



Structure of Integrating Systems

Carol VanDeusen Lukas, EdD, and Barbara Simon, M.A.

The MDRC and the Center for the Study of Healthcare Provider Behavior are collaborating on an ongoing study of facility integrations in VHA. Now in its second of three years, the study is designed to systematically assess the implementation and effectiveness of 14 VHA integrating systems. Previous *Transition Watch* articles have offered lessons about the integration process and the impact of the characteristics of integrating facilities. This article examines service structures in integrating systems and looks briefly at the perceived impact of those structures.

Beyond the basic requirements to have a single system director and merged data systems, integrating systems in VHA have had considerable flexibility to structure their integrations as they felt appropriate. While there is no single structure that represents an ideal integrated system, our expectation is that the objectives of increasing efficiency (by reducing duplication and realizing economies of scale) and of improving patient care and access (by strengthening the continuum of care/consistency of care across the system and redirecting resources into new and expanded services) require some means of bringing operations together across campuses.

Service Structures

Services within an integrating system can be organized in different ways. Drawing from the results of a survey conducted in September 1997 of service chiefs in the 14 integrating systems¹, we grouped services under three structures. Looking across systems we found that:

- *The majority of services have combined (60%). By combined we mean the service has a single system-wide chief who oversees staff at two or more campuses. Com-*

binced services can offer a single standard of care and coordinated resources across the system while maintaining access at all campuses. They also offer the potential benefit to staff of requiring few changes in work locations. Combined services will not necessarily reduce duplication in services, however.

- *Just under one-fifth of integrating services have consolidated (18%). By consolidated we mean the service has a single system chief with staff based in one location and with no counterpart service elsewhere in the system. Consolidated services offer the promise of increased efficiency by eliminating duplication across campuses.*
- *Roughly one-fifth of the services remain separate (22%). By separate we mean campuses maintain their own services with separate chiefs and staff. Separate services are not generally considered to be integrated.*

Within this broad pattern, there is considerable variation among systems in their mix of service structures, as shown in Figure 1. In Black Hills, for example, virtually all of the services are combined. In Chicago and Central Alabama, in contrast, over half the services remain separate, suggesting that these integrations are still in progress.

Earlier studies of private-sector multi-hospital and system integration have suggested that administrative services are much more likely to be integrated than clinical services.² However, in VHA **a substantial majority of clinical services across systems (76%) are structurally integrated** : 55% are combined and 21% are

IN THIS ISSUE

Integrating Systems	Page 1
Process of Change	Page 3
Quality Improvement Study	Page 5
Changing Provider Behavior	Page 6

¹ The terms *service* and *chief* are used broadly here. Service refers to major organizational units such as service, section, service line or department. Chief is used to designate the top manager of a service even though his or her title may be director, service line manager, ACOS or manager. Working from each system's organizational chart, integration coordinators helped us identify the appropriate people to survey. The survey achieved an 91% response rate.

² Shortell SM, Gillies R, Anderson DA, et al. Remaking health care in America: building organized delivery systems. Jossey-Bass, 1996.

Continued on page 2

consolidated. Among administrative services, 67% are combined and 13% are consolidated. Somewhat more clinical (24%) than administrative (20%) services remain separate.

Perceived Impact of Facility Integration

As a preliminary measure of integration impact, the study survey asked chiefs to rate the impact of the integration on their services on a range of dimensions with responses ranging from 1 to 5 where “1” is very/mostly negative and “5” is very/mostly positive. Using factor analysis, we created two perceived impact scores:

- *operational impact* which includes ability to *operate efficiently*; *the adequacy of resources* provided; the ability to *deliver service or support* in accordance with the service’s mission; and the ability to *obtain services or support* from staff or services at other campuses in the system; and
- *clinical impact*, which applies only to clinical services and includes *quality of services* provided; *patients’ access to care*, and *ability to coordinate care* among providers and services for patients seen by the service’s staff.

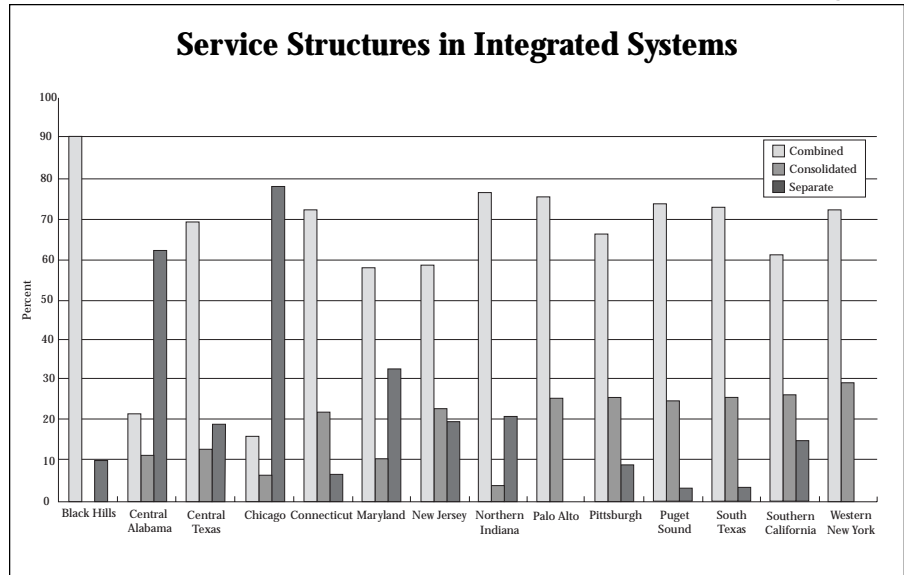
Across systems, the average score for perceived *operational impact* of integration was marginally positive: (3.51 where 3.0 is neutral) and the average score for perceived *clinical impact* was somewhat higher (3.81).

Preliminary analyses suggest that differences in perceived impact, both operational and clinical, are related to service structures:

- **Chiefs in systems with low proportions of services remaining separate (<10%) report significantly higher positive impacts than chiefs in systems with high proportions of separate services (>50%).** If

Table 1: Perceived Impact of Integration By Service Structure			
	Combined	Consolidated	Separate
Clinical impact	4.09	3.48	3.45
Operational impact	3.71	3.31	3.10

Figure 1.



most services remain separate, integration probably has not resulted in much change at the service level and we would not expect to see much impact.

- **Across systems, chiefs of combined services report significantly higher positive impacts than chiefs of separate services, as shown in Table 1.** Chiefs of consolidated services fall between the other groups.

Further Thoughts

From these analyses, two findings are particularly striking. First, the high proportion of structurally-integrated clinical services is impressive. As mentioned above, studies of private sector multi-hospital integration indicate that clinical integration typically lags far behind administrative integration, even though clinical integration is thought to be the most important element in the ability of integrated delivery systems to achieve more cost-effective delivery of care. Second, the preliminary finding that chiefs of combined services report higher impacts of integration than chiefs of consolidated services is intriguing – and one that we are continuing to investigate further. The difference is particularly strong among clinical services. At least two explanations are possible: 1) Combining services could be a more effective strategy than consolidating them. 2) Since many consolidated clinical services were consolidated before the facilities integrated, integration resulted in fewer changes in consolidated services than in newly-combined services and the perceived impact of integration might have been relatively small. We are continuing

Continued on page 4

The Process of Change: How Some VISNs Have Tackled it.

Victoria A. Parker, D.B.A., Post Doctoral Research Fellow

William H. Wubbenhorst, Project Manager, Service Line Evaluation Project

In the course of our field research for the service line implementation project, we heard about several unique approaches to moving through the change process. In the spirit of learning from experience, we share these change stories so that other facilities and VISNs can consider both these ideas and the underlying principles of change management they represent. Our thanks to the interviewees for sharing these stories with us, and allowing us to share them with you.

Rooms for change

Two facilities in VISN 7, each undergoing a major reorganization to service lines, adopted very similar strategies for managing the change process by designating an information room for staff. While Tuscaloosa called its room “product line central” and Atlanta called its “the situation room,” both functioned as places where employees could come to read information about their changing organization, and about other hospitals that had undergone similar changes, and where they could also convey their own reactions and concerns. At Tuscaloosa, these reactions were elicited on a yellow sticky board, monitored by full-time staffer, who was also available to respond to questions. In Atlanta, a computer terminal with an anonymous log-on was available for comments and questions, which were responded to in the bi-weekly newsletter “The Rumor Mill.” The rooms were set up and operated for the duration of the change planning process—about eighteen months.

Rituals for change

In Tuscaloosa, the change from a traditional organizational structure to a service line structure was made on a large scale, and employees needed ways in which to acknowledge the emotions associated with a such a major transition. The solution, which Ken Ruyle, Facility Director, initially perceived as being “way out there,” was to hold a ceremonial burial, complete with a eulogy for the old organizational structure and its strengths. This was followed by a hospital-wide picnic the next day, celebrating the “birth” of the new structure.

Stages of Organizational Change

Perlman and Takacs (1990)* have developed a 10-stage model of organizational change analogous to Kubler-Ross’ work on death and dying. As employees move from equilibrium with the current state through denial, anger, bargaining, chaos, depression, resignation, openness, readiness, and reemergence, there are actions managers can take to help move the process along. The stories here about VISN 7 reflect actions consistent with this model—providing a room in which employees could explore and react to the “chaos” stage of change and a public ceremony in which the “depression” stage of change could be expressed.

*Perlman D, Takacs GJ. The 10 stages of change. *Nursing Management*, 21: 33-38, 1990.

Guidelines for change

In VISN 16, the development of clinical guidelines for specific disease categories doubled as a process for developing network-level thinking at the facility level.

Continued on page 4

Transition Watch is a quarterly publication of the Office of Research and Development’s Health Service Research and Development Service that highlights important information and learnings from the organizational change processes under way 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:

GERALDINE MCGLYNN

INFORMATION DISSEMINATION PROGRAM, MANAGEMENT DECISION AND RESEARCH CENTER (152-M)
VETERANS AFFAIRS MEDICAL CENTER, 150 SOUTH HUNTINGTON AVENUE, BOSTON, MA 02130-4893

PHONE: COM (617) 278-4433 OR FTS 839-4433
FAX: (617) 278-4438 EMAIL: geraldine.mcglynn@med.va.gov

One chief nurse involved in the process had this to say about it: “We’ve done clinical guidelines which have really helped bring us together; each hospital was responsible for developing one piece (e.g. for the management of angina) and selling it to the other medical centers.” Dr. Higgins, VISN 16’s network director, said that it has “been a tremendous team-building exercise.” Another network staff member commented that this process had caused facility management, by necessity, to become less internally focused, and more involved in the VISN as a whole.

Employee Participation As a Strategy For Change

Creating opportunities for employee participation in organizational change efforts can have many benefits:

- it breeds commitment
- builds mutual support and reinforcement in the face of the ambiguity of change
- develops understanding of the need for change
- results in early “disciples” who are likely to bring others into the process

VISN 16’s guideline development process is one example of how this mechanism can work to benefit the overall progress of the change process.

*Charns MP, Tewksbury LJS. Collaborative management in health care: implementing the integrative organization. San Francisco: Jossey-Bass, 1993.

More is better

The VA Pittsburgh Healthcare System (VAPHS) is facing simultaneous changes at three different levels. First, as a tertiary facility in VISN #4 that has implemented a transfer pricing mechanism to follow patients, the VAPHS must develop stronger referral relationships

Structure of Integrating Systems

Continued from page 2

to analyze the working arrangement associated with each structure, and the relationships between service structure, working arrangements and perceived impact and other measures of integration effects. ■

with its four spoke facilities. As described by one VISN staff member, the VAPHS Director has developed a “we will not be undersold” posture in an effort to strengthen VAPHS’ role as a regional referral center. The VAPHS Director meets regularly either by phone or in person, with the directors of each of the spoke facilities, whom he refers to as his board of directors.

Second, as a recently integrated healthcare system with three campuses, the VAPHS has cut the number of service chiefs in half, from 60 to 30. Third, the VAPHS has now reorganized its healthcare services delivery system into 12 product lines. Under this new structure, the VAPHS plans to give all of its clinical care dollars to care management organizations who, in turn, will “buy” needed care from newly created specialty care and patient support organizations (or product lines).

Is this too much change to undergo all at once? Not necessarily, according to the VAPHS director: “One thing that is constant is change; VISN change, integration change, and now reorganization into product lines. This plethora of changes has been helpful...staff are not preoccupying themselves in any particular initiative, they are participating and making things happen.”

Capitalizing on Unfreezing

In Kurt Lewin’s (1951)* classic model of the change process, moving an organizational system from its current state to a new, desired state must be preceded by a period of “unfreezing,” in which existing organizational beliefs and routines are called into question. Once the change process is complete, some “refreezing” is necessary in order to turn the new organizational features into routine parts of organizational function. Thus, once unfreezing has been accomplished (often a considerable feat in itself!), it may be easier to implement multiple changes rather than to wait until after one process has been completed and refreezing has occurred. This may be the phenomenon that is enabling VAPHS to move rapidly on so many different fronts.

*Lewin K. *Field theory in social research*, New York: Harper & Row, 1951.

Getting a second opinion

In the Pacific Northwest VISN (#20), facility-level decision making is enhanced by feedback and scrutiny from a number of network-wide committees ranging from mental health service delivery to facilities management and construction. When the Portland Medical Center submitted a \$3 million proposal to build an outpatient center in neighboring Vancouver, they got a second opinion from the VISN's facilities management committee. This committee, consisting of a small group of engineering staff and others, conducted a "walk through" inspection of the facility. They identified existing space which could be renovated and along with new construction, could serve the same purpose as a separate stand alone center. When Portland took a closer look, they found the committee's recommendation to be a better idea than their original proposal, since it would give them the opportunity to consolidate other facility functions and improve the coordination of patient care.

Building on Small Victories

The benefits of a change process (for example, the development of integrated service networks with network-level review functions) are often questioned at the outset. Rosabeth Kanter's* recent work on successful change processes suggests that beginning with small, demonstrable gains in areas not necessarily central to the organization may be a viable approach to building momentum for change without engaging the worst of the potential resistance. Thus, the success of VISN 20's facilities management committee in helping Portland with a specific project may have helped develop some interest and trust in other VISN-level initiatives.

*Kanter R M, *Rosabeth Moss Kanter on the frontiers of management*, Boston: Harvard Business School Press, 1997.

Concluding thoughts

As you can see, there are many different approaches to the process of change management. While we are not recommending any of the particular approaches described above, we do hope that consideration of these alternatives and of the underlying principles of change management they represent will be helpful to you in continuing to manage the processes of change within your facility and/or VISN. ■

Quality Improvement Study Launches 1998 Survey

The 1998 survey for the National VA Quality Improvement Study is now being distributed to VHA employees across the country. MDRC staff oversee the study, which is supported financially by the National Science Foundation and the Department of Veterans Affairs' Health Services Research and Development Service. Between 75 and 125 employees at each VHA facility have been selected randomly to complete the survey, which was first conducted in 1997.

The survey questionnaire comprises a core set of items that were in the 1997 questionnaire allowing facility managers to benchmark their facility's performance with last year's results. A small number of new items have been added as well to address issues that are currently of concern to VHA headquarters. In general survey questions seek employees' perceptions pertaining to their facility's commitment to quality improvement, culture, decision-making processes and organizational structure.

The survey process is essentially the same as it was in 1997. A study liaison at each facility will distribute the questionnaires to selected employees who will be given business reply envelopes for returning their completed questionnaires to the data entry site at the Hines VAMC.

Survey results are expected to be available in June. For questions about the survey, contact Gary J. Young at 617-232-9500 (extension 4614). ■

1997 Survey Results for Quality Improvement Study Now Available on the KLF Menu

The 1997 survey results for the Quality Improvement Study can be accessed at the web address <http://152.125.190.53/QM/start.htm>. Visitors can simply click on National VA Quality Improvement Study 1997 to obtain the survey results.

Transition Watch

HSR&D Special Projects Office (152)
VA Medical Center
Perry Point, MD 21902

Changing Provider Behavior

A very practical aspect of changing a health care system is identifying successful strategies to improve the quality of health care by changing what health care providers do routinely in practice. Recently, the Veterans Evidence-based Research, Dissemination and Implementation Center (VERDICT), a new HSR&D Center for Excellence, conducted a systematic review of the literature regarding strategies for changing provider behavior. The full results of their review are available in their Spring, 1998 newsletter which you can receive by calling Karen Stamm at (210) 617-5300 ext. 4266. We thought *Transition Watch* readers would be interested in their findings so with permission, we have published the summary insights here.

Multiple strategies can help keep providers informed and optimize practice behavior. These strategies include printed materials, traditional continuing education, intensive conferencing, computerized tools, outreach visits, local opinion leaders, audit and feedback and multi-faceted approaches. Research concerning which strategies work in which settings is limited: studies are often small, use inadequate analysis techniques, or fail to evaluate sustainability of effects. Despite limitations, available evidence supports the following insights:

- Use printed educational materials as an adjunct, not as a single strategy.
- If you're trying to implement changes in simple, periodic behavior, such as test ordering, computerized reminders work well. If you're trying to change behavior in a more complex process, such as disease management, reminders alone won't work. Try breaking the process into individual

elements and combine strategies that work well for each element.

- When the aim is to change drug-prescribing behaviors, three strategies show good results: reminders, outreach visits and audit and feedback.
- Use decision aids, such as computer algorithms, for medication selection and dosing situations where errors can occur easily.
- Feedback and reminders are particularly effective when readily available to physicians at the time of need.
- Don't rely solely on relatively unproved expensive strategies to optimize provider behavior (e.g., audit and feedback programs).
- Incorporate approaches that show positive impacts in changing behavior (e.g., outreach visits and intensive workshops) into continuing professional development programs.
- Don't expect miracles! Optimizing provider practice and achieving attendant improvements in patient outcomes is very difficult. In many instances, changes in organizational structures will be necessary. ■

Transition Watch is now available on the world wide web at <http://www.va.gov/resdev/prt> or via our fax-on-demand server. Dial the fax-on-demand server at (617) 278-4492 or (FTS) 839-4492 and follow the voice prompts.