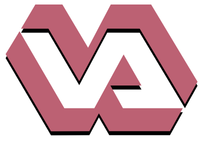

Transition Watch

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VISN Service Line Implementation: Who's Doing What?

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Health Services Research & Development's Management Decision and Research Center continues to study the Service Line implementation process. The service line evaluation project staff completed site visits to all 22 Veterans Integrated Service Networks (VISNs) in September, 1997 and we now have a tally of what service lines have been implemented or are being planned in the VISNs. In our travels and interviews we found many service line activities at the facility level as well. We will address facility level service line implementation in a future *Transition Watch* article and focus on VISN level service lines now.

As described in the last issue of *Transition Watch*, service lines are defined as an organizational model which provides:

1) a comprehensive set of services to meet the needs of a particular segment of the market (e.g., women, geriatrics) or

2) an integrated set of services (e.g. cancer, heart or diabetes centers) distinguished from other services by the technology or specialty employed.

In some cases we found a discrepancy between the above definition of service lines and what some VISNs defined as service lines. Thus, our tally of service lines in a particular VISN sometimes differed from that of the VISN. For example, what a VISN might call a standing clinical committee on primary care, we would call a primary care service line team. A more common example is that some VISNs may call non-clinical or administrative entities a service line while we would not. Several VISNs have diagnostic services or clinical support "service lines" that do not meet the above definition of service lines. After our analysis and verification with each VISN, we feel confident that the chart on pages 2-3 summarizes the type and number of VISN service lines and their status as of November, 1997. The chart also includes diagonostic and clinical support services.

While some differences in terminology exist, four main areas of clinical service lines emerge. The table below shows the number of VISNs implementing service lines in these four areas.

Service Line	Number of VISNs Implementing
Mental Health/Behavioral Health	18
Primary Care	15
Extended Care/ Geriatrics/ Long Term Care	13
Medical Surgical (individually or together as composite service line)	6

Organizational Variations

Three different organizational variations can be used to implement service lines: task forces, teams and service line divisions. Each varies in the level of integration achieved among staff and facilities.

- **Task forces** bring together a group with a variety of perspectives for what is usually a limited period to complete a defined activity.
- **Teams** are more permanent with broader management and clinical responsibilities than task forces and team leaders often have input into members' performance evaluations.
- **Service line divisions** are permanent, and control budget and personnel as well as most if not all clinical and administrative functions needed to support the service line.

As shown in the VISN Service Line chart, a majority of service lines implemented at the VISN level are currently utilizing task forces. Six VISNs have one or more team structures. Five VISNs project that they will

IN THIS ISSUE

Service Lines ..... Page 1
Analysis of Facility Integrations .... Page 4
Quality Improvement Study .... Page 7

VISN Service Line Implementation As of November, 1997

VISN#	VISN Name	SL Name	Status of SL		Status of Budget Authority	
			Current	Projected	Current	Projected
1	**New England Healthcare System CT, MA, NH, RI, VT**	Mental Health	Task Force	Undecided	No	Undecided
		Extended Care	Task Force	Undecided	No	Undecided
		Ambulatory Care	Team	Undecided	No	Undecided
		Acute Inpatient	Task Force	Undecided	No	Undecided
2	**Upstate NY VA Healthcare Network NY**	Mental Health	Task Force	Division	No	Yes
		Geriatrics/ Extended Care	Task Force	Division	No	Yes
		Medical /Surgical Care	Task Force	Division	No	Yes
		Diagnostics/ Therapeutics	Task Force	Division	No	Yes
3	**New York/New Jersey VISN NY, NJ**	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
		Geriatric/ Extended Care	Task Force	Task Force	No	No
		SCI	Team	Division	No	Yes
		Prosthetics	Division	Division	Yes	Yes
		Operative/ Invasive Procedures	Task Force	Task Force	No	No
		Diagnostic Services	Task Force	Task Force	No	No
		Support Services	Task Force	Task Force	No	No
4	**Stars & Stripes Network PA, WV, DE**	Prim. Care & Consult. Medicine	Task Force	Undecided	No	No
		Geriatrics & LT Care	Task Force	Undecided	No	No
		Surgery	Task Force	Undecided	No	No
		Clinical Support Services	Task Force	Undecided	No	No
		Behavioral Health	Task Force	Undecided	No	No
5	**VA Capital Network MD, WV, DC**	Mental Health	Task Force	Division	No	Yes
		Geriatrics/Extended Care	Task Force	Division	No	Yes
		Women's Health	Task Force	Team	No	No
6	**Mid-Atlantic Network VA, NC, WV**	Mental Health	Task Force	Division	No	Yes
		Primary Care	Task Force	Division	No	Yes
		SCI	Task Force	Division	No	Yes
7	**Atlanta Network GA, SC, AL**	Mental Health	Team	Undecided	No	No
		Primary Care	Team	Undecided	No	No
		Extended Care	Task Force	Undecided	No	No
		Specialty & Ancillary	Task Force	Undecided	No	No
8	**VA Sunshine Healthcare Network FL, PR**	Mental Health	Task Force	Task Force	No	No
		Extended Care/ Geriatrics	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
9	**Mid South Healthcare Network KT, TN, WV**	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
10	**Veterans Healthcare System of Ohio OH**	Mental Health	Task Force	Team	No	Yes
		Primary Care	Task Force	Team	No	Yes
		Extended Care	Task Force	Team	No	Yes
		Medical/ Surgical	Task Force	Team	No	Yes
		Rehabilitation	Task Force	Team	No	Yes
		Clinical Support Services	Task Force	Team	No	Yes

implement a division structure for one or more of their service lines.

VISNs using Task Forces

A wide variation exists among the service line task forces to date. For example, in VISN 4 the service line task forces comprise 5 standing committees that report to a Health Services Council. The Health Services Council, in turn, is one of five councils (and the only one that is clinically-focused) that report to the Executive Leadership Council. Its membership consists primarily of clinical staff involved in the delivery of that particular service.

In contrast, VISN 7 has assigned each facility director collateral duty as chair of a service line task force. For example, the facility director for the Atlanta VA Medical Center is also the Service Line Director for Primary Care. As the service line director, he is responsible for chairing and directing the planning efforts for primary care throughout the VISN, although he has no formal authority in that role.

VISN Service Line Implementation As of November, 1997, *continued*

VISN#	VISN Name	SL Name	Status of SL Current	Status of SL Projected	Status of Budget Authority Current	Status of Budget Authority Projected
11	**VISN 11 MI, IN**	Mental Health	Task Force	Task Force	No	No
		Extended Care	Task Force	Task Force	No	No
12	**Great Lakes Healthcare System IL, WI, MI**	Cardiac Surgery	Task Force	Task Force	No	No
		Mental Health	Task Force	Undecided	No	No
		Path. & Lab Med.	Task Force	Task Force	No	No
		Imaging	Task Force	Task Force	No	No
		Prosthetic	Task Force	Task Force	No	No
13	**VA Upper Mid West Network MN, SD, ND**	Mental Health	Task Force	Division	No	Yes
		Primary Care	Task Force	Division	No	Yes
		LT/ Extended Care	Task Force	Division	No	Yes
		Specialty Care	Task Force	Division	No	Yes
14	**VA Central Plains Network NE, IA**	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
15	**Heartland Network MO, KS, IL**	Mental Health	Team	Team	Approval	Approval
		Primary Care	Team	Team	Approval	Approval
		Specialty Care	Task Force	Team	No	Undecided
		Clinical Support	Task Force	Team	No	Undecided
16	**VISN 16 MS, TX, LA, AR, OK**	Mental Health	Team	Team	No	No
		Primary Care	Task Force	Team	No	No
		Extended Care	Task Force	Team	No	No
		Tertiary Care	Task Force	Task Force	No	No
17	**Heart of Texas Health System TX**	None	Traditional	Traditional		
18	**VA Southwest Network NM, TX, AZ**	None	Traditional	Traditional		
19	**Rocky Mountain CO, WY, UT, MT**	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
20	**Northwest Network OR, WA, AK, ID**	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
		LT Care	Task Force	Task Force	No	No
		Surgical	Task Force	Task Force	No	No
		Medical Specialties	Task Force	Task Force	No	No
21	**VA Sierra Pacific Network CA, NV, HI, Philippines**	Mental Health	Team	Undecided	No	Undecided
		Primary Care	Task Force	Undecided	No	Undecided
		Extended Care	Team	Undecided	No	Undecided
		Orthopedics	Task Force	Undecided	No	Undecided
		Cardiac Care	Task Force	Undecided	No	Undecided
		Urology	Task Force	Undecided	No	Undecided
22	**Desert Pacific Healthcare Network NV, CA**	None	Traditional	Traditional		

VISNs using Teams

Six VISNs currently have service line teams in place. VISN 15, for example, has already designated service line directors for mental health and primary care, with corresponding service line managers at the facility level. While these local service line managers still officially report to the facility Chief of Staff and Director, they get their policy leadership (i.e., practice guidelines, staffing mix) through the service line.

VISN 10 is proposing to move from six service line task forces to service line teams within the next year or two. All the service line directors are MDs, (except for primary care, which has not yet been filled but is slotted as an MD), and are expected to have budget and policy control over their designated clinical areas. The pre-existing service line councils will continue at the behest of these service line directors, and the facility director role will change to a medical site manager. Service line directors will oversee clinical service delivery throughout the network by means of controlling and directing the funds used to provide particular services (i.e.,

Continued on page 6

Integration Planning and Implementation

News from the Facility Integration Study

by Brian S. Mittman, Ph.D.

In the previous issue of *Transition Watch*, we reported early findings emerging from the ongoing study of facility integrations conducted by the MDRC, in collaboration with the Center for the Study of Healthcare Provider Behavior, an HSR&D Field Program. This study is examining the process of integration and its effects, and is designed to produce insights and recommendations for VHA managers and clinicians charged with monitoring and guiding the facility integrations already in process, as well as those expected in the future.

The previous article described the characteristics of integrating facilities and discussed important integration process barriers and facilitators. The current article reports additional study findings, addressing selected issues encountered during integration planning and implementation processes—including the role of organizational culture and organizational change processes in integration, the need for comprehensive and frequent communication with staff and external stakeholders, and the tension between comprehensive planning and flexibility in designing and guiding the integration process. Like the first article, this article reports early observations and findings, rather than final conclusions. However, the findings described below are derived from completed interviews with staff at all 14 integrating systems included in the study sample, and appear to be well- supported.

The planning and implementation processes observed among the 14 integrating systems we studied displayed many similarities in their basic outlines and sequence of steps, or "phases," but varied considerably in their details. For example, the 14 integrating systems vary in terms of the composition and role of the Steering Committee or other oversight group guiding the integration, the level of involvement of mid- and lower-level facility staff in integration planning and implementation, and the timing of key decisions (such as the appointment of a single medical director for the integrated system and the appointment of key chiefs for integrated services and departments). While we continue to analyze these differences to assess their determinants and implications for integration success, several key themes and findings have already emerged from our work in this area.

Integration planning and implementation must address differing organizational cultures and their implications.

Many of the hurdles encountered during the planning and implementation processes stemmed from often stark differences in the integrating facilities' organizational cultures (comprising the employees beliefs, values and assumptions). Although we observed these differences at each of the 14 integrating systems, the differences were generally greater at integrations between a large, urban tertiary care medical center and a smaller rural facility—especially those with a significant long-term care or mental health focus. The small facilities were typically described as being like a family, with informal means of operating and low turnover. The tertiary facilities, because of their size, mission and urban location, were described as operating more formally and bureaucratically and with higher staff turnover. Differences in culture are often played out in lack of trust or perceptions of lack of respect of staff in one facility for another. These differences then lead to difficulties in communicating and reaching consensus regarding alternative approaches to integrating departments or activities.

Many of the systems we studied used a variety of methods to try to bridge gaps in culture. Some sites began the integration process with a series of informal get-togethers at "neutral" locations (half-way between the integrating facilities) to allow staff to become acquainted in a low-pressure setting. Other sites had staff representing all organizational levels from each facility spend a day or other period with their counterparts at the other facility. In each case, these gatherings and exchanges allowed staff to meet each other on a personal level, helping to replace stereotypes or preconceived perceptions with more accurate understandings of their colleagues' beliefs, values and assumptions.

Integration is a major organizational change and change causes disruption. The change process must be managed carefully to minimize its adverse impact on staff and the integrating organizations overall.

VHA facilities have undergone considerable changes in recent years due to budget reductions, VISN reorganization and other actions taken to implement the *Prescription for Change*. Yet even against this back-

drop of continuous change, the magnitude and pervasiveness of disruption involved in most integrations are considerable, producing significant levels of organizational and staff stress, uncertainty, disruption and anxiety. Although managers at the integrating facilities we studied generally recognized this issue and the importance of frequent, ongoing communication, the strategies used have varied widely. Some of the techniques used offer valuable lessons for other VHA facilities negotiating similar changes.

For example, most systems held one or more town hall meetings at key stages of integration planning and implementation, but the number and timing of these meetings varied, as did the information relayed—and its acceptance by facility staff. Features of town hall meeting programs that contributed to success included:

- meeting schedules that allowed staff from all facilities and all shifts to attend,
- meeting agendas that provided complete information regarding integration plans and processes—including plans that remained tentative or still under consideration,
- opportunities for follow-up meetings or communications between service chiefs and middle managers and their staff, to confirm and elaborate on information provided by senior managers at the town hall meetings, and
- meetings that were part of a broader communication program including newsletters, electronic mail messages, telephone "rumor hotlines" and other mechanisms.

Staff reactions to town hall meetings appeared related to staff-management relationships more generally, including staff's general perceptions of senior management. While some managers felt that communicating only final plans was important to avoid alarming staff through rumors and misinformation, the failure to discuss tentative plans usually had the opposite effect, encouraging and contributing to rumors rather than preventing them.

A related issue concerning organizational change and communication that emerged from our interviews relates to the communication of "bad news" and senior management's ability to make promises to staff. While managers varied in the way in which they discussed RIFs, staff reassignments and other staffing issues, the most effective strategy appears to be one in which management clearly communicated an explicit position regarding RIFs and other staffing issues, committing to as much as possible while not over-stating this commitment. For example, the Director at one system promised staff that there would be no RIFs for the remainder of the fiscal year, but that he could not make any promises regarding future years. Staff appeared to appreciate this honesty and he was able to follow through on his commitment. Another Director promised that there would be no RIFs resulting from integration. Committed to keeping that pledge, he set a time limit on integration and declared it complete after two years, recognizing that he might need to implement RIFs in the future.

One final study observation surrounding organizational change and communication is the importance of helping staff distinguish between integration and the effects of other concurrent changes (e.g., budget reductions). Staff at many sites attributed a variety of adverse events and changes to integration, leading to negative feelings regarding integration, when these events and changes were actually results of other, unrelated trends. Since the success of integration depends in large part on staff acceptance and positive contributions, clarifying the costs and benefits of integration as distinct from other changes is important to ensure success.

Effective integration planning and implementation require a balance between careful, comprehensive planning, prompt action, and flexibility; and require broad input from internal and external stakeholders.

Integration leaders must walk a fine line between comprehensive planning and pre-determination of organizational structures and change processes on the one hand, and flexible, responsive planning and change processes on the other hand. They must also trade off the efficiencies available through reliance on a small group of planners with the ability to proceed quickly, vs. a more inclusive process that provides broader input, at the cost of decreased efficiency and speed. Integration leaders need to keep in mind that once implemented, many changes are irreversible, or reversible only at considerable cost (both monetary and in terms of internal and external stakeholder confidence and acceptance).

Our study suggests the importance of having a small, high-level group develop the overall strategic direction for the integration (with input—but not intensive involvement—from other stakeholders). This plan would address decisions about the mission of each

Continued on page 6

Veterans Intergated Service Networks

Continued from page 3

Mental Health) at the facility level. Medical site managers will be given a core budget to cover administrative and building maintenance costs and then must negotiate with the service line directors for the clinical (i.e., service delivery) component of their budget.

VISNs using Divisions

At this time, only VISN 3 has implemented a service line division. Their prosthetics service line division maintains both line and budgetary authority for the delivery of prosthetic services throughout the VISN. VISN 3 is also planning to move their Spinal Cord Injury service line team to a service line division. Four other VISNs are proposing a transformation to service line divisions and are taking different approaches to achieve this goal. VISN 2 is creating new service line director positions; facility directors may apply for these positions if they have the needed qualifications. VISN 6, on the other hand, proposes to convert its facility triads of directors, chiefs of staff and associate directors, into service line directors, managers (at the network level) and local service line chiefs, respectively.

Traditional

Three VISNs do not currently envision implementation of service lines at the VISN level. For the purposes of this study we describe those three VISNs as traditional organizations. While, many of the facilities located within the traditional VISNs are organized along service lines, there are no network-level service line structures. However, the term traditional does not mean that a VISN is inactive. For example, one of these VISNs, #17 in Texas, is undergoing one of the most extensive facility integration efforts in VHA. A considerable amount of VISN 17's efforts are dedicated to assuring a smooth and successful integration process.

Undecided

Four VISNs are undecided on whether they will evolve beyond their current service line task force status. In these VISNs, extensive internal discussion continues on the control of resources and the relative roles and responsibilities of network service line directors versus facility directors.

What's Next for Service Lines?

The implementation of service lines at the VISN-level is still in its developmental stages, as are VISNs themselves. For some VISNs, reorganization into service lines is the primary tool for integrating their facilities into a single health network. For others, it is one of the tools, but not necessarily the primary one, for becoming an integrated delivey system. Finally, there are VISNs for which service lines are not currently part of their network building strategy at all.

In the next phase of our service line project, we'll look at service line implementation at the facility level. We expect further insights into service line implementation, given the great diversity among facilities, and because facility-level service lines have been in place for a number of years at some facilities. We have researched roughly half of the facilities to date. We will be contacting the remaining facilities by phone over the next couple of months. ■

Analysis of Facility Integrations

Continued from page 5

facility, about the broad organizational structure for the system—including key managers—and about how further integration planning and implementation will occur (e.g., structure of planning and implementation work groups or committees, processes for developing and approving detailed plans). Subsequent planning and implementation (e.g., development of shared departmental policies and procedures, decisions regarding staffing reassignments and service delivery details) would then occur within a broader, more inclusive process, with the active involvement of lower-level staff and external stakeholders (such as veterans group representatives, local political and community leaders).

The Integration Study's full report will provide an extensive discussion and analysis of these issues (including detailed descriptions of the planning and implementation policies and practices used by many of the 14 integrating systems we studied), as well as a comprehensive discussion of additional issues. The collective experience of the managers and staff of these systems offer valuable insights for future integrations, and valuable lessons and recommendations for organizational change and transitions more generally. ■

Service Excellence: Quality Improvement Study Findings

by Gary J. Young, J.D., Ph.D.

It is now almost two years since the publication of *Vision for Change*, VHA's ambitious plan for transforming itself to meet the challenges of serving veterans in the 21st century. Clearly, much progress has been made since the publication of *Vision for Change*. The task of securing employee commitment to the transformation goals (as formally outlined in *Prescription for Change*) continues as a top priority for VHA senior managers. VISN and medical center directors use a wide variety of strategies to secure employee commitment to the transformation effort, including town meetings, retreats, training and education opportunities, and financial incentives. What works best? There has been little analysis of what strategies seem to work best and what are the major barriers and challenges to securing employee commitment to the transformation goals. In this *Transition Watch*, we share some information relevant to this issue.

At the MDRC we are studying VHA's transformation as part of the National VA Quality Improvement Study, which is supported financially by the National Science Foundation and VA's Health Service Research and Development Service. A primary focus of the project is the issue of aligning employee behavior with the goals of VHA's transformation effort, particularly the goal of providing excellence in service as defined by customers. By alignment we refer to a fit between the goals of an organization and the behaviors of employees. Transformations disrupt an organization's alignment by establishing new organizational goals that require new employee behaviors. Frequently, there is a long lag between the time the goals change and the time employee behaviors change.

As part of our study, we proposed three key organizational processes for achieving alignment during a transformation:

- **Translation**: Transformation goals are translated down to the personal performance goals of all employees. Employees understand how their performance goals relate to and support the achievement of high-level goals.
- **Feedback:** Performance measurement systems exist that provide employees with reliable and timely information for assessing their progress in achieving quality goals.
- **Reward and recognition:** Reward and recognition systems promote and reinforce behaviors directed at achieving transformation goals.

While all VISN and medical center directors have been engaged to some degree in these processes, substantial differences exist in emphasis and focus. As many *Transition Watch* readers know, we conducted an employee survey in 1996 that was designed to obtain information about these processes and other managerial factors (i.e., culture and leadership) related to VHA's transformation goal of excellence in customer service quality. Employees were asked to answer, using **five-point scales**, a series of questions concerning:

- whether their own performance goals are related to customer service quality (shown as relevance on Figure 1),
- whether they understand how their own customer service goals are related to those of their immediate supervisor (shown as linkage on Figure 1),
- whether they receive timely feedback about their own progress in contributing to better customer service quality and (shown as feedback on Figure 1),
- whether they believe they will be rewarded and recognized for making contributions to customer service quality (shown as reward and recognition on Figure 1).

Using the survey data we assessed the degree to which medical centers used the three processes we believe are critical to aligning employee behavior with transformation goals. Three key findings emerged from the survey data.

Finding 1. Medical Centers with Higher Alignment Scores Had Greater Improvement In Customer Service Quality

We created an alignment score for each medical center combining the responses of its employees to those questions concerning the three organizational processes discussed above. The higher the score, the higher the medical center's degree of alignment with customer service quality. We correlated medical centers' alignment scores with their degree of improve-

Continued on page 8

Service Excellence

Continued from page 7

ment in customer service quality for outpatient care (using 1995 and 1996 surveys from the VHA Customer Feedback Center). We found the higher the medical center's alignment score, the higher the degree of improvement in customer service quality. The relationship was statistically significant ($p< .05$).

We also compared those medical centers that fell into the top 25% for the alignment score with those that fell into the bottom 25%. The medical centers in the top 25% had almost twice the level of improvement as did the bottom 25% (see chart below).

Does Stronger Alignment Lead to Quality Improvement?

Alignment Index Score	*Outpatient 1995 Customer Satisfaction Score (%Problems)*	*Outpatient 1996 Customer Satisfaction Score (%Problems)*	*% Improvement 1995-1996*
Top 25%	28.00	24.67	11.89
Bottom 25%	27.17	25.39	6.55

Finding 2: Culture and Leadership Facilitate the Alignment Effort

We found medical centers whose culture is relatively more supportive of teamwork and cooperation and whose senior managers are more actively involved in promoting customer service quality have significantly higher scores on our alignment measure. Moreover, medical centers with better leadership scores also had a greater degree of actual improvement in customer service quality.

Finding 3: Alignment Appears To Break Down at Lower Levels Of The VHA Hierarchy

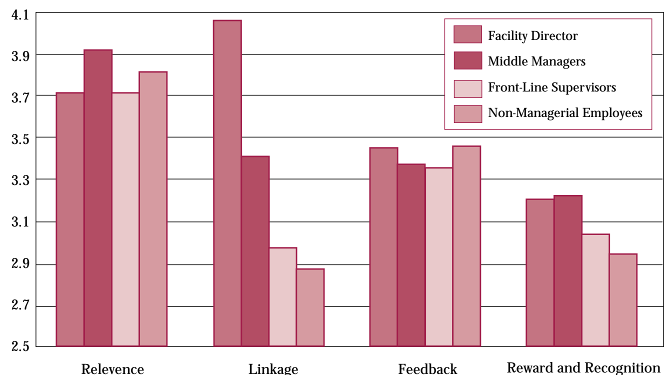
We examined the alignment scores by administrative level (facility director, service chiefs, front-line supervisors, and non-managerial employees) throughout VHA. These data indicate that alignment grows weaker as you move down the hierarchy (Figure 1). Specifically, as you move down the hierarchy employees are less likely to understand how their own efforts to improve customer service quality were related to the goals of their supervisor or VISN Director, and employees are less likely to believe they will be rewarded for making improvements in customer service quality. These findings are consistent with the VA One survey, conducted by the Office of Personnel Management, which also indicated that reward and recognition is a problem area for VHA.

We note that these three findings are based on only one year of data. We will conduct surveys in 1998 and 1999 to assess the continuing role of alignment in VHA's transformation effort. In subsequent editions of *Transition Watch* we will report additional findings from the study. ■

Figure 1

Where Does Alignment Break Down?

Alignment Scores by Administrative Levels



Transition Watch is a new quarterly publication of the Office of Research and Development that will highlight important information and learnings from the organizational change processes underway within the Veterans Health Administration. Special focus will be given particularly to findings from three organizational studies: the Service Line Implementation Study, the Facility Integration Study and the National Quality Improvement Study. The goal of *Transition Watch* is to provide timely and supportive feedback to VHA management throughout the change processes being studied as well as to draw on the change literature to assist managers in their decision making. For more information or to provide us with your questions or suggestions, please contact:

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