performance indicator, as a lower average wait time is not necessarily a sign of improved performance. An average wait time below the target wait time indicates the system is providing faster than desired access to services, and is thus consuming more than the necessary level of resources. We do not include indicators of patient satisfaction because we assume these are constant in our model, and thus do not affect model behavior. General patient satisfaction with the disability assessment process is outside the scope of our research efforts, but future models may include measures of patient satisfaction.

1-8.2 Lean v. agile scenarios
System behavior was simulated for each system redesign approach. The resulting performance measures are shown in Table 3 and Figure 19 and analysis of the various outputs of the runs is presented below. These simulations reveal the trade-offs inherent between the two approaches of increasing clinician productivity and/or resource flexibility in environments of extreme demand uncertainty.

In our model, agile-based redesign results in an average patient wait time that appears to support the C&P managers’ fears, that hiring permanent clinicians will decrease system performance. However, the variation in total wait time indicates that the opposite is true: staffing more flexibly lowered to the total range of service time variation to less than 28.7% of the range of the base case. The maximum average patient wait time in the agile scenario is only 37 days, compared to over 50 days in the lean-based scenario. For comparative purposes, the clearest measure of system performance is absolute wait time error, which is the total accumulated difference between the actual wait time and the target wait time. The scenarios that focus on increasing flexibility generate only 28% of the wait time error accumulated during the base case and lean-based simulations.
Table 3. Performance measures for lean, agile, and combined system redesign scenarios.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>unit</th>
<th>Base Case = ‘Borrowing’ specialists (100%)</th>
<th>‘Borrowing’ mid-level providers</th>
<th>Hiring specialists</th>
<th>Hiring mid-level providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total waiting time (min. avg. max.)</td>
<td>[days]</td>
<td>13.2, 26.3, 50.5</td>
<td>13.2, 26.3, 50.5 (100%)</td>
<td>23.9, 27.2,</td>
<td>23.9, 27.2,</td>
</tr>
<tr>
<td>Average report insufficiency</td>
<td>[%]</td>
<td>3.15%</td>
<td>3.15%</td>
<td>0.54%</td>
<td>0.54%</td>
</tr>
<tr>
<td>Average total cost</td>
<td>[dollars / year]</td>
<td>$5,707,000</td>
<td>$2,066,000 (36.2%)</td>
<td>$4,587,000 (80.1%)</td>
<td>$1,661,000 (29.1%)</td>
</tr>
<tr>
<td>Average clinician utilization</td>
<td>[%]</td>
<td>99.06%</td>
<td>99.06% (100%)</td>
<td>101.7%</td>
<td>101.7% (102.1%)</td>
</tr>
<tr>
<td>Average clinician productivity</td>
<td>[exams / hour]</td>
<td>0.475</td>
<td>0.654 (137.7%)</td>
<td>0.593</td>
<td>0.816 (171.8%)</td>
</tr>
<tr>
<td>Average cost per patient</td>
<td>[$ / patient]</td>
<td>$3,841</td>
<td>$1,391 (36.2%)</td>
<td>$2,795</td>
<td>$1,012 (26.3%)</td>
</tr>
<tr>
<td>∑(absolute waiting time error)</td>
<td>[days]</td>
<td>6.07</td>
<td>6.07 (100%)</td>
<td>1.74</td>
<td>1.74 (28.7%)</td>
</tr>
</tbody>
</table>

The experiment includes four different scenarios; specific parameter changes included in Table 1. This table reports average service times (computed by Little’s Law), average report insufficiency, total cost, clinician utilization, productivity, cost per patient and the sum of the absolute wait time error over the entire simulation. Performance measure calculations included in Appendix C. Demand is simulated around a base demand rate of 655 disability assessments per week supplemented with a pink noise process with a standard deviation of 0.075; to match the historical data this demand is supplemented with an increasing ramp of slope 0.08 from week 80 to 87.5, then ramp of -0.08 from week 87.5 to 95. The time horizon for each simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.

This result suggests our counter-intuitive recommendation of hiring permanent clinicians into the C&P clinic renders the system more able to adjust to highly variable demand for services than the ad hoc borrowing of clinicians. The trade-off in flexibility between a long time to hire (~52 weeks) against a short time to borrow (~16 weeks) is off-set by the added flexibility of near-instantaneous adjustments in hours assigned per week. It should be noted that this improved performance in simulation is not the result of C&P managers hiring excess clinicians or demanding excessive work hours from their clinicians: average clinic utilization in the agile scenario is just 2% above the base case. Improved system performance is generated by a greater ability to use of both overtime and under-time, as C&P managers are better able to react to changes in the demand rate than before.
The lean scenario of changing staff to more efficient providers does not affect patient wait time or clinic utilization rates. Instead, it is the C&P system’s ability to respond to demand that determines the wait time error. The more flexible the resources, meaning the fewer constraints on the speed and size of service capacity adjustment, the better the system will be able to maintain a desired wait time when faced with fluctuating demand. These simulations suggest that changing individual provider productivity has no long-term effect on maintaining desired patient access to services.

The operational change proposed to increase resource flexibility, hiring clinicians directly into the C&P clinic, also generates the added gains of greater productivity due to lower clinician turnover (if working directly for C&P, the average clinician will gain experience for many years instead of only for a few months). This causes an increase in exam quality (as measured by the exam return rate) over the base case. Exam quality in the model is determined by the effects of fatigue and experience, and is assumed not to be affected by inherent differences in skill sets between specialists and mid-level providers. Long periods of overtime could lead to fatigue and reduce quality, which are included in the model in feedback loop R2a, and while clinic utilization does increase slightly under the more flexible staffing scenario, it is not enough to affect performance. As this might be an artifact of the specific demand pattern used, the effects of alternate demand patterns on clinic utilization rates are examined in subsequent simulations.

In summary, changing to more efficient providers seems to only affect costs and average productivity levels and not patient access. Regardless of the level of system flexibility, switching to mid-level providers reduces the cost of providing C&P services by ~63% (i.e., from the base case to agile scenario, and from the lean to combined scenario). Most of these gains are generated by differences in base salary, as mid-levels’ salaries are assumed to be, on average, 50% of those of specialists. Cost is also reduced by differences in clinician productivity, which is also higher for mid-levels than specialists, thus reducing the total FTE required to meet demand, further reducing costs in those scenarios. These factors combine to affect average cost per patient, which is significantly lower with mid-levels than with specialists. It should be noted that switching to a more agile service system does increase the use of overtime, which does increase costs (as seen in the kink in the behavior of cost over time in the agile and combined scenarios in Figure 19). However, this increase in costs is always less severe than the costs incurred by the greater fluctuations in resources required under the less flexible system.

Figure 19 shows a comparison of the behavior of costs and service times under the four scenarios, each of which is driven by identically distributed exogenous demand. These charts reveal the range of possible costs and patient wait times that the C&P clinic and their patients will face under a demand pattern equivalent to that of historical demand. Taking this dynamic behavior into account, agile redesign clearly improves both costs and patient access over the base
case, even if the average cost and wait time remain almost unchanged. Facing the identical demand pattern, it is evident that the lean redesign scenario improves only cost, though a much larger cost reduction than under the agile redesign. This extreme reduction in cost per patient and total costs is maintained in the combined scenario; the cost savings provided by switching to mid-level providers is not undone by the increased use of overtime inherent to our agile-derived approach.

These redesign scenarios indicate that the hospital’s initial process redesign plan would have improved system performance, but not in the direction expected: lean redesign would have decreased costs, but the planned changes would not have impacted the core problem of patient access. The largest improvement to both the average and the distribution of cost and patient wait time comes from changing both provider type and the system structure in which those providers work. This combined lean+agile scenario increases patient access and reduces cost simultaneously, as shown in Figure 19.

Figure 19. Comparison of average patient wait time to total costs under four scenarios, 1000 runs each. At left: base case (blue) and agile (silver). Right: lean (orange) and combined (white).

The experiment includes four different scenarios; specific parameter changes included in Table 1. This chart reports instantaneous average service time (computed by Little’s Law) and instantaneous cost (calculations included in Appendix C) over 1000 simulations. Demand is simulated around a base demand rate of 655 disability assessments per week supplemented with a pink noise process with a standard deviation of 0.14 (doubling the original demand variation, which subsumes the assumption that the sudden changes in demand seen in June through August 2010 were natural, not special cause, variation and thus such ‘spikes’ should be included in long-term policy sustainability analysis). The time horizon for each simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.

1-8.3 Alternate demand pattern scenarios
The response of the model to a permanent change in the dynamics of the demand rate of C&P patients is examined. The aim is to explore how the system would behave under rising demand for services and to investigate inherent system behaviors obscured by the randomness introduced in previous scenario tests. We examine two scenarios, one where demand increases from a
constant level to linear growth (ramp increase), and a second scenario, with a sudden, permanent increase in demand (step increase). The first simulations were prompted by possibility that demand for services will indeed rise over the coming years. C&P managers were eager to test the system's robustness against this plausible scenario. The second set of simulations is a more abstract test of system performance. Testing the model against only one change in demand, as opposed to the continuously changing demand in all other scenarios, is the clearest way to reveal inherent patterns of behavior in the system’s response to changes in demand.

Results of experiments with linear increasing demand are shown in Figure 20. Under constantly increasing demand, the system is able to maintain it desired level of service performance with minimal error under all plausible redesign scenarios. Delays inherent to the policy of ad hoc borrowing lead to continuing oscillations in average patient wait time, regardless of whether or not those providers are specialists or more productive mid-level clinicians. The more flexible, agile-derived structure also produces oscillations, but they have smaller amplitude and dampen more quickly. As in the scenarios testing against the historic demand pattern, the type of provider does not affect the behavior of patient wait time, but does affect cost per patient. Tests with linearly decreasing demand show nearly identical behavior. Thus, our initial policy conclusion appears robust against the future demand pattern C&P managers were most concerned about.

![Figure 20. Dynamic behavior of cost per average patient and average patient wait time under four scenarios with linearly increasing demand.](image)

The experiment includes four different scenarios; specific parameter changes included in Table 1. This chart reports instantaneous average service time (computed by Little's Law) and instantaneous cost per patient (calculations included in Appendix C) over 1000 simulations. Demand is simulated as a steady ramp increase of .1% from a base rate of 655 assessments per week. The time horizon for each simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.
If the system is presented with a sudden, permanent increase in demand, the effects increased resource flexibility become even clearer. Under the base case structure, one change in demand leads to continuing oscillations in average patient wait time for over two years. While it is impossible to see this trend in the historical data, as demand and other process parameters are always subject to small fluctuations, this result further supports our dynamic hypothesis that increasing resource flexibility renders the system more able to absorb changes in demand for services than a more efficient system. Altering the demand pattern does not appear to affect our recommendations on system redesign.

![Figure 7. Comparison of behavior of average patient wait time under lean and agile-based scenarios.](image)

The experiment includes two different scenarios; specific parameter changes included in Table 1. Scenarios with more flexible clinic structure respond with less oscillation, regardless of provider type. This chart reports instantaneous average service time (computed by Little’s Law). Demand is simulated as a base rate of 655 assessments per week, supplemented with an instantaneous increase of 25% in week 10. The time horizon for each simulation is 150 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 weeks.

### 1-8.4 Impact of operational change

Hospital leadership were persuaded by these simulation results, and decided to follow the combined strategy of improving both resource flexibility and efficiency by moving away from ad hoc borrowing specialists to direct hiring of mid-level providers. Armed with model simulations and analysis, they were able to defend this significant budget outlay, and the decision to move away from the standard business practice of mandating high clinic utilization rates at all times. The simulations assuaged managers’ fears of massive overtime costs, and potential downsides of not being able to quickly remove providers from the clinic that they will no longer need if demand declines.

The shift away from ad hoc borrowing to hiring mid-level providers to work directly and solely for the C&P clinic started in February 2011, with the first two physician assistants transferred in from another VA hospital in April of that year. More mid-level providers have joined the C&P
As expected, increasing the flexibility of personnel resources resulted in the sustained reduction in patient wait time. We present data on demand and system performance for two years following implementation of our agile-derived operational plan in Figure 21. Over the 12 months following implementation, average patient wait time dropped from over 48 days down to 9 days. A simplistic calculation of the benefits generated by implementing our recommendations (defined as \( \Sigma \) (reduction in average service time * patients seen per month) over the post-implementation period (i.e., from July2011 to March2013), where “reduction in service time” = [average service time pre-implementation (i.e., average over March2009 to Feb2011) – service time in a specific post-implementation month (i.e., any month after July2011)]) finds a total of \(~550\) years of avoided patient delay. While this calculation and resultant estimated impact could certainly be refined, the sheer scale of the improvement must be recognized.

Moreover, the implementation of our recommendations appears to prevent extreme variation in demand from degrading service performance. Six months following implementation, C&P experienced a sudden, sharp increase in demand, which was even larger than the ‘spike’ in demand in 2010 which triggered the initial patient access crisis. With the more flexible system structure in place, this ‘spike’ in demand had almost no affect average patient wait time. The operational shift from moderately flexible personnel resources to highly flexible resources appears to have secured clinic access over the long-term and made the C&P clinic resilient to a high level of demand volatility. Patient access to C&P clinic appears to have stabilized, despite an increasingly volatile demand rate.
However, while stable, patient wait times remain much lower than predicted by the model. Increasing efficiency and flexibility was not intended to improve performance beyond previous levels, only to ensure that future spikes in demand did not create new patient access crises. Post-implementation, average patient wait time was expected to return to ~25 days. We offer three possible explanations for this sustained increase in service performance.

Our first hypothesis is that the sustained increase in performance, generated by both increased flexibility and provider efficiency, is evidence of C&P managers changing their desired performance level. After the initial success following the staff and management changeover, the C&P management team received significant honors for their improved performance. Hospital leadership see themselves as being in the vanguard of improving C&P clinics the VA nationwide, and are in the process of designing new metrics and setting more stringent standards by which to judge C&P performance. The ability to keep patient wait times close to 10 days has provided a level of notoriety the hospital does not wish to relinquish.

A second possible explanation is that C&P managers have hired too many mid-level providers and are even less able to reduce staffing levels than previously thought. This would force them to maintain a higher service capacity than necessary, which would diminish the backlog of patients faster than the incoming demand rate, reducing patient wait times toward zero. In a

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**Figure 21.** C&P clinic demand and system performance pre- and post-implementation, taken from Jan 2013 VA AMIS290 report.
similar vein, the third possibility is that regardless of the accuracy of the staffing for average demand, C&P managers are not allowing their staff to work less than 40 hours per week, thus creating a similar effect of excess service capacity. In times when patient demand is lower than normal, not allowing providers to work less than the normal number of hours per week would lead to draining the patient backlog to lower than desired to maintain a target average wait time of 25 days. Keeping average hours worked per week above 40 leads to further problems, by allowing fatigue to accumulate, eventually leading to lower quality, burnout, and higher staff turnover rates. For this agile-derived strategy to be effective over the long-term, resource flexibility has to be maintained in both directions; C&P managers must allow small periods of both over and under-utilization of resources.

With the limited information available post-implementation, the first explanation appears the most likely: that the initial success of clinic redesign has allowed C&P managers and hospital leadership to set new, more rigorous performance standards. The stability of patient wait times at 10±1 days for over one year in the face of highly variable demand suggests that exam quality reductions, rework, and clinician burnout are not occurring. However, the limited documentation during the previous period of ‘ad hoc’ borrowing of clinicians from other service lines prevents a direct comparison to rule out other possible causes. There is no clear understanding of what the aggregate FTEE in the C&P clinic was before implementation, so it is almost impossible to prove that FTEE have remained constant, or if, in the move to mid-level providers, that the C&P clinic has increased effective service capacity.

More in-depth post-implementation data collection and analysis was not supported by the hospital. We can only assume that the lean portion of our operational plan was effective at reducing costs, as estimated by the model. However, even the limited data available does shed light on a crucial issue for the long-term effectiveness of the agile portion of this operational plan. The C&P clinic, and hospital systems in general, appear to maintain two conflicting management goals: to keep patient wait times low and stable, and to keep resource utilization rates high. In service systems with variable demand, these two goals cannot both be met simultaneously. Before the ‘spike’ in demand in 2010, the previous management focus in the C&P clinic was on maintaining high utilization rates. Ignoring the inherent trade-off with patient access and focusing management efforts solely on utilization rates is a potential root explanation for why the C&P clinic was so unprepared for sudden increases in demand. C&P managers must find a balance in this trade-off that is acceptable both to the hospital budget and to patient satisfaction and safety. In practical terms, they must allow ‘under-time’ as well as overtime, or fatigue will drive quality down, increase rework, and undo the gains realized from increased flexibility. Indeed, this work shows that the benefits of flexibility far outweigh the costs of both periodic low utilization rates and overtime pay.
1-9. Conclusion
This work yields specific, practical lessons for C&P departments across the country, as well as more general conclusions on the importance of agility in the management of the service delivery systems faced with highly volatile demand. With this research, we address a gap in current understanding of real world implementation of agile-based redesign strategies. This case study represents the first implementation of agile-derived clinic redesign in healthcare delivery, identifying increasing market sensitivity as a successful means to accomplish both cost reduction and improve access to services. Specifically, we validate reducing capacity adjustment time as a successful agile policy in healthcare service supply chains and develop an understanding of why it is effective.

The principle finding of this study is that, when facing volatile demand for services, increasing system flexibility yields more improvement than increasing personnel or resource efficiency. Our simulation analysis suggests that problems with timely patient access are generally better alleviated by creating a system structure that allows for more rapid synchronization of supply with demand than simply increasing the effective service capacity though lean-based initiatives. The ability to make swift and adequate adjustments to service capacity makes it possible to achieve better performance while simultaneously reducing costs.

The ability of the C&P clinic to respond to demand variability determines its performance over the long term. These simulated scenarios indicate that without changes to C&P management's ability to adjust assigned hours per week, there would continue to be limited service capacity flexibility, which would inevitably result in periods of lengthy delays for patients. Changing provider or clinic process efficiency has no sustained effect on patient access, but has a significant effect on average cost and productivity. This study also demonstrates that increasing personnel efficiency alone cannot compensate for variability in the demand for services. For a C&P clinic to improve on all performance measures, managers should both increase provider efficiency to reduce cost, and make those providers flexible to improve system responsiveness.

This study also illustrates the value of simulation modeling in healthcare management and system redesign. We chose to use simulation to help managers develop strategies and system structures that are robust against demand variation over other common uses, such as demand forecasting or estimating required service capacity. We believe the real value of simulation modeling is not generated by anticipating the external environment, but through eliminating any potential problems created by the environment by changing the underlying structure of the system itself. Specifically, the development of a qualitative influence diagram offers a useful structure to base the stakeholder interviews, and provided, often for the first time, C&P managers with a holistic view of the system where they could finally clearly interpret the interactions between their own decisions, process steps, and performance metrics. Dynamic simulation proved an invaluable investigative tool to permit comparison of the relative benefits and
probable costs of various change options under consideration. The model also became a learning laboratory which permitted risk free experimentation and encouraged creative thinking and imaginative solutions. On a small scale, this case study demonstrates the potential for healthcare simulation to contribute to clinic redesign initiatives and ultimately its potential value in reducing health care costs, increasing system performance, and improving patients’ access to care.
Chapter 2. The Unintended, Adverse Effects of 'Leaner' Healthcare

2-1. Abstract
The redesign of healthcare systems is currently dominated by 'lean', a paradigm that in healthcare focuses on reducing process waste to achieve sustained increases in efficiency. This study finds that applying lean to individual clinics in healthcare service delivery chains exacerbates demand variation amplification (i.e., bullwhip effect) inherent to most service supply chains, leading to the unintended consequences of wider distribution of service delays, increased provider fatigue, reduced quality of care, and the possibility of increased patient mortality. We use system dynamics to explore possible countermeasures adapted from the 'agile' redesign paradigm to mitigate these structural effects. This research highlights the importance of collaborative planning and performance measurement in healthcare and offers critical managerial insights for hospital systems considering applying lean methods to their service delivery chains.

2-2. Introduction
The purpose of this paper is to seek out the unintended, adverse effects of lean implementation in healthcare service delivery chains. 'Lean' is currently the most popular strategy for redesigning health care systems, with a significant number of hospitals and medical groups in the US adopting a version of lean production as their approach to improving quality and efficiency (Liker and Morgan, 2006; Robinson et al, 2012; Joosten et al, 2009). The lean approach in healthcare is adapted from the Toyota Production System, and focuses on the elimination of waste, or muda, which is defined as any activity that consumes resources but generates no redeeming value in the eyes of the 'customer' (Womack & Jones, 1996). Essentially, lean is used to redesign health care service delivery chains to be able to serve more patients with fewer resources.

Considering the fraught state of US healthcare, this is a worthwhile goal; however, evidence for the success of lean-based redesign in healthcare is lacking. While some hospitals do report tangible benefits achieved in individual clinics, such as decreased processing or wait time or reduced costs (Silvester, et al, 2004), no large-scale, or system-wide, impacts have been reported. Most lean efforts, and the published outcomes evidence supporting the use of lean methods, come from case studies confined to a single process or clinic, rather than to a complete patient pathway or disease cohort (Radnor et al, 2012). To quote Donald Berwick (Miller, 2005), past Administrator of the Centers for Medicare and Medicaid Services, “there are still 'no Toyotas' in health care,” meaning that generally the lean-based redesign of healthcare delivery systems are limited in scope, duration, and impact. After more than a decade of use in healthcare, this lack of evidence suggests that lean is not having the impact it was predicted to, and is not achieving same levels of savings and productivity gains as seen in lean manufacturing.
Furthermore, it can be inferred from multiple studies from the supply chain literature that following 'lean' strategies is inappropriate in the context of healthcare. Christopher and Towill (2001, 2002) find that lean is not the appropriate method to use in markets with high demand variability and high requirements for customization, as is the case in healthcare, where each patient comprises a unique set of current symptoms, past conditions, and treatment preferences, which in turn requires a unique set of resources. Evidence from US manufacturing suggests that redesigning systems toward efficient, high-speed, low-cost service delivery renders them less able to respond to unexpected changes in demand or supply. The adoption of lean redesign methods in US product distribution chains is one suggested cause for increased occurrence of stock-outs and rising percentage of mark-downs, which is when a retailer reduces the price of a product to quickly sell excess inventory, between 1980 and 2000 (Lee, 2004). In markets with variable demand, following lean redesign strategies may create a trade-off between service delivery efficiency and the ability to respond quickly to changes in customer demand. This trade-off may be acceptable in services where the cost of temporarily not meeting demand is relatively low. However, in healthcare, where being able to respond in an appropriate and timely fashion is critical to providing effective care, the potential for life-threatening consequences of ‘lean’ diminishing the ability to match supply of services to demand is worth investigating.

Our hypothesis is that ‘lean,’ in its current state of affecting single, isolated improvements in clinic efficiency without regard to the complex dynamics of the healthcare setting, is detrimental to the responsiveness of healthcare services to patient demand, leading to reduced access to services, and further possible subsequent consequences in service quality and cost. We test for these feedback effects in simulation, and in turn, evaluate the importance of matching system redesign strategy to context. We use simulation to identify possible counter-measures adapted from the ‘agile’ manufacturing redesign paradigm, which was developed in custom manufacturing to accommodate demand variability and unpredictability. ‘Agile’ strategies focus on improving resource flexibility and sharing demand information, and as redesign strategies, have been shown to lead to superior abilities in terms of service and quality (Narasimhan et al, 2006).

To date there has been minimal research on the effect of unpredictable demand variability on the outcomes of lean redesign efforts, in either service or manufacturing contexts, nor any work firmly criticizing the use of lean in healthcare in the literature (Brandao de Souza, 2009). We believe this represents a crucial gap in knowledge. Expanding on the theory set by manufacturing supply chain management research, we explore the possibility that lean is being applied to an area to which it is not suited, exposing both patients and providers to unknown risks. The aim of this research is to better understand the complex effects of lean improvement in healthcare on overall service delivery, quality, and cost in a service chain with unknown, variable demand. We use system dynamics simulation to validate the existence of a significant trade-off between increased efficiency and service access, and search for adverse effects in cost
and service quality. System dynamics has proven well suited to address the complexity that characterizes many health system issues (Homer & Hirsch, 2006), and has been used previously in health care service supply studies (Lane et al. 2003).

This research highlights why resource responsiveness to demand is important for healthcare quality, and reveals the potential risks to patients of focusing redesign efforts solely on waste reduction and increasing clinic productivity without regard to inherent demand volatility. Specifically, we seek answers to the following research questions:

- What are the adverse effects or increased risks generated by following a ‘lean’ redesign strategy in area with unpredictable, highly variable demand (such as healthcare)?
- Does a following ‘lean’ strategy without addressing demand volatility reduce the effectiveness of healthcare redesign efforts in the long-term?
- How can agile strategies (specifically, cooperative planning and coordination of performance measures) be incorporated into lean-based redesign to mitigate these risks and mitigate the trade-off between efficiency and service access?

The paper is organized as follows. First, we review lean-based redesign of healthcare service delivery systems, and present our hypothesis on lean redesign increasing patient and provider risk. Second, we develop our research model from the literature and review alternative redesign paradigms. Third, we discuss and justify system dynamics as an appropriate methodology for understanding behavior of healthcare delivery systems and describe the logic of our simulation model. Next, we analyze inherent model behavior and compare these behaviors to the literature to further validate our simulation model. Subsequently, we explore the effects of lean-based redesign on our healthcare service model, specifically considering effects on distribution of service times and variation in the patient-to-provider ratio as proxies for service quality and patient safety. Additionally, we investigate and discuss the impact of applying ‘agile’-based strategies, specifically coordinated planning and implementation of redesign activities on service times and quality of care. The concluding section of this paper discusses the implications of our findings for both healthcare supply chain researchers and managers, research shortcomings, and possible future work.

2-3. Problem Description
To understand the effects of lean implementation on healthcare delivery, some of the fundamental concepts of lean system redesign must be explained. Despite the seemingly simple aims underlying what is generically referred to as 'lean,' the methodology itself is multi-faceted and is constantly evolving as it is applied to new sectors of the economy. We present a brief outline of this evolution, and discuss the current iteration of lean as adapted to the healthcare context, with its emphasis on waste reduction in individual clinics. Next, we find support from the supply chain management literature for our hypothesis that this redesign approach has
exposed both patients and providers to unnecessary risk through simultaneously decreasing responsiveness to patients’ needs, and increasing demand variability and provider fatigue.

2.3.1 The evolution of ‘lean’
The roots of lean can be found in Japanese manufacturing, particularly the Toyota Production System. It was initially created as an alternative production and management system to better fit the Japanese post-war context of scarce resources than traditional methods of mass production (Holweg, 2007). Even before the name ‘lean’ was coined, Toyota executives were bringing together a comprehensive production method with the goal of creating a smooth, cost-minimizing flow of products and services through the production system to the customer (Womack and Jones 1996). The initial writings by Taiichi Ohno and Shigeo Shingo, the primary creators of the Toyota Production System, identify what would later be called ‘lean’ as methods for addressing three specific concerns: removing waste, or the non-value adding components of a process (muda); stabilizing uneven demand and variation in information flows and process production (mura); and improving working conditions to prevent injuries and excessive strain on employees (muri) (Hines et al., 2008). Achieving these goals would allow Toyota to not simply produce more cars, but to produce them more efficiently.

Besides being an empowering management philosophy and set of production goals, the Toyota Production System also contains a set of analytic tools to assist workers with achieving those goals. Now dubbed ‘lean methods,’ these tools help workers identify the steps in work processes that create value as defined by the customer, target improvements to the smooth production of goods, services or information, and eliminate waste in production. Increasing quality and productivity is achieved through the application of these specialized tools in facilitated group workshops (kaizen events) coupled with creating an organizational culture that supports continuous improvement and refinement of work processes. The redesign of production processes is comprehensive, constant, and coordinated, with all workers at Toyota, from line-workers to the CEO, responsible for striving toward more efficient, smoother, and safer production.

Womack and Jones (1996) are usually credited with spreading the management principles developed to enhance car production at Toyota to a world-wide manufacturing audience. Their landmark 1996 study showed that the Toyota Production System could be distilled into five core ‘lean principles’ that could be applied to virtually any manufacturing system, outlined in Table 4. The ability to apply these lean principles to any production system is based on the simplifying assumption that organizations are composed of interrelated production processes, and through engaging with these five principles, organizations can transform their processes to increase value and reduce waste and variation regardless of the product or service delivered. This assumption, that organizations can effectively be abstracted into a network of interconnected processes, theoretically allows lean methods to be applied to any economic sector, physical product, or
service. With the publication of this work, a specialized production system focused on efficiency evolved into the abstract management philosophy dubbed ‘lean thinking.’

In practice, organizations seeking to operationalize lean thinking must adapt this broad ‘philosophy’ to meet their specific context. Operational definitions of lean continuously evolve as lean is applied to new industries, resulting in a plethora of definitions in the literature as each tries to subsume a greater variety of production and service sectors (Laursen et al, 2003; for example: LAI, 1996; Liker, 2004; Bhasin & Burcher, 2006, among others). While there are many more definitions and conceptual frameworks, all overlap in some way or are based on many of the same fundamental concepts. The main differences appear in implementation, where some tools and aims are highlighted, and others received reduced attention, depending on how useful they are, and how easy they are to apply, in a given context. As is evident in healthcare, not all concepts translate cleanly into each new context.

### 2.3.2 Lean in healthcare

The guiding principles of lean and subsequent methodologies have only recently been adapted to the healthcare context; for examples, the reader is referred to publications by the NHS Institute for Improvement and Innovation (NHSI, 2007) and by the Institute for Healthcare Improvement (Miller, 2005). Implemented in the health care setting, lean is commonly used to minimize patient delays in the Emergency Department, reduce the number of return visits, eliminate medication and medical errors, and prevent inappropriate procedures. Optimistically, the Institute for Healthcare Improvement (Miller, 2005) states that there is no a priori reason why applying lean in a healthcare context should not be possible and that it should create the gains in efficiency and quality seen in other sectors. However, in practice, translating lean principles and tools into healthcare has been challenging. Three areas of difficulty stand out as contributing to a situation where lean redesign efforts expose patients and providers to unnecessary risk: difficulties in defining ‘value’ leading to implementation efforts that focus mainly on easily quantifiable operational costs and staffing ratios; focusing on waste reduction, while ignoring the

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**Table 4. The five Lean principles (Womack & Jones, 1996)**

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<td>1)</td>
<td>Specify the value desired by the customer.</td>
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<td>2)</td>
<td>Identify the value stream for each product/service providing that value and, challenge all of the wasted steps.</td>
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<tr>
<td>3)</td>
<td>Make the product flow continuously. Standardize processes around best practice allowing them to run more smoothly, freeing up time for creativity and innovation.</td>
</tr>
<tr>
<td>4)</td>
<td>Introduce ‘pull’ between all steps where continuous flow is impossible. Focus upon the demand from the customer and trigger events backwards through the value chain.</td>
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<tr>
<td>5)</td>
<td>Manage towards perfection so that non-value adding activity will be removed from the value chain so that the number of steps, amount of time and information needed to serve the customer continually falls.</td>
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other two main lean aims of stabilizing uneven demand and improving working conditions; and implementation decisions based on individual project impact leading to isolated, un-collaborative changes. These three factors combined result in a situation that far from resembles the original redesign efforts at Toyota. Each is discussed in detail below.

The most problematic of these adaptation issues is the current difficulty lean practitioners have in defining ‘value’ in healthcare. All lean improvements are theoretically driven by improving ‘value’ for the customer, which is often prosaically defined as, ‘what the customer is willing to pay for.’ While the patient might be the ultimate ‘customer’ of every care process, intermediate ‘customers,’ such as physicians, surgeons, clerks and payers, are often more central to an individual lean project in healthcare, and each would define value differently based on their perspective (Muir, 2007). In health care, since there is no single customer to focus lean improvement on, value is defined by a complex and fragmented customer community, which leads to what Young and McClean (2008) describe as a bewildering array of value-concepts, reflected in a plethora of quality measures and frameworks. Without a clear definition of value, it is far easier to create project goals around quantifiable cost savings than to try to justify qualitative measures of patient satisfaction or empowerment, even if they are closer to the original concept of ‘value.’ The lack of a cohesive, unifying customer and subsequent definition of value hinders improvement initiatives and restricts them to quantifiable improvements in clinic productivity, like patient throughput or resources per patient, rather than systems issues of improving service quality and patient experience (Radnor et al, 2012).

The lack of a comprehensive definition contributes in part to our second crucial context challenge, which is the singular focus of lean in healthcare on waste elimination. Graban (2008) finds that most healthcare organizations that have attempted to implement lean have focused only on the elimination of waste, while ignoring the other foci of lean theory: smoothing flow and improving workplace environments and conditions. Reinforcing this trend, the seminal introduction to lean implementation in healthcare in the US by IHI (Miller, 2005) focuses almost solely on eliminating waste. In healthcare, there is a general perception that lean is only concerned with waste reduction and subsequent cost reduction, not systematic improvement involving stabilizing variation in demand or preventing injuries and excessive strain on employees (Robinson et al, 2012).

Unfortunately, the prescribed attention to system-wide analysis of uneven flow of patients, products, or information across entire value streams, which is fundamental to lean manufacturing, is not the current state of lean implementation in healthcare. Projects are implemented regardless of their impact on patient flow into other clinics or care processes, such systemic consequences are not taken into consideration. Most hospitals and healthcare organizations prioritize lean redesign projects by their individual return-on-investment, implementing redesign projects in the easiest, highest return clinics first.
This 'low-hanging fruit' project selection strategy results in our third key difference between lean manufacturing and lean as it is applied in healthcare settings. By implementing only those opportunities that require a minimum of effort instead of targeting an entire patient pathway lean projects create 'islands of success', rather than holistic, sustainable improvement (Graban, 2008). Most lean redesign efforts in healthcare focus solely on the individual process level (Bhasin & Burcher, 2006) and most often within individual clinics (Allen et al., 2004). As such, lean healthcare creates disparate improvement, as the majority of healthcare providers tend towards small, enclosed projects rather than adopting an organization or system-wide approach (Spear, 2005; Young & McClean, 2008; Brandao de Souza, 2009; Burgess & Radnor, 2010).

Organizations rarely adopt a broader mindset and take a system-wide perspective on either implementation efforts or outcomes analysis (Murman et al., 2002; Bhasin, 2008). What results is isolated, scattered efforts at improving individual clinic productivity, based on ease of implementation rather than long-term, systemic impact.

The importance of adopting a holistic approach in both implementation and analysis has just begun to be discussed among the healthcare process improvement experts (Spear, 2009). Few lean practitioners identify the current state of isolated lean redesign projects as problematic. Even the exemplars of lean healthcare, such as Virginia Mason hospital in Seattle and Royal Bolton in the UK, have very few lean projects that involve multiple specialties or clinics (Kenny, 2011; Burgess & Radnor, 2010). To date, healthcare organizations tend to understand ‘lean’ as a collection of standalone, operational tools for improving productivity, rather than as a broader, pan-organizational value-creation philosophy.

Even with the growing number of case studies, there are no examples of lean implementation following a systems approach in healthcare, nor research on applying lean methodologies in complex systems. While it is obvious that one-off, disjointed implementation is not optimal, it remains as yet unexplored whether lean implementation could, in fact, increase risk to patients or be detrimental to quality of care. There is almost no literature on the unintended effects of lean implementation and very little criticism of lean implementation in healthcare in general (Brandao de Souza, 2009). Lean practitioners are often more concerned that isolated improvements will not generate the scale of improvement necessary to sustain organizational commitment to process improvement, rather than exploring the potential negative effects on patient care and safety (Hines et al., 2004; Spear, 2005; Radnor & Boaden, 2008). Indeed, most lean practitioners reject the very concept of a trade-off between health care quality and efficiency, believing increased efficiency to be an unmitigated benefit with no downside risk. At most, some authors critique lean implementation by acknowledging ‘mistakes along the lean journey’ (Kenny, 2011), but almost all these errors are confined to the domains of organizational politics, management, or staff effort, rather than increasing risk or harm to patients.
2-3.3 Possible unintended consequences

However, the possibility of lean generating unintended, detrimental effects is very real. Previous research in supply chain management finds that increasing efficiency in a service delivery chain without regard to either the context or an understanding of how those changes would affect the entire delivery chain can reduce the ability of that system to meet changes in customer needs. In supply chain literature, this ability to meet a constantly changing set of customer or patient needs is called ‘flexibility.’ Through studies in manufacturing contexts, flexibility is identified as a necessary capability of successful supply chains (Lau, 1996; De Toni & Tonchia, 2005; Krajewski et al, 2005).

We find that this capability is even more critical for healthcare service delivery chains, as patient needs are constantly changing and the definitions of quality in almost all healthcare services contain time sensitive components (Aronsson et al, 2011). The more flexible a healthcare service supply chain, the faster and more accurately it can respond to the current needs of its patients. Conversely, the longer patients wait for the accurate healthcare service, the more likely their condition will deteriorate in the interim. Our hypothesis is that lean (defined for healthcare as improving process efficiency in individual clinics regardless of the interactions between clinics) reduces the flexibility of a care delivery system, which reduces the ability to meet patients’ needs and provide care in a timely way, directly reducing quality of care.

Even if lean practitioners reject this trade-off, there are over 15 years of supply chain management research supporting existence of an inverse relationship between efficiency and flexibility (Slack, 1983; Easton & Rothschild, 1987; Carlsson, 1989). This trade-off is found in theoretical research, industry case studies (Wheelwright, 1995), and large, cross-sectional industry surveys. For example, Suarez et al (1996) find that printed circuit board assembler plants in the US, Japan, and Europe that are more automated, while more efficient, were less flexible than their less automated counter-parts. A more recent study of 126 Spanish automotive suppliers (Sanchez & Perez, 2005), has similar findings, correlating supply chain and process flexibility with superior ROI, market share, and profitability. Even at Toyota, Adler et al. (1999), find evidence for a trade-off between efficiency and production flexibility. If this trade-off exists in healthcare service delivery as well, then this would mean that the more ‘lean’ a system becomes, the less that system will be able to meets its patients’ needs and the lower overall quality of care it will provide.

Is it a heroic assumption that these relationships and conclusions derived from manufacturing are applicable to healthcare service delivery? One piece of supporting evidence is, ironically, the current dominance of lean methods in healthcare redesign, which is founded on this same assumption that lessons learned in manufacturing can be applied effectively to healthcare. Also, the inverse relationship between flexibility and efficiency should be valid in healthcare if we understand the underlying causes for this behavior in manufacturing, and find those same causal
relationships in healthcare. In manufacturing, this trade-off is most often credited to the existence of supply chain uncertainty (Stevenson & Spring, 2007), with the more uncertainty present, the more severe the trade-off between the two. Indeed, most literature on supply chain management describes flexibility as a response to, or a means to cope with, uncertainty (Gerwin, 1987; Upton, 1995; D'Souza, 2002; Bertrand, 2003; Sheffi & Rice, 2005; White et al., 2005). Disney and Towill (2003) find the key source of uncertainty in the supply chain to be end-customer demand, specifically as it relates to quantities, timing and individual customer specifications. Most healthcare services face inherent demand uncertainty in at least one, if not all three of these dimensions: volume of patients per day, timing of individual patient arrivals, and specification of individual patient needs (Walley, 2007). Other healthcare service researchers have practically defined the healthcare context by demand uncertainty (Aronsson et al, 2011).

While obvious contextual differences exist between manufacturing and services, recent service chain simulation studies suggest that they do not mitigate this inverse relationship between flexibility and efficiency, nor the importance of demand uncertainty as a condition for that trade-off. Anderson and Morrice (2000, 2001) find that decreasing service time, an outcome of increasing efficiency, in a service supply chain results in greater demand variation amplification, or the service supply chain equivalent of the ‘bullwhip effect’ (Forrester, 1958, 1961; Lee et al, 1997). The bullwhip effect is a key cause of demand variability and supply chain stress, and leads to reduced access to services (as measured by the distribution of service delivery time), and subsequent degradations in service quality and increasing employee fatigue.

Some researchers have proposed that the bullwhip effect is inherent to service chains, including healthcare (Anderson et al, 2005). Based on simulation studies, their explorations of generic service chains reveal demand variation amplification to be an inherent behavior, even under the most simplistic conditions. Even without such common practices as demand forecasting, production batching, or price fluctuations, which have all been proposed causes for the bullwhip effect in manufacturing, service chains display demand variation amplification. Substantial evidence for the existence of the bullwhip effect in healthcare is limited, as the complexity of healthcare service systems makes such direct measure of variation amplification difficult to discern (Sethuraman & Tirupati, 2005). Little empirical research exists on managing service capacities (Sameul et al, 2010), but recent work finds variation amplification in real-world healthcare systems. Even with significant external variation, internal variation is clearly introduced by system structure and dynamics. For example, a case study conducted in a 127 bed hospital in Uttar Pradesh, India revealed dynamic system behavior equivalent to the bullwhip effect (Sameul et al, 2010). The bullwhip effect was similarly identified in the a study of a UK hospital: Based on interviews with hospital staff and data from hospital's EHR system, analysis of emergency patient arrivals and discharges revealed amplification of demand variability downstream in the service chain (see Figure 22, from Walley, 2007). In this case, distortions in
demand clearly led to performance degradation, as downstream services reported reduced resource availability and greater probability of exceeding desired utilization and occupancy rates. These are similar consequences to the effects seen in manufacturing systems, where the bullwhip effect has been a suggested cause for increasing stock-outs and higher costs.

![Figure 22. Patient admission and discharge rates showing downstream variation amplification in UK hospital (adapted from Walley, 2007).](image)

The bullwhip has also been reported in Australia: Sethuraman and Tirupati (2005) directly identify the bullwhip effect in the patient pathway for elective surgeries. The increasing variation in demand for services as elective patients move to downstream clinics creates the need to make more beds available in post-operative care wards than indicated by the initial demand. On peak days, when the bullwhip effect causes the number of elective surgeries to be artificially high, there is a shortage of beds in the patient wards, which restricts the number of surgeries and reducing the theater utilization and hospital throughput on subsequent days. Demand for nursing services is directly affected by higher variability, resulting in higher labor costs. Higher demand variation amplification is also associated with increased dependence on part-time or temp agency staff. Increasing demand variability inside the patient care pathway generally results in greater stress on employees, higher operating costs, and lower hospital revenues.

Further support for the inverse relationship between flexibility and efficiency occurring in service systems is found in an empirical study of a European telecom company (Akkermans & Vos, 2003), where business process redesign efforts, which increased individual employee productivity, reduced the telecom’s overall ability to respond to both demand and process variability. Most recently, Anderson et al. (2005) explore the behaviors inherent to a generic model of service delivery chains, concluding that trade-off between efficiency and flexibility is
fundamental to the structure of service chains, just as past supply chain management research has suggested it is to manufacturing systems. It is becoming increasingly clear that reducing flexibility in service delivery systems faced with demand uncertainty will lead to reduced performance.

As much as healthcare is a service, and subsumes the same basic system structures and relationships of other services, these studies suggest that following a lean redesign approach exposes both patients and providers to unnecessary risk through simultaneously decreasing responsiveness to patients’ needs, and increasing demand variability and provider fatigue. With the importance in healthcare of responding quickly and accurately to patients’ needs, managers and process owners ought to be able to work toward increasing flexibility intentionally, not decreasing it accidentally through well-intended lean-based improvement projects. These studies, when taken together, establish a serious argument for the search for these effects in healthcare and, if found, to identify strategies to mitigate them.

2-4. Review of Criticisms of Lean-based Systems Redesign

Despite the lack of a specific focus on potential harm from the unintended side-effects of lean-based service system redesign, we find secondary support for our hypothesis in the current literature critiquing the use of lean redesign in manufacturing. This section presents a literature review on the previous critiques of lean redesign, highlighting the importance of matching redesign approach to context characteristics and discussing possible alternative redesign strategies.

The current state of research into the use of lean redesign methods focuses on the effectiveness of lean in different contexts, the role context plays in selecting a redesign strategy, and comparisons of lean to other redesign strategies. Both simulation and empirical work by industrial supply chain management researchers suggest that, to be effective, a system redesign strategy must fit the context to which it is applied. Differences in competitive criteria - either cost, quality, or customer value (Christopher & Towill, 2001); product life cycle - long or short, consumable or durable goods (Bruce et al, 2004); and demand pattern - highly volatile or predictable (Christopher, 2000) are all key characteristics which influence the choice of appropriate redesign method. Differences in these characteristics are a large determinant of how effective a redesign strategy will be at improving supply chain performance (See Figure 23).

The consensus among supply chain researchers is that commodities and mass-production are the contexts are best suited for a lean approach, where demand is relatively predictable and production volumes are large, thus facilitating the level schedule requirements necessary for a lean supply chain (Suzaki, 1987; Naylor et al, 1999, Childerhouse & Towill, 2000). Clearly, these are not the characteristics found in healthcare, where demand for services is highly volatile.
and inherently unpredictable, service volumes are small (when compared to manufacturing), and service quality is decidedly more important than cost (Aronsson et al., 2011). These differences support our hypothesis that using lean in the healthcare context is potentially counter-productive, as healthcare does not appear to meet the conditions where following a lean redesign strategy is most appropriate.

Most studies contrast lean with 'agile,' an enterprise transformation strategy that was designed for contexts of volatile demand and highly variable customer inputs and requirements. ‘Agile’ is a strategy that emphasizes organization-wide flexibility as the method for meeting customer demand at the lowest total cost (Lee, 2004). Gunasekaran (1998) defines agile manufacturing as the capability to survive and prosper in a competitive environment of continuous and unpredictable change by reacting quickly and effectively to changing markets, driven by customer-designed products and services. Agility involves increasing flexibility along several dimensions, including production volume, variety of customer inputs and requirements, and the capability to execute unplanned, new activities in response to unforeseen shifts in market demands or external supply disruptions (Brown & Bessant, 2003; Prince & Kay, 2003; Sharifi & Zhang, 2001). A more complete breakdown and comparison of lean and agile strategies is found in Appendix A.

<table>
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<th>Variety/Variability</th>
<th>Volume</th>
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<tr>
<td>Hi</td>
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<tr>
<td>Lo</td>
<td>LEAN</td>
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“Lean” works best in high volume, low variety and predictable environments.

“Agility” is needed in less predictable environments where the demand for variety is high.

Figure 23. System re-design classification matrix (adapted from Christopher, 2000).

Both the production and demand attributes of healthcare are more suited to redesign based on the agile paradigm, where the unpredictability of patient demand is impossible to eliminate, and reacting quickly and accurately to changes in patient demands is crucial to providing quality services. Supply chain researchers have recently suggested the use of agile strategies as an appropriate and effective method for improving healthcare service delivery, and as an important avenue for future research in healthcare service delivery (Vries & Huijsman, 2011). This
impetus to apply agile redesign strategies in healthcare further supports our hypothesis: if increasing flexibility is key to success in markets with characteristics similar to those found in healthcare, then the inverse should be true as well, that reducing flexibility in healthcare will decrease successful service delivery.

While there are many studies on applications of agile redesign in manufacturing contexts, there are no studies on how to apply or develop 'agility' in a service supply chain. Thus, if our current conclusion is correct, and agile should be recommended over lean as the most effective system redesign strategy in healthcare, there are almost no operational insights available for healthcare managers on how to develop 'agility' in their hospitals or clinics. Despite the importance of services in the world economy and the maturity of the supply chain management field, service supply chain management literature is still in its earliest development and is a relatively new framework for understanding service delivery. Scholars have yet to come to agreement on a conceptual framework for service supply chains, let alone conduct experiments or simulations to generate practical advice for managers attempting to improve service delivery. To date, multiple, competing conceptual models for service supply chains currently exist (Giannakis, 2011; Baltacioglu et al, 2007; Sampson & Froehle, 2006; Ellram et al, 2004), which has hindered the development of standard service supply chain simulation models and other tools for operational analysis. Furthermore, there is no agreement between service supply chain researchers on a complete set of distinguishing fundamental differences between services and manufacturing, such as the intangible nature of services and the simultaneous interaction of customer and service provider, to name two. The dominant trend in current scholarship in service supply chains appears to be a focus on resolving these theoretical issues rather than developing actionable conclusions relevant to healthcare operations and business managers.

2-5. Methodology/Approach
In this section, we describe the use of system dynamics in healthcare, and justify its use as the most appropriate method for understanding healthcare service delivery systems.

Despite the lack of a concise conceptual model, system dynamicists have been generating practical, operations-level policy recommendations for managing service supply chains through exploring both generic and real-world systems with simulation models for over 10 years. Anderson and Morrice published the first system dynamics simulation of a service supply chain in 1999, by adapting the foundational system dynamics manufacturing supply chain simulation model (for examples, see Forrester, 1958; and Lyneis, 1980) to include some of the key phenomena of services more recently agreed upon by service supply chain scholars: the intangibility of services and the simultaneous interaction of customer and service provider. The model was developed mainly to research the phenomenon of up-stream demand amplification (known in manufacturing chains as the bullwhip effect) and the effectiveness of the counter-
They base their model parameters on information from the mortgage industry, but identify generic policy conclusions applicable to any service delivery system.

Closely following that publication, Akkermans and Vos (2003) use a similar model (modified to include endogenous effects of schedule pressure on quality and rework) to illuminate the causes of, and counter-measures for, demand variation amplification in the telecom industry. Again, they use system dynamics simulation to identify actionable counter-measures to demand amplification that are universally applicable across service types. More recently, Anderson et al. (2005) use more generic version of their original model to evaluate structural causes of amplification in the service chain and Lee (et al, 2009) use a similar model to evaluate the use of alternative capacity management control policies.

The important concepts that differentiate a service supply chain from a manufacturing or product supply chain are captured in each of these models’ structures. They are 1) the replacement of a tangible finished goods inventory for a customer order backlog, 2) service provision is intangible and non-storable (portrayed as an instantaneous rate, tasks per time, rather than a tangible stock), 3) service provision is determined by the simultaneous availability of customers and service providers, and 4) order backlogs can only be managed by adjusting service capacity. There is no finished goods inventory to act as a buffer to demand variation; instead, backlogs can only be managed by adjusting service capacity. This generic simulation model integrates well with the recent conceptual service supply chain literature, subsuming both Sampson’s (2000) proposed ‘dyad’ and Christopher and Peck’s (2004) proposed ‘network’ structures. Each clinic in the chain of service delivery is composed of the same basic participants and tangible and information flows as Sampson's model, but each of these clinics is in turn linked through the exchange of information and customers. We believe this structure represents an operationalized synthesis of current service supply chain concepts.

The models used in all of these studies are based on the same underlying structures and no clear criticism or alternative structure has emerged in the system dynamics literature. There are no criticisms of this method, system dynamics, or particulars of these simulation models’ structures in the service supply chain literature. Indeed, Sampson and Froehle cite these models as "clear exceptions" to what they describe as the normally "forced and unclear" application of supply chain management principles and models to services (2006, p.337). The continuity of the models' structure over time and lack of a clear alternative lead us to believe it is not unwarranted to label this a 'standard' service supply chain simulation model.

Furthermore, we believe this method could become the standard tool for the study of healthcare service supply chains. The complexity of the services and resources incorporated in the provision of healthcare necessitate formal methods for integrating and synthesizing these diverse
components, understanding the evolution of the design and behavior of delivery systems, and developing strategies for improved management and coordination (Giannakis, 2011).

Conventional analytic methods are generally unable to satisfactorily address situations in healthcare where demand for services changes over time and where patient risk factors, diseases, and health resources are in a continuous state of interaction and flux (Schorr, 1997). It is widely accepted by healthcare professionals that healthcare delivery cannot be understood by looking at factors in isolation (Lane, 1999), as many healthcare delivery systems are conceived of as complex systems (Parchman et al, 2011), where 'everything affects everything else' (Brailsford et al, 2010).

System dynamics provides a formal, mathematical approach to simulating systems where multiple feedback processes all interact to produce in continuous change. This approach is particularly well suited to modeling complex, adaptive systems, where multiple, interconnected feedback loops render system behavior difficult to understand and interpret (Vennix, 1996). Thus, system dynamics has been identified as an appropriate method for improving the management of healthcare systems (Young, 2005), because it can provide a strategic perspective of the management of the system as a whole instead of basing understanding on the behavior of individual parts (Lane et al, 2000). System dynamics can describe the interactions of patients and care processes over time and be used to evaluate the effects of different policy interventions before proceeding with any high-risk or high-cost intervention (Young et al, 2004).

System dynamics modeling has been used extensively in healthcare (approximately 1500 publications since 1991, Brailsford, 2008), and a recent review of system dynamics modeling in healthcare concludes that the method can be used effectively for quantitative analysis when based on simulation models (Dangerfield, 1999). System dynamics has already been used for quantitative analysis of the underlying reasons for failed management interventions in cardiac catheterization services (Taylor & Dangerfield, 2005), and to analyze the effects of business process redesign on mental healthcare performance (Wolstenholme et al, 2006). A general discussion of the role of system dynamics in analyzing healthcare systems can be found in Taylor and Lane (1998). The reader is directed to (Homer & Hirsh, 2006) for more examples that to support for the use of system dynamics simulation as a tool for understanding healthcare service supply chain management.

2-6. Dynamic Hypothesis and Simulation Model
In this section, we define our simulation model’s mathematical structure, key relationships and feedback structures, and give a detailed examination of our main abstractions and assumptions.
To explore our dynamic hypothesis, we model a generic healthcare service delivery chain that consists of four separate clinics. This structure allows us to test our hypothesis that the ‘leaner’ any one clinic becomes, the less the overall chain is able to provide quality patient care. The healthcare service system is modeled in continuous time, and is simulated in Vensim® software. The use of continuous, as opposed to discrete, flows in the model is a reasonable approximation of the perpetual adjustments (hiring and firing) necessary in the management of service organizations, and is a common method for abstracting these systems in both operations management and system dynamics literature (Sethi & Thompson, 2000). This model is concurrent with previous system dynamics service supply chain models, visualized in Figure 24.

The purpose of the model is to capture the essential elements of reality common to most healthcare delivery chains rather than perfectly simulate one specific service. As is, the model’s structure could represent many healthcare service chains. The four distinct clinics in this healthcare service delivery could portray a multi-month process that takes a patient across multiple organizations and locations: from the emergency department, to an imaging lab, then an operating theater, and finally, through to outpatient rehabilitation. This service chain could also represent a hospital’s core service of emergency medicine, all taking place inside the one department: patient intake, triage, clinical interview, and discharge. This model could just as easily be parameterized to represent an elective service: a visit to a family doctor, a referral to a specialist, scheduling elective surgery, and receiving a bill. This generalizability comes at the cost of simplicity; the idiosyncrasies particular to any one service chain are not included in the model.

Our fundamental assumption is that the elements we exclude from the model would not, even collectively, be enough to overcome the dynamics inherent to the structure contained within this simplified model. Applying lean redesign methods to any healthcare delivery chain would yield similar effects. This model could be further adapted to a specific health care context through adding additional clinics or feedback structure, or changing model parameters. For example, the
patient pathway could be changed to allow patients to leave and enter any clinic without first receiving the services of the previous clinic (as would be more realistic in a complex system, such as a hospital, where patients can move quickly between clinics and specialty services as their conditions change). We could allow patients to leave a clinic wait list if the wait time increases beyond their personal tolerance; we could also allow endogenous demand, connecting current service quality to future demand. However, none of these possibilities are universal features of healthcare delivery chains. For example, some patients cannot leave once a service has started (you can leave the ER waiting room, but you cannot leave the OR waiting room), and waiting for some services is more tolerable than others (many patients would probably prefer to wait indefinitely for a colonoscopy, whereas for patients with acute myocardial infarctions waiting more than 90 minutes for percutaneous coronary intervention can be fatal). Including service or disease specific feedbacks would lessen the impact of our analysis and policy conclusions. While all these are excellent areas for future research, just like past service supply chain modelers, we believe our generic analysis and policy conclusions should still be applicable, regardless of the type of service provided (Anderson et al, 2005).

Each clinic in our model operates in an identical manner, but is autonomous, as capacity decisions are based only on the information available at each clinic. Each clinic is linked as the output of clinic $i$ forms the input signal of clinic $i+1$, but each clinic requires a separate resource to serve its patient backlog, which could either be from requiring a different set of skills to complete the tasks in each clinic, or that an organizational structure prevents sharing resources between clinics. Each clinic has a finite capacity, which is derived from the number of staff working in that clinic, their productivity (as measured by tasks/clinician/hour), and their working hours (hours/week/clinician). The manager of each clinic has sole responsibility for operational performance and control over service capacity in their clinic. Each clinic manager’s implicit goal is to keep service performance at a desired level (measured in average days wait time), while keeping service capacity costs to a minimum. They use the information available to them on the order backlog of their clinic and the current service capacity. While this structure is far from optimal, it is a realistic representation of how real managers make decisions in similar settings (Sterman, 1989). This structure follows the common ‘staff to demand’ heuristic found currently in most hospitals and healthcare centers (Litvak et al, 2005).

2-6.1 Model equations
A more specific stock and flow model of one representative clinic is presented in Figure 25, graphically displaying the three control loops fundamental to clinic management: one to prevent number of customers waiting for service from going negative (the Work Availability loop), one representing manager's decisions on hiring and firing to balance workforce with demand (the Capacity Management loop), in which is embedded the manager's decisions comparing current workforce with desired workforce to achieve desired service capacity (the Meeting Workforce Goal loop). A full set of model equations and parameters is reported in Appendix D.
Figure 25. Stock and flow diagram of one clinic in an operational service supply chain structure. The main capacity adjustment loop is highlighted; parameters adjusted to explore behavior inherent to the model’s structure are circled.

Mathematically, the structure of this first control loop is as follows, where $B(t)$ is the order backlog, $C_i(t)$ is the service capacity, and $r_{ci}(t)$ is the task completion rate in the clinic on day $t$. Note that $r_{ai}(t)$ is the new patient demand rate, which is determined exogenously. Equations have been slightly modified from those used in previous system dynamics service supply chain models to include a specific measure of clinician productivity.

$$
B(t) = \int_0^t [r_a(t) - r_c(t)] dt + B_0
$$

$$
r_c(t) = \min \left( \frac{B(t)}{\mu_i}, \left( C(t) \times \frac{w_i}{\delta_i} \right) \right)
$$

where $B_i(t)$ = patient backlog at $t$, measured in units of patient tasks
$R_{ai}(t)$= arrival rate of patients at $t$, measured in units of patient tasks/week
$R_{ci}(t)$ = completion rate of patients at $t$, measured in units of patient tasks/week
$B_{i0}$ = initial backlog (patients in-progress) at $t = 0$, measured in units of patient tasks
$\mu_i$ = minimum task delivery time at clinic $i$ (fixed in this model to 0.05 weeks).
$w_i$ = standard work week at clinic $i$ (fixed in this model to 40 hours / week).
$\delta_i$ = productivity of clinicians at clinic $i$ (measured in clinician*hour / patient task).
The manager's decision-making heuristic in each clinic is quantified as:

\[
C(t) = \int_0^t \left[ \frac{e(t)}{\tau_i} \right] dt + C_0
\]

\[
C_d(t) = \left( \frac{B(t)}{\lambda_i} \right) \left( \frac{\delta_i}{w_i} \right)
\]

where 
- \( C_i(t) \) = resource capacity available at \( t \), measured in units of clinician FTEs
- \( e_i(t) \) = the net capacity error = \( C_{id}(t) \cdot C_i(t-1) \), measured in units of clinician FTEs
- \( C_{id}(t) \) = resource capacity desired, measured in units of clinician FTEs
- \( C_i(t-1) \) = resource capacity at previous time step, measured in units of clinician FTEs
- \( C_{i0} \) = initial capacity (providers) at \( t = 0 \), measured in units of clinician FTEs
- \( \tau_i \) = the average nominal delay required to adjust capacity at clinic \( i \). Roughly equivalent to the time to add or remove an individual clinician from the clinic roster (initialized to 2 weeks).
- \( \lambda_i \) = the average nominal delay required to complete an order in the backlog of clinic \( i \). We refer to \( \lambda_i \) as the average service delay, the target average patient wait time, desired process time, or simply wait time (initialized to 1 week, but subject to changes from lean improvement).

The net capacity error portion of the equation denotes the gap between desired and actual capacity, where the target capacity depends on the local backlog at time \( t \) and the target patient wait time. Using this ratio guarantees that, on average, the patients in each backlog will not be delayed longer than the target service delay (\( \lambda_i \)). Desired service capacity is also affected by the productivity of clinicians and the number of hours they work. \( \tau \) represents the time it would take to close the gap between actual and desired service capacity, and holds for most desired changes in service capacity. \( \tau \) determines the degree to which the capacity responds to the gap between the desired and the current workforce.

This decision equation is based on observations and interviews done in actual healthcare setting with both clinic managers and front-line providers and observations across multiple clinical settings. The translation of healthcare management decision heuristics into abstract, generalizable equations is a contribution to the healthcare management simulation literature. Support for our particular abstraction can be found in its similarities to the capacity management decision heuristics modeled in other services (Akkermans & Vos, 2003). Furthermore, this equation replicates the capacity adjustment decision rule used in Anderson et al (2005), which
they have found in use by capacity managers in a wide range of services. Case studies cited include an oil field development company, a mortgage service company, and custom manufacturing (where finished inventories are also impossible).

Historically in healthcare, managers have used a fundamentally different staffing heuristic, not basing their decisions on current demand for services, but to ensure that enough staff were always available to meet peak demand. For example, employees were assigned to a clinic based on the number of beds in that clinic, regardless of whether or not those beds were in use (Buerhaus, 1995). During periods of below average demand, it was acceptable for staff to be underutilized. But, a large portion of hospitals’ operating expenses is labor related, and as competition and public pressure to reduce cost increased, many hospitals began to reduce what became to be seen as excess staffing. With the advent of managed care, hospitals changed clinic management to base desired capacity on the average demand (Litvak et al, 2005), bring the industry in line with almost all other services. While this is not an optimal decision rule for system performance, or even for local performance, we agree with Drezner (et al, 2000) that simulations should try to replicate the rules found to be used most often in the service being examined, regardless of the existence of more effective capacity management algorithms. There is no evidence of more sophisticated decision heuristic in common use in service capacity management (Anderson et al, 2005).

The model is initialized in equilibrium, designed and calibrated to fulfill all initial incoming orders and maintain the desired service delay. The patient backlog at each clinic is set initially to $\lambda(r_{i,0})$. Initial service capacity is set to $(r_{i,0} \cdot \delta_i)/w_i$, ensuring that it starts in equilibrium, where service capacity matches demand. If there were no change in the demand for services, then no other rates or levels would change, thus the total service time with remain $\sum$. All clinic parameters in this abstract model (productivity, target wait time, etc.) are identical, which is not realistic, but allows for clearer interpretation of model behavior.

2.6.2 Simulating lean improvements
Lean-based redesign efforts are modeled as a sustained increase in the productivity of service providers in a single clinic. Reducing waste in a clinic could take many forms, but the overall effect would be a reduction in process time, also referred to as an increase in patient throughput. Operationally, we assume that lean improvement efforts results in a successful and sustained reduction in time per task ($\delta_i$). Lean improvement also affects desired service delay ($\lambda_i$) in that clinic. Service standards as well as service performance improve after successful lean implementation (Graban, 2008). In equilibrium, a more efficient process would require fewer staff (as each is now more efficient because non-value added process steps have been removed) if demand is unchanged. This is common effect of lean implementation (Sterman et al, 1997). Even if hospitals have included a no lay-offs policy in their lean implementation initiatives, it is common for workers to still be moved out of their original clinic after productivity increases
This approximation of the outcome of lean-based redesign efforts is congruent with the current iteration of lean as applied in healthcare.

We recognize that this simulation model is a highly simplified version of reality. Even though the purpose of each step in health care delivery is to improve the health of the patient, we feel the need to clearly acknowledge that feedbacks to patient health are absent from the model. We assume that the specific service provided by each clinic in the process of care is essential to the overall service and adds value to the patient. Moreover, most health care services contain more than four process processes, while some processes can potentially be done in parallel. However, adding more clinics does not significantly change the analysis or policy conclusions. One of the operational abstractions necessary for this model to be representative is that each clinic has a finite resource capacity, but has no other constraints on service production (space, equipment, etc.). Lean-based initiatives have other impacts on an organization than simply improving process productivity. Effects on organizational culture, sustainability and standards erosion, tipping point phenomena, and organizational learning effects are all explored in other works; all of which could be included as extensions of the current model for future research. Furthermore, our model structure assumes managers have no knowledge of initial patient demand and no knowledge of the order backlogs at any other clinic in the service chain, as is common in healthcare, but far from optimal. These abstractions give the model the simplicity to allow us to focus on the fundamental dynamics inherent to the healthcare service supply chain. The effect of relaxing these assumptions will be explored in future research based in specific healthcare sites or services.

2.7. Simulation Analysis

In this section, we discuss our selection of performance measures and how they compare to general performance measures previously developed for the evaluation of service chains. Next, we present simulations that establish demand variation amplification as an inherent system behavior and a causal connection between demand uncertainty and the trade-off between flexibility and efficiency. We test for the effects of lean redesign in a healthcare service chain, finding support for our hypothesis. Finally, we discuss how model structure creates these behaviors and the implications for patient risk.

2.7.1 Performance measures

Our performance measures must clearly identify both if and how lean-based redesign directly reduces quality of care through limiting the ability of a healthcare supply chain to meet patients’ needs and provide care in a timely way. Research in manufacturing and recent simulation work in service supply chains suggests that these adverse effects will be caused by reduced flexibility, as the system will be less able to respond to unknown, variable demand, and by the unintended consequence of lean efforts increasing the demand amplification effect, adding to the demand
uncertainty already present in the environment. We select performance measures common to evaluating service chains, and that will reveal these effects, if they exist.

Our most common measure of service quality is both applicable to services in general and a basic measure of patient care: total service time. In this study, total service time is how long the average patient is in the system before discharge, or the time it takes the average patient to traverse all the steps in the service chain, thus completing the service requested. Average patient service time in a clinic is defined through Little’s Law, as the quotient of the current backlog of patients by the rate at which the clinic delivers its service and they are sent to the next clinic. Service time is a common measure of service performance, especially in services where quality of service is subjective and difficult to quantify. This provides a measure of whether lean reduces ability to provide care in a timely way. Converting this absolute measure into a dimensionless ratio (of desired wait time, λ, to actual wait time (B/r,t)), gives us an instantaneous error rate by which to judge system performance. We also measure the distribution of total service time over the course of a simulation, to determine if lean-based redesign causes some patients to wait longer, even if average service time remains unchanged.

Besides timeliness, another measure of quality common to both service delivery and healthcare is the likelihood of error generation during the care process. Error generation in healthcare is attributed to the creation of adverse events, medication errors, wrong-site surgeries, and other patient safety hazards. Past research in healthcare service delivery has linked the ratio of patients to providers, and the subsequent clinician stress and fatigue, to increased error generation. The mismatch between resources and peaks in demand is a major source of provider fatigue and reduced quality of care in most healthcare services (Kane et al, 2007; Robertson & Hassan, 1999). For example, higher patient to provider ratios have been correlated with increased patient mortality and failure-to-rescue (deaths following complications) rates within 30 days of admission (Aiken et al, 2002). One large, multi-state study involving 500 US hospitals found an inverse relationship between the number of registered nurses per patient and urinary tract infections, pneumonia, thrombosis, and pulmonary compromise (Kovner & Gergen, 1998). Another study finds that when medical interns are made to work overtime (shifts >24 hours), they made 35.9% more serious medical errors than when all shifts were <24 hours (Landrigan et al, 2004). Robert et al (2000) find that higher ICU patient:staff ratios significantly increase the risk of bloodstream infections. Studies of both neo-natal and adult ICUs indicate that times of high nursing workload correlate with higher risk of inadequate supervision, medication errors, increased infection rates, and premature discharge, all leading to significantly higher patient mortality rates (Carayon & Gurses, 2005; Tarnow-Mordi et al, 2000; Beckmann et al, 1998). This wide array of data clearly supports the premise that the appropriate staff to patient ratio must be maintained to provide optimal patient care, and falling below an appropriate, ‘normal’ ratio leads to increased errors and adverse events.
The definition of what is considered a 'normal ratio' must be based on specific healthcare process and clinic in question. Variation in care practices, patient population characteristics, and process design all contribute to the development of site-specific patient to provider guidelines. However, some researchers have attempted to directly estimate the relationship between the patient:provider ratio and patient mortality. One of the largest and most robust study in this area of research was taken from a sample of 168 hospitals in Pennsylvania (Aiken et al, 2002). Adjusting for factors such as hospital size, teaching status and technological capacity, this research finds that for each additional (non-critical) patient assigned to an RN above the level of adequate staffing (defined as 4:1 for non-critical care wards), the mortality rate of all patients being cared for by that nurse increases by 7%. This implies that doubling the number of patients in a clinic would increase patient mortality by 31%, if nurse staffing remained unchanged. In starker terms, this doubling of workload (from a ratio of 4:1 to a ratio of 8:1 patients to nurses) would be expected to lead to 5.0 excess deaths per 1000 patients, and 18.2 excess deaths per patients with complications (Aiken et al, 2002 – for the calculations necessary to apply this mortality likelihood to our model, see Appendix B). While this odds ratio may not be generalizable to other hospital units or entire hospital populations, the authors find no change in their estimates depending on type of patient, using the outcome measure of inpatient deaths or deaths within 30 days, sampling either medical or surgical nurses, or the ratios of other skilled and unskilled practitioners to patients. We recognize the controversial nature of this precise association between mortality and nurse workload, and do not wish for discussions of the applicability of this relationship to occlude the more generalizable conclusions derived from our simulations. Thus, we do not include any estimates of patient mortality or error generation in our model, even if there is evidence to support such feedback effects between provider workload on patient safety. Meaningful estimates of excess patient mortality could be generated for a particular care delivery process, if the model was parameterized from more specific data on patient backlogs, workload increases, and the effects of patient to provider ratios on key patient outcomes by type of clinic and specialty. Any work to develop a more precise estimate would also need take the beneficial impact of reduced care delivery time into account, as reduced length-of-stay has been correlated with improved patient outcomes and reduced risk. Including the dynamic feedback effects of these changes to patient risk would complicate the interpretation of model behavior, and reduce its significance to only specific patient characteristics and individual care processes. While challenging, we believe this is necessary future research for both patient safety and healthcare service delivery researchers.

To keep the analysis as widely applicable as possible, we report only variation in the patient:provider ratio as a proxy for error creation and patient safety risk. We operationalize our measure through observing changes in clinic workload. Workload is defined as a dimensionless ratio of the service capacity necessary to see the current backlog of patients within the target
service delivery time (equivalent to the desired service capacity) and the current service capacity. Using this ratio removes any need to define a 'normal' ratio of patients to providers, and is robust against changes in provider productivity or patient characteristics. This proxy for stress and patient safety risk can be modified to suit any service delivery system, and is accepted as a general measure of service supply chain stress and a main contributing factor to reduced service quality and increased rework. This ratio was first proposed by Akkermans and Vos (2003), and is similar to the measures of “schedule pressure” found in other canonical system dynamics workforce models (Lyneis & Ford, 2007).

To illustrate how this measure is used, assume a 10% increase in patient demand makes the workload measure triple from 0.1 to 0.3, this suggests severe demand variation amplification, but it also indicates that the system is not put under serious pressure because the workload is still well below 1.0, where 1.0 indicates that demand for services and current service capacity are in equilibrium, and thus all current patients can be seen within the desired service time.

\[
Workload_t = \left( \frac{B_{i,t}}{\lambda_i} \right) \left( C_{i,t} \times \frac{W_i}{\delta_i} \right)
\]

This measure, workload, also provides an estimate of system flexibility. If the ratio of patients to providers is often not balanced, then the system is not able to effectively and efficiently address changes in demand for services with changes in service capacity. For example, when workload is high, there are more patients waiting than there are necessary providers to diagnose, treat, and care for them in a timely manner, indicating that the system was not able to successfully respond to the initial increase in demand. The same is true when workload is below 1: the system has more resources than it needs to be able to provide the standard level of care.

This measure provides an instantaneous measure of provider stress and system flexibility, and is useful for evaluating behavior over the course of a simulation. However, to facilitate comparison of stress and flexibility across multiple simulations, we must condense this behavior into one number. Based on a technique common to control theory (White, 1999), we use the sum of the absolute difference between equilibrium and actual workload generated in all clinics. This accumulated error (the difference between desired and actual workload) stores the history of behavior over the entire simulation, resulting in a less volatile and clearer picture of how different policies affect performance over time, not just at one moment in time. The accumulated stock of error is the preferred system performance measure in service supply chain simulation, as this formulation treats all error equally, not the square of error as in standard deviations (for discussion, see Anderson et al, 2005).
2-7.2 Inherent model behavior

System behavior offers key evidence toward model validation. Comparison of behavior generated by the structure of the model against well-established behaviors found in empirical studies adds weight to model design. From the literature, a service supply chain with delays, bounded rationality, and no demand signaling, which faces unknown, variable demand should produce its own internal variation, which amplifies the variation in the original demand. This 'bullwhip effect' is theorized to be inherent to all real-world service and production systems, and is the key performance problem to analyze in both service and manufacturing supply chains (Anderson & Morrice, 2005; Lee et al, 2009). The bullwhip effect, or its equivalent in non-inventoried service chains, has been reported in multiple healthcare services. Case studies and analyses of real-world hospital and clinic admissions and discharge rates have shown increasing downstream variation amplification (Walley, 2007; Sethuraman & Tirupati, 2005; Jack & powers, 2004). In each of these studies, this variation amplification effect is related to increased costs, employee stress, and resource utilization rates. In manufacturing, the bullwhip effect is similarly credited with creating undue stress on supply chain resources, increased costs, lower customer satisfaction, lower service quality, and lost sales. Examples of these adverse outcomes attributed to the bullwhip effect exist in the case studies of many diverse service industries, as well.

The existence of variation amplification between clinics in our service chain is significant because stress placed upon a healthcare system by demand variability has been shown to lead to more medical errors, sicker patients, and is believed to be a leading cause of adverse patient outcomes (Needleman et al, 2002; Berens, 2000; Pronovost et al, 1999). Increasing demand variation should exacerbate our hypothesized adverse effects of lean-based redesign, reducing the ability of the service system to meet patient needs and to provide the requested care in a timely way. Demand variation amplification is a pervasive problem, and should be generated by this model.

We also look for the model to generate an appreciable trade-off between supply chain efficiency and flexibility. This relationship, while not yet reported in the healthcare literature, is found in both service and manufacturing supply chain case studies, and would align with the current understanding of generic service supply chain behavior. If this inverse relation is demonstrated, then model behavior should also indicate that uncertainty in end-customer demand acts an amplifier on that relationship, with increasing uncertainty leading to increases in efficiency having larger negative correlation with overall system flexibility. Producing these behaviors would further align our model with the current understanding of service systems.

To test for these behaviors, we first simulate a base case scenario, which contains no lean-based redesign or increases in clinic efficiency, productivity, or patient throughput. The system faces a minimal level of demand uncertainty, but one that will clearly expose inherent model behavior: a
one-time 20% increase in patient demand. Key parameters in the model are initially set to the relative equivalents of those found in other generic service supply chain models. The total desired patient service time is one month, spread evenly over each clinic ($\lambda_i$ is 1 week); the time to add or remove a provider from any clinic roster is two weeks ($\tau_i = 2$ weeks), and the productivity of each provider is 1 exam per hour ($\delta_i = 1$ hour / exam / clinician). The model starts in equilibrium, where exogenous demand is a constant rate of 100 patients per week, and each clinic is staffed with 2.5 FTE, which is the number needed to meet that demand in the target service time ($\sum \lambda$). Thus, desired capacity and actual service capacity are equal, and our performance measure, workload, is 1.0 in each service clinic. This scenario represents the most basic service delivery system, where local managers control the workforce at each clinic using only information on their local clinic backlog and provider productivity.

This model structure clearly generates the demand variation amplification effect. The results for weekly demand for services and system stress for all clinics in this healthcare delivery chain over a 60 week period are contained in Figure 26 and Table 5. This finding compliments previous service supply chain modeling studies, as the effect manifests in increasing upstream variation in both order backlogs and service capacity. Each clinic transfers variation to subsequent clinics, magnifying demand as it moves up the service chain, creating system stresses proportionally much larger than the initial increase in demand. The amplification effects arise from delays in demand signaling and the limited information and bounded rationality of individual clinic managers. Clinics in this model are highly compartmentalized; they share no data on productivity, patient backlog or service quality. In this model, there is no coordination of functions between clinics, which represents the typical level of coordination of care both between healthcare organizations and inside hospitals.

![Graph showing workloads](image)

Figure 26. Base case analysis of changes in individual clinic workloads resulting from a 20% increase in demand in week 10.

Demand rate changed from 100 tasks per week to 120 tasks per week. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.
Further tests also reveal that model structure generates the trade-off between efficiency and flexibility found in the supply chain management literature. Increased efficiency is modeled as a sustained reduction in providers’ average time per task ($\delta$) and the target service delivery time ($\lambda$) in all clinics. These two changes are necessary to typify the operational effects of increasing efficiency in healthcare, where the two most common goals are improving patient care and reducing costs (Robinson et al., 2012; Miller, 2005). In most case studies of redesign efforts hospitals credit lean redesign with improvements in both patient care (as measured by reducing patient backlogs, inventory, reduced waiting times), as well as reductions in operational costs (Nelson-Peterson & Leppa, 2007; Jones, 2006). Adjusting both system parameters simultaneously ensures that the benefits of increased efficiency are spread between these two goals; both patient service times and total clinic workforce are reduced in the steady state, thus, patient care is improved and overall costs are reduced. Increasing provider productivity without decreasing target service time would simply result in cutting costs (as the number of necessary providers would decline), while decreasing desired service times would improve patient care, but without decreasing provider time per exam would require more staff and thus incur higher costs. In these scenarios, the benefits of increasing service chain efficiency are shared between the hospital and the patient.

Table 5. Comparison of service times and workload errors caused by one-time step increases in demand.

<table>
<thead>
<tr>
<th>Change in demand</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
<th>Global Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in</td>
<td>Workload</td>
<td>Service</td>
<td>Workload</td>
<td>Service</td>
<td>Workload</td>
</tr>
<tr>
<td>demand</td>
<td>Error</td>
<td>Time</td>
<td>Error</td>
<td>Time</td>
<td>Error</td>
</tr>
<tr>
<td>+10%</td>
<td>0.349</td>
<td>0.01838</td>
<td>0.551</td>
<td>0.02219</td>
<td>0.845</td>
</tr>
<tr>
<td>+20%</td>
<td>0.652</td>
<td>0.03472</td>
<td>1.200</td>
<td>0.04115</td>
<td>1.556</td>
</tr>
<tr>
<td>+30%</td>
<td>0.921</td>
<td>0.04944</td>
<td>1.426</td>
<td>0.05768</td>
<td>2.165</td>
</tr>
</tbody>
</table>

This experiment includes three different scenarios for model parameter governing exogenous demand, which is varied from the base case of 100 tasks per week to 110, 120, and 130 tasks per week. The table reports accumulated absolute workload error and standard deviation of average service time (computed by Little’s Law) for each scenario, and the sum of these performance measures for all clinics. The time horizon for each simulation is 60 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.

We define time per service ($\sum \delta$) in the service chain as the measure of efficiency, and measure flexibility (the ability of system to respond to changes in demand) through accumulating workload error over the course of the simulation. With these definitions, a perfectly flexible service chain would be able to match any change in demand with changes in clinic service...
capacity, leading to no fluctuations in workload or total service time. By contrast, a perfectly inflexible service chain would never respond to changes in demand, leading to no variation in clinic workforce size, and thus patients themselves would bear all the burden of demand variation through fluctuations in service time. As currently designed, our generic healthcare chain lies between these two extreme cases, not completely resilient against demand uncertainty, but not completely inert either.

Simulations presented in Figure 27 indicate that increasing total supply chain efficiency results in increased workload error. The same step increase in demand of 20% in week 10 results in very different workload error rates depending on the level of clinic efficiency in each simulation. These results can be explained by the changes made to the system structure. Improving the chain’s efficiency increases the speed of service delivery, which results in reducing the size of clinic patient backlogs. In service chains, these backlogs act as buffers on demand variation; therefore, shrinking service times (and subsequently shrinking buffers) allow more variation amplification through to the service chain (Anderson et al, 2005). If demand variation is not absorbed by patient backlogs, then it is more directly felt by service capacity, as there is no finished goods inventory to absorb changes in demand. The clinics in this more efficient system are more exposed to variations in demand, and the resulting system is harder to keep in control than when the system provides services more slowly. This results in more demand variation amplification, and thus more system stress and reduced performance.

To clarify, in all these scenarios the chain itself does not become less flexible absolutely as efficiency increases, but only relatively less flexible, as the increased efficiency has led to increases in internal demand variation. With increasing efficiency creating to a more pronounced ‘bullwhip effect,’ the level of flexibility set by model parameters (τ) is no longer adequate to maintain initial performance levels. Changes in service supply chain efficiency have a similar effect: doubling the efficiency results in approximately doubling the workload error accumulated over each simulation. When faced with increasing demand volatility, even if caused by internal variation amplification, the delivery system needs more flexibility to maintain equivalent performance (both as measured by distribution of service times and workload measures).
Finally, the third behavior from the literature our model replicates is the relation between increasing external demand uncertainty and the severity of the trade-off between flexibility and efficiency, see Figure 28. Doubling the external demand variability from a 10% increase to a 20% increase causes nearly the same doubling in workload error and service time variation. These results reveal the importance of patient demand uncertainty in generating adverse behaviors, both directly and through inherent variation amplification effects inside the service chain structure. It should be noted that any increase in workload variation caused by increased efficiency is only a consequence of the initial level of demand variation. Lowering the volatility of end-customer demand directly reduces system stress and variation in performance caused by the amplification effect. If external demand variation is low, then increasing the efficiency of the service chain will create less amplification effect than when external demand variation is high. The amplification effect becomes more pronounced compared to the increase in efficiency as exogenous demand for services becomes more variable. System performance is dependent on a combination of its structure and on the severity of the demand fluctuations it faces.
Finding all three defining behaviors of service supply chains – the demand variation amplification, or ‘bullwhip,’ effect; the inverse relationship between service chain efficiency and flexibility; and crucial role of external demand variation in that trade-off – suggest that our model is an accurate representation of a generic healthcare service delivery chain. While still sufficiently abstract to yield generalizable results, the model is valid enough to test for adverse effects of isolated lean-based redesign efforts in healthcare.

Figure includes twelve different scenarios for the model parameter governing provider efficiency, delta, reporting total accumulated absolute workload variation and variation in average service times (computed by Little’s Law) for all clinics for each scenario. Demand is increased in week 10, which is varied from the base case of 100 tasks per week to 110, 120, and 130 tasks per week. The time horizon for each simulation is 60 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.

2.7.3 Effects of lean-based redesign
We compare system behavior following implementation of isolated, lean-based redesign efforts in the service supply chain. These scenarios are intended to explore the long-term, systemic effects of lean redesign on healthcare delivery. Lean is manifest in our model through sustained reduction in time per task ($\delta_i$) and target service delivery time ($\lambda_i$). These parameter changes are our operational definition the outcome of successful lean-based clinic redesign in healthcare, where clinic efficiency is primarily improved to reduce costs and improve quality of care. Specifically, we test a 50% reduction in time per task and target service delivery time in clinics 1 through 4, in an environment with unknown, stochastic demand for services. These scenarios represent four lean implementation options, where system stakeholders have targeted different clinics in the service delivery chain for lean-based redesign. Due to the isolated, disjointed nature of lean in healthcare, we only increase productivity in one of the possible four clinics in
the service chain for each simulation. The lack of a coordinated redesign efforts is standard in healthcare, as organizational silos and diversity of skill sets reduce the ability of lean practitioners to conduct projects across multiple clinics and specialties.

Each simulation starts in equilibrium, with adequate service capacity to meet initial patient demand. These scenarios represent a system that has returned to equilibrium after any disruptions caused by the clinic redesign itself, thus excluding the destabilizing implementation effects inside one clinic (which has been studied in detail elsewhere; for example, see McManus & Rebentisch, 2008). Other possible effects of lean improvement beyond process efficiency, such as socio-technical transformations and organizational culture change, are outside the scope of this research. Current lean practice in healthcare has not proven to stimulate these long-term effects, and the impact on of such factors on patient care and service delivery is uncertain. Clinic managers’ decision heuristics are unchanged by lean implementation and the paradigm of staffing to demand remains constant throughout.

Our findings suggest that lean implementation in a single clinic achieves the desired effect of improving overall service performance, as measured by total average service time (see Table 6). As expected, a 50% decrease in one clinic results in an approximate 12.5% decrease in the average total service time per patient, regardless of which clinic is improved. This reduction in service time should lead to improved patient health outcomes, as patients complete treatment faster than pre-implementation, as well as improved costs, as fewer staff are needed in the redesigned clinic’s workforce.

However, improving an individual clinic’s efficiency also causes demand variation amplification to increase, resulting in increased variation in workload and distribution of service times, which suggests our hypothesis that lean redesign contributes to patient and provider risk is correct. Lean redesign has caused our workload performance measure to increase dramatically, up to a 21% increase in the worst case scenario. As increasing workload has been shown empirically to lead to higher patient safety risks and worse patient health outcomes, this mounting mismatch between providers and patients is a cause for concern. This increased workload error also indicates lean redesign places increased stress on ancillary system resources, as workload error results in increased administrative and education costs from increased hiring, training, and firing rates.
Table 6. Comparison of service times and provider stress levels of four lean-based redesign scenarios, when patient demand is stochastic and unknown.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Desired Performance</th>
<th>Actual Performance</th>
<th>Range of Total Avg. Service Time</th>
<th>Probability of Exceeding Base Case Service Time</th>
<th>Accumulated Workload Clinician Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Avg. Process Time (avg.)</td>
<td>Total Avg. Service Time (min., avg., max.)</td>
<td>Max. time – Min. time</td>
<td>P(x &gt; 4 weeks)</td>
<td>[</td>
</tr>
<tr>
<td>Base Case (w/ random demand)</td>
<td>4</td>
<td>3.4947, 3.9959, 4.7324</td>
<td>1.2377</td>
<td>48.88%</td>
<td>45.139 (100%)</td>
</tr>
<tr>
<td>Improvement in Clinic 1</td>
<td>3.5</td>
<td>2.9421, 3.4980, 4.202</td>
<td>1.2981 (4.88%)</td>
<td>2.37%</td>
<td>54.659 (+21.09%)</td>
</tr>
<tr>
<td>Improvement in Clinic 2</td>
<td>3.5</td>
<td>2.9386, 3.4980, 4.2386</td>
<td>1.3000 (5.03%)</td>
<td>2.37%</td>
<td>51.007 (+13.00%)</td>
</tr>
<tr>
<td>Improvement in Clinic 3</td>
<td>3.5</td>
<td>2.9366, 3.4980, 4.2428</td>
<td>1.3062 (5.53%)</td>
<td>2.37%</td>
<td>48.800 (+8.11%)</td>
</tr>
<tr>
<td>Improvement in Clinic 4</td>
<td>3.5</td>
<td>2.9443, 3.4980, 4.1972</td>
<td>1.2529 (1.23%)</td>
<td>2.40%</td>
<td>47.023 (+4.17%)</td>
</tr>
</tbody>
</table>

The experiment includes five different scenarios for the model parameter governing provider efficiency, delta, and desired service time, lambda; reporting average service times (computed by Little’s Law), range of average service times, probability of exceeding the base case desired time of 4 weeks, and total accumulated absolute workload variation for all clinics for each scenario. Demand is simulated around a base demand rate of 100 tasks per week with a pink noise process with a standard deviation of 10%. The time horizon for each simulation is 60 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.

Lean-based redesign has also caused service time distribution to increase, by approximately 5.5% in the worst case scenario. While this is evidence of increased variation and system stress due to lean efforts, this is unlikely to have direct adverse effects on patient care. For even if the distribution is wider, the overall range has shifted enough that all patients are still being treated faster than before lean redesign occurred. The likelihood of a patient care episode lasting longer than 4 weeks is now only 2.37% post-lean implementation, compared to pre-implementation service levels of 48% of patients exceeding the service standard of 4 weeks. These results indicate that increasing service time distribution is not cause for concern nor should it affect patient safety or quality of care.

We found similar behavior in our base case scenarios, where decreasing overall service times created internal demand variation amplification. The key finding from this experiment is that not all lean implementation options produce the same level of variation amplification and provider
workload stress. Improvements in efficiency made at the first clinic in a service chain create more amplification effect, and thus, more system stress and patient risk than improvements made at the end of the service chain. Improving the efficiency in the first clinic increases variance in the patient:provider ratio in all subsequent clinics, but improving the last clinic only increases variance of that final clinic’s task completion rate. In our model, a 50% improvement in the first clinic results in a 21% increase in workload and service time variation for the entire system over the base case, where an identical reduction in time per task in the final clinic in the service delivery chain only results in a 4% increase in total workload and performance variation.

These results indicate that the common understanding of the impacts of lean redesign in healthcare is fundamentally incomplete. Not only does using lean to redesign individual clinics toward greater efficiency lead to greater provider stress levels and probable patient safety risk, it does so for not just that one clinic, but all subsequent clinics in the service chain. Even if lean redesign in healthcare is limited to individual clinics, and the intended benefits of redesign indeed are limited to the engaged clinic, this research indicates that the adverse effects of redesign efforts are not. All downstream clinics suffer if one clinic improves, as they now experience amplified demand variation.

Figure 29. Accumulated absolute workload error in each clinic after lean improvement.
The experiment includes five different scenarios for the model parameter governing provider efficiency, delta, and desired service time, lambda. For each clinic individually, these parameters were reduced by 50%. Chart reports total accumulated absolute workload variation for each clinic for each scenario. Demand is simulated around a base demand rate of 100 tasks per week with a pink noise process with a standard deviation of 10%. The time horizon for each simulation is 60 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.
While the reported trend in system performance is generally applicable, the precise increases in workload variation generated by the model are not. They are not derived from observations of any specific healthcare service supply chain or case study, and are completely dependent on model parameters (target service times, exogenous demand variation, etc.). This makes the precise estimation of the impact of lean-induced demand variation amplification in our model on patient safety impossible. However, this does not mean that it does not exist. For illustration purposes only, we use the relationship between the patient:provider ratio and patient mortality reported by Aiken et al (2002) to calculate these effects for our simulation results. If their analysis was applicable, we would find that all four lean improvement strategies increase patient mortality over the base case. Increases in mortality would range from 3.3% in the best case to the worse case resulting in a 19% increase in patient mortality over the base case scenario (see Appendix D for calculations). Even if these ratios are off by an order of magnitude, this analysis suggests lean redesign has a significant adverse impact on preventable patient deaths.

These results suggest that lean could be better suited to healthcare services where quality is not closely tied to the patient:provider ratio. This could be either in clinics where clinicians and patients are more immune to schedule pressures, like a screening clinic; or where quality is less flexible, perhaps in a service chain with many checklists and redundant inspections. These findings also highlight the importance of pursuing other lean aims besides increasing efficiency. Taking from the iteration of lean still used in manufacturing, standardizing work processes and error proofing could be used to counter the effects of demand variation amplification on patient safety. To counter the bullwhip effect itself, heijunka, or level loading, a primary element of the Toyota Production System, could be brought to the fore of lean as applied in healthcare. Currently, analyzing and improving the flow of patients through a healthcare system is more the realm of queuing theorists and operations researchers than front-line staff engaged in clinic redesign. Refocusing lean re-design efforts on patient safety and process reliability issues could further prevent the hypothesized increases in patient safety risks.

2-8. Exploration of Agile-based Counter-Measures

Since reduction in relative supply chain flexibility is the source of our simulations’ patient safety problems, we believe redesigning the service supply chain base on ‘agile’ principles is a potential solution. While not completely opposing or mutually exclusive redesign strategies, focusing on the principles of ‘agility’ will lead to a supply chain toward operating effectively in an environment of continually and unpredictably changing customer demands, as defined by Goldman et al. (1995). The more ‘agile’ a service supply chain, the more accurately and quickly it responds to market changes, and the more it sees demand changes as opportunities rather than obstacles (Sharifi & Zhang, 2001). Pursuing an ‘agile’ system redesign strategy should allow the service chain to work toward perfectly accommodating individual customer care needs.
Both redesign paradigms seek to improve value for the patient, but through different approaches, focusing on different aspects of care delivery. Where lean in healthcare focuses mainly on waste elimination and increasing efficiency in individual clinics, agile focuses on process integration, meaning the collaborative design and implementation of co-operative service delivery and capacity management. This form of co-operation in service supply chains is becoming more prevalent in some areas of healthcare, as team-based care models for primary care (e.g., the Patient Centered Medical Home, or PCMH) are becoming standardized. As of 2007, an estimated 27% of primary care practices follow some elements of the PCMH model, where disparate elements of the healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services) are coordinated through a patient’s primary care provider (Beal et al, 2007). If not specifically called ‘agile,’ these changes are consistent with the supply chain literature examples of agile redesign activities.

In healthcare, there is growing recognition that individual clinicians no longer provide care as stand-alone entities but rather through complex networks of activities and specialties. Healthcare systems that can better structure, co-ordinate and manage the relationships of their clinicians, technicians, and specialists in a network produce better patient outcomes. Consistent with the move toward team-based care, care networks that improve co-ordination among providers show improved quality, reduced errors, and increased satisfaction (Rosenthal, 2008), with one recent study of a Seattle health system demonstrating 29% fewer emergency visits, 6% fewer hospitalizations, and total savings of $10.30 per patient per month over a twenty-one month period (Reid et al. 2010). Healthcare service delivery researches see the potential benefits of agile-based redesign, and are calling for more research into how to apply agile principles in healthcare settings (Vries & Huijsman, 2011).

We believe this approach could limit the patient safety risks caused by lean redesign. Collaborative planning releases individual clinics from the motivation to promote their own efficiency without regard to the cost it places on downstream clinics. Coordinating redesign efforts across the entire service chain allows service chain managers to work toward optimal performance from the patient’s perspective, as they experience the entire chain, rather conducting isolated improvements in individual clinics.

We operationalize co-operative planning and implementation of redesign activities across the four clinics in our care delivery chain, by varying the distribution of individual clinic’s performance standards and productivity levels while keeping total desired service time for the entire service delivery chain constant at three weeks, i.e., \( \sum \lambda = 3 \) weeks. In these scenarios, the performance standard has been set for the service chain as a whole, allowing clinics to vary their individual efficiencies, within the constraint that total patient service time remains at 3 weeks.
Since all of these scenarios have the same desired total service time, regardless of the distribution of those patients in the chain, no one scenario should have patients waiting longer than any other. All subsequent effects are caused by the distribution of individual clinic efficiencies, not by changes to the overall performance standard. It should be noted that in these scenarios the service chain has a shorter service time than in the previous experiment, as the average patient is completing treatment and leaving the system after 3 weeks, rather than 3.5 weeks. Based on our analysis of inherent behaviors, this should cause more internal demand variation amplification than results reported in previous sections. This service chain is ‘leaner’ than the chain in previous scenarios, but it is a more coordinated chain, as well.

These experiments are designed to reveal the extent workload and distribution of service time can be affected by coordinated planning and management. Desired clinic performance is determined exogenously by model parameters defining individual clinic’s target service time and provider efficiency rates (\(\lambda_i\) and \(\delta_i\), respectively). An individual clinic’s parameters are varied between 1 and 0.25; while the units of these parameters are different (weeks and exams per provider per hour, respectively) varying them together is a more accurate representation of how changes to clinic performance measure would be achieved in an actual healthcare delivery chain. These are the same parameters modified to simulate lean-based redesign activities. These scenarios could represent a combination of lean methods with an overarching agile strategy, but it is not necessarily following a lean-based approach that causes clinic efficiency to increase.

In our simulations, service supply chains that increase the performance of clinics toward the end of the chain produce substantially less workload variation and provider stress than chains which set desired performance equal across all clinics (see Figure 30). The ‘balanced performance’ strategy generated an accumulated workload error of 75.915 over the course of the simulation – the worst of all scenarios, while the ‘end improving’ strategy only generated a workload error of 48.182, which is 36.5% less than the balanced strategy. Furthermore, setting higher performance standards on the clinics in the end of the chain creates less variation than setting higher performances standards at the beginning of the chain.

Changing the distribution of service time standards did not affect total average service time, as \(\sum \lambda\) remained constant, but did significantly affect the range of service times. Similar to workload error, the ‘balanced performance’ strategy yielded the worst performance, with the largest range of total service times. Coordinating improvement efforts so the clinic at the end of the service chain has the best performance results in the smallest range of total service times, with a range of almost half as wide as the ‘balanced’ approached. This finding suggests that system stakeholders can prevent lean redesign causing deleterious fluctuations in system workload through restricting lean efforts to the end clinics in a service chain.
Figure 30. Comparison of service times and provider stress levels of service chains with multiple performance standards distributions; demand is stochastic and unknown.

The experiment includes seven different scenarios for the model parameter governing provider efficiency, delta, and desired service time, lambda. For each clinic individually, these parameters redistributed to maintain $\sum \lambda = 3$ weeks. Chart reports the total range of average service times (computed by Little's law) and accumulated absolute workload variation summed over all clinics for each scenario. Demand is simulated around a base demand rate of 100 tasks per week with a pink noise process with a standard deviation of 10%. The time horizon for each simulation is 60 weeks. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.03125 weeks.

Just as in the lean redesign scenarios, changing these performance parameters alters the desired patient backlog level implicit in clinic managers’ decision heuristics, affecting the size of the buffer each clinic maintains against demand variation. By setting performance standards higher in the final clinics of the service chain, the clinics at the beginning of the service delivery chain were allowed lower relative efficiency and larger patient backlogs, when compared to the balanced strategy. This provides these clinics with more buffer, so less internal demand variation amplification is passed on to subsequent clinics. This front-loaded service supply chain buffers to the entire supply chain from external demand variation, resulting in less variation amplification overall. With all else equal, keeping patients concentrated at the beginning of a service delivery chain better accommodates demand fluctuation, resulting in less system stress at any point in the simulation. Holding relatively more patients at the front of the care process (and fewer in the later clinics, to maintain an equivalent total number) leads to less workload variation than any other distribution.
Reversing this distribution of performance standards, so the clinics in the beginning of the chain hold smaller patient backlogs than clinics at the end of the chain does not yield the worst system behavior. In this scenario, demand variation is more amplified by these clinics because the first clinic’s patient backlog is relatively smaller than before, but this effect is countered by later stage clinics having more of a buffer against that internally created variability. Setting performance standards equally across all clinics generates the most demand variation amplification. We believe the clinics in this scenario amplify inherent demand variation at the same frequency, reinforcing each other’s effects (similar behavior has been shown in cascaded pink noise filters, see Sterman, 2000).

These results indicate that global coordination of performance standards and planning of improvement efforts can directly affect the flexibility of the service supply chain. We show that lean, or other performance improvement strategies, can be applied so as to achieve the goals of process time reduction without creating adverse effects on workload and patient safety, if knowledge of system feedback effects is taken into account. While changing individual clinic performance can be disruptive to the other clinics in the service chain, changing performance can also be used to reorganize the structure of the service supply chain to mitigate the demand variation amplification effect. These results clearly support the importance of collaborative planning and design of service chains in healthcare. To minimize workload stress and the danger it represents to patient safety, setting performance standards should not be left to individual clinics, but set in a coordinated manner by system stakeholders for all clinics to optimize the performance of the chain as a whole.

Comparing this set of simulations to the previous experiment with lean-based redesign of individual clinics further reveals the power and importance of coordinated improvement planning and coordination of performance standards. Under the best coordinated planning scenario, this service chain achieves better performance and less variation in total service time than any of the isolated redesign scenarios, with an equivalent level workload stress. Thus, with coordinated planning, it is possible to create performance improvement without generating increases in internal demand variation amplification. For example, in the ‘end improving’ scenario, average service time is maintained at 3 weeks, a 17% improvement over the best isolated lean scenarios, but the workload error is practically equivalent. By purposefully varying performance standards across clinics in the service chain, instead of allowing individual clinics to set their own improvement schedules and performance standards, healthcare systems managers can use the behaviors inherent supply chain structures to dampen internal demand amplification and the stress it causes.

Our analysis suggests that coordinated planning and implementation of lean methods can lead to system-wide improvements, if these changes in individual clinic efficiency and performance are used toward the goal of creating a more ‘agile’ service chain. Using lean to shift the total patient
backlog from an equal distribution to the beginning of the service chain can reduce the demand amplification effect, and theoretically reduce excess patient mortality caused by variation in the patient:provider ratio. Depending on the situation, this general finding could lead to counter-intuitive recommendations for application of lean in specific contexts: it could be possible to find that, in order to achieve both improved service time and reduced workload variation, the clinic with the worst performance should not be improved at all. Indeed, it is even foreseeable that increasing service delays in one clinic would lead to overall increases in quality of care.

Understanding the magnitude of demand variation and the impact of service supply chain design on variation amplification are crucial to making appropriate decisions for effective coordinated planning and making healthcare chains safer and more ‘agile.’

These results should not be inferred as the optimal strategy for all healthcare service chains, but represent a possibility to be considered when undertaking the redesign of service delivery. While these results, that workload volatility will be reduced if patient backlogs are relatively larger in the first clinics of a service chain, are generally applicable, any changes to clinic performance must be evaluated in context. The cost and health consequences of changing individual clinic efficiency and service delivery times, even if total service time remains constant, can vary dramatically depending on the healthcare service in question. The decision to change clinic performance standards should be made with a concrete evidence-base to determine the effect of service time on patients’ specific conditions, a deep understanding of demand patterns and resultant system behavior, and cooperation and coordination between all system stakeholders.

2-9. Conclusion
We have shown that while lean redesign can improve individual clinic productivity, and thus decrease local cost and service times, this performance improvement can lead to unintended increases in provider workload and risk to patients. Systems analysis suggests that successful individual improvement efforts in one clinic can have counter-intuitive, adverse consequences on clinics throughout the entire healthcare service chain. Increasing clinic efficiency increases the demand variation amplification effect, which leads to increased workload variation and stress on system resources.

The dominant lean implementation strategy, of prioritizing projects based on impact and effort of implementation, the ‘low-hanging fruit strategy,’ ignores the reality that healthcare is a complex, adaptive system. This naive, narrow focus leads to unintended effects on patient health and safety. Numerous studies have reported the connection between clinician workload and quality of care; we are the first to report a connection between lean redesign efforts and systemic clinical workload variation amplification. This research reveals previously unknown negative aspects to lean redesign initiatives in healthcare.
Our exploratory simulation study finds that the impact of lean on patient health is determined by its effect on the distribution of patients along the service chain. While reducing patient backlogs in general increases the downstream variation amplification effect, using lean to shift the bulk of patient backlogs to the front of the chain creates more upstream buffer against demand variation, thus reducing the amplification effect overall. This strategy can be used to reduce the occurrences of staff shortages and patient risk. If lean projects are conducted strategically, taking into account the dynamic feedback effects inherent to service delivery chains, then we believe it is possible for lean improvements to simultaneously achieve increased care efficiency and patient safety.

These research results lead to important hospital management implications. The first implication is the crucial importance of the effect of agile-based design on service supply chain performance. Focusing on flexibility through the coordination of performance standards allows service chains to achieve higher efficiency, reduced costs, and higher quality. When over half of the patients admitted to hospitals in the US arrive through the emergency department (Stern et al, 1991), healthcare services must be designed to respond both quickly and accurately if they are to meet the unique set of needs presented by individual patients. Healthcare managers and leaders should explore the beneficial effects of increasing flexibility in actual healthcare service chains.

A second implication is the importance of quality controls in healthcare to prevent workload variation from affecting patient health. Hospitals in the U.S. have a poor record of measuring and responding to overwork due to variation in the patient:provider ratio. In a national survey of hospital staff nurses, more than one-quarter of respondents reported working unpredictable, ‘mandatory overtime’ during the 28-day study period (Rogers et al, 2004). Another similarly designed self-report survey of critical care nurses reported that over 60% worked ten or more overtime shifts during that 28-day study period (Scott et al, 2006). Only one state has addressed this issue, with a mandate to maintain a standard ratio of patients to nurses at all times (California: Office of the Governor, 2004). Using lean methods to implement standard work, checklists, error-proofing, and the application of other human factors engineering methods would limit the effect of abnormal patient:provider ratios on patient health outcomes.

Finally, this research highlights the importance of demand volatility in general on patient outcomes. Past research has shown patient:provider ratios to be correlated with patient mortality rates. In practice, the link between quality and performance is not at all obvious or immediately made by clinic managers. Hospital managers need more information on quality elasticity across different health care providers and settings to support effective health care staffing decision making. Excess patient mortality will continue to occur as long as the healthcare system fails to mitigate the stresses that contribute to operational dysfunction. If setting staffing levels equal to average demand is an unavoidable paradigm for US hospitals under the current pressures to
reduce healthcare costs, then both lean practitioners and healthcare leaders must focus their efforts on smoothing variation to reduce needless stress and improve patient safety and quality of care. The operational definition of lean in healthcare needs to be recast to incorporate those aspects from the Toyota Production System, such as *heijunka* (or load leveling) and standardized work, that have been discounted in its current iteration.

One limitation of this study is the potential bias generated by excluding, 1) the dynamic effects of increased patient service time on patient health, and 2) the effect of service quality on clinic rework rates. These elements should be included in future simulation studies, but must be calibrated to a specific service delivery chain. Past service supply chain research suggests that these additional feedbacks may magnify the variation amplification effect (Akkermans & Vos, 2003), thus our model potentially under-estimates the bullwhip effect and its subsequent effects on provider workload. Another limitation is the lack of a direct measure of the impact of the patient:provider ration on risks to patient health. More precise estimation of the effects of various clinical staff workloads in diverse clinical settings would increase the significance of our results. We do not including the more qualitative effects of lean initiatives on employee satisfaction, engagement, and morale in our model, which could also impact long-term quality of care.

To operate effectively, our healthcare system must fully realize the benefits of its complexity, rather than be limited by it. Until we know enough to redesign healthcare service delivery chains to mitigate demand variation amplification, any innocent attempts to use lean methods to improve clinic efficiency in healthcare delivery will almost certainly reduce patient safety to some extent. Coordinating service delivery is complex and non-intuitive; it is of dire importance that we undertake a serious and sophisticated study of the intersection of operational systems issues and patient health, and act on what we learn. Essential components of such work would include:

- Aggressive research to identify robust policies from the agile redesign paradigm which mitigate variation and amplification in the demand for healthcare services;
- Pilot programs to test operational changes designed to reduce system stress by improving flow and efficiency simultaneously, and based on these case studies;
- Development of closer collaborations and communication between system scientists, lean practitioners, and providers, both in clinical care and healthcare administration.

Attempts to improve the healthcare system by separately addressing the highly interdependent issues of quality, efficiency, and systems management are unlikely to be productive, but combining them would be a powerful strategy. If undertaken, the result will be an increased ability to make optimal management decisions for patient care and health outcomes, that is, decisions that simultaneously decrease overall costs and increase care quality.
Chapter 3. Adapting Agile Strategies to Healthcare Service Delivery

3-1. Abstract
Agility is a fundamental characteristic of successful supply chains faced with volatile and unpredictable demand, and has been suggested as a promising new paradigm for improving healthcare delivery. Agility is an organization-wide capability that seeks to improve overall responsiveness to customer demands, synchronize supply to demand, and cope with uncertainty. However, even if many conceptual models of agility are available, extant literature fails to clearly delineate how ‘agile’ can be applied in healthcare services and to what extent healthcare systems can benefit from these approaches, nor are there comparisons to current healthcare system redesign paradigms. Given the resource constraints in most hospitals, it is useful, if not critical, to develop a good understanding of how, and to what effect, the agile paradigm can be applied in healthcare. We test specific agile operational practices in a simulated healthcare environment using system dynamics modeling, establishing the comparative effectiveness of changes to system structures that promote market sensitivity, demand information sharing, and centralized planning. This study provides healthcare managers and policy makers with concrete guidance to improve system performance through adopting agile practices, and opens a new area for service supply chain management research.

3-2. Introduction
Healthcare has long been considered to be among the most complex systems in modern society (Longest, 1974), and as healthcare continues to increase in scope and complexity, so will the challenges to manage that system effectively. Present day healthcare delivery is defined by the idea that networks of clinicians, rather than individual clinicians, provide patient care, and that the success or failure of healthcare delivery is ultimately determined by the ability of those clinicians to coordinate their activities. As healthcare increases in complexity, these previously disparate care processes and clinicians become harder to manage and align, resulting in increased risk to patients and inefficient use of system resources. At the same time, increasing competition, expanding public health challenges, and decreasing resources create an increasing necessity to deliver healthcare services in a more efficient way. Hence, being able to understand and quickly adapt to the ever-changing needs of patients as they move through networks of healthcare providers is crucial to the success of our healthcare delivery system. Ensuring that the proper supply of care can be synchronized to meet the peaks and troughs of demand is clearly of critical importance to providing cost-effective, high-quality healthcare.

The ‘old’ solutions of reducing costs by cutting back on staff and services are shortsighted at best. Other solutions taken from the manufacturing sector, such as lean or TQM, have yet to yield the scale of improvements predicted. Furthermore, healthcare has been slow to adopt the service supply chain management practices that have benefitted other industries (McKone-Sweet
et al, 2005). Research into supply chain principles applied in healthcare settings is still in its infancy; therefore, no operations-level guidelines exist for healthcare managers seeking to improve system-wide service delivery.

To address this gap, this paper explores the use of a relatively new management paradigm in healthcare. Taken from custom manufacturing and service delivery, ‘agile’ is a set of organization-wide strategies which optimize service delivery in volatile demand environments with highly variable customer requirements. First coined by researchers at the Iacocca Institute at Lehigh University, in 1991, ‘agile’ focuses on increasing system responsiveness to customers through improved resource coordination and flexibility, by redesigning organizational structures, information systems, logistics processes, and management decision heuristics.

Agile has recently been suggested as a means to improve healthcare service delivery (Vries & Huijsman, 2011), but specific practices or policies to increase 'agility' have not been developed for service chains, including healthcare. Moreover, the comparative effectiveness of individual agile practices is unknown, as are the trade-offs created by individual agile practices on cost, service access, and service quality. While theoretical agile concepts seem perfectly suited for improving the management of complex healthcare organizations faced with inherently variable demand, practical implementation remains challenging.

We seek to determine how agile principles can be operationalized in healthcare redesign efforts to address issues of patient access, service quality, and cost control. The research questions to be answered in this paper are:

- What are key agile operational plans or practices (structural changes to process or information flows or management decision-making) that can be applied or adapted to improve performance of healthcare service delivery chains?
- How do these different agile-derived practices impact cost, quality, and access to services under unpredictable, variable demand?

To this end, we uncover operational plans from agile and service supply chain literature, then using system dynamics modeling, examine the effectiveness of these operations-level changes in simulation in a generic healthcare service chain. We present our findings as guidelines healthcare managers and policy makers to improve system performance through adopting agile practices. This study opens a new area for service supply chain management research and provides recommendations for future empirical field tests.

The paper is organized as follows. Section 4 briefly details the current trends in increasing healthcare delivery complexity, difficulty with demand and supply synchronization, and resultant service quality and patient safety impacts. In section 5, an ‘agile’ literature review and summary of current knowledge gaps are presented. Sections 6 and 7 report the methodological approach
and formal mathematical conceptualization of the healthcare service chain and agile strategies, respectively. Section 8 is devoted to describing performance measurement and ‘base case’ simulation analysis. In Section 9 the experimental design is presented and results are discussed. Finally, Section 10 provides the conclusions.

3.3. Problem Description

With the growing complexity of healthcare, providers are increasingly dependent on sharing care delivery activities with other, specialized healthcare professionals to provide adequate patient care. Patients are now treated in service chains or service networks that combine interventions into serial encounters with specialized providers and link these encounters into clinical pathways. Moreover, the redesign of hospital services and the implementation of integrated care programs are frequently cited as being critical strategies to decrease resource utilization and improve healthcare quality (Aptel and Pourjalali, 2001). Clearly, from both a theoretical and practical point of view, the health service operations are in the process of changing significantly.

However, the variability and unpredictability inherent to healthcare demand and internal operations render this network approach to care delivery difficult to manage (Li et al, 2002). Individual patient cases are variable and work cannot always proceed according to schedule or plan. New developments in a patient’s condition, unexpected diagnostic findings or surprising reactions to medication may call for sudden changes in planned processes with ripple effects throughout the service supply chain. The growing interdependence of healthcare delivery, coupled with pressure to reduce costs and serve greater numbers of patients, makes these delivery chains increasingly difficult to manage and coordinate.

There is also evidence of healthcare service chain generate internal increased demand variability. Similar to the ‘bullwhip effect’ (Forrester, 1958, 1961; Lee et al, 1997) in manufacturing, research on healthcare service chains has identified structural tendencies toward demand amplification as a key cause of supply chain stress, and leads to reduced access to services (as measured by the distribution of service delivery time), and subsequent degradations in service quality and increasing employee fatigue. Even with significant external variation, internal variation is clearly introduced by system structure and dynamics. For example, a case study conducted in a 127 bed hospital in Uttar Pradesh, India revealed dynamic system behavior equivalent to the bullwhip effect (Sameul et al, 2010). The bullwhip effect was similarly identified in the a study of a UK hospital: Based on interviews with hospital staff and data from hospital's EHR system, analysis of emergency patient arrivals and discharges revealed amplification of demand variability downstream in the service chain (Wally, 2007). In this case, distortions in demand clearly led to performance degradation, as downstream services reported reduced resource availability and greater probability of exceeding desired utilization and occupancy rates. These are similar consequence to the effects seen in manufacturing
systems, where the bullwhip effect has been a suggested cause for increasing stock-outs and higher costs. A study of a large hospital in Australia also directly identifies the bullwhip effect in the patient pathway for elective surgeries (Sethuraman & Tirupati, 2005). The increasing variation in demand for services as elective patients move to downstream clinics creates the need to make more beds available in post-operative care wards than indicated by the initial demand. On peak days, when the bullwhip effect causes the number of elective surgeries to be artificially high, there is a shortage of beds in the patient wards, which restricts the number of surgeries and reducing the theater utilization and hospital throughput on subsequent days. Demand for nursing services is directly affected by higher variability, resulting in higher labor costs. Higher demand variation amplification is also associated with increased dependence on part-time or temp agency staff. Increasing demand variability inside the patient care pathway generally results in greater stress on employees, higher operating costs, and lower hospital revenues.

There is mounting evidence that the US healthcare system has difficulty matching supply of services to patient demand, coordinating transfer of patients between providers in healthcare service chains, and managing demand variability. Each of these issues adversely affects care quality and patient health outcomes. Kane et al (2007) find that the mismatch between resources and peaks in demand is the major source of provider fatigue and reduced quality of care in most healthcare services. With the management systems currently in place, this variation leads to mistakes in care delivery and increased patient safety risks. Specifically, the stresses placed upon a healthcare system by variability have been found to lead to more medication errors, hospital-acquired infections, sicker patients, and are a leading cause of adverse patient outcomes (Needleman et al, 2002; Berens, 2000; Pronovost et al, 1999).

Studies of variation in the patient to provider ratio, a key measure of service supply chain coordination, find that variability is the norm in healthcare services (De Vries et al, 1999). Higher patient to provider ratios have been correlated with increased patient mortality and failure-to-rescue (deaths following complications) rates within 30 days of admission (Aiken et al, 2002). Large, multi-state studies frequently report inverse relationships between the number of nurses per patient and common nosocomial complications, such as urinary tract infections, pneumonia, thrombosis, and pulmonary compromise (Kovner & Gergen, 1998). Ensuring that the proper supply of care resources can be synchronized to meet the peaks and troughs of demand is clearly of critical importance to providing cost-effective, high-quality healthcare.

The common management practice in healthcare is to accommodate fluctuations in demand with ‘mandatory’ overtime. Driven by the need to maintain competitive advantage and minimize costs, the common practice in healthcare is to set staff levels equal to the average demand for services as opposed to setting staff to accommodate peak demand (Litvak et al, 2005). Although such staff management strategies help to reduce labor-related costs, this staffing trend leads to the undesirable consequence of care units being increasingly understaffed during periods of peak
demand, which limits their ability to match services with patient demand. This results in the use of excessive overtime as a management solution to demand variability. Excessive overtime is a pervasive problem in healthcare; for example, in a national survey of hospital staff nurses, more than one-quarter of respondents reported working unpredictable, ‘mandatory’ overtime during the 28-day study period (Rogers et al, 2004). A more recent survey of critical care nurses reported that over 60% worked ten or more overtime shifts during the 28-day study period (Scott et al, 2006). This capacity management trend leads to higher turnover rates (some estimates of nurse turnover rates in the US are as high as 20% per year, see Hayes et al, 2012), which leads hospitals to incur excessive training costs and to lower average staff experience levels. Excessive ‘mandatory’ overtime is also one of the key drivers of increased provider fatigue and error rates, further reinforcing the argument that current healthcare management strategies need improvement, and currently contribute to patient safety risk and deterioration in quality of care.

These reported pressures and adverse feedbacks to care quality all indicate that current service supply management strategies are failing in healthcare. The healthcare sector is far behind other industries with respect to successful service supply chain management. As currently managed, the average healthcare delivery system exposes patients to unnecessary risk and provides sub-optimal use of system resources and personnel. However, with healthcare expenditures currently 18% of GDP and climbing, hospitals cannot return to past practices of setting staff levels based on peak demand; nor, with the near-exponential increase in the number of clinical trials and the medical evidence-base (NIH, 2013), can they effectively simplify care delivery. Healthcare managers need new service management strategies to be able to respond effectively to changes in patient demand and to mitigate the adverse effects of demand variability on patient care.

Other sectors are able to harness the insights developed by industrial supply chain management research, where firms have faced similar challenges of demand variability and the need for increasing supply chain integration. With minimal abstraction, it is possible to align most healthcare service performance improvement or care coordination questions with those from industrial supply chain management, mostly relating to how a high resource utilization can be matched with a high customer service level. Recent empirical studies show that a significant portion of the costs associated with service chains in the health care sector could be reduced by implementing effective supply chain management principles (Burns, 2000; Dacosta-Claro, 2002; Oliveira & Pinto, 2005). The current discourse in the service supply chain management literature supports the assumption that existing concepts, models and supply chain management practices can be extended to service chain management in health services (Vries & Huijsman, 2011). The healthcare managers should be able to benefit from the lessons learned in the industrial sector.

However, improving healthcare service delivery chains cannot be done by simply transferring product and manufacturing knowledge and models (Ellram et al, 2004; Sengupta, Heiser &
Service chain management in a healthcare setting is characterized by some unique features, which make it difficult to apply knowledge gleaned from the industrial sector to the healthcare sector in a direct way. The unpredictable, stochastic demand for services, individual patient attributes driving the need for customized services, the inability to maintain physical buffers of finished inventory, the inherent uncertainty in the duration of care processes, and other distinctive characteristics of health service operations impede a straight forward application of industrially-oriented supply chain management practices. In practice, Bohmer (2009, p. 16) finds that “many of the approaches and tools drawn from industrial settings fail to adequately account for the residual uncertainty in medical care or explicitly address the experimental nature of much care.” Most manufacturing-based supply chain management paradigms, such as 'lean,' Total Quality Management, or Six Sigma do not function effectively in systems with high levels of inherent process variability and demand uncertainty (Lee, 2004), but it is precisely these context-defining characteristics that cause most of the present difficulties in healthcare service integration and care coordination.

Service chain management in a healthcare context is very much an emerging field, and has not yet identified how to overcome these contextual difficulties, nor has the field identified a service chain management paradigm suited to the healthcare context. Subsequent questions of how service delivery integration and coordination of care systems regarding patient flows and resource management can be best achieved operationally still are a relatively unexplored area of service supply chain management, and starting from this question there are only limited academic studies addressing the challenges unique to the healthcare setting (Vries & Huijsman, 2011). Most service supply chain management research is still theoretical or conceptually-focused as opposed to operational in nature (Sampson & Froelhe, 2006), currently providing little to aid managers in the midst of redesigning their systems and integrating care processes. Healthcare managers face a significant gap in knowledge around the optimal design and management of complex care delivery systems that ensure effective patient care.

If the current trend to integrate patient care through increasingly complex provider networks continues, then matching supply and demand throughout the healthcare service chain will become increasingly difficult. As a result, both patients and providers will suffer. Hospital managers need insight from service management researchers that directly address the problems arising from the variability and complexity of demand within a hospital and coordination issues between healthcare units. They require guidance on decision structures and designs of service chains that create the flexibility necessary for the dynamic nature of health itself and which enhance the effectiveness and efficiency of care delivery in the face of complexity. Service supply chain scholars need to identify and develop a new service management paradigm that accommodates the uncertainty and variability inherent to healthcare, specifically to conduct operations-level research to improve the design and management of healthcare service chains.
3-4. Literature Review

There is one supply chain management paradigm that does address the context issues which separate most healthcare operations from those in industrial or manufacturing settings. ‘Agile’ is a manufacturing paradigm, coined by researchers at the Iacocca Institute at Lehigh University in 1991, that describes the strategies they observed as crucial to enterprise success in environments of rapid and unpredictable change (Iacocca Institute, 1991; DeVor et al., 1997). In essence, an agile manufacturing system is one that is capable of operating profitably in a competitive environment of continually and unpredictably changing customer opportunities (Goldman, et al. 1995). Similarly, Gunasekaran (1998) defined ‘agility’ in manufacturing as the capability to survive and prosper in a competitive environment of continuous and unpredictable change by reacting quickly and effectively to changing markets, driven by customer-designed products and services. An ‘agile’ organization as one that able to compete successfully within a state of dynamic and continuous change (Sarkis, 2001), through efficiently changing operating states in response to uncertain and the changing demands placed upon it (Narasimhan et al. 2006).

‘Agile’ is more than a description of an ideal supply chain. Many manufacturing companies have experienced high costs associated with holding excess inventories as consumer preferences change, or incurring stock-outs and decreased to market share in times of unanticipated demand, and have followed agile principles to re-designed their supply chains to better accommodate such demand volatility, resulting in increased revenues and market share (see Lee, 2004 for discussion). There are academic journals dedicated to the advancement of theory and practice of agility in manufacturing systems (e.g., International Journal of Agile Management Systems). Harvard Business School has published case studies highlighting the principles of agile manufacturing (1991). Since its inception, the agile paradigm has had a profound impact on the design and management of manufacturing systems facing the same problems that healthcare currently faces: the need to integrate and coordinate disparate units in a delivery chain, all in the face of unpredictable, volatile demand.

In an operational sense, agile is a set of strategies that solves the problem of demand uncertainty and variability through increasing system flexibility (Lee, 2004). It encompasses re-design of organizational structures, information systems, logistics processes, and management decision heuristics, all to achieve timely and effective response to rapidly changing demand environments (Christopher & Towill, 2002). Agility involves increasing the capability to quickly identify shifts in market demands or external supply disruptions and execute new, unplanned activities in response (Brown & Bessant, 2003; Prince & Kay, 2003; Sharifi & Zhang, 2001).

There are four commonly agreed upon distinguishing operational characteristics of agile supply chains (Harrison et al., 1999; Christopher, 2000), as outlined in Figure 31. They are highly market sensitive; capacity adjustment decisions are driven by demand information; planning is
centralized, not left up to individual units; and processes and performance management are integrated across all units in the chain. Each is discussed in detail below.

First, market sensitivity means that the supply chain is capable of reading and responding to real demand in real time. This is a direct contrast to most organizations, where long production times and logistical delays tend to require they be forecast-driven rather than demand-driven. A key operational requirement of agile supply chains is to be able to quickly change production resources to respond to real-time demand data. Agile supply chains often make use of information technology systems to capture and share data on demand quickly throughout the entire supply chain (Harrison et al., 1999).

Christopher (2000) suggests that, to be truly ‘agile,’ the use of information technology to share data between partners in the supply chain must be taken farther, in effect, creating a virtual supply chain, defined as a supply chain that is information based rather than inventory based. This does not imply simply reducing physical inventory; instead of coordinating flows of physical goods, agile organizations must acquire the capability to coordinate production capacity (Lee, 2004). Shifting to information based supply chain coordination means that all elements in the chain act upon the same data, i.e. real demand, rather than being dependent upon the distorted information that emerges when orders are transmitted from one step to another in an extended chain (Argawal et al, 2007). Without being subsumed under the agile paradigm, research into the phenomenon of demand variation amplification (the ‘bullwhip effect’) has shown that this
operational strategy improves supply chain performance, in terms of reducing risk of stock-outs, reduced ‘phantom’ demand, and decreased average costs (Croson & Donohue, 2003; Chen et al., 2000).

This shared information between supply chain partners can only be fully leveraged through the third key characteristic of agile supply chains: centralized planning, meaning the collaborative design and implementation of cooperative management structures. Operationally, centralized planning requires disparate units in the production chain to make management decisions and set performance goals to maximize performance of the total chain, not the performance of each individual production unit. Each unit must take the adjacent units into consideration when making production decisions. Central planning creates a shared systems perspective and ensures the appropriate incentives structure is in place to lead to maximizing overall performance (Cannella & Ciancimino, 2010; Cachon & Fisher, 2000). Operationalizing this aspect of agility has been shown to improve visibility of production requirements and reduce the amount of stock (or production capacity) held in anticipation of predicted and often distorted demand (Hewitt, 1999).

This idea of the supply chain as a confederation of partners linked together through a network of continuous collaboration leads to the fourth ingredient of agility. More than cooperation on strategic planning and goal-setting, process integration implies cooperation between production units on production activities themselves. There is a broad assortment of operational plans supporting the concept of process integration in the literature. Examples range from the co-design of new products, so design accommodates both end-user preferences and factory and production constraints; to the most extreme manifestation of direct sharing of production and management resources between production units (Lee, 2004).

Some of these individual operational plans have been tested through the simulation of generic service chains, even if not directly subsumed under the paradigm of ‘agile.’ Most of these simulation studies inadvertently target market sensitivity. Anderson et al (2005) explore the effects of increased market sensitivity through changing in service capacity adjustment decision-making times, finding that decreasing decision delays leads to improvement in overall supply chain performance. Lee et al (2010) examine the effect of supplementing demand data with information on the derivative of changes in demand. Their results are mixed, finding that with optimal control schemes it was possible to halve the costs associated with demand variation amplification, but that including derivative-based information could also lead to increasing oscillations in some scenarios.

The other operational strategy tested in simulation is virtual integration, with Anderson and Morrice (2000) assessing the effect of sharing end-customer demand data in real time in a simplified service chain. As is commonly reported in manufacturing settings, they found that
incorporating end-customer demand data with local demand data in individual service unit decision making led to increased performance, both in terms of total reduced costs and improved service delivery times. Although not directly discussed, their work also reveals the necessity of centralized planning in service chains. The parameter set that created their lowest-cost, highest-performance scenario would have been unsustainable without centralized planning, as costs were not shared equally across service units. If individual units made decisions only to maximize their own performance, the service chain would never be able to implement this optimal scenario. Cooperating to redistribute the costs and benefits of service delivery redesign seems crucial to the ability to achieve optimal performance.

There is also some anecdotal empirical evidence supporting the use of agile strategies in healthcare service delivery chains. Service chain integration is becoming more prevalent in healthcare, as team-based care models (e.g., the Patient Centered Medical Home, or PCMH) are becoming standardized. As of 2007, an estimated 27% of primary care practices follow some elements of the PCMH model, where disparate elements of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services) are coordinated through a patient’s primary care provider (Beal et al, 2007). There are a few reports suggesting that these changes lead to better care quality, reduced errors, and increased patient satisfaction (Rosenthal, 2008), with one recent study of a Seattle health system demonstrating 29% fewer emergency visits, 6% fewer hospitalizations, and total savings of $10.30 per patient per month over a twenty-one month period (Reid et al. 2010). Health services are also moving toward virtual integration as well, with the recent mandate to create health information exchange, which will provide the capability to electronically move clinical information among disparate healthcare information systems (HITECH, 2009). All this suggest that agile strategies have promise in the healthcare context and should be further explored.

The question how to best integrate agile strategies into healthcare is an uncovered field in the area of supply chain management, and has only most recently been suggested. The November 2011 special issue on healthcare of the international journal Supply Chain Management highlights the need for in-depth research into the strengths and weaknesses of the agile management paradigm in the context of health services. There are clear gaps in knowledge of the application of agile strategies, namely: What are the clearest translations of agile strategies into operational plans applicable and feasible in healthcare service delivery? How do they compare to each other in effectiveness, as defined as the ability to increase total service chain flexibility and mitigate the adverse effects of demand volatility? Do agile strategies need to be implemented as a bundle to be effective, or are they effective at creating service chain flexibility when implemented separately? Answering these questions to further the adaptation and use of agile strategies to healthcare could contribute significantly to the broader field of patient logistics and the improvement of healthcare service management.
3-5. Methodology/Approach

The literature on supply chain analysis is rich with classifications of methods used to investigate supply chain performance and the effects of demand variation (Riddalls et al, 2000; Kleijnen & Smits, 2003; Dejonckheere et al, 2004; Disney et al, 2004; Geary et al, 2006; Towill et al, 2007; Disney & Lambrecht, 2008). Riddalls et al. (2000) submit that the choice of which methodology is most appropriate is determined by decision-making level under consideration, commonly divided into 1) the local, tactical level for day-to-day decision making, and 2) the implication of strategic design on supply chain performance and overall network functioning. Holweg and Disney (2005) recommend the latter category be analyzed using methods based on the dynamics of the system in question. They recognized three distinct and methodologically independent research domains: continuous time differential equation models, discrete time difference equation models, discrete event simulation systems.

The choice of methodological approach adopted in this paper is based on the need to explore the dynamic interaction effects of various operational plans, and to develop a general understanding of their inherent dynamics when applied in a healthcare service chain. We adopt a continuous time approach, namely system dynamics simulation modeling. The service chain and governing decision heuristics are modeled through first-order nonlinear differential equations. The formal mathematical expressions of the system are reported in the next section. We have not used discrete-event simulation (DES) or stochastic modeling (of variables like ‘patient inflow’ or ‘treatment time’) because our primary objective is not to quantify numerical results for one specific healthcare delivery chain, but to understand and illustrate to healthcare managers the deterministic behaviors of healthcare delivery systems in general. The use of continuous, as opposed to discrete, flows in the model is a reasonable approximation of the perpetual adjustments (hiring and firing) necessary in the management of service organizations, and is a common method for abstracting these systems in both operations management and supply chain management research (Sethi & Thompson, 2000). For an in-depth discussion of the trade-offs and appropriate problems for using system dynamics or DES see Tako and Robinson (2009) and Kleijnen (2005).

System dynamics is an appropriate chose for modeling healthcare systems, as it encourages both a systemic view of the interactions of patient flows and information, and a strategic perspective on the management of healthcare delivery systems. System dynamics modeling has been used to address several healthcare related problems and has resulted in about 1500 publications since 1991 (Brailsford 2008). Dangerfield (1999) reviews system dynamics modeling in healthcare and concludes that the method can be used effectively in quantitative ways when based on simulation models. Examples of modeling efforts range from the use system dynamics simulation to analyze the reasons for the failure of management interventions in cardiac catheterization services (Taylor & Dangerfield, 2005), to the improvement of acute patient flows in the UK National Health Service (Lane & Husemann, 2008). With the trend toward care
The use of system dynamics to understand the dynamics of healthcare service delivery builds on a rich history of developing insights into supply chain management. Forrester (1961), the creator of system dynamics, laid the foundations for the use of the continuous time approach towards the study of supply chain dynamics. Later, the work on ‘beer game’ simulation (Sterman, 1989) ushered a new era in supply chain management research into understanding how micro-level decision structures, bounded rationality, and misperceptions of system feedback cause macro-level behavior (Cannella & Ciancimino, 2010). Subsequent system dynamics-based research in service supply chains has led to knowledge of how the defining phenomena of services, for example, the intangibility of services and the simultaneous interaction of customer and service provider, affect system behavior.

This paper builds on a thread started by Oliva and Sterman’s (2001) simulation study of a single-stage service process, as well as Anderson’s (2001a, 2001b) analytical models of similar issues. It relates to research on managing service chain dynamics (such as the ‘bullwhip’ effect), information sharing, and coordination of management decision making (e.g., Lee et al, 1997; Chen, 1998, 1999). Anderson and Morrice (1999, 2000) first consider a multi-stage service system in their model of the mortgage service industry, and start the exploration of the impact of resource acquisition delays on demand variation amplification. In their case study of a European telecom firm, Akkermans and Vos (2003) use a similar model to develop insight into the interdependence between workload, work quality and variation amplification. However, their model is highly context specific and the analysis space is limited by the narrow set of policy options available to the firm’s management. Perhaps the most closely related research exists in the linear programming work Anderson et al. (2005, 2006), which uses a relaxation of a system dynamics model to evaluate the structural causes of, and counter-measures to, demand amplification in a generic service chain. Such uses of system dynamics have been cited as "clear exceptions" to what is normally described as the "forced and unclear" application of supply chain management modeling methods to services (Sampson & Froehle, 2006, p.337).

3-6. Model Design
The healthcare service chain we model here is an abstract representation of a broad spectrum of possible healthcare delivery networks. The purpose of the model is to capture the essential elements of reality common to most healthcare delivery chains rather than perfectly simulate one specific service. Our delivery chain consists of three stages, the three most clearly defined stages
in any patient care event: diagnosis, treatment and recovery, as indicated in Figure 32 (Aronsson et al, 2011). While all steps can be performed by one or several organizations depending on the patient, we represent each stage with a finite workforce capacity handling the different tasks inside a stage, which can represent the organizational separation and specialization among hospitals, or between departments inside a single hospital. The health care service system is modeled in continuous time, and is simulated with Vensim® software. This model is concurrent with previous system dynamics service supply chain models, visualized in Figure 33.

Figure 32. The functional steps in a healthcare process (adapted from Aronsson et al, 2011).

To illustrate how patients flow through this chain, take the example of the care of patients with acute myocardial infarctions (sudden heart attacks). It is a care process that involves several departments inside the hospital and often requires addition rehabilitation services after treatment. There are also clear quality implications of care lead-time, as mortality rates are highly correlated with diagnosis and treatment delays (Gulli et al, 2010). These patients often arrive unscheduled, by ambulance to an emergency department. A diagnosis is made which normally includes lab-tests and X-rays. After diagnosis, the patient is transferred to the cardiac catheterization lab for coronary angioplasty (PCI) or bypass surgery (CABG). After the operation, the patient recovers in a cardiac care unit. When leaving the hospital there are often extended needs for recovery involving physical therapy and social services, which has to be planned and coordinated with family, physical therapists, and possibly personal care attendants.

3-6.1 Traditional service supply chain structure
These archetypical functional steps, as outlined by Aronsson (et al, 2011), map directly to our model structure: where boxes represent patient service backlogs, hourglasses represent patient care events (interaction between patient and provider or other staff and resources), and arrows represent the direction of patient flow.
While clinics in our service chain are obviously linked, as the output of one clinic forms the input to the next, each clinic in our model operates autonomously, as management decisions are based only on the information available inside each clinic. Each clinic has sole responsibility for operational performance and control of its own resource actions, i.e., acquiring and releasing workforce. Each clinic requires a separate set of resources to serve its patient backlog; no resources are shared between clinics. Resource sharing may be possible in some healthcare service chains, depending on the specifics of a particular care process, but the high level of specialization and the complexity of healthcare ensure that resource sharing is not the norm. For simplicity, we assume that there are no dropped or lost patients and all of the patient care events in a backlog are eventually concluded.

Each of the three clinics is identical, with a finite capacity for patient care, derived from the number of providers working in that clinic. Each clinic’s implicit goal is to keep service performance at a desired level (measured in average service time), while keeping service capacity costs to a minimum. While this structure is far from optimal, it is a realistic representation of the common ‘staff to demand’ heuristic found currently in most hospitals and health care centers (Litvak et al, 2005).

A more specific stock and flow model of one representative clinic is presented in Figure 25, graphically displaying the three control loops fundamental to clinic management: one to prevent number of customers waiting for service from going negative (the Work Availability loop), one representing manager's decisions to add or remove providers from the clinic schedule to balance workforce with demand (the Capacity Management loop), in which is embedded the manager's decisions comparing current workforce with desired workforce to achieve desired service capacity (the Meeting Workforce Goal loop). The formal mathematical details are described below, and the full set of model equations and parameters is included in Appendix E.
Figure 34. System dynamics model of a single representative care delivery unit; the main capacity adjustment loop is highlighted.

There are two streams of activities in the model. The first one is the uncertain flow patients coming into a clinic as shown in the top portion of Figure 25. The patient backlog accumulates based on the difference between inflow of demand arrival, \( R_{ia} \), and completion rate, \( R_{ic} \). Note that the patient backlog (\( B_i \)) is actually the healthcare work-in-progress, which is number of patients being diagnosed, treated, or recovering, and has a different meaning than the traditional backlog in an industrial supply chain. The completion of each stage in patient care requires a certain number of resources (personnel, equipment, rooms, etc.) for a certain duration. In this model, we assume that all patients eventually complete each clinic’s care process, though some patients can be delayed as accumulated demand backlog due to capacity shortages, as shown in the expression of, \( R_{ic} \), in Equation 1.

\[
B(t) = \int_0^t [R_{a}(t) - R_{c}(t)] dt + B_0
\]

where  
\( B(t) \) = patient backlog at \( t \), measured in units of patients  
\( R_{a}(t) \) = arrival rate of patients at \( t \), measured in units of patients/day  
\( R_{c}(t) \) = completion rate of patients at \( t = \min[C_i(t), B_i(t)/T_{in}] \), measured in units of patients/day  
\( C_i(t) \) = resource capacity available at \( t \), measured in units of patients/day  
\( T_{in} \) = minimum patient care time, measured in units of days
\[ B_{i0} = \text{initial backlog (patients in-progress) at } t = 0, \text{ measured in units of patients} \]

Note that patient backlog (\(B_i(t)\) and \(B_{i0}\)) is expressed in number of patients. Completion rate and resource capacity (\(R_{ia}, R_{ie}\) and \(C_i\)) are expressed in the number of patients per day, and completion time (\(T_{im}\)) is expressed in days. There is a minimum completion time even if unlimited resources are available. With the minimum care completion time, adding more resources past a certain level will not reduce the backlog, merely the resource utilization.

The second flow in the model is the flow of workforce as shown in the bottom part of the model in Figure 34. The resource capacity available, \(C_i(t)\), accumulates based on the net capacity discrepancy, \(e_i(t)\), which is defined as the resource capacity needed to care for all patients in the desired time, \(C_{id}(t)\), minus the resource capacity currently available, \(C_{i(t-1)}\), as shown in Equation 2.

\[
C(t) = \int_0^T \left[ \frac{e(t)}{T_c} \right] dt + C_0
\]

where \(C_i(t) = \text{resource capacity available at } t, \text{ measured in units of patients/day}\)

\(e_i(t) = \text{the net capacity error } = C_{di}(t) - C_i(t-1), \text{ measured in units of patients/day}\)

\(C_{id}(t) = \text{resource capacity desired } = \left[ \frac{B_i(t)}{T_{is}} \right], \text{ measured in units of patients/day}\)

\(C_i(t-1) = \text{resource capacity at previous time step, measured in units of patients/day}\)

\(T_{is} = \text{target patient care service time, measured in units of days}\)

\(T_{ic} = \text{delay for resource capacity change process, measured in units of days}\)

\(C_{i0} = \text{initial capacity (providers) at } t = 0, \text{ measured in units of patients/day}\)

In the traditional service supply chain, any single clinic only receives information about patient flow from the adjacent upstream clinic. Each clinic calculates the resource adjustment in any given period, \(C_{id}(t)\), on the basis of local data and parameters (service capacity level \(C_i(t)\), delays in the resource adjustment process, \(T_{ic}\)) and on the desired service capacity. This desired service capacity is, in turn, modeled as a rate of patients per day, calculated from the current patient backlog and the desired care delivery time. The overall capacity adjustment decision is moderated (divided) by the delays inherent to the resource capacity adjustment process, \(T_{ic}\), which represent delays in decision making and the schedule modification process itself. The denominator of \(T_{ic}\) captures the first-order effect of capacity adjustment, and approximates reality for all but extreme target capacity changes. Implicit in these equations is the assumption that one unit of capacity is required to process one unit of patient backlog each day. This assumption can be relaxed by scaling the capacity appropriately. Note that net resource adjustment rate, is expressed in the number of patients per day per day, while the units of resource capacities, \((C_{id}, C_{i(t-1)}, C_{i0})\) are expressed in units of number of patients per day.
This capacity adjustment policy is derived both from the literature and from interviews conducted with healthcare department chiefs and clinic managers. Anderson (1997) finds an identical stock correction mechanism in custom machine tool industry, Anderson and Morrice (2000, 2001) in a mortgage services company, Akkerman and Vos (2003) in a telecom company, and Anderson et al (2005) in the service supply chains of an oil field development firm. While not an optimal decision heuristic by any means, it is the rule most often used in practice in service supply chain management. Note that the rule in Equation 2 is simpler than the standard stock-adjustment rule found in manufacturing supply chain modeling (Sterman, 2000); we believe this is justified because there is no significant supply line of capacity on order in this system.

Health care service delivery chains are complex and require a great deal of coordination. Based on its use in similarly complex fields, we believe this base structure is both abstract enough to be generalizable across services, and structurally sound enough to yield insights into the dynamics of healthcare service delivery management. We use it as a base upon which to test the adoption of multiple agile-derived operational plans, each explained in detail below.

3-6.2 Agile operational plans
We identify specific operational plans from the literature on service supply chain management which can be subsumed under the agile paradigm. This assembled set of plans covers all four of the key characteristic of an agile supply chain: market sensitivity, information driven, centralized planning, and process integration. Each is described in detail below; including the structural changes to information flows and management’s decision heuristics, along with its mathematical formulation.

3-6.2.1 Market Sensitivity
Despite its importance in manufacturing supply chain management research, increasing market sensitivity is not directly discussed as such in the service supply chain literature. As a conceptual framework of ‘agility’ has not yet been universally adopted (Li et al, 2008), there are many meanings of the term market sensitivity depending on context and level of detail under investigation. It could refer to the ability of a manufacturing chain to elicit and respond to patient preferences in new product development (product characteristics), or the ability to perceive, evaluate, and respond to changes in total demand with accurate adjustments to production and inventory quotas (availability), or to identify the relative value of a product in the market and adjust price accordingly (price). In general, market sensitivity is the ability to make swift and appropriate decisions in reaction to changes in demand, in any of its dimensions.
For healthcare delivery, where patients have limited knowledge of the price and relative quality of any given service or provider, the most significant dimension of demand, from a clinic manager’s perspective, is total volume. We narrow our focus through defining market sensitivity as the ability of a service chain to respond quickly to changes in demand for a given service with accurate changes in service capacity in order to maintain an adequate level of service availability. Including the price and service characteristics of patient demand are possible extensions for future work, but are more apposite to the analysis of national healthcare policy than improving healthcare delivery. With this definition, we find two operational plans in the literature that address increasing market sensitivity. Both were first developed in manufacturing and only recently tested (separately) in simulation in service supply chains.

The first focuses on the impact of increasing the speed of capacity adjustment decision making, modeled as a reduction in the service capacity adjustment time, \( T_c \). Analysis of mortgage service simulations (Anderson & Morrice, 2000) suggest that decreasing service capacity adjustment delays is one operational plan available to managers of individual clinics to improve the responsiveness of their clinic to changes in patient arrival rates. In subsequent research, however, they find reducing the equivalent of had mixed effectiveness, improving service delivery (as measured by the variance in average service time), but increasing variance in subsequent stages’ capacity stocks and backlogs (Anderson et al, 2005). A reduction in \( T_c \) could be achieved through many operations-level changes, from increasing the frequency of information gathering and analysis on the current patient backlog level, to streamlining the HR process for hiring and firing, to improving the quality of training to reduce the training time for new hires, to improving coordination between managers and employees over clinic schedule changes. All would reduce \( T_c \), and make the clinic more sensitive to changes in demand volume.

The second focuses on improving the information used to make the capacity adjustment decision. This operational plan captures emerging trends in demand volume, through including a measure of the change in the patient backlog along with the actual size of the backlog itself. This ‘derivative control’ is common to physical manufacturing systems (temperature control, velocity control, etc.), and is part of a standard engineering control algorithm called PID (Proportional, Integral, Derivative Control), which is mainly used as a means to minimize the error between a measured value and a target value, given the presence of adjustment delays (Axsater, 1985). Our current decision equation falls under the domain of proportional control, where the rate of capacity adjustment is a proportion of the error between the desired and the actual service capacity. Fundamentally, a PID control algorithm improves basic proportional control in two ways. Integral control creates a system memory of the accumulated error over any period of time when error is being corrected, and adds that error to the correction itself, thus preventing ‘steady-state error.’ Derivative control increases the correction in response to rising error, thus returning the system to its desired state faster that if the system responded proportion to the error
alone. The derivative of the error is a faster signal to clinic managers than the error itself, as the derivative peaks when signal from proportional gap is only at its inflection point.

In simulation, supplementing standard proportional control-base heuristics with integral and derivative control has been found to significantly improve the control of supply chains faced with volatile demand, allowing a reduction in inventory safety stock by over 80% without sacrificing product availability (White, 1999). For discussion of the application of PID in manufacturing settings, see White (1999) and Saeed (2009, 2008). A similar approach was recommended for improving decision-making in strategic management by Warren (2007). The study of the addition of integral and derivative control in service chains is an emerging area of service supply chain research, and has only been explored in simulation. Results from Lee (et al, 2010) indicate that using derivative control to supplement a manager’s decision heuristics leads to performance improvement. However, the inclusion of integral control is proposed to not be useful in managing service chains, as the common decision heuristic used produces no steady-state error.

Including derivative control in our clinics’ capacity adjustment decision requires changes to model equations. The new equation for net capacity error is shown below.

\[ e^*(t) = \left( K_p e(t) + K_a T_d \frac{d[e(t)]}{dt} \right) \]

where \( e^*(t) \) = is the error calculated with derivative control
\( e(t) \) = the net service capacity error
\( K_p \) = gain (sensitivity) constant of the traditional control; normally \( K_p = 1 \)
\( K_d \) = gain (sensitivity) constant of derivative control
\( T_d \) = derivative time constant

Setting the \( K_d \) parameter to zero eliminates derivative control. Changing the parameters for \( K_p \) and \( K_d \) influences the gain of the traditional and derivative controls, respectively. Adjusting these parameters can be used to optimize the decision equation for a given set of costs.

**3-6.2.2 Information Driven**

The importance of demand information in optimizing supply chain management is well known. End-to-end sharing of real-time demand data is one of the common solutions in the supply chain management literature for minimizing the demand amplification (bullwhip) effect inherent to supply chains (Disney & Towill, 2002; Chatfield et al, 2004; Dejonkheere et al, 2004; Shang et al, 2004; Byrne & Heavey, 2006; Kim et al, 2006; Hosoda et al, 2008; Kelepouris et al, 2008; Argawal et al, 2009). Unlike a traditional supply chain, in an ‘information driven’ system, the
information flow consists of both the transmission of stages’ orders in the up-stream direction and sharing information on market demand. Each stage remains autonomous and makes decisions on production and distribution independently, but all stages make those decisions on the basis of shared, global information. This prevents extreme internal demand variation amplification, as each stage now has some understanding of real demand, not just local demand from the downstream stage.

Expanding the data available to supply chain managers at each stage almost always leads to lower costs and fewer stock-outs. The effects of sharing end-customer demand data in industrial supply chains has been tested many times in simulation, under many constraining assumptions, with all findings indicating that sharing end-customer demand data improves performance. There are fewer results from analysis of real world data, but they also re-enforce this finding. For example, Hosoda (et al, 2008) find that sharing ‘point-of-sale’ data in real-time between a supermarket chain and a soft-drink manufacture reduced the holding and backlog costs incurred by the manufacturer by 8-19%. In a similar study conducted in a Greek retail grocery company, consisting of 250 retail stores and 7 central warehouses, Kelepouris (et al, 2008) find that information sharing results in a 21% reduction in order variability and a 20% reduction in average inventory. These, and other studies, confirm the value of shared information on end-customer demand for mitigating the bullwhip effect and associated costs in physical supply chains.

The usefulness of sharing end-customer demand data has not been empirically examined in service supply chains, but has been explored in simulation. Anderson and Morrice (2000, 2001) test the effect of sharing information on real demand with each stage in their mortgage services chain, finding that adding this information to each stage’s decision heuristic does improve performance. However, the use of end-customer demand data can create a trade-off between the level of variation in patient backlog and in service capacity. Anderson (et al, 2005) assert that the stages in a service chain can always decrease their backlog variation by paying more attention to end-customer demand rather than local backlog, but only up to a certain point, beyond which capacity variation will start to increase. Thus, information sharing can only lead to limited improvements before creating a direct trade-off between customer service (variation in patient wait times) and personnel costs (variation in capacity). The precise tipping points are determined by the parameters of a process (for discussion, see Anderson et al, 2006). The common strategy advocated for service supply chain scholars is to use a mix of both, rather than completely relying on one or the other. Determining the optimal weights for both types of data in management decision depends on the cost structure in a given service chain.

We change the ‘capacity management’ loop to include data on initial patient demand, supplementing local patient backlog data. The first term represents the degree to which the target capacity relies on the end-customer demand rate. The second term denotes how the target
capacity depends on the magnitude of the local backlog, $B_i(t)$ and the target service care time. The first term represents the service capacity needed to meet end customer demand at time $t$ and the second term represents the capacity required to guarantee that, on average, the orders not yet met in the local backlog will not be delayed longer than an acceptable amount of time (i.e., the service delay). The weighted sum of these two terms determines target capacity.

$$C_d(t) = \text{resource capacity desired} = \left[ R_a(t)\alpha + \frac{(B_i(t)(1-\alpha))}{T_s} \right]$$

Where $R_d(t) = \text{arrival rate of patients in the first clinic in the service chain at time } t$

$B_i(t) = \text{local patient backlog}$

$T_s = \text{target patient care service time}$

$\alpha = \text{the relative weight of end-customer demand in the desired capacity calculation. We assume that } 0 \leq \alpha \leq 1.$

This modification to management’s decision heuristic can be supplemented with previous agile operational plans for increasing market sensitivity, both decreasing capacity adjustment time and including derivative control.

### 3-6.2.3 Coordinated planning

The literature on service supply chain management commonly defines 'centralized planning' as a system where decisions are made to maximize efficiency and performance of the total chain, as opposed to decisions being made locally to maximize the performance of individual stages (Anderson et al, 2006). In formal mathematical terms, the control policies for adjusting capacities in all stages are determined simultaneously by optimizing a single objective function for the supply chain. In most services, the optimal level of coordination between stages in a service chain is not obvious, nor are the appropriate methods to create that coordination, i.e., by supply contact or direct ownership (Holweg, et al, 2005). Confounding factors, like tighter integration leading to organizational diseconomies of scale (Zenger, 1994) or the loss of market share due to shifting brand differentiation strategies, may outweigh any gains in operational improvements from increased coordination. Separate from studies of information sharing, limited empirical research in the service supply chain management literature on the impact of transitioning to centralized planning has been reported. Many studies in manufacturing collaboration and centralization report high degrees of difficulty of integrating external collaboration with internal production and inventory control (Cachon & Lariviere, 2001; Stank et al, 2001). Anderson (et al, 2006) provide anecdotal evidence from the oil-field development industry, where firms with centralized planning are found to be no more competitive or successful than firms with individually managed stages.

Simulation studies of service supply chain centralization are also few, and contain inconclusive results.
While highly abstract, special case, linear models have been developed which show centralization leading to improved performance (Anderson et al, 2006), the common strategies for moving toward centralized service chains have been shown to have adverse effects on performance. Anderson (et al, 2005) assert that the default centralization strategy for service chains is to move stages toward uniform decision making (in terms of the type of information used, management's decision rules themselves, and target performance measures, such as service delivery times). Changing these decisions is the least complex way to implement ‘global’ supply chain policies, particularly if the stages are inside the same firm. However, moving away from idiosyncratic decision strategies to more uniform decision making inadvertently results in worse performance than if decision strategies had not been aligned (Anderson et al, 2005). Their simulation research suggests that adopting a single management decision heuristic (modeled as identical capacity adjustment times and target service delivery times for all stages) across the entire service chain is actually leads to significant increases in variation in both demand for services and capacity adjustment. Centralization is a difficult strategy to implement effectively in service supply chains, as seemingly benign actions can generate unforeseen adverse consequences.

Other examples illustrate how optimizing delivery in a service supply chain through centralization is not simple or intuitive. Under the simplifying assumptions of a linear relaxation of a dynamic optimization model, Anderson (et al, 2006) find that while transitioning to centralized decision making usually leads to increased operational efficiencies for the total chain when compared to local decision making, improvements are not shared equally between supply chain stages. Centralized planning usually decreases backlog and capacity variation overall, but when measured in isolation, the first stage is almost always worse off than before. The use of a single optimization equation to govern both stages almost always results in improvements in the performance of the second stage, but at the cost of decreased performance of the first stage. Depending on the cost and pricing schemes of the services offered in each stage, centralized decision making could lead to increased costs Anderson (et al, 2006). For example, they conclude that if the first stage has a sufficiently higher cost structure (both of holding excess backlog and/or cost of changing capacity) than the second stage, centralized control of capacity adjustment is of no direct benefit. They conclude that centralized planning may improve total chain performance in some situations and under some limiting assumptions, but it is difficult to achieve in practice, with a high possibility of being counter-productive.

Based on these works, we believe the most promising manifestation of the agile concept of centralized planning is the creation of an ‘unbalanced’ service chain, where each stage follows a different management decision heuristic (modeled as differing capacity adjustment times and target service delivery times). While varying service targets and capacity adjustment processes is by no mean an optimization, exploration of such policies could lead to simple, straightforward guidance for healthcare service chain managers. To test this strategy, we run three sets of
simulations, where we vary 1) target service times, or $T_s$; 2) capacity adjustment delays, or $T_c$; and 3) both simultaneously. Operationally, these would be time and resource intensive policies to implement: changing target service times in an individual clinic directly affects service quality and resource requirements; changing capacity adjustment times might involve negotiation with national accreditation bodies, state review boards, internal HR committees, union representation, etc. In order to keep these changes somewhat inside the realm of possibility and comparable to our other policy experiments, we keep the total capacity adjustment and service delivery times constant for all simulations. Thus, while any one clinic may alter their parameters, the sum of these parameters across the service chain will remain constant. It is also important to note that the parameter adjustments we use to manifest these operational changes to decision making can easily accompany the other agile operational plans identified in previous sections.

3-6.2.4 Process Integration & Performance Management

Supply chain integration has been described as the ‘holy grail’ of supply chain improvement (Holweg et al, 2005). It is widely accepted that creating a totally seamless, synchronized supply chain will lead to increased responsiveness and lower inventory costs. Jointly creating the common practices for “information sharing, replenishment, and supply synchronization … is essential to avoid the costly bullwhip effect that is still prevalent in so many sectors” (Holweg et al, 2005, p.180). However, in the light of the complexity of today’s global supply chains, most firms find it is hard to reap the full benefits from their efforts of integrating with their supply chain partners. Only a few individual success stories have been reported in the industry sector; mainstream implementation within these industries has been much less prominent than expected. In practice, the issue of how to benefit from process integration and how to use performance management to improve capacity utilization and inventory turnover is still not well understood, nor even well defined (Lapide, 2001).

There are many reasons complete integration remains elusive to most firms. The right approach for any firm depends on the supply chain context, in terms of geographical dispersion of retailers and supplier plants, complexity of distribution networks, and constraints on production modifications, as well as in terms of product characteristics and demand patterns (Holweg et al, 2005). Also, there are many different possible strategies to pursue to integrate a supply chain, and most steps toward complete integration, from information sharing to adopting uniform decision rules and service targets, are costly to implement, provide unequal benefit to each stage, and have high potential for generating adverse effects. While the promises of improved performance generated by each strategy are real, actually achieving successful implementation is rare, and achieving those improvements is rarer still.

Most of the supply chain improvement strategies found in the literature and discussed in this paper could not occur without integration of some kind. If the decision to adopt any of these strategies was driven solely by the benefits that would accrue naturally to each stage, then none
of them would ever be adopted. For example, out of many possible scenarios, the lowest cost strategy identified in a simulation of the mortgage service industry (Anderson & Morrice, 2000), is where each stage only uses end-customer demand to make capacity adjustment decision. While by far the most efficient supply chain structure overall, the first stage bears all the burden of demand volatility, while all the benefits of information sharing go only to the downstream stages. Such a ‘raw deal’ would never arise without the integration of these stages through the creation of additional structures to redistribute the overall benefits of information sharing more equally between supply chain partners. More recent studies suggest this is the norm, that sharing information will only improve performance of downstream stages, never the first stage (Anderson et al, 2006). The same dynamic occurs with strategies to promote efficiency through centralized planning, where no matter what the cost schemes, fundamentally, the benefits of centralized planning do not accrue evenly across all stages in a service chain.

Obviously, it is difficult to encourage each stage to participate in these different improvement strategies when local incentives differ so dramatically. This shows how crucial integration is to achieving efficient supply chain operations. The successful implementation of any of the other improvement strategies discussed requires finding and implementing an incentive scheme to compensate each stage appropriately. Supply chain simulation is an important tool in the design of such integrative incentive structures.

To explore the impact and importance of the agile strategy of supply chain integration, we focus on the need for altering performance measures to promote and sustain these policies and, with a generic cost structure, how efficiency gains must be redistributed to ensure that these policies are actually beneficial to each stage, not just overall. We determine the change in performance caused by each strategy for each stage, and use these findings to describe the necessary redistribution scheme so all stages would be willing to participate. The integration of incentive structures and performance management is key to achieving operational efficiency.

3-7. Simulation Analysis
In this section, we discuss our selection of performance measures and how they compare to general performance measures previously developed for the evaluation of service chains. Next, we present base case simulations that, consistent with the literature, establish demand variation amplification as an inherent system behavior.

3-7.1 Performance measures
The most common measures of supply chain simulations are of backlog and capacity variation (for discussion, see Anderson et al, 2006). These most clearly reveal the extent of inherent demand variation amplification, the ‘bullwhip effect,’ in a supply chain, and quantify the effects of mitigation strategies. It is possible to associate costs with each, but these can be very different
depending on specifics of supply chain and stage in question. Not all variation creates cost equally. In a healthcare service chain, costs between service chains and between individual clinics vary considerably. For example, an increase in the post-surgery patient backlog would cost a hospital thousands of dollars per day, as patients took up more hospital beds and attendant care; whereas an increase in the backlog of patients in the ED waiting room would cost almost nothing. Obviously, the impact to patient is also very different. In the first case, there is probably a null effect, with increased risk of nosocomial complications countered by increased attention; while an increased backlog in the second case clearly has a detrimental effect on patient health. The same is true for service capacity variation: hiring and training a personal care attendant incurs very different costs than hiring and training a pediatric neurosurgeon. Reducing service capacity also incurs some costs, quantitatively with possible severance pay and qualitatively through reduced morale with remaining staff. However, to keep our simulation results generalizable, we do not associate a cost measure with variation, only reporting averages and standard deviations of both backlog and service capacity. It should be noted that adding cost equations to each stage in the model is easily done, if context specific cost data are available.

We also use service time as a measure of performance, which is a common measure of both general service quality and healthcare quality (Parsuraman et al, 1988). Instantaneous average service delivery times for each clinic are calculated based on Little’s Law, as the quotient of the current backlog of patients by the rate at which the clinic completes its service, and summed to generate the total average service time. We report both the average and standard deviation of service time for each clinic and the chain as a whole.

\[
\text{Average Patient Service Time} = \frac{B(t)}{R_c(t)}
\]

where \( B(t) \) = patient backlog at \( t \)
\( R_c(t) \) = completion rate of patients at \( t \)

The final measure we consider when evaluating the impact of agile strategies on service chains is the patient to provider ratio. Like service time, this is another measure of care healthcare quality. Healthcare services research has linked the ratio of patients to providers, and the subsequent clinician stress and fatigue, to increased error generation, patient safety risk, and reduced overall care quality (Kane et al, 2007; Robertson & Hassan, 1999). Higher patient to provider ratios have been correlated with increased patient mortality, failure-to-rescue (deaths following complications), urinary tract infections, pneumonia, thrombosis, and pulmonary compromise (Aiken et al, 2002; Kovner & Gergen, 1998). While not a precise measure of service quality, it is easily comparable across stages and service chains and could be easily modified to provide more setting specific indications.
However, patients and service capacity are not directly comparable in our model, as they are measured in different units. We convert the measure of patients to that of service capacity, through comparing it to the target service delivery time. This adjusted measure, normally called ‘workload,’ now represents the ratio of the service capacity necessary to see the current backlog of patients within current standard of care and the service capacity currently available. This measure of stress and patient safety risk can be modified to suit any service delivery system, and is accepted as a general measure of service supply chain stress and a main contributing factor to reduced service quality and increased rework. This ratio was first proposed by Akkermans and Vos (2003), and is similar to the measures of ‘schedule pressure’ found in system dynamics workforce models (Lyneis & Ford, 2007).

\[
\text{Normalized Workload} = \left( \frac{B(t)}{Ts} \right) / C(t)
\]

where \( B(t) \) = patient backlog at \( t \),
\( Ts \) = target patient care service time
\( C(t) \) = resource capacity available at \( t \)

To illustrate how this measure is used, assume a 10% increase in patient demand makes the workload measure triple from 0.1 to 0.3, this suggests severe demand variation amplification, but it also indicates that the system is not put under serious pressure because the workload is still well below 1.0, where 1.0 indicates that demand for services and current service capacity are in equilibrium, and thus all current patients can be seen within the desired service time.

This measure provides an instantaneous measure of provider stress and system flexibility, and is useful for evaluating behavior over the course of a simulation. However, to facilitate comparison of stress and flexibility across multiple simulations, we must condense this behavior into one number. Based on a technique common to control theory (White, 1999), we use the sum of the absolute difference between equilibrium and actual workload generated in all clinics. This accumulated error (the difference between desired and actual workload) stores the history of behavior over the entire simulation, resulting in a less volatile and clearer picture of how different policies affect performance over time, not just at one moment in time.

This measure also provides an estimate of overall system flexibility. If the ratio of patients to providers is often not balanced, then the system is not able to effectively and efficiently address changes in demand for services with changes in service capacity. For example, when workload is high, there are more patients waiting than there are necessary providers to diagnose, treat, and care for them in a timely manner, indicating that the system was not able to successfully respond to the initial increase in demand. The same is true when workload is below 1: the system has more resources than it needs to be able to provide the standard level of care.
3-7.2 Base Case
We run an initial simulation to reveal dynamic behaviors inherent to the system. Key parameters in the model are initially set to the relative equivalents of those found in other generic service supply chain models. The total desired patient service time is 15 days, spread evenly over each clinic ($T_s$ is 5 days); the time to add or remove a provider from any clinic roster is four times as long ($T_c = 20$ days). The model starts in equilibrium, where exogenous demand is a constant rate of 10 patients per day, and each clinic is staffed with the exact number needed to meet that demand in the target service time. Thus, initially, there is no variation in backlog or service capacity, and average service time is equal to desired service time. Desired capacity and actual service capacity are equal, therefore our performance measure, workload, is 1.0 in each service clinic. This scenario represents the traditional healthcare service delivery system, where local managers control the workforce at each clinic using only information on their local clinic backlog and provider productivity. In this base case scenario, the system is disturbed from that equilibrium by a minimal level of demand uncertainty, a one-time 10% increase in patient demand.

The model structure clearly generates the demand variation amplification effect, as expected. The results outlining the effect of variation in demand for services on each clinic over a one year period are contained in Figure 35. These oscillations are mirrored in the clinic performance measures. For example, the 10% increase in demand causes clinic workload to peak at 13.4%, 14.5%, 20.0%, in the first, second, and third clinic, respectively. Patient service time averaged over the course of the simulation do not vary significantly between clinics (as would be expected in a return to equilibrium), but the variation is significant, with service times error peaking at 0.67, 0.72, and 1.0 days. This finding compliments previous healthcare service delivery research (Walley, 2007; Sethuraman & Tirupati, 2005), with has identified increasing downstream variation common to both service rates and patient backlogs.

The amplification effect arises from delays in demand signaling and the limited information and bounded rationality of individual clinic managers. As each clinic transfers demand to subsequent clinics, they unknowingly magnify variation as patients move up the service chain, creating system stresses proportionally much larger than the initial increase in demand. Clinics in this model are highly compartmentalized; they share no data on capacity adjustment, patient backlog or service quality. This lack of coordination and information on the other stages is the chain represents the typical organization of care both between healthcare organizations and inside hospitals.
Given this ‘global’ perspective on system behavior, the decision rules used in the model clearly lead to unintended adverse effects. After the initial demand disturbance, it takes the clinics between six months and over a year to realign the supply of services with demand, creating intense variation in patient service times, clinic workload, and care quality. These results, while somewhat dependent on model parameters, suggest that the traditional organizational structures governing the management of services do not provide the necessary flexibility to synchronize service supply with fluctuating patient demand.

![Figure 35. Base case analysis of individual clinic service rates.](image)

Demand rate changes from 10 patients per day to 11 patients per day. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

3-8. Exploration of Agile Strategies

Increasing service chain flexibility is crucial to synchronizing clinical resources with patient demand, and thus the ability to provide cost effective, quality healthcare. In this section, we test whether each previously identified agile operational strategy improves supply chain flexibility, compared to the base case. While the literature suggests that all should improve performance, mitigate the ‘bullwhip effect,’ and improve system flexibility, not all have been examined in dynamic simulation, and none of them have been systematically evaluated against the others in an identical setting, facing an identical demand pattern. These simulations will provide an understanding of their general compare effectiveness in modifying the behavior of service chains. They also answer questions on whether or not a service chain requires improvement in
all four characteristics to become ‘truly agile,’ as proposed by Christopher (2000), or if some characteristics and operational plans are equally impactful on their own. We also discuss the feasibility of implementation of each operation strategy, specifically the need for an incentive structure to compensate for possible reductions in the performance of individual clinics. Finally, we discuss how each change in model structure creates these new behaviors and the generalizable implications for healthcare managers.

3.8.1 Market sensitivity
The first set of scenarios explores the impact of reduced service capacity adjustment time, $T_c$. Changes in this parameter can represent any operation changes that directly affect the speed of management decision making. Decreasing the capacity adjustment time has been shown to mitigate the ‘bullwhip effect’ in dynamic simulations of service chains (Anderson & Morrice, 2000, 2001; Anderson et al, 2005). Reducing this parameter means that each clinic now responds proportionally faster to any change in demand, rendering each clinic more market sensitive, and thus allowing less patient backlog to accumulate. Reducing the ability of the clinic to accumulate unwanted patient backlog is key to reducing downstream demand amplification.

We also explore the effects of the addition of derivative-based information into each clinic’s decision heuristic. Adding this signal to the information used in the base case is shown to improve clinic performance and reduce costs associated with demand variation (Lee et al, 2010). The derivative is a faster signal of changes in the patient backlog than simply the measures of the backlog itself; by definition, the derivative peaks when patient backlog is only at its inflection point and still rising.

All of these operational strategies to improve market sensitivity have effect predicted: all yield improvements over base case. However, not all have an equal impact on performance, as shown in Figure 36. The key finding in this set of simulations is that the addition of derivative control appears to be the most effective operational strategy of the set for improving system performance. All strategies reduce the amplitude of variation, but decreasing capacity adjustment time increases the oscillation frequency, while the addition of derivative control returns the system to equilibrium faster than any other strategy in this set. Furthermore, doubling $K_d$, the weight clinic managers give to the information on the derivative in their decision equation, further improves the performance under the derivative control strategy. Such adjustments are more common in highly measurable systems such as manufacturing, and while more difficult in the healthcare setting, this simulation sheds light onto the improvements made possible by ‘fine tuning’ management’s capacity control heuristics.
Figure 36. Resultant service times from market sensitivity simulation runs. Behavior of total service delivery time (sum of each clinic’s instantaneous average wait time, as computed by Little’s Law) in response to an instantaneous 10% increase in demand in week 10. Figure includes five different scenarios for the model parameter and formulae governing market sensitivity. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

In terms of total service chain performance, a greater than 50% reduction in the service capacity adjustment time is required to create the same benefits as basic derivative control (see Figure 37). Basic derivative control generates a 78% decrease in workload error over the course of the simulation and a 63% decrease in service time variation, compared to the base case. One could infer these results to indicate that both methods are equally useful, but they are not equally cost-effective. Derivative control is by far easier to implement. Including information on the derivative of the patient backlog in a manager’s decision could be done with a simple spreadsheet, while changing the service capacity adjustment time would require intense effort in HR process redesign. Achieving a 75% reduction would be difficult for most healthcare clinics, with 50% being practically impossible.
Figure 37. Resultant service supply chain performance under various market sensitivity strategies.

Behavior of total accumulated absolute workload variation and variation in total average service times (sum of each clinic’s instantaneous average wait time, as computed by Little’s Law) in response to an instantaneous 10% increase in demand in week 10. Figure includes five different scenarios for the model parameter and formulae governing market sensitivity. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

All individual clinics incur some benefits under each market sensitivity strategy (see Figure 38). Downstream clinics benefit more from any market sensitivity strategy than upstream clinics, as the effects of dampened demand variation are cumulative, and because downstream stages initially incurred more of the burden of inherent demand variation amplification. In terms of variation in patient backlog and service capacity, derivative control leads to slightly better outcomes than a 50% reduction in service capacity adjustment times in all clinics. Under the derivative control scenario, the final clinic has 46% less variation in capacity and 63% less variation in its patient backlog, compared to -42% and -62% change under the $0.5T_c$ scenario. These results reveal that actual implementation of either strategy can be accomplished without the creation of additional incentives or a benefit redistribution structure. While downstream clinics do benefit from the adoption by upstream clinics, there is no need create further incentives to encourage any clinic to participate.
Behavior of variation in patient backlogs and service capacities in response to an instantaneous 10% increase in demand in week 10. Figure includes five different scenarios for the model parameter and formulae governing market sensitivity. The time horizon for each simulation is 350 days. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

3.8.2 Information Sharing

The second set of scenarios explores the impact of including real-time, end-patient demand data in the decision equation at each clinic. Including this information means that each clinic now responds to both changes in their local patient backlog and to the patients that have started the care process but have not yet arrived at their clinic. Increasing the visibility of real demand throughout the supply chain has been shown to mitigate the ‘bullwhip effect’ in real-world manufacturing chains (Holweg et al, 2005). Including initial patient demand in individual clinic’s capacity adjustment decision making has also improved performance of service chains in dynamic simulations (Anderson & Morrice, 2000, 2001; Anderson et al, 2005). However, implementing this strategy in the real world requires a costly change in operations: including the installation of IT infrastructure to collect and transmit the data in real time, and training managers on how to incorporate these new data into their decision heuristics. Also, the relative weight given to each source of information is both difficult to intuit correctly and fundamentally important to determining overall performance. It should be noted that initial patient demand is a different type of information than managers used in the base case: it is an instantaneous rate of patient arrival, as opposed to a stock of patients waiting (or, depending on the formulation, the stock of patients in process).

We test two different versions of the information sharing strategy, one where information on initial patient demand completely replaces local backlog in the capacity adjustment decision ($a = I$), and another, more reasonable version, where managers use a mix of local backlog and initial
patient demand \( (a = 0.5) \). In the runs described, all clinics use the same relative weight parameter (we did run experiments varying these weights between clinics, but those runs did not yield significant system improvement or insight into model behavior). For the chain as a whole, both versions of the information sharing strategy reduce workload and service time variation under most scenarios, as shown in Figure 39.

The mixed information version leads to significant improvements in mitigating workload variation, but basing capacity adjustment decisions fully on initial patient demand (i.e., not using local information at all) appears to yield even more improvement. Under the condition \( a = 1 \), total accumulated workload error is 84\% lower than the base case; service times in this version are also more controlled under most scenarios. These results suggest that using initial patient demand in place of local demand increases system flexibility, yielding a faster and more accurate response to demand variation than the traditional decision structure.

We explore the validity of the strategy of only using initial patient demand in all clinics by testing it in multiple versions of our generic service chains, where all clinics are no longer identical. The variation in individual clinic parameters provides a more realistic and representative simulation of the complexity seen in actual healthcare service chains. In these scenarios, each clinic is portrayed as conducting a different care processes, requiring different target clinic service times. Also, each clinic manages their service capacity differently, with each clinic subject to a different capacity adjustment decision time. Target service time is set at either 2, 5, or 8 days (labeled as L, M, and H for ‘low,’ ‘medium,’ and ‘high’ values); while capacity adjustment time varies between 7, 20, and 33 days. Despite these changes, each scenario remains comparable to the other strategy evaluation simulation runs because total service time and total capacity adjustment delays for the overall chain remain constant (\( \sum T_s = 15 \) and \( \sum T_c = 60 \), for all scenarios).

Even under these more realistic conditions, where all clinics are not identical, making decisions solely with initial patient demand often yields better outcomes than either the mixed information strategy or the base case. Only in one simulation run, where the first clinic's parameters produce low market sensitivity, as the capacity adjustment time is set to 33 days, did this strategy lead to a worse outcome, specifically a service time variation 73\% worse than the base case. In cases when the first clinic is equally or more responsive to changes in demand than the base case, overall system performance improved. Results are described in Figure 39.
Figure 39. Resultant service supply chain performance under various information sharing strategies.

Behavior of total accumulated absolute workload variation and variation in total average service times (sum of each clinic’s instantaneous average wait time, as computed by Little’s Law) and in response to an instantaneous 10% increase in demand in week 10. Figure includes seven different scenarios for the model parameter and formulae governing information sharing under differing assumptions of clinic characteristics (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). The time horizon for each simulation is 350 days. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

This variation in service chain performance can be explained by examining the behavior of individual clinics, as shown in Figure 35. Not all clinics are affected equally by the extreme reliance on initial patient demand information. A detailed analysis reveals that most of the predicted benefits of relying on initial patient demand are generated in the model by the complete elimination of variation in downstream clinics patient backlogs. This is more than the complete elimination of the amplification of variation, or ‘bullwhip effect,’ it is the complete elimination of any variation whatsoever. However, these impressive outcomes only occur in the improbable scenario where all clinics have identical capacity adjustment times. More realistic scenarios with variable decision making practices between clinics indicate that these results would not be produced in real-world healthcare service chains, where maintaining identical management decision making heuristics and HR processes across the entire chain is highly unlikely.

These uneven outcomes across clinics render implementation of the information sharing strategy difficult. In almost all scenarios, the first clinic in our service chain incurs more variation in patient backlog when including initial patient demand in their management decisions than they would without. This leads to more variation in service times and service quality levels. Even when demand information is combined with local backlog information, such as the $a = 0.5$
scenario, the first clinic is still subject to an increase in backlog variation. Any implementation of information sharing strategies would require a drastic benefits redistribution mechanism to compensate the first clinic for the use of demand information.

Figure 40. Variation in individual clinic backlogs and capacities following information sharing strategies. Behavior of variation in patient backlogs and service capacities in response to an instantaneous 10% increase in demand in week 10. Figure includes seven different scenarios for the model parameter and formulae governing information sharing under differing assumptions of clinic characteristics (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). The time horizon for each simulation is 350 days. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

The only case where patient backlog variation in the first clinic declines is when increasing market sensitivity (through a reduction in $T_c$) overcomes the detrimental effects of initial patient demand data. These simulations indicate that market sensitivity of the first clinic is a significant factor in determining the performance of the overall chain. When first clinic's ability to respond to changes in demand is low, the variation created in the first clinic outweighs the benefits of increased market sensitivity in downstream clinics. For example, in the ServTime-HML scenario, decreasing market sensitivity in the first clinic is (by an increase $T_c$ by 65%, to 33 days) results in a 367% increase in overall service time variation over the base case (as shown in Figure 39), even though opposing parameter changes in downstream clinics rendered them more responsive to the increased demand fluctuations generated by the first clinic. This set of scenarios exposes that replacing local backlog data with initial patient demand data is not a feasible solution for improving service chain performance. Any differences between clinics in management practices and decision heuristics will eliminate the benefits indicated in previous simulation studies (Anderson & Morrice, 2000).
Moreover, while the information sharing strategy does reduce variation in some scenarios, it does so by creating a more significant problem. The complete use of initial patient demand rate in management decisions leads to steady state error in patient service time, as shown in Figure 41. Completely ignoring local data results in a dangerous scenario, where individual clinic managers are blind to the impact of delays in capacity adjustment on patient service times. This consequence, no matter what the possible benefits from reduced variation, is not acceptable in healthcare service chain management.

This steady-state error results from only using a proportional control based on the rate of demand, which cannot keep track of the error built up over the time period when a correction is being made. The 100% initial patient demand decision heuristic will synchronize a clinic quickly to any new demand rate under many clinic configurations and parameter sets, but once supply is again matched with demand, there is no information retained on the accumulation of error that has developed in the interim. Without including this information on clinic backlog, as would occur in the initial decision heuristic, these patients are never accounted for, and their impact on performance is never corrected.

Under the scenario of the 100% use of initial patient demand rate, more variation in demand would lead to more accumulated error remaining unaccounted for. If a system is experiencing demand variation around a steady mean, this ‘ignored’ error would cancel itself out, but if demand fundamentally increases or decreases, steady state error will necessarily occur. With the likelihood of a steady mean demand rate a near impossibility, relying solely on initial patient demand to make clinic capacity adjustment decisions is not a realistic option for healthcare services.

Figure 41. Resultant average patient service times from information sharing simulation runs. Behavior total service time (sum of instantaneous average service times, as calculated by Little’s Law, for each clinic) in response to an instantaneous 10% increase in demand in week 10. Figure includes seven different
scenarios for the model parameter and formulae governing information sharing under differing assumptions of clinic characteristics (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). The time horizon for each simulation is 350 days. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

3-8.3 Coordinated planning
The final set of scenarios explores the impact of centralized planning, specifically the use of a systems perspective to determine clinic decision heuristics and target service times to maximize supply chain performance. These changes are meant to maximize performance for the total chain, even if individual clinics generate worse performance. From past simulation research, we know that service chains should not move toward decision synchronization, as services with identical stages show worse performance than services with varied stages (Anderson et al, 2005). We explore the implications of this finding to determine if healthcare services can operationalize increasing decision and service target variation to improve overall performance.

We manifest this idea through changes to clinic parameters $T_c$ and $T_s$. To illustrate the possible feedback effects, consider the example of an increase in $T_c$, which results in the clinic now responding proportionally slower to any change in demand, rendering that clinic less market sensitive, and thus allowing more patient backlog to accumulate. Similarly, reducing $T_s$ results in a clinics needing to maintain more staff for the same level of demand, which allows patients to wait less on average to complete services in that clinic. Analogous to the ‘more realistic’ scenarios in the previous section, we maintain a fixed $\sum T_c$ and $\sum T_s$ for the service chain as a whole, thus there are no improvements in overall standard of care or market sensitivity. These parameter changes isolate the effects of a redistribution of HR resources (changing $T_c$ allows clinics to make and execute capacity adjustment decisions faster) and service delivery standards (changing $T_s$ directly affects a clinic’s average service time).

Decision and service standards de-synchronization has a minimal effect on the behavior of total service time. There is a minor improvement in workload error, compared to the base case, confirming results from previous studies (see Figure 42).
Figure 42. Resultant service supply chain performance under various coordination strategies. Behavior of total accumulated absolute workload variation and variation in total average service times (sum of each clinic’s instantaneous average wait time, as computed by Little’s Law) in response to an instantaneous 10% increase in demand in week 10. Figure includes five different scenarios for the model parameter and formulae governing service chain coordination (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

Simulation results suggest that maintaining relatively longer average service times in the first clinic in the service chain yields the best performance of these decision and performance standard de-synchronization scenarios. Changes to the parameter governing target service time ($T_s$) alters the desired patient backlog level implicit in clinic managers’ decision heuristics, affecting the average size of the buffer each clinic maintains against demand variation. By setting performance standards higher in the final clinics of the service chain, the clinics at the beginning of the service delivery chain are allowed lower relative efficiency and larger patient backlogs, when compared to the balanced strategy. This provides the first clinic with more patient demand buffer, so less internal demand variation amplification is passed on to subsequent clinics. This ‘front-loaded’ service supply chain buffers the entire service chain from external demand variation, resulting in less variation amplification overall. All else equal, keeping patients concentrated at the beginning of a service delivery chain better accommodates demand fluctuation, resulting in less system stress in any clinic. Holding relatively more patients at the front of the care process (and fewer in the later clinics, to maintain an equivalent total number) also leads to less workload variation than any other distribution.

Changes to capacity adjustment time have a similar effect, but less pronounced than the de-synchronization of service targets. This occurs because the size of $T_c$ is relative small compared to $T_s$. If the $T_c:T_s$ ratio were larger, then unbalancing capacity adjustments would have more impact on service performance. Re-designing HR processes to affect capacity adjustment rates
could be an important operational improvement if applied in a service chain where $T_c:T_s$ is relatively small.

Figure 43. Variation in individual clinic backlogs and capacities following centralization strategies. Behavior of variation in patient backlogs and service capacities in response to an instantaneous 10% increase in demand in week 10. Figure includes five different scenarios for the model parameter and formulae governing service chain coordination (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

Overall, these simulations suggest that using centralized planning to redistribute service targets and capacity adjustment times has limited impact on service performance, compared to other possible agile strategies. Furthermore, the fundamental characteristics of individual clinics in actual healthcare service supply chains limit the ability of managers to alter these service targets.

There also exist complex interaction effects between operational strategies to alter these parameters. Tests combining both parameter changes across the service chain (still maintaining $\sum T_c = 60$ and $\sum T_s = 15$) reveal that the impact of changing one set of parameters is strongly influenced by the distribution of the other set, as shown in Figure 44. These experiments reveal a general conclusion that clinics with low desired patient backlog levels should maintain high market sensitivity, as they have minimal buffer against variation in demand, so they must be able to change service capacity quickly to minimize the accumulation of error. In these runs, the strategy of ‘front-loading’ the service chain, where the first clinic maintains the largest patient backlog (the ServTimes-HML scenario), still produces the best performance; however, it can also produce nearly the worst performance if capacity adjustment times have the opposite distribution (the CapAdj-LMH scenario, where the first clinic is the most market sensitive). The opposite strategy, of ‘rear-loading’ the service chain (where both ServTimes parameters are distributed LMH), also produces little workload error if matched with a similar distribution of capacity adjustment times. These seemingly contradictory results further reduce the ability to make simple guidelines for unbalancing service chains.
Figure 44. Resultant workload error following clinic parameter re-distribution. Behavior of total accumulated absolute workload variation in response to an instantaneous 10% increase in demand in week 10. Figure includes 25 different scenarios for the model parameter and formulae governing service chain coordination (parameters delta and tau varied between 2, 5, and 8 days and 7, 20, and 33 days respectively). Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

Attempting to actively alter variation in clinic standards to increase performance should not be made without first understanding the relative market sensitivity of each clinic in the service chain, and vice versa. This centralization strategy presents no simple solutions. Considering the diversity of requirements for any healthcare clinic, the difficulty clinic managers will have assessing the relative value of $T_s$ and $T_c$ for all clinics in a healthcare chain, and the complexity of service delivery in the real world that is not included in this model, this strategy is probably the least useful of the agile operational strategies tested so far.

3-8.4 Results summary
This series of operational simulations leads to multiple conclusions. The first key finding is that agile strategies do not need to be implemented together to produce significant results. Promoting individual agile characteristics appears to be an effective improvement strategy for service delivery chains.
Second, under these simplifying assumptions, improving market sensitivity is the most effective agile strategy for improving performance in service chains, as shown in Figure 45. The specific operational plan of introducing derivative-based controls into managers’ decision heuristics yields the most improvement in service quality and reduction in cost drivers. This operational change also mitigated internally produced demand variation amplification, the ‘bullwhip effect,’ more than any other agile operation plan. Furthermore, the inclusion of derivative information improved both overall system performance and that of individual clinics, thus requiring no extra benefits redistribution mechanism to encourage the adoption of this strategy.

The third key finding is that implementation of operational plans to increase a service chain’s ability to be ‘information driven’ can unintentionally produce significant adverse effects. While the sole use of initial patient demand in capacity adjustment decisions appears to be a promising strategy, basing this ‘feed forward’ proportional controller on the exogenous variable of patient demand leads to steady-state error in key performance metrics. These simulations expose the importance of including endogenous variables in each clinic’s control decisions. However, a blended information approach, which is a much more likely implementation in real-world service chains, is not as effective at controlling the bullwhip effect and minimizing the patient safety risk and care delivery costs created by those demand fluctuations than strategies to promote market sensitivity.

![Figure 45. Comparative effectiveness of selected agile operational plans in response to a one-time 10% increase in demand.](image)

The experiment includes seven different scenarios for the model parameter governing market sensitivity, information sharing, and service chain coordination. Chart reports the total range of average service times (computed by Little’s law) and accumulated absolute workload variation summed over all clinics for each scenario,
in response to an instantaneous 10% increase in demand in week 10. The time horizon for each simulation is 350 days. Simulation was conducted in Vensim® software version 6.0 using Runge-Kutta integration methods, with a time step of 0.0625 days.

3-9. Conclusion

To date there has been limited success in making system-wide service supply chain management improvements in healthcare (McKone-Sweet et al, 2005; Vries & Huijsman, 2011). We still face significant challenges designing and implementing cost-effective, and at the same time flexible, healthcare systems which increase the availability of scarce service resources and improve patient access to care. Past efforts applying management strategies developed in manufacturing settings have led to little sustained improvement (Joosten et al, 2009). Defining structural differences between services and manufacturing necessitate the adoption of new strategies more suited to the challenges facing healthcare operations and management.

This paper provides a structured assessment of the impact of one possible new strategy, ‘agile,’ on service performance in simulated healthcare delivery chains. In doing so, we bridge the supply chain and healthcare management literatures and establish ‘agile’ as a new area of study for service supply chain management research. Our research objectives were to develop a set of operational plans from the literature on ‘agility’ and service supply chain management and assess the impact of these agile-derived plans in a generalized healthcare service chain. The knowledge gained was to provide healthcare managers with useful guidelines for redesigning service delivery.

To fulfill the research objectives, we describe and test three sets of agile-based operational strategies, focusing on key characteristics of supply chain agility: increasing market sensitivity, the use of real-time demand information, and centralized planning. We assess the impact to the service system based on three criteria: variation in the stocks of patients and service capacity in each clinic (to expose the ability of each strategy to mitigate the bullwhip effect), average patient service time, and provider workload. These are measured both at the local (single clinic) and systemic level (total service chain).

We determine that agile is a valuable strategy for increasing system flexibility and mitigating internally caused demand variation. Scenarios show improved system performance from both the patients’ and providers’ perspective, with agile-based operational modifications leading to reduced variation in service times, improved service quality, and the potential for decreased costs.

Of the agile characteristics under study, increasing market sensitivity led to the most improvement, with the specific operational plan of supplementing manager’s traditional decision making heuristic with derivative control resulting in superior performance. Study results
indicate that demand volatility can be effectively controlled in healthcare by applying derivative control to the resource adjustment decision. The addition of derivative control reduces the oscillation of patient backlogs and the discrepancy between demand and service capacity created by the simplistic feedback control methods commonly used in healthcare. The application of derivative controls in service chains could refute the conundrum identified by Anderson (et al, 2005), that there is generally a trade-off between policies that improve service quality by reducing backlog variability and those that reduce personnel costs by reducing capacity variability. We find that the addition of derivative control can effectively accomplish both.

In practice, derivative controls could be used to dampen oscillations resulting from any capacity management decision, from resource acquisition, release and write down of capital investments, to hiring and workforce training. Even the most basic derivative control should lead to a sizable improvement in synchronization of service resources with demand and, if implemented in all clinics, significantly mitigate the bullwhip effect. The addition of derivative-based controls is relatively simple to implementable in real-world service chains. Optimizing these control equations could further improve cost, utilization and stability of workforce management in healthcare, if reliable and timely data were available.

Study results also indicate that investing in IT systems to share demand data between clinics might not as useful in healthcare as predicted from the research done in manufacturing sectors. Our evidence runs counter to the common supposition on the value of information sharing strategies in healthcare, as summed up by Baltacioglu (et al, 2007, p121) as "effective management of healthcare supply chain is only possible via the implementation of effective information and technology management systems." In our simplified service delivery chain, the use of initial patient demand rates either has less impact on performance than agile practices which increase market sensitivity, or leads to significant disruptions in service times and the alignment of clinic incentives. While possibly beneficial when viewing the chain as a whole, relying on initial patient demand does not appear to be an appropriate strategy for all clinics.

Generating results that are in direct disagreement with commonly held supply chain management beliefs could easily be attributed to the abstract nature of our simulation model. Effective information and technology management systems may address key issues and feedbacks that we have decided not to include, such as links between service delivery times and patient health, or between provider workload, service quality, and rework. These information systems may also be useful in managing details on individual patient demand and provider characteristics not allowed by the mathematical underpinnings of our model. Other critiques of this research could be leveled at the applicability of our results to inform decisions in real-world healthcare chains, as our exogenous demand pattern is undoubtedly not representative of the usually stochastic demand pattern in healthcare. Each of these shortcomings deserves the attention of further research.
Our abstract model is a first step toward understanding and informing the application of agile strategies in healthcare. These results provide only the most general guidance on where agile-derived efforts to improve service delivery will yield the most return. Healthcare managers are still ‘on their own’ to adapt these recommendations to their unique care settings and service delivery chains. Future work should be directed to examining the validity of our findings under the constraints inherent to different service settings, both in simulation of specific healthcare service chains and empirically in pilot implementation projects in real-world clinics. Another thread of future research centers on derivative control. To truly develop useful guidelines for implementing an agile systems approach in healthcare, the ability of healthcare managers to use derivative control in individual clinics must be empirically evaluated. Case studies of the effectiveness of derivative control in ‘noisy’ real-world service chains would undoubtedly shed light onto important implementation challenges. A second piece of this thread would be exploring opportunities for ‘tuning’ proportional and derivative-based control decisions, based on data quality and availability and on the bounded rationality of clinic managers. Increasing knowledge in these areas together will support the creation of effective, flexible service chain management that suits the dynamic nature of health itself, and hopefully will lead to enhanced effectiveness and efficiency of healthcare operations.
4. Conclusion

Healthcare services exist in complex systems, fraught with delays and prone to generating unintended consequences. The growing complexity and interdependence of healthcare service delivery, and the inherent variability of patient demand, ensure that matching the supply of services with its demand is almost impossible to ensure for any significant period of time. This mismatch between patients and providers has been shown to lead to significant adverse effects. With the management systems currently in place, this variation leads to mistakes in care delivery and increased patient safety risks. Kane et al (2007) find that the mismatch between resources and peaks in demand is the major source of provider fatigue and reduced quality of care in most healthcare services. Specifically, the stresses placed upon a healthcare system by variability have been found to lead to more medication errors, hospital-acquired infections, sicker patients, and are a leading cause of adverse patient outcomes (Needleman et al, 2002; Berens, 2000; Pronovost et al, 1999). Our ability, or lack thereof, to respond to demand variability may be the most pressing problem facing healthcare delivery today.

Currently, providers and hospital managers alone do not have the necessary resources or knowledge to overcome the challenges presented by both exogenous and endogenous demand variation. Research into the causal relationships between demand variation, capacity management, system stress, and service quality has been ongoing in many industries for many years, yet is curiously deficient in healthcare service delivery. Despite increasing efforts to improve healthcare delivery through practices based on ‘lean’ methods, healthcare remains one of the least efficient, most dangerous, and highest cost industries in the US. Indeed, one of the key contributions of our research is the conclusion that implementing lean in the scatter-shot, “low-hanging-fruit” fashion currently the norm in healthcare could actually be contributing to demand variation, provider workload, and patient safety risks.

This research recommends a new approach to improving healthcare delivery. Each of the experiments conducted here supports a core, counter-intuitive concept: When facing volatile demand for services, modifying management decision-making processes to increase the ability to synchronize service capacity to demand yields more improvement to patient access and cost than increasing personnel or resource efficiency. Our main contributions center on revealing the importance of ‘agile’ strategies for improving healthcare delivery. With the insight generated by testing in simulation what we previously only theories and correlations, we find that agile-based practices can improve the access, quality, and cost of healthcare delivery systems. We attempt to identify and define a set of operational plans for the core set of agile strategies, and the first to evaluate their comparative effectiveness in simulation.

We propose that supplementing manager’s traditional decision making heuristic with derivative control at each stage (i.e., clinic or hospital department) in a healthcare delivery chain will result in superior performance over all other agile-derived operational plans under study, including the
sharing of real-time demand information. At a conceptual level, such a control mechanism has been suggested by Warren (2007) for improving strategic decisions and Saeed (2009, 2008) for controlling instability in manufacturing supply chains, but not explored for improving specific operations like healthcare. Our results indicate that the application of derivative controls in service chains could refute the conundrum identified by Anderson (et al, 2005), that there is a necessary trade-off between policies that improve service quality by reducing backlog variability and those that reduce personnel costs by reducing capacity variability. We find that the addition of derivative control can effectively accomplish both.

The applied project in the C&P clinic is first application of operational changes derived from an agile strategy (e.g., increasing market sensitivity) in empirical study in healthcare. While implemented as only a pilot project limited to one hospital, the estimated impact of the agile-based operational changes we prescribed is a savings of over 550 years of avoided delay. Taking these results together, we find that the agile strategy of improving market sensitivity in a healthcare service chain can produce considerable performance improvement. These simulation experiments and implementation case study are the first steps to bring ‘agile’ from the realm of academia to the managers of healthcare service delivery systems.

Our research also contributes to the adaptation of lean methods to the healthcare service system context. Through the course of this research and through working hands-on with hospital partners, we have come to see agile not as a substitute for lean, but a complement. Working together, this combination of methods and philosophies represent a new evolution of lean to better fit the demanding, highly volatile context of healthcare. Drawing upon Liker’s (2004) House of Lean diagram, we see creating demand-responsive management structures as a necessary foundation for lean-based improvement efforts in services with high demand variability. Unlike the large-scale, low-variability context of mass-manufacturing where lean first developed, in healthcare, one must first create management systems that respond effectively to the unavoidable demand variation and uncertainty before any other lean-based improvement work can be effective. This is a paradigm shift for lean, one that requires recognizing the inherent limitations of previous methods for controlling variability in the context of healthcare, and a willingness to focus improvement efforts instead on adapting to that variability.

Most of this research is based on a simulation model of a generic healthcare delivery chain. This model incorporates the dynamic interplay between external demand variability, clinic manager’s decision heuristics, and resource allocation structures. The structures and assumptions made in the model’s design subsume the important concepts that differentiate a service chain from a manufacturing or product supply chain and are supported by both the system dynamics and service supply chain literature. This simplified, serial stage model builds on a research thread started by Anderson and Morrice (1999, 2000), who were the first to use system dynamics to simulate a multi-stage service system with their model of the mortgage
service industry. Subsequent dynamic serial service models, including publications by Akkermans and Vos (2003) and Anderson et al. (2005, 2006), are all based on similar underlying assumptions.

While the dynamic simulation model we create captures the essential elements of reality common to most healthcare delivery chains, it is an abstract representation with inherent limitations in both replicating observed behavior and the applicability of our conclusions to any real-world healthcare service system. The main abstraction that permits clear analysis of the bullwhip effect and the effect changing management structures has on healthcare service delivery is also the limitation to the direct applicability of this model to any one healthcare service delivery chain. Chains of identical clinics, where desired service times, capacity adjustment practices, and service quality are all equivalent, are simply not a realistic representation of almost any healthcare delivery system. The stages, clinics, or departments in any healthcare service chain are more likely to be different in all of these characteristics than they are to be the same.

However, while not universally applicable, there are many healthcare services where the differences in these parameters and structures are minimal, and thus could benefit from the knowledge generate by a dynamic analysis of this abstract model. The applicability of our conclusions depends on how closely a real-world healthcare service chain’s stages are to having similar properties. For example, consider an elective surgery chain, which starts with a visit to a primary care provider, then next to a specialist, then to an out-patient surgery clinic. Each of these stages in our service chain could conceivably have a desired average patient wait time of two months (i.e., two months to get an appointment with a primary care physician, two months to get an appointment with a specialist, and two months to schedule an out-patient procedure). In this example, the capacity management processes and inherent delays would also be similar any one of these clinics: they must go through the same process of posting a position for, interviewing, credentialing, and finally hiring a new clinician, which, when summed together, are probably equivalent no matter the type of clinician, whether general practitioner, specialists, or specialty surgeon.

Clearly, our conclusions and recommendations should not be applied to a patient care chain with stages with very dissimilar desired service times; for example, our model is not an accurate representation of the care process for a patient suffering a heart attack. This patient care chain starts in the emergency department (where desired service time is measured in minutes), then moves to the in-patient recovery wards (where the desired service time is measured in days), and finally to physical therapy (where the desired service time is measured in months). The orders of magnitude differences in parameters governing each stage in this chain would overwhelm our current conclusions. Given the impact of the assumption of equal model parameters on overall model behavior, we propose this as the subject for future research, both in simulation and especially in quantitative analysis of real-world healthcare service chains.
There are other limitations and potential bias inherent to the structure of our generic model. By excluding, 1) the dynamic effects of increased patient service time on patient health, 2) the effect of service quality on clinic rework rates, and 3) variation in both individual patient and provider characteristics, we limit both the complexity of model behavior and the scope of our subsequent operations improvement analysis. These elements should be included in future simulation studies, but, to provide value, they must be calibrated to fit a specific service delivery chain. Past service supply chain research suggests that these additional feedbacks may magnify the variation amplification effect (Akkermans & Vos, 2003), thus our model potentially underestimates the bullwhip effect and its effects on clinic performance.

Analysis of our model’s assumptions and limitations sheds light on significant research questions in the management of healthcare systems. A key unknown presented here is the impact of variability on the quality of care in any given clinic or healthcare service. To find the motivation to address variability in healthcare, both individual providers and healthcare leaders must first have a clear understanding of the affect variability in the patient:provider ratio has on patient health outcomes. Wide-spread understanding of the determinants of quality elasticity, and their impact on patient health and safety are necessary to effectively guide the work of both lean practitioners and healthcare managers.

We must also discover and test other operational plans to increase system flexibility. Undoubtedly, we have only uncovered the tip of the ‘agility iceberg.’ Given the risks identified and the potential benefits gained from a careful examination of the handful of operational plans we have presented here, we call on other researchers and healthcare improvement practitioners to seek out and report new methods for adapting to demand variability. Further refinement of the broad strategies subsumed under the concept of ‘agility’ to the concrete problems of healthcare will not only aid us is in stemming the unsustainable increase in healthcare spending, but will lead to increases in the quality of care for all.
Table A1

<table>
<thead>
<tr>
<th>Source</th>
<th>Definition: lean manufacturing</th>
<th>Performance dimensions: leanness</th>
<th>Associated practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>de Treville and Antonakis (2006)</td>
<td>Integrated manufacturing system intended to maximize capacity utilization and minimize buffer inventories through minimizing system variability</td>
<td>Conformance quality; delivery reliability; processing time</td>
<td>JIT manufacturing, total quality management; total preventive maintenance; Kaizen; design for manufacturing and assembly; supplier management; human resource training and involvement</td>
</tr>
<tr>
<td>Hopp and Spearman (2004)</td>
<td>Production that is accomplished with minimal buffering costs</td>
<td>Low buffering cost; low variability in process times, delivery times, yield rates staffing levels, demand rates, etc.</td>
<td>Pull production; eliminate obvious wastes; swapping inexpensive buffers for expensive ones; variability reduction; continuous improvement</td>
</tr>
<tr>
<td>Shah and Ward (2003)</td>
<td>Collection of practices that work together synergistically to create a streamlined, high quality system that produces finished products at the pace of customer demand with little or no waste</td>
<td>Cost efficiency; conformance quality; delivery reliability; product mix flexibility</td>
<td>Just-in-time manufacturing; total preventive maintenance; total quality management; human resource management (22 sub-practices)</td>
</tr>
<tr>
<td>McLachlin (1997)</td>
<td>Extent to which certain JIT flow and quality practices are implemented</td>
<td>Cost efficiency; conformance quality; delivery reliability; delivery speed; product mix flexibility</td>
<td>Employee involvement; JIT flow; quality management (17 sub-practices and antecedents)</td>
</tr>
</tbody>
</table>

Table A2

<table>
<thead>
<tr>
<th>Source</th>
<th>Definition: agile manufacturing</th>
<th>Performance dimensions: agility</th>
<th>Associated practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown and Bessant (2003)</td>
<td>Involves the ability to respond quickly and effectively to changes in market demand</td>
<td>Proactive and reactive flexibility; delivery speed; design quality (customization); cost efficiency</td>
<td>Just-in-time manufacturing; total quality management; customer linkages; supplier alliances and information sharing; wide range of skill training; advanced information and manufacturing technologies</td>
</tr>
<tr>
<td>Prince and Kay (2003)</td>
<td>Ability to respond to sudden changes and meet widely varied customer requirements in terms of price, specification, quality, quantity, and delivery</td>
<td>Delivery speed; product introduction speed; stable unit cost; changeover flexibility</td>
<td>Information and communications technologies; computer controlled manufacturing; modular facilities</td>
</tr>
<tr>
<td>Sharifi and Zhang (2001)</td>
<td>Ability to sense, respond to, and exploit anticipated or unexpected changes in the business environment</td>
<td>Delivery responsiveness; delivery speed; product model flexibility (customization); product introduction flexibility; volume flexibility</td>
<td>Advanced soft and hard technologies; internal networks; worker empowerment; concurrent teams</td>
</tr>
</tbody>
</table>
Appendix B: Calculations for Estimating the Effect of Patient:Provider Ratio on Patient Mortality Rate (adapted from Litvak et al, 2005).

First, to adapt an estimate of the effect of increased patient:provider ratio on patient mortality based on the work by Aiken et al (2002) for our model necessitates the assumption that nurses are the constraining service capacity (not attending physicians, residents, rooms, or equipment) in our generic healthcare service chain.

To compute the increase in mortality, first we use the workload measure generate for each clinic to determine the proportion of patients above the standard patient:nurse ratio for every time step, or \( \rho \). If this ratio is above 1 (implying more patients than the standard desired ratio of 4:1), then we multiply the proportion of patients exposed the increased risk defined as \( \rho^* \), by the 7% mortality odds ratio increase reported by Aiken et al (2002). Not all patients are initially affected by increases in provider workload, only those patients directly receiving care from overworked nurses. We accumulate the changes in this instantaneous patient mortality risk for the affect patient population, then compare these results to those from the base case scenario with no lean improvement and report the proportional difference. No literature was found citing decreases of patient to nurse ratios below this standard leading to improved patient outcomes, suggesting diminishing returns in patient health to the number of hours of nurse time per patient.

To calculate \( \rho^* \), we assume a standard 4:1 patient to nurse ratio, and define the total number of patients in a clinic as \( P \), thus the number of nurses in the steady state will be \( 0.25 \cdot P \). The number of patients with increased mortality will be \( 5 \cdot \rho \cdot P \), as the additional \( \rho \cdot P \) patients will be distributed over \( \rho \cdot P \) nurses: this assumes even distribution of one additional patient per nurse (for discussion, see Litvak et al, 2005). Since the total number of patients has increased to \( P(1 + \rho) \), the proportion of patients subjected to the 7% increase in mortality is:

Under this formula, the number of patients in a clinic will have to increase to 25% more than adequate staffing levels for all patients to be subject to increased risk, and increasing beyond 25% would result in adding new patients with a 14% increase in mortality rate for \( \rho^* \). We include this measure not to specify some number of avoidable deaths cause by lean redesign, but as a representation of the relative effects of provider workload on patient safety.
Appendix C: Model Equations for Chapter 1– Formulations, stock and flow diagrams, units, and commentary

Stock and Flow Diagram of Service Backlog sector:
Stock and Flow diagram of Capacity Adjustment sector:

The following formulae and commentary are included as exact model code, to facilitate model replication. The specific formulae for calculating performance measures are included in a separate section at the end of this appendix.

Input = (1 + STEP(Step Height, Step Time) +
(Pulse Quantity/Pulse Duration)*PULSE(Pulse Time, Pulse Duration) +
RAMP(Ramp Slope, Ramp Start Time, Ramp End Time) +
RAMP(Ramp Slope 2, Ramp Start Time 2, Ramp End Time 2) +
Sine Amplitude*SIN(2*3.14159*Time/Sine Period) +
STEP(1, Noise Start Time)*Pink Noise)

~ Dimensionless

~ Input is a dimensionless variable which provides a variety of test input patterns, including a step, pulse, sine wave, and random noise.

Change in Pink Noise = (White Noise - Pink Noise)/Noise Correlation Time
Change in the pink noise value; Pink noise is a first order exponential smoothing delay of the white noise input.

Standard PDY = IF THEN ELSE("Lean Switch, 1=PA"=1,0.87, 0.63)

~ requests/Employees/hours
~ Variation in productivity is based on breadth of skill set and understanding of the purpose of forensic examination: PAs and MDs can conduct more aspects of a patient's request than a specialist, who can only examine issues in their area of expertise. PAs can see, on average 0.87 of a patient's request, while one specialist can complete 63% (based on skill set and distribution of exams per patient).

Days Wait Time = Delivery Delay*"Days/week"
~ day

"Lean Switch, 1=PA" = 1
~ DMNL

"Agile Switch, 1=Cent" = 0
~ DMNL

Effect of Work Pressure on Workweek = IF THEN ELSE("Agile Switch, 1=Cent"=1,"Table for Effect of Work Pressure on Workweek -- Centralized"(Work Pressure), "Table for Effect of Work Pressure on Workweek - Distributed"(Work Pressure))
~ Dimensionless
~ High schedule pressure leads to overtime; low pressure to a reduction in hours worked.

Desired Workforce = SMOOTH(Desired Service Capacity / Perceived Employee Effectiveness, Time to Adjust Desired Workforce)*(1 +"Capacity Slack Fraction (can be included as a test)"
~ Employees
~ Desired number of employees based on the throughput requirements, the perceived employee effectiveness, and a slack fraction to ensure excess capacity to absorb random variations. The desired workforce does not change instantaneously as it takes time to authorize the changes in the desired workforce.
Total Work = Error Creation Rate + Request Arrival Rate
~ requests/Week
~

Reported Days Wait Time = Reported Delivery Delay * "Days/week"
~ days
~

Error Discovery Rate = Undiscovered Errors / Time to Discover Errors
~ requests/Week
~ The rate at which errors are discovered by the customer. First order delay from the undiscovered errors stock.
~

Initial Workforce = INITIAL(((1 / Standard Workweek) * Exogenous Request Arrival Rate) / ((Standard PDY *(1 - Steady State Rookie Fraction)) + (Standard PDY * Steady State Rookie Fraction * Rookie productivity fraction))))
~ Employees
~

Rookie Employees = INTEG (Hiring - Maturing - Rookie Lay Off Rate - Rookie Quits, Initial Workforce * Steady State Rookie Fraction)
~ Employees
~ Recently hired employees that have not achieved full productivity.
~

Experienced Employees = INTEG (Maturing - "Exp. Lay Off Rate" - Expert Quits, Initial Workforce * (1 - Steady State Rookie Fraction))
~ Employees
~ Employees that have achieved full productivity.
~

Desired Completion Rate = Service Backlog / Target Delivery Delay
~ requests/Week
~ To complete requests in the target delivery time, the completion rate must be equal to the backlog divided by the target time.
~

"Yearly Cost of C&P - FS" = "Fee-Service Employee's Cost"
~ Dollar/year
~

"Yearly Cost of C&P - Salary" = Salaried Employees' Cost
~ Dollar/year
~
"Changing costs - Fee for Service" = "Cost per Patient - Fee for Service"
  ~ Dollar/(year*patient)
  ~

"Avg. Cost - Fee for Service" = "Cumulative Cost-FS"/Total time
  ~ Dollar/year
  ~ Last reported value report average over entire simulation.

"Avg. Cost - Salary" = "Cumulative Cost - Salary"/Total time
  ~ Dollar/year
  ~

"Avg. Cost - SalaryOT" = "Cumulative Cost - Salary OT"/Total time
  ~ Dollar/year
  ~

"Avg. Cost per Patient - Fee for Service" = "Cumulative Cost per Patient - FFS"/Total time
  ~ Dollar/year/patient
  ~ Last reported value report average over entire simulation.

"Total Yearly Cost - Salary" = "Yearly Cost of C&P - Salary OT" + "Yearly Cost of C&P - Salary"
  ~ Dollar/year
  ~

Cumulative Service Backlog 0 = INTEG (changing SB 0,0)
  ~ requests*Week
  ~

Salaried Employees' Cost = Total Employees*Cost per Employee
  ~ Dollar/year
  ~

changing SB 0 = Service Backlog
  ~ requests
  ~

"Cumulative Cost per Patient - FFS" = INTEG ("Changing costs - Fee for Service",0)
  ~ Dollar/(year*patient)*Week
  ~

"Cost per Patient - Salary" = ZIDZ("Total Yearly Cost - Salary", Service Backlog) * "Avg. Requests per Patient"
  ~ Dollar/(year*patient)
  ~
  ~ Dollar/year
  ~ Last reported value report average over entire simulation.

"Cost per Patient - Fee for Service" = ZIDZ("Yearly Cost of C&P-FS", Service Backlog) * "Avg. Requests per Patient"
  ~ Dollar/(year*patient)

"Cumulative Cost - Salary OT" = INTEG ("Yearly Cost of C&P - Salary OT",0)
  ~ (Dollar/year)*Week

OT Cost Ratio = 1.5
  ~ DMNL
  ~ Salaried employees make time and a half if they work overtime.

"Yearly Cost of C&P - Salary OT" = (IF THEN ELSE(Workweek>Standard Workweek,
(Workweek/Standard Workweek)-1, 0)) * Total Employees * Cost per Employee * (OT Cost Ratio)
  ~ Dollar/year

"Fee-Service Employee's Cost" = (Workweek/Standard Workweek) * Total Employees * Cost per Employee
  ~ Dollar/year

"Cumulative Cost - Salary" = INTEG ("Yearly Cost of C&P - Salary",0)
  ~ (Dollar/year)*Week

Noise Multiplier = 1
  ~ DMNL [1,5,0.1]
  ~ Multiply the standard deviation by 2 for demand to match historical data without including a separate spike.

Noise Standard Deviation = 0.075 * Noise Multiplier
  ~ Dimensionless
  ~ The standard deviation of the pink noise process.

Cumulative Delivery Delay 0 = INTEG (changing delivery delay,0)
  ~ Week*Week
changing delivery delay = Delivery Delay
~ Week
~ I use this to calculate average performance.

"Avg. Delivery Delay" = (Cumulative Delivery Delay 0/Total time) * "Days/week 0"
~ day
~ Last reported value report average over entire simulation.

"Days/week 0" = 7
~ day/Week

"Avg. Absolute Delivery Delay Error" = (Cumulative Error in Delivery Delay/Total time) * "Days/week"
~ day
~ Last reported value report average over entire simulation.

"Avg. Instantaneous PDY" = Effective Workforce/Total Employees
~ Dimensionless

Effect of Inexperience on Probability of Error Free = Table for Effect of Inexperience on PEF("Avg. Instantaneous PDY")
~ Dimensionless
~ The more experience the workforce has, the less likely they will be of introducing an error while processing a task. Average Productivity is used as a proxy for experience since it captures the amount learning achieved by the workforce.

"Avg. Reported Delivery Delay" = (Cumulative Delivery Delay/Total time) * "Days/week"
~ day
~ Last reported value report average over entire simulation.

Standard Workweek = Normal Workweek
~ hours/Week
~ Hours worked per week under normal conditions, i.e., neutral work pressure.

"Days/week" = 7
~ day/Week
changing insufficiency = Insufficiency Rate
~ Dimensionless
~

changing CU = Clinic Utilization Rate
~ Dimensionless
~

Cost per Employee = IF THEN ELSE("Lean Switch, 1=PA"=1,75000, 150000)
~ Dollar/year/Employees
~ Sp=150000, PA=75000

"Avg. Backlog" = Cumulative Service Backlog / Total time
~ requests
~ Last reported value report average over entire simulation.
~

"Avg. Clinic Utilization Rate" = Cumulative CU Rate / Total time
~ Dimensionless
~ Last reported value report average over entire simulation.
~

"Avg. Cost per Patient - Salary" = "Cumulative Cost per Patient - S" / Total time
~ Dollar/year/patient
~ Last reported value report average over entire simulation.
~

"Avg. Insufficiency Rate" = Cumulative Insufficiency Rate / Total time
~ Dimensionless
~ Last reported value report average over entire simulation.
~

"Avg. Productivity" = "Cumulative Avg. PDY" / Total time
~ requests/Employees/hours
~ Last reported value report average over entire simulation.
~

"Avg. Requests per Patient" = 1.6
~ requests/patient
~

"Avg. Service Capacity" = (Cumulative Service Capacity / Total time)
~ Employees
Last reported value report average over entire simulation.

"Cumulative Cost-FS" = INTEG ("Yearly Cost of C&P-FS",0)
~ (Dollar/year)*Week

Long Term Workweek = SMOOTHI(Workweek, Burnout Onset Time, Standard Workweek)
~ hours/Week
~ Exponential smoothing of the workweek over the period for the onset of burnout. The 'long term' label refers to the fact that the burnout onset time is much longer than the fatigue onset time.

changing SB = Service Backlog
~ requests

"Changing costs - Salary" = "Cost per Patient - Salary"
~ Dollar/(year*patient)

"Productivity" = (Service Capacity/Total Employees)*(Standard PDY)
~ requests/Employees/hours
~ Average productivity for Total personnel.

Clinic Utilization Rate = Workweek/Standard Workweek
~ Dimensionless

Cumulative Service Backlog = INTEG (changing SB,0)
~ requests*Week

"Cumulative Avg. PDY" = INTEG (changing productivity,0)
~ requests/Employees/hours*Week

Recent Workweek = SMOOTHI(Workweek, Fatigue Onset Time, Standard Workweek)
~ hours/Week
~ Exponential smoothing of the workweek over the period for the onset of fatigue. The 'short term' label refers to the fact that the burnout onset time is much longer than the fatigue onset time.
"Cumulative Cost per Patient - S" = INTEG ("Changing costs - Salary",0)
- Dollar/year*patient*Week

Cumulative CU Rate = INTEG (changing CU,0)
- Dimensionless*Week

Total time = 150
- Week

Cumulative Insufficiency Rate = INTEG (changing insufficiency,0)
- Dimensionless*Week

Cumulative Service Capacity = INTEG (changing service capacity,0)
- Employees*Week

Effect of Fatigue on Probability of Error Free = Table for Effect of Fatigue on PEF(Recent Workweek/Standard Workweek)
- Dimensionless
- The longer the workweek, the more likely it is employees will introduce an error while processing a task.

Effect of Burnout on Turnover = Table for Effect of Burnout on Turnover(Long Term Workweek/Standard Workweek)
- Dimensionless
- The higher the workweek, the higher the turnover rate. The accumulation of the workweek happens over a period of 52 weeks.

changing productivity = "Productivity"
- requests/Employees/hours

Workweek = Effect of Work Pressure on Workweek*Standard Workweek
- hours/Week
- The workweek is the standard workweek modified by the effect of schedule pressure on workweek.

Desired Service Capacity = Desired Completion Rate/(Standard PDY*Standard Workweek)
- Employees
This is the required service capacity based on the desired production rate and the standard work intensity and time allocation.

Standard Completion Rate = Service Capacity * Standard Workweek * Standard PDY requests/Week

The standard completion rate is the rate at which tasks would be completed by the current workforce at the standard workday and spending the standard time on each task.

Service Capacity = Effective Workforce * Effect of Fatigue on Productivity

The workforce effectiveness is affected by the accumulated fatigue resulting from extended workweeks.

Workforce Adjustment Rate = (Desired Workforce - Total Employees) / Time to Adjust Workforce

Adjustments to the workforce. Smoothed over the time to adjust workforce.

Perceived Employee Effectiveness = SMOOTH( Service Capacity / Total Employees, Time to Perceive Productivity )

Management perception of workforce effectiveness. Note that this is an aggregate measure that does not distinguish the employees experience, nor the effects of fatigue, work intensity, or productivity.

Changing delay = ABS( Delivery Delay - Target Delivery Delay )

Week

Note that this is an aggregate measure that does not distinguish the employees experience, nor the effects of fatigue, work intensity, or productivity.
changing reported delay = Reported Delivery Delay
  ~ Week
  ~ I use this to calculate average performance.

Delivery Delay = Service Backlog / Request Completion Rate
  ~ Week
  ~ The average time to complete customer requests is determined by Little's Law as the ratio of the backlog to completion rate.

Cumulative Delivery Delay = INTEG (changing reported delay, 0)
  ~ Week * Week

Target Clinic Utilization = 1
  ~ DMNL

Reported Delivery Delay = DELAY FIXED (Delivery Delay, 8, Delivery Delay)
  ~ Week
  ~ There is a 2 month reporting delay as data from each facility is sent to the national office, then returned to the sites in an official monthly report.

Ramp End Time 2 = 95
  ~ Week
  ~ End time for the ramp input.

Ramp Slope = -0.001
  ~ 1/Week
  ~ Slope of the ramp input, as a fraction of the base value (per week).

Ramp Slope 2 = 0
  ~ 1/Week
  ~ Slope of the ramp input, as a fraction of the base value (per week).

Ramp Start Time = 0
  ~ Week
  ~ Start time for the ramp input.
Ramp Start Time 2=87.5
  ~ Week
  ~ Start time for the ramp input.

Hiring=MAX(Desired Hiring Rate, 0)
  ~ Employees/Week
  ~ Vacancies filled by hiring.

Ramp End Time=500
  ~ Week
  ~ End time for the ramp input.

Perceived Error Discovery Rate=SMOOTH(Error Discovery Rate, Time To Perceive Arrival Rate)
  ~ requests/Week
  ~ The instantaneous error discovery rate, averaged over the period of 1 week. VAMC Boston managers receive weekly reports on rework.

Perceived Completion Rate=SMOOTH(Request Completion Rate , Time To Perceive Arrival Rate)
  ~ requests/Week
  ~ The instantaneous request completion rate, averaged over the period of 1 week. VAMC Boston managers receive weekly reports on work completed.

Perceived Request Arrival Rate=SMOOTH(Request Arrival Rate, Time To Perceive Arrival Rate, Request Arrival Rate)
  ~ requests/Week
  ~ The instantaneous demand averaged over the period of 1 week. VAMC Boston managers receive weekly reports on demand.

Time To Perceive Arrival Rate= 0.1
  ~ Week
  ~ VAMC Boston runs reports weekly on most C&P data.

Duration Over Which To Calculate Trend=2
  ~ Week
  ~ Duration Over Which To Calculate Trend

"Exp. Lay Off Rate"=IF THEN ELSE( Rookie Lay Off Rate < Desired Lay Off Rate, MIN(Desired Lay Off Rate, \}
Maximum Layoff Rate), 0 }
~ Employees/Week
~

"endogeneous P-control"=Desired Completion Rate
~ requests/Week
~ Proportional reaction to endogenous variable (service backlog).

Accumulating Error=
(Desired Completion Rate-Request Completion Rate)/Error Correction Time
~ requests/(Week*Week)
~ Changes in gap between desired and actual completion rates.

Change in Error=((Desired Completion Rate-Request Completion Rate)-Exp Avg of Error) / Error Correction Time
~ requests/(Week*Week)
~

Cumulative Error= INTEG (Accumulating Error,0)
~ requests/Week
~ Accumulation of uncorrected error. Allows for error correction even when proportional control has waned due to reduction in the instantaneous error.

Error Correction Time= 8
~ Week
~ Time to correct error between desired and actual completion rates.

Exp Avg of Error= INTEG (Change in Error,0)
~ requests/Week
~ Historical average of change in gap between desired and actual completion rates.

"exogeneous P-Control"=Request Arrival Rate
~ requests/Week
~ Proportional reaction to exogenous variable (demand).

weight of demand=1
~ DMNL [0,1,0.1]
~ Determines how much the system responds to exogenous or endogenous variables.
Normal Workweek = 40 hours/Week

Probability of Error Generation = 1 - (Effect of Fatigue on Probability of Error Free * Effect of Inexperience on Probability of Error Free)

Dimensionless

Formulated as one minus the combined probability of being error free from fatigue and inexperience.

"Table for Effect of Work Pressure on Workweek -- Distributed":
\[ \begin{align*}
&(-0.25,0), (0,0.8), (0.15,0.82), (0.25,0.85), (0.4,0.9), (0.5,0.9), (0.75,0.98), (1,1), (1.25,1.02), (1.5,1.035), (1.75,1.045), (2,1.05), (2.25,1.05) \\
\end{align*} \]

Dimensionless

High schedule pressure leads to longer hours.

"Table for Effect of Work Pressure on Workweek -- Centralized":
\[ \begin{align*}
&(-0.25,0), (0,0.5), (0.25,0.55), (0.5,0.69), (0.75,0.85), (1,1), (1.25,1.15), (1.5,1.3), (1.75,1.4), (2,1.45), (2.25,1.45) \\
\end{align*} \]

Dimensionless

High schedule pressure leads to longer hours.

"Avg. Layoff Time" = IF THEN ELSE("Agile Switch, 1=Cent" = 1, 8, 2) Week

The average time required to lay off a worker. Laying off clinicians working directly under C&P is a full HR process (8 weeks). Borrowed staff only take 2 weeks to remove: all they have to do is re-structure their clinic profiles in the EMR.

Maximum Layoff Rate = Rookie Employees / "Avg. Layoff Time" Employees/Week

The maximum layoff rate is determined by the number of workers and the layoff time.

Desired Lay Off Rate =
\[ \text{Willingness to Lay Off} \times \text{MAX}(0, -\text{Desired Hiring Rate}) \]

Employees/Week

The firm desires to lay people off whenever the desired hiring rate is
negative, modified by their willingness to lay off. Willingness to Lay Off = 0 implies a no layoff policy.

Rookie Lay Off Rate = MIN(Desired Lay Off Rate, Maximum Layoff Rate)
~ Employees/Week
~ The layoff rate is the lesser of the desired or maximum rate.

Willingness to Lay Off = 1
~ Dimensionless
~ The willingness to layoff employees. Zero = no layoff policy; 1 implies the firm is just as willing to layoff employees when there are too many as to hire when there are too few.

Cumulative Error in Delivery Delay = INTEG (changing delay, 0)
~ Week*Week
~

Expert Quits = Experienced Employees*Experienced Quit Fraction*Effect of Burnout on Turnover
~ Employees/Week
~ Experienced employees turnover.

Steady State Rookie Fraction = "Matur-ing Time"*(Experienced Quit Fraction)/(1+"Matur-ing Time"*Experienced Quit Fraction)
~ Dimensionless
~ Rookie fraction in equilibrium, or steady state growth. Used to initialize the model.

"Capacity Slack Fraction (can be included as a test)" = 0
~ Dimensionless
~ Test constant to introduce permanent slack in the authorization of the workforce. Set to 0 to start the system in equilibrium

Effective Workforce = Experienced Employees + (Rookie Employees*Rookie productivity fraction)
~ Employees
~ Expected output from the labor pool accounting for the effect of labor mix on average productivity. Measured in FTE (Fully Trained Equivalents).

Desired Hiring Rate = Replacement Rate + Workforce Adjustment Rate
The desired hiring rate replaces employees that left the hospital and adjust for changes in the desired workforce.

Replacement Rate = Total Quit Rate

"Matur-ing Time" = IF THEN ELSE("Agile Switch, 1=Cent"=1, 16, 52) Week

Time to Adjust Workforce = IF THEN ELSE("Agile Switch, 1=Cent"=1, 52, 16) Week

Rookie productivity fraction = 0.5 Dimensionless [0,1]

Rookie Quits = Rookie Employees * Rookie Quit Fraction * Effect of Burnout on Turnover Employees/Week

Total Employees = Rookie Employees + Experienced Employees Employees

Experienced Quit Fraction = IF THEN ELSE("Agile Switch, 1=Cent"=1, 0.005, 0.02) Dimensionless/Week [0,2]
Fraction of Experienced employees that leaves C&P every week. Centralized staff are less likely to quit, as they work for C&P full time; whereas currently most specialists view C&P as secondary to their normal work.

Time to Adjust Desired Workforce = 2

Time to Perceive Productivity = 13

Total Quit Rate = Rookie Quits + Expert Quits

Maturing = Rookie Employees / "Matur-ing Time"

Rookie Quit Fraction = 0

Table for Effect of Burnout on Turnover:

Initial Arrival Rate = INITIAL(655)

The initial rate at which work arrives is set to the initial value of the standard completion rate. Note that the equation type is INITIAL, which ensures that the initial arrival rate remains constant even if the standard completion rate varies. By setting the initial arrival rate to the standard completion rate we ensure that tasks arrive at exactly the rate the organization can handle given the initial staff and standard...
values for the workday and time per task.

| Table for Effect of Fatigue on PEF = f(Recent Workweek/Standard Workweek). |
| ~ Dimensionless |
| ~ Non-linear relationship. Effect of Fatigue on PEF = f(Recent Workweek/Standard Workweek). |

Error Creation Rate = IF THEN ELSE(Rework Switch=1, Request Completion Rate*Probability of Error Generation, 0) ~ requests/Week

| Table for Effect of Inexperience on PEF = f(Average Productivity) |
| ~ Dimensionless |
| ~ Non-linear relationship. Effect of Inexperience on PEF = f(Average Productivity) |

Time to Discover Errors = 4 ~ Week [1,24,1]

On average, the VBA reads the reports 1 month after submission.

Exogenous Request Arrival Rate = MAX (Initial Arrival Rate*Input, 0) ~ requests/Week

The exogenous request arrival rate can be configured to include a range of test inputs. It is set to the product of the initial arrival rate and the test input. The test input allows users to specify a range of input patterns, including a step, pulse, ramp, cycle, and pink noise, or combinations of these.

Burnout Onset Time = 52 ~ Week

Time for the extended workweek to have an effect on turnover.

Pulse Quantity = 0 ~ Dimensionless*Week

The quantity to be injected to customer orders, as a fraction of the base value of
Input.

For example, to pulse in a quantity equal to 50% of the current value of input, set to .50.

Request Arrival Rate = Exogenous Request Arrival Rate
~ requests/Week
~ Request Arrivals are set to an exogenous rate, as the delivery delay in this model is too small a part of total delivery delay to impact customer preferences.

Sine Period = 52
~ Week
~ Period of sine wave in customer demand. Set initially to 52 weeks to simulate an annual cycle

Effect of Fatigue on Productivity = Table for Effect of Fatigue on Productivity (Recent Workweek)
~ Dimensionless
~ Long workweeks reduce employee productivity.

Sine Amplitude = 0
~ Dimensionless
~ Amplitude of sine wave in customer orders (fraction of mean).

Pink Noise = INTEG(Change in Pink Noise, 0)
~ Dimensionless
~ Pink Noise is first-order autocorrelated noise. Pink noise provides a realistic noise input to models in which the next random shock depends in part on the previous shocks. The user can specify the correlation time. The mean is 0 and the standard deviation is specified by the user.

Step Height = 0.25 - 0.25
~ Dimensionless
~ Height of step input to customer orders, as fraction of initial value.

Step Time = 10
~ Week
~ Time for the step input.
Fatigue Onset Time = 3
  ~ Week
  ~ Time for the extended workweeks to have an impact on employee productivity.

Pulse Time = 1e+012
  ~ Week
  ~ Time at which the pulse in Input occurs.

White Noise = Noise Standard Deviation * ((24 * Noise Correlation Time / TIME STEP)^0.5 * (RANDOM 0 1 \( \cdot - 0.5 \)))
  ~ Dimensionless
  ~ White noise input to the pink noise process.

Noise Start Time = 1e+014
  ~ Week
  ~ Start time for the random input.

Undiscovered Errors = INTEG (Error Creation Rate - Error Discovery Rate, Error Creation Rate * Time to Discover Errors)
  ~ requests
  ~ Stock of undiscovered errors.

Noise Correlation Time = 10
  ~ Week [2,100,2]
  ~ The correlation time constant for Pink Noise.

Noise Seed = 0
  ~ Dimensionless [0,100,1]
  ~ Random number generator seed. Vary to generate a different sequence of random numbers.

Work Pressure = Desired Service Capacity / Service Capacity
  ~ Dimensionless
  ~

Table for Effect of Fatigue on Productivity:
(0,0), (0,1), (20,0.97), (40,1), (60,0.8), (80,0.4), (100,0.1), (120,0.03), (140,0.01), (160,0)

~ Dimensionless
Extended workweeks leads to reduced productivity.

Pulse Duration = 13
  ~ Week
  ~ Duration of pulse input. Set to Time Step for an impulse.

Rework Switch = 1
  ~ Dimensionless
  ~ Switch to control if the probability of error response to fatigue is active.

Maximum Completion Rate = Service Backlog / Minimum Delivery Delay
  ~ requests/Week
  ~ The maximum completion rate is determined by the backlog and minimum time to complete a customer request.

Request Completion Rate = \( \min(\text{Potential Completion Rate}, \text{Maximum Completion Rate}) \)
  ~ requests/Week
  ~ The rate at which customer requests are completed is the lesser of the maximum rate or the potential rate, which in turn is determined by labor, workday, and the time spent on each task.

Minimum Delivery Delay = 0.5
  ~ Week
  ~ The fastest possible completion time for customer requests.

Potential Completion Rate = Service Capacity * Standard PDY * Workweek
  ~ requests/Week
  ~ The potential completion rate depends on the net available labor force, the workday, and the average time spent on each task.

Service Backlog = \( \text{INTEG} (\text{Request Arrival Rate} + \text{Error Discovery Rate} - \text{Request Completion Rate}) \)
  ~ requests
  ~ The initial backlog is set to the equilibrium value determined by the arrival rate and target delivery delay.

Target Delivery Delay = 3.85
The Boston VAMC goal is to complete each request within three weeks (within the mandate set nationally at 30 days).

Performance Measures

Total waiting time (min. avg. max.) = Maximum, Average, and Minimum of Delivery Delay

Delivery Delay = Service Backlog/Request Completion Rate

The average time to complete customer requests is determined by Little’s Law as the ratio of the backlog to completion rate.

where:

Average Delivery Delay = Maximum value of (INTEG(Delivery Delay, 0)/Total Time)

Average report insufficiency = Maximum value of ("Avg. Insufficiency Rate")

Average total cost = Maximum value of ("Avg. Cost - Salary" + "Avg. Cost - SalaryOT")

where:

OT Cost Ratio = 1.5

Cost per Employee = IF THEN ELSE("Clinician Switch, 1=PA"=1, 75000, 150000)

Average clinician utilization = Maximum value of ("Avg. Clinic Utilization Rate")

Dollar/year/Employees

Specialists make $150,000 per year and PAs make $75,000 per year.
Average clinician productivity = Maximum value of ("Avg. Productivity Rate")
= (INTEG ((Service Capacity/Total Employees)*(Standard PDY), 0)
 /Total Time
~ requests/Employees/hours
~ Average productivity for Total personnel.

Average cost per patient = Maximum value of ("Avg. Cost per Patient - Salary")
= INTEG(ZIDZ("Yearly Cost of C&P - Salary OT+Yearly Cost of C&P - Salary", Service
Backlog) * "Avg. Requests per Patient", 0)
/ Total Time)
~ Dollar/(year*patient)

where:
"Avg. Requests per Patient" = 1.6
~ requests/patient

Avg. absolute waiting time error = Maximum value of ("Avg. Absolute Delivery Delay Error")
= (INTEG((ABS(Delivery Delay-Target Delivery Delay) )*"Days/week", 0)
/Total time)
~ day
Appendix D: Model Equations for Chapter 2 – Formulations, stock and flow diagram, units, and commentary

Stock and flow diagram of a generic healthcare service delivery chain:

The following formulae and commentary are for one representative clinic in the service chain. All clinics are identical, as are all formulations for performance measures for each clinic.

Task 1 Backlog = INTEG ("End-Customer Demand"-Completing Task 1, ("End-Customer Demand")*("Target Task 1 Service Delay (lambda 1)"))
~ Tasks
~ This is the backlog of tasks to be completed.

Service Capacity for Task 1 = INTEG ("Hiring/Firing for WF1", Initial Workforce 1)
~ Employees
~ Service capacity for each stage is determined by hiring, and affects the rate of completing tasks (along with workweek and time per task).

Completing Task 1 = MIN(Maximum Completion Rate 1, (Service Capacity for Task 1*Workweek 1/Time per Task 1))
~ Tasks/Week
~ The rate at which stage tasks are completed is the lesser of the maximum rate or the potential rate, which in turn is determined by labor, workday, and the time spent on each task.

Desired Completion Rate 1 = Task 1 Backlog/"Target Task 1 Service Delay (lambda 1)"
~ Tasks/Week
~ To complete tasks in the target delivery time, the completion rate must be equal to the backlog divided by the target time.
Desired Service Capacity 1 = Desired Completion Rate 1 * Time per Task 1 / Workweek 1
~ Employees
~ This is the required service capacity based on the desired production rate and the standard work intensity and time allocation.

Maximum Completion Rate 1 = Task 1 Backlog / Minimum Delivery Delay 1
~ Tasks/Week
~ The maximum completion rate is determined by the backlog and minimum time to complete a customer request.

"Hiring/Firing for WF1" = Service Capacity Gap 1 / "Task 1 Capacity Adjustment Time (tau 1)"
~ Employees/Week
~ The hiring or firing rate depends on the gap between the desired and actual service capacity and the speed at which managers can adjust capacity.

Service Capacity Gap 1 = Desired Service Capacity 1 - Service Capacity for Task 1
~ Employees
~ This represents manager’s actions comparing desired service capacity to actual service capacity. Note that there are no perception delays, just action delays.

Time per Task 1 = Standard Time per Task * Improvement 1
~ Employees*Hours/Tasks
~ The time spent on each task (in person-hours/task) is the time workers allocate to each task. Changing this efficiency parameter is the main effect of lean improvement activities, included here at “improvement 1”

Initial Workforce 1 = (Exogenous Task Arrival Rate * Time per Task 1) / Workweek 1
~ Employees
~ This starts the model in equilibrium, with the appropriate size workforce for the exogenously determined demand rate.

Exogenous Task Arrival Rate = Initial Arrival Rate * Input
~ Tasks/Week
~ The exogenous task arrival rate can be configured to include a range of test inputs. It is set to the product of the initial arrival rate and the test input. The test input allows users to specify a range of input patterns, including a step, pulse, ramp, cycle, and pink noise, or combinations of these. For simplicity, we only include formulations for pink noise, as the other demand patterns are straightforward.

Input = 1 + STEP(Step Height, Step Time) + (Pulse Quantity / Pulse Duration) * PULSE(Pulse Time, Pulse Duration) + RAMP(Ramp Slope, Ramp Start Time, Ramp End Time) + RAMP(Ramp Slope 2, Ramp Start Time 2, Ramp End Time 2) + Sine Amplitude * SIN(2 * 3.14159 * Time / Sine Period) +
STEP(1, Noise Start Time)*Pink Noise

~ Dimensionless
~ Input is a dimensionless variable which provides a variety of test input patterns, including a step, pulse, sine wave, and random noise.

Change in Pink Noise = (White Noise - Pink Noise)/Noise Correlation Time

~ 1/Week
~ Change in the pink noise value; Pink noise is a first order exponential smoothing delay of the white noise input.

"End-Customer Demand"=Exogenous Task Arrival Rate

~ Tasks/Week
~ End-Customer Demand is set to an exogenous rate.

Pink Noise = INTEG(Change in Pink Noise,0)

~ Dimensionless
~ Pink Noise is first-order auto-correlated noise. Pink noise provides a realistic noise input to models in which the next random shock depends in part on the previous shocks. The user can specify the correlation time. The mean is 0 and the standard deviation is specified by the user.

White Noise = Noise Standard Deviation*((24*Noise Correlation Time/TIME STEP)^0.5*(RANDOM 0 1 - 0.5 ))

~ Dimensionless
~ White noise input to the pink noise process.

**Parameters**

Standard Task Service Delay= 1

~ Week
~ This represents the target service delay for each stage in the service chain for the average patient.

Standard Time per Task=1

~ Employees*Hours/Tasks
~ How many hour it takes one employee to do one task.

"Task 1 Capacity Adjustment Time (tau 1)"=2

~ Week
~ This represents the time it takes managers to actually manifest the changes in staff they decide are necessary. A two week capacity adjustment time is the relative equivalent of a two week delay between deciding to hire a new staff member, and that new employee actually coming on board.

Initial Arrival Rate=100

~ Tasks/Week
This represents the initial exogenous demand rate.

Workweek 1 = 40
   ~ Hours/Week
   ~ Hours worked per week under normal conditions, i.e., neutral work pressure.

Noise Correlation Time = 4
   ~ Week
   ~ The correlation time constant for Pink Noise.

Noise Standard Deviation = 0.1
   ~ Dimensionless
   ~ The standard deviation of the pink noise process.

Noise Seed = 70
   ~ Dimensionless
   ~ Random number generator seed. Vary to generate a different sequence of random numbers.

Minimum Delivery Delay 1 = 0.05
   ~ Week
   ~ The fastest possible completion time for customer requests.

Performance Measures
Desired Backlog 1 = ("End-Customer Demand")*("Target Task 1 Service Delay (lambda 1)")
   ~ Tasks
   ~ The appropriate number of patients (represented by tasks) to keep in a clinic's queue to maintain the desired performance time.

"Inst. Average Process Time 1" = Task 1 Backlog/Completing Task 1
   ~ Week
   ~ By Little's Law, this is the average time each patient waits in the queue before their clinical tasks are complete.

Workload 1 = Desired Service Capacity 1/Service Capacity for Task 1
   ~ Dmnl
   ~ This is the ratio of patients (converted to the units of "providers" by the desired performance standard (measured in weeks) to the actual number of providers available.

"Acc. Workload 1 Error" = INTEG (ABS(Workload 1), 0)
   ~ Dmnl*Week
   ~ This is the sum of all error over the course of the simulation. This allows for one number to represent the dynamic behavior over an entire simulation, to
facilitate easy compare to other simulations.

"Target Task 1 Service Delay (lambda 1)" = Standard Task Service Delay * Improvement 1

~ Week

~ The organization's goal is to for the average customer to complete the process within 4 weeks (one week per stage of service delivery).
Appendix E: Model Equations for Chapter 3 – Formulations, stock and flow diagram, units, and commentary

Stock and flow diagram of the generic healthcare service delivery chain:

The following formulae and commentary are for one representative clinic in the service chain. All clinics are identical, as are all formulations for performance measures for each clinic.

"Patient Backlog (B)" = INTEG ("Patient Arrival Rate (Ra)" - "Patient Care Completion Rate (Re)", ("Patient Arrival Rate (Ra)")*Target Service Time)

~ patient
~ This is the backlog of patient waiting for service.

"Patient Arrival Rate (Ra)" = Exogenous Patient Arrival Rate

~ patient/Day
~ The arrival rate of patients into the clinic.

"Patient Care Completion Rate (Re)" = MIN(Maximum Completion Rate, "Service Capacity (C)"

~ patient/Day
~ The rate at which provider see patients is the lesser of the maximum rate or the potential rate, which in turn is determined by labor, workday, and the time spent on each task.

"Service Capacity (C)" = INTEG ("Hiring/Firing", Desired Care Capacity)

~ patient/Day
~ Service capacity for each clinic is determined by hiring, and affects the rate of completing tasks.
Desired Care Capacity = IF THEN ELSE(POS Demand Switch = 1, ("Patient Arrival Rate (Ra)" * Fraction of POS demand used) + ("Patient Backlog (B)" * (1 - Fraction of POS demand used))/Target Service Time), "Patient Backlog (B)"/Target Service Time)
~ patient/Day
~ To complete requests in the target delivery time, the completion rate must be equal to the backlog divided by the target time.

Maximum Completion Rate = "Patient Backlog (B)"/Minimum Delivery Delay
~ patient/Day
~ The maximum completion rate is determined by the backlog and minimum time to complete a customer request.

"Hiring/Firing" = IF THEN ELSE(PID Switch = 1, "PID-Gap"/ Time to Adjust Workforce, (Gap/ Time to Adjust Workforce))
~ patient/Day/Day
~ The hiring or firing rate depends on the gap between the desired and actual service capacity and the speed at which managers can adjust capacity.

"P-Control" = Gap
~ patient/Day
~ Proportional control.

"I-Control" = Cumulative Error
~ patient/Day
~ Integral control.
Cumulative Error = INTEG (Accumulating Error, )
~ patient/Day
~ Accumulation of uncorrected error. Allows for error correction even when proportional control has waned due to reduction in the instantaneous error.

Accumulating Error = Gap/Error Correction Time
~ patient/(Day*Day)
~ Changes in gap between desired and actual completion rates.

Gap = (Desired Care Capacity - "Service Capacity (C)")
~ patient/Day
~ The difference between desired and actual completion rates.

Exp Avg of Error = INTEG (Change in Error,0)
~ patient/Day
~ Historical average of change in gap between desired and actual completion rates.
Change in Error = (Gap - Exp Avg of Error) / Error Correction Time
   ~ patient/(Day*Day)
   
"D-Control" = Trend in Error Correction
   ~ patient/Day
   ~ Derivative control.

Trend in Error Correction = (Gap - Exp Avg of Error)
   ~ patient/Day
   ~ The trend of the error correction rate.

"PID-Gap" = (P Wt*"P-Control") + (I Wt*"I-Control") + (D Wt*"D-Control")
   ~ patient/Day
   ~ Total, weighted desired capacity derived using PID control.

Exogenous Patient Arrival Rate = Initial Arrival Rate*Input
   ~ patient/Day
   ~ The exogenous task arrival rate can be configured to include a range of test inputs. It is set to the product of the initial arrival rate and the test input. The test input allows users to specify a range of input patterns, including a step, pulse, ramp, cycle, and pink noise, or combinations of these. For simplicity, we only include formulations for pink noise, as the other demand patterns are straightforward.

Initial Arrival Rate = INITIAL(10)
   ~ patient/Day
   ~ The base rate of demand.

Input = 1 + STEP(Step Height, Step Time) +
   (Pulse Quantity / Pulse Duration)*PULSE(Pulse Time, Pulse Duration) +
   RAMP(Ramp Slope, Ramp Start Time, Ramp End Time) +
   RAMP(Ramp Slope 2, Ramp Start Time 2, Ramp End Time 2) +
   Sine Amplitude*SIN(2*3.14159*Time/Sine Period) +
   STEP(1, Noise Start Time)*Pink Noise
   ~ Dimensionless
   ~ Input is a dimensionless variable which provides a variety of test input patterns, including a step, pulse, sine wave, and random noise.

Pink Noise = INTEG(Change in Pink Noise, 0)
   ~ Dimensionless
   ~ Pink Noise is first-order auto-correlated noise. Pink noise provides a realistic noise input to models in which the next random shock depends in part on the previous shocks. The user can specify the correlation time. The mean is 0 and the standard deviation is specified by the user.
Change in Pink Noise = (White Noise - Pink Noise)/Noise Correlation Time
~ 1/Day
~ Change in the pink noise value; Pink noise is a first order exponential smoothing delay of the white noise input.

White Noise= Noise Standard Deviation*((Noise Correlation Time/TIME STEP)^0.5*(RANDOM 0 1() - 0.5))
~ Dimensionless
~ White noise input to the pink noise process.

**Parameters**

**Time to Adjust Workforce= 20**
~ Day
~ This represents the time it takes managers to actually manifest the changes in staff they decide are necessary. A 20 day adjustment time is the relative equivalent of a three week delay between deciding to hire a new staff member, and that new employee actually coming on board.

**Fraction of POS demand used 1 = 0.0**
~ Dimensionless [0,1,0.1]
~ Determines the relative importance of local backlog and initial-customer demand in managing a clinic’s service capacity.

**PID Switch=0**
~ Dimensionless
~ Setting this to “1” changes clinic managers decision heuristics to include derivative control.

**P Wt= 1**
~ Dimensionless
~ Determines the relative weight of proportional control, compared to other control feedbacks.

**I Wt= 0**
~ Dimensionless
~ Determines the relative weight of integral control, compared to other control feedbacks.

**D Wt= 1**
~ Dimensionless
~ Determines the relative weight of derivative control, compared to other control feedbacks.

**Target Service Time=5**
~ Day [0,10,0.5]
~ The clinic’s goal is to for the average customer to complete the process within five days.

**Minimum Delivery Delay=0.5**
~ Day
The fastest possible completion time for customer requests.

Step Time = 10
- Day
- Time for the step input.

POS Demand Switch = 1
- DMNL
- Setting this to “1” allows clinics to use initial demand (POS = point of sale, which is terminology from supply chain management).

Noise Correlation Time = 10
- Day [2,100,2]
- The correlation time constant for Pink Noise.

Noise Seed = 46
- Dimensionless [0,100,1]
- Random number generator seed. Vary to generate a different sequence of random numbers.

Noise Standard Deviation = 0.3
- Dimensionless
- The standard deviation of the pink noise process.

Noise Start Time = 1e+012
- Day
- Start time for the random input.

Step Height = 0.1
- Dimensionless
- Height of step input to customer orders, as fraction of initial value.

Error Correction Time = 10
- Day
- Time to correct error between desired and actual completion rates.

Performance measures
Accumulated Error = INTEG (ABS Error,0)
- Day*Day
- This is the sum of all error over the course of the simulation. This allows for one number to represent the dynamic behavior over an entire simulation, to facilitate easy compare to other simulations.

Exp Avg of Error = INTEG (Change in Error,0)
- Patient/Day
- Historical average of change in gap between desired and actual completion
Cumulative Error = INTEG (Accumulating Error,0)

\[ \text{~ patient/Day} \]
\[ \sim \text{Accumulation of uncorrected error. Allows for error correction even when proportional control has waned due to reduction in the instantaneous error.} \]

Exp Avg of Error = INTEG (Change in Error ,0)

\[ \text{~ patient/Day} \]
\[ \sim \text{Historical average of change in gap between desired and actual completion rates.} \]

Gap = (Desired Care Capacity - "Service Capacity (C)")

\[ \text{~ patient/Day} \]

Error = Target Service Time - Actual Service Time

\[ \text{~ Day} \]

Norm Rel Error = (Actual Service Time/Target Service Time) - 1

\[ \text{~ Dimensionless} \]

Actual Service Time = "Patient Backlog (B)" / "Patient Care Completion Rate (Re)"

\[ \text{~ Day} \]
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