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Service Lines and Other Organizational Arrangements at the Medical Center Level: A Preliminary Review

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In previous issues of ***Transition Watch***, we have reported on service line developments at the VISN-level as part of our on-going study of VHA service line implementation. In this issue, we begin to examine how service lines and other similar interdisciplinary organizational arrangements have been utilized at the medical center and integrated system levels.

What exactly are service lines?

One of the important things we have learned is that the term "service line" is both limiting and confusing and does not adequately represent the full range of organizational arrangements that are different from traditional (*i.e.*, service- or discipline-based) functional designs. To remedy this confusion, we have developed a more inclusive (and, we hope, more neutral) term, Interdisciplinary Organizational Arrangement (IOA), that encompasses the full spectrum of organizational forms. The term IOA allows us to identify points along a continuum of interdisciplinary integration and limits usage of the term "service line" to a specific type of arrangement, as defined in the soon-to-be-released VHA service line guidelines.[1]

Figure 1 below provides a visual tool for understanding the degree to which VHA medical centers and integrated systems have implemented interdisciplinary organizational arrangements. The functional (*i.e.*, traditional) organization and the IOA divisional organization form the two ends of the continuum. At the extreme left end, the focus lies with individual professional and nonprofessional functions, representing a facility organized entirely on the basis of discipline (*i.e.*, doctors report to doctors, nurses report to nurses). At the extreme right end, the divisions operate as autonomous

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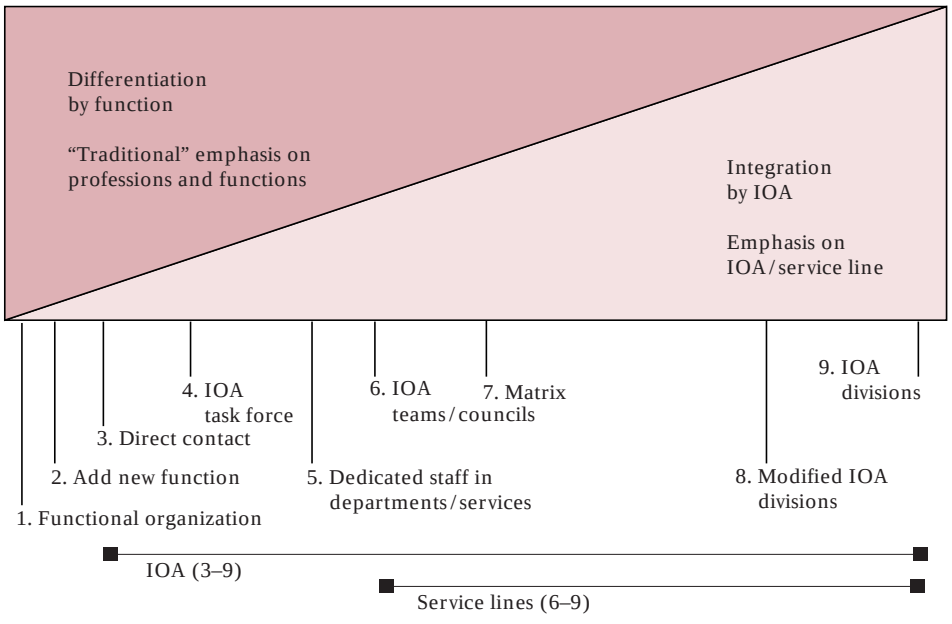
Figure 1: Continuum of Organizational Configurations



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[1] *VHA Service Line Implementation Guide.*

businesses, each containing all the functions, or disciplines, it needs.

IOAs first appear at point #3 (Direct contact) on the continuum, while service lines appear at point #6 (IOA teams) on the continuum.[2] Below is a brief description of the types of IOAs we identified at the VHA medical centers and integrated systems.

- **IOA Task Forces** bring together a group of people from different disciplines for what is usually a limited period to complete a defined activity. They are not service lines themselves, but often serve as precursors to service lines.
- **IOA Teams/Councils** are more established IOAs with broader on-going management and clinical responsibilities than Task Forces. Team leaders usually have input into IOA staff performance evaluations.
- **Matrix** structures represent IOAs in which personnel authority for staff within the IOA is shared equally between discipline-based managers (usually service chiefs) and IOA managers/teams.
- **Modified IOA Divisions** are permanent IOAs with primary personnel authority over staff within the IOA. Service chiefs, or some other representative of particular disciplines from outside the IOA, continue to have input into those particular IOA staff evaluations.
- **IOA Divisions** are also permanent IOAs with personnel authority. However, unlike Modified Service Line Divisions, performance evaluations are done solely by the IOA manager with no discipline-based input from *outside* the IOA.
- **Mixed** structures are IOAs where the personnel authority over staff varies by discipline. For example, nurses within a particular IOA may report directly to an IOA manager (with secondary input from a nurse executive), while a social worker in that same IOA may report directly to a Chief of Social Work, with the IOA manager having input into that social worker's performance evaluations.

IOAs at VA medical centers and integrated systems

The findings described in this article are drawn both from a recent survey of all 144 VHA medical centers and integrated systems regarding IOAs as well as from site visits to selected facilities. Though respondents were asked to list *all* IOAs at their medical center or integrated system, detailed information on only Primary Care and Mental Health IOAs was requested because earlier findings indicated that these were the two most common areas of IOA implementation.

Clinical Areas of VA Medical Center IOAs

Over 90% of all VA medical centers and integrated systems reported having at least one clinical IOA. Table 1 below shows the clinical IOAs reported.

Table 1: Frequency of Interdisciplinary Organizational Arrangements

Interdisciplinary Organizational Arrangement (IOA)	*Number of VA Medical Centers*
Primary Care	110[3,4]
Mental Health	108
Long Term Care/Extended Care	47
Tertiary Care/Medical Specialties	29
Ambulatory Care	24[4]
Spinal Cord Injury	15
Rehab and Physical Medicine	10

Consistent with the findings at the VISN level, Primary Care and Mental Health are the most frequent areas of IOA activity.[5] This contrasts with findings we have reported in the past about IOA distribution in the private sector, where narrower clinical areas (such as cancer care) dominate.[6]

The Longevity of IOAs at VA Medical Centers

Some view the use of service lines and other IOAs as a relatively recent phenomenon within VHA. However, as demonstrated by Figure 2 on page 3, our survey indicated that IOAs, including service lines, are not new. In fact, twenty-two percent (22%) of Primary Care IOA managers and seventeen percent (17%) of Mental Health IOA managers were appointed in 1995 or earlier.

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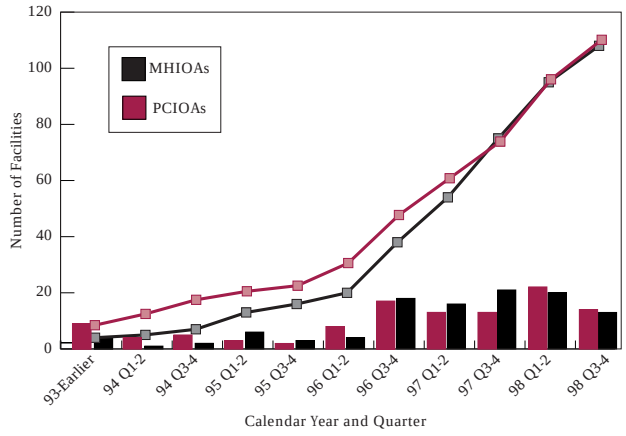
[2] For additional information regarding IOAs/Service Lines, please refer to previous issues of ***Transition Watch***.
[3] Twenty-nine percent (29%) of the Primary Care IOAs were actually part of larger, more inclusive IOAs (*e.g.*, Ambulatory Care, Medicine, Outpatient Services, *etc.)*.
[4] Thirteen (13) Primary Care IOAs are part of Ambulatory Care IOAs and are reported in both categories.
[5] ***Transition Watch***, Winter 1997 and Fall 1998.
[6] ***Transition Watch***, Summer 1998.

Figure 2: Start Dates of Mental Health IOAs and Primary Care IOAs



Types of Primary Care and Mental Health IOAs

Figure 3: Mental Health and Primary Care IOAs

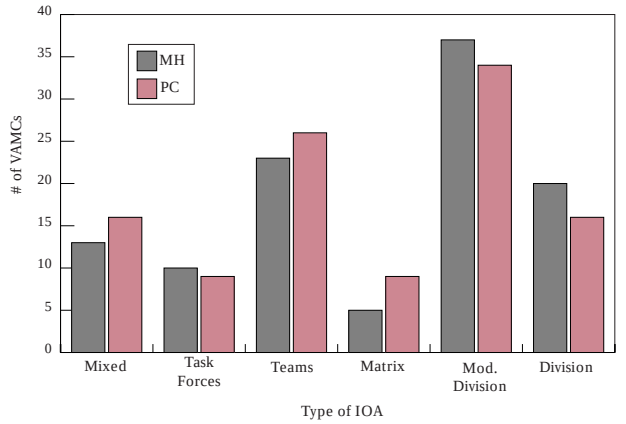


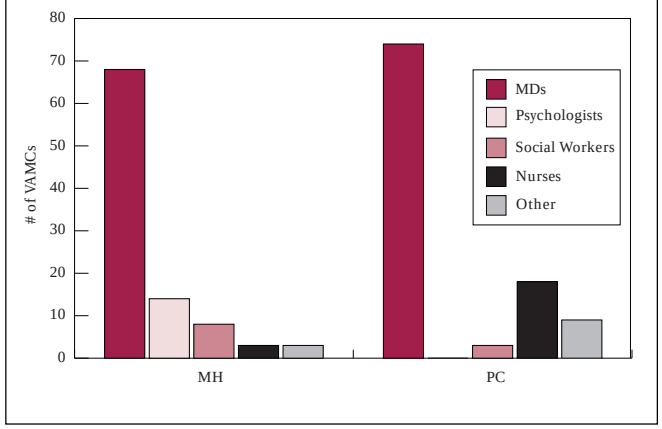
Figure 3 above shows the distribution and types of IOAs we found at VHA's 144 medical centers and integrated systems. See page 2 for a detailed description of the IOA structures.

As is evident from Figure 3, IOAs are found at all points along the continuum. However, the more highly integrated division and modified division structures are used in the majority of IOAs in both Mental Health and Primary Care. This contrasts with our findings in the private sector, where the types of IOA structures are more uniformly distributed across the continuum.

Who Leads the IOAs?

Within both Mental Health and Primary Care IOAs, most managers are physicians as shown in Figure 4 below. Seventy percent (70%) of all Mental Health IOA managers are psychiatrists. Seventy-one percent (71%) of Primary Care IOA managers are either primary care (55%) or specialty (16%) physicians.

Figure 4: Discipline of IOA Managers



Responses to detailed questions about reporting relationships and evaluations made it clear that within-discipline reporting and evaluation was far more common for physicians than for other disciplinary groups. It is more likely that nurses report to non-nurse IOA managers than for physicians to report to non-physician IOA managers. We will continue to investigate possible effects of cross-discipline reporting relationships.

Concluding thoughts

The degree and duration of medical center / integrated system IOA activity within VHA is intriguing. We look forward to discerning the lessons to be learned from the experience of the "early adopters" as we probe into various outcome measures and their possible association with how the IOA is organized. ■

Lessons from the Analysis of Facility Integrations

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Last November, Dr. Kenneth W. Kizer distributed to Network and Medical Center directors the first comprehensive report from the analysis of facility integrations being conducted by the HSR&D Management Decision and Research Center and the Center for the Study of Healthcare Provider Behavior at Sepulveda. This article highlights lessons learned contained in that report. The full report is available on the VA Intranet at vaww.va.gov/resdev/integrt.htm.

Pre-Integration Perspective

- *The pre-integration similarity of the participating facilities strongly influences structural integration.*
  Dissimilar facilities—a small facility and a larger, more complex tertiary care facility—usually achieved structural and operational integration more quickly than did similar facilities attempting to integrate. This was particularly true with respect to clinical services. Following integrations between dissimilar facilities, acute inpatient services generally were offered only at the dominant, tertiary care campus. The larger facility in these integrations became the *dominant partner* in the system.

  Integration of facilities that were similar in size, complexity and academic affiliation were less likely

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  to have consolidated their services to one campus or to have integrated departments across campuses at the time of our data collection. These facilities integrated as relatively *equal partners*.

  Slower integration in equal-partner systems appears to be related to two factors. First, if there is substantial service overlap, it is more difficult to determine which services should be consolidated and where. Second, the dynamics of negotiation are different. Between equal partners, more issues have to be negotiated extensively; a dominant partner often gives prompt answers.

Processes of Integration

- *Effective early planning processes are based on a model of shared leadership.*
  Formal literature and broad experience with organizational change highlight the importance of staff involvement in change during integration. Yet at VHA, involvement without direction was frustrating. Staff morale and satisfaction with the planning process were higher in systems where top management clearly led the integration process, but also appointed and involved middle management early in the process, and involved staff within the framework of a new system organization chart and clear guidelines for planning.

- *Prompt appointment of a system director is a marker for swifter integration, more complete service integration and higher staff morale.*
  Systems whose directors were appointed immediately moved through the integration process more quickly and had a higher proportion of integrated services than systems where these appointments lagged. At these early-appointment systems, staff were more satisfied with the integration process, and service chiefs felt that integration had a more positive impact on staff morale. Slower director appointment appear to signal more complex integration challenges, or have repercussions on other decisions and activities that further delay the overall integration process.

- *Delayed appointment of service chiefs fosters uncertainty among staff and diminishes productivity.*
  Prompt appointment of service chiefs was important for two reasons. First, planning workgroups were not as effective when led by two facility chiefs vying for the system chief position. Second, long delays left staff uncertain about their reporting relationships, lowered morale and reportedly paralyzed the organization as staff waited for a new leader. Interim chiefs can fill an important gap, but they need clear authority during their assignment.

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- *Integration workgroups need clear direction and leadership.*
  Extensive staff participation in workgroups did not by itself guarantee satisfaction with the integration process. Staff were disillusioned when workgroup products were submitted to a governing board or system leadership – only to languish without any action or feedback. This suggests workgroups need the governing body to provide:
  - clear charges and guidelines,
  - workgroup leaders with authority, and
  - clear criteria by which workgroup products are reviewed and used if they meet those criteria.

- *Academic affiliation plays a key role in defining the cultures and standards of the integrating facilities, but medical schools generally are critical players in the integration process only when both facilities have strong academic affiliations.*
  At the 10 systems where only one campus had a strong academic affiliation, medical schools participated but did not play a pivotal role in integration planning because the teaching relationship was secure. At the one system where both campuses had strong affiliations with different medical schools, the medical schools played a pivotal role—and the process was initially difficult. Early negotiations with and between the deans about how academic activities will be shared or divided are essential.

- *Depending on the timing, the JCAHO accreditation process can facilitate or impede integration.*
  When facilities were surveyed separately, the accreditation usually slowed integration because the facilities had to hold off on integrating policies, medical by-laws, and committees. When facilities chose or were required to do joint surveys, the survey speeded integration because accreditation deadlines required systems to move quickly to combine policies and committees, and a common goal brought staff together.

Structures of Integrated Systems

- *Careful attention is needed to manage the campus(es) where top management is not located, particularly in dominant-partner systems.*
  In nine of the 10 dominant-partner systems, the larger, more complex, affiliated facility served as the system headquarters where top leadership and all or most service chiefs were based. While efficient for managers, the strong headquarters arrangement potentially created a management vacuum at the smaller campus (es). To deal with this problem, six of the 10 dominant-partner systems designated a site manager, often an associate director. Site managers provided day-to-day supervision and advocated for the campus on systemwide issues. However, this arrangement sometimes left staff in the middle of conflicting decisions and directives from site managers and service chiefs. Care should be taken to clearly delineate and communicate the responsibilities of site managers in relation to service chiefs.

- *While reorganization of functions and reporting relationships complicates and frequently slows the integration process, most system leaders feel reorganization is needed to meet the changing demands on their system.*
  Eleven integrating systems reorganized to new structures with redefined functions and reporting relationships, usually into service lines. Five systems reorganized during early stages of integration while six systems integrated first under their existing organizational structures and reorganized later. Reorganization usually complicates integration. While early appointment of appropriate leadership is critical in integrating systems, chiefs and senior managers serving under the traditional structure may lack the skills and experience required for the new structure. One strategy for making early management appointments while maintaining flexibility to bring in appropriate leaders as the system reorganizes is to appoint interim chiefs. In VHA, this was a viable but not a perfect solution. At several systems, the interim chiefs felt that they were without authority. The roles, responsibilities and authority of the interim chiefs should be clearly defined.

- *Systems with a higher proportion of integrated services are more likely to report a positive impact from integration than systems in which many services remained separate at each campus.*
  Chiefs of integrated departments were more likely to perceive a positive impact of integration on their clinical and managerial operations than were chiefs of departments that remained separate. At systems

where most departments remained separate, integration probably did not produce much change at the department level, and therefore would not be expected to show a significant impact.

- *Clinical as well as administrative departments are integrated in most systems.*
  Clinical integration is key to improving patient care. Unlike many private-sector hospital mergers, VHA systems were successful in structurally and operationally integrating clinical services, usually at the same time as administrative services. Across systems, four-fifths of clinical and administrative departments were structurally integrated, either by consolidating services to one campus or by combining them under single leadership with staff at more than one campus. In general, clinical chiefs perceived a higher positive impact from integration than did administrative chiefs.

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- *Combined departments can provide an effective structure for coordinating services and creating a single standard of care across the system.*
  By combining departments under single leadership with staff at multiple campuses, systems can maintain veteran access and minimize staff dislocation. They can also coordinate services, develop a single standard of care and potentially eliminate duplication if they are operationally integrated, as the majority of VHA combined departments were. Across systems, four-fifths of combined clinical departments and three-quarters of combined administrative departments had the same policies across campuses; two-thirds of combined clinical departments had common clinical protocols. Chiefs of combined departments perceived a stronger positive impact from integration than did chiefs of separate departments.

- *Chiefs of combined departments must balance the need for regular communication with staff at all locations and the physical strains of travel.*
  Management across campuses is essential in an integrated system. Department chiefs tried to split their time between campuses and/or use video/teleconferencing to meet with staff. The method used most depended on the type of service (administrative chiefs were more likely than were clinical chiefs to spend time at each campus), and, not surprisingly, on the distance between campuses. In a multi-campus system, broad-based communication is particularly important. It is not enough, however, to tell service chiefs that they should communicate well. System leadership should work with chiefs to plan and carry out effective mechanisms and processes to support communication, decision-making, and accountability across campuses.

- *Integrated systems will continue to evolve, but there are practical advantages to formally drawing closure to facility integration.*
  Systems defined integration and judged its completion in different ways. Many VHA systems announced their integration complete after they reached certain milestones, such as reassigning staff or creating common policies and procedures. While the leaders at these systems generally recognized that their systems would continue to evolve and change, they also saw benefits to delineating the integration period. For example, they found that a time limit allowed them to make and keep specific promises — such as no RIFs resulting from integration. In addition, a time limit enabled the system to move beyond facility integration and the negative connotations associated with it. These systems found that by declaring an end to integration, they were able move on to face new challenges as an integrated system. ■

Corrections & Amplifications

In the Fall 1998 *Transition Watch*, the table, "VISN Service Line Implementation as of October 1998" inaccurately represented the VISN 5 Women's Health Service Line organizational arrangement. The Current and Projected columns should read "Task Force", with "No" in the Budget Authority Projected column. Authors apologize for this error.

Second Survey Completed from the National VA Quality Improvement Project (NVAQIS)

Kamal R. Desai, Ph.D.

MDRC staff recently completed the second round of employee surveys as part of the National VA Quality Improvement Project (NVAQIS). The NVAQIS, which has been supported both through HSR&D funding and by a grant from the National Science Foundation, is examining and supporting VHA's transformation through a variety of data collection strategies, including employee surveys, interviews with headquarters staff and network directors, and site visits to facilities.

The second round of employee surveys was conducted during the second half of the calendar year for 1998. We thank all the survey participants and facility-VISN liaisons for their splendid effort. Just like the first round of employee surveys which covered fiscal year 1997, we surveyed managerial as well as non-managerial employees at all VA facilities. The survey covered all of the same topics that the first survey addressed, which pertain to facility-level characteristics. These topics are organizational culture, emphasis on total quality improvement, and performance goals and evaluation. In addition, the survey included several new topics that were added to support an ongoing study on service-line implementation.

The survey procedures for the second survey were identical to those of the first survey. In brief, we randomly selected about 100 non-managerial employees from each facility for a total of 14,370 non-managerial employees. In addition, we sent a separate questionnaire to all department heads and service line managers at participating facilities. In total, we sent approximately 17,500 questionnaires to VA employees. Due to integration of VA facilities between the time we conducted the first and second surveys, the total number of facilities participating in the second survey declined from 162 to 146.

At the end of the survey period, we had received 8,914 surveys (62.03% response rate). The facility response rates for non-managerial employees ranged from 37% to 98%. About 121 out of 146 facilities had response rates over 50%, and 37 out of 146 facilities had response rate over 70%. We received 2,030 responses (66.12% response rate) from managerial employees.

Table 1: Comparison of FY97 and FY98 Response Rates

	FY97	*FY98*
Non-Managerial Employees	69.40%	62.03%
Managerial Employees	66.64%	66.12%

Nearly 50% of the facilities had response rates over 70% for managerial employees. Table 1 compares FY97 and FY98 response rates.

Results from the second survey will be available soon on the KLFMENU. For prior reports from the NVAQIS, see *Transition Watch* volume 1, number 1 (Fall 1997), and volume 1, number 3 (Spring 1998). ■

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 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. *Transition Watch* is available on the web at www.va.gov/resdev/prt and on our Fax service by calling (617) 278-4492 and following voice prompts. For more information or to provide us with your questions or suggestions, please contact:

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