MDRC

MANAGEMENT DECISION AND RESEARCH CENTER

INTEGRATION OF AFFILIATED VA MEDICAL CENTERS: PRELIMINARY REPORT

HEALTH SERVICES RESEARCH AND DEVELOPMENT SE

OFFICE OF RESEARCH AND DEVELOPMENT
DEPARTMENT OF VETERANS AFFAIRS

Integration of Affiliated VA Medical Centers:

Preliminary Report

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Highlights

Between June and September 2000, teams from the HSR&D Management Decision and Research Center visited the VA Boston Healthcare System, the VA New York Harbor Healthcare System and the VA Chicago Health Care System to learn about the integration of the medical centers in each system and the impact of integration on the system's academic mission. This is the first of three rounds of data collection for this project. Among the key findings from the preliminary analyses:

- Only Boston has made structural changes to consolidate its core inpatient services to one campus, and the implementation of those changes is not complete.
- Chicago and New York have integrated their administrative services, but not most clinical services; most clinical services operate in parallel under separate leadership at both campuses. Both systems have merged their policies, committees and medical by-laws across campuses in preparation for JCAHO surveys as integrated systems this fall. Chicago has delayed its planning for further structural integration until after the JCAHO process. New York has no immediate plans for further consolidation of clinical services.
- Boston and New York are proud of passing their JCAHO surveys with good scores. Chicago faces its survey in December.
- The clinical and academic plan in Boston is for the two major affiliates, Boston University and Harvard, to share services. Early implementation shows expected, but not insurmountable, problems. Residents for both schools have begun working side by side in several services with no major difficulties.
- Because there have been few structural changes to consolidate key services in Chicago and New York, integration has not yet had a major direct impact on medical training in those systems. In New York, there is some concern in Brooklyn that referrals of patients to Manhattan for certain specialty services leaves the volume in those services too low for quality care and teaching in Brooklyn. In Chicago, there is a fear that with continued uncertainty about integration, talented clinicians will leave the system.
- In research, different administrative and review functions have been joined in each system. Integration has not yet had a major impact on research, however.
  - Boston has joined its IRBs but has kept separate associate chiefs of staff for research (ACOSs/R) and R&D committees.
  - Chicago has separate ACOSs/R but they share some administrative resources and both ACOSs sign proposals going out. IRBs are integrated with each medical school so there are arguments against merging them across VA.
  - New York Harbor has appointed a systemwide ACOSs/R, but has not made other changes.
- Staff in all three systems are concerned about the future of VA's academic mission, not only because of their integration, but also because of budget cutbacks and increased clinical demands.

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Preliminary Case Summary
November 2000

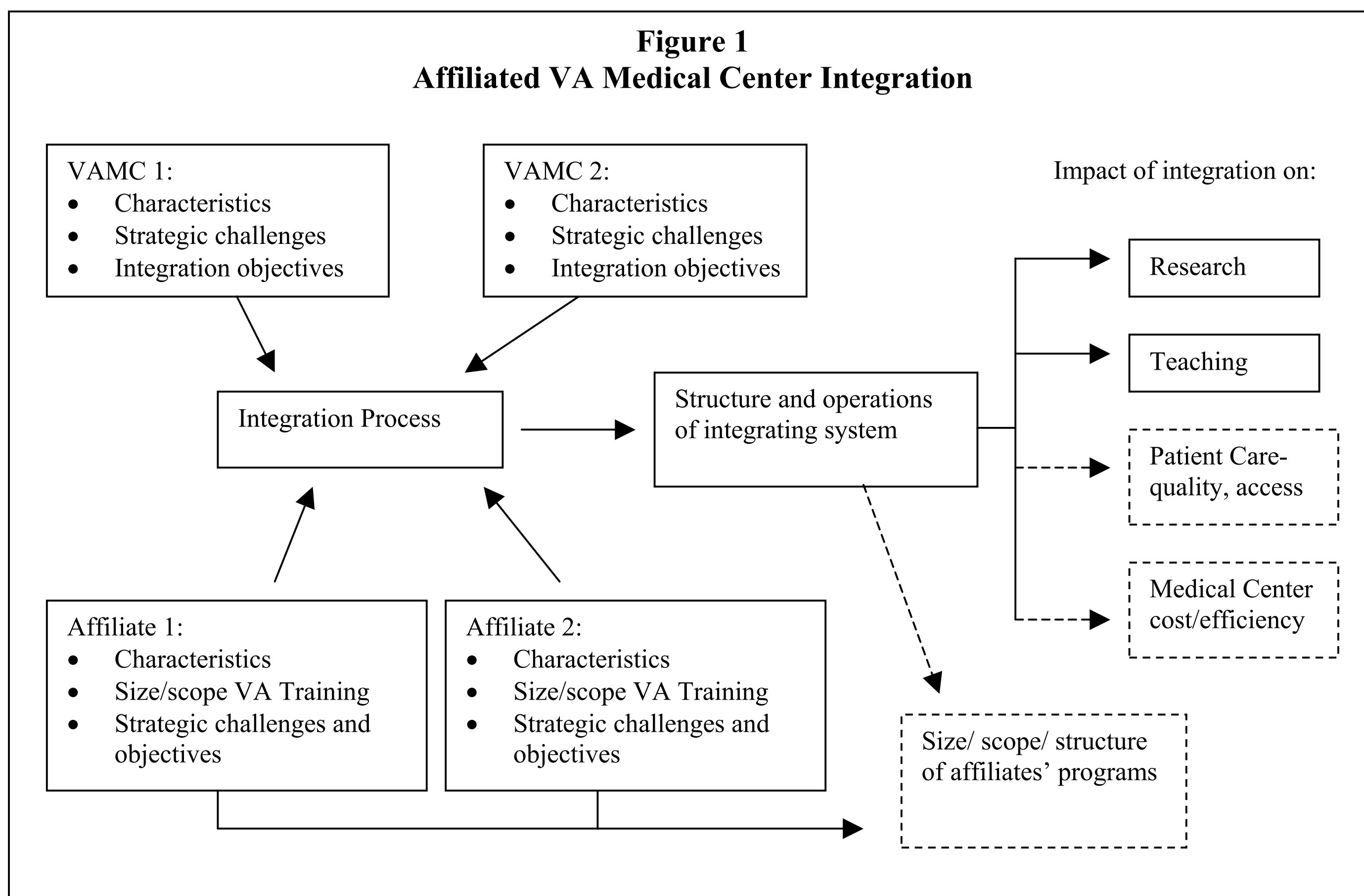
Study Background and Framework

The objective of this project is to study the impact of medical center integration on the academic missions of education and research in the Veterans Health Administration (VHA). The Management Decision and Research Center (MDRC), which is part of the VHA Health Services Research and Development Service (HSR&D), was asked to conduct this study by the Chief Research and Development Officer. VHA, like private-sector health care systems, has used facility integration as an important component of its strategy to transform VHA into a more efficient, patient-centered health care system.

Our focus in this study is on the integration of highly affiliated VA medical centers. Most VHA integration involves only one affiliated medical center. A few have limited or no academic affiliation. A few systems, however, involve the integration of at least two medical centers, each with its own medical school affiliation. Three of these complex types of integration, in Boston, Chicago, and New York, are the subjects of qualitative case studies.

Our basic conceptual framework is straightforward, as illustrated in Figure 1. We expect

Figure 1
Affiliated VA Medical Center Integration



the characteristics of the newly integrated VA health care system and its component VA medical centers (VAMCs), as well as the characteristics of the academic affiliates to determine the nature of the integration process. The integration process determines the structure of the integrated system that, in turn, affects the size, scope and substantive direction of teaching and research. Our goal in this project is to describe the integrated systems on these dimensions in order to begin to identify the key relationships among the dimensions and the factors that affect their academic missions. Our emphasis is on the clinical services.

Since the term integration is broad and commonly used in many ways, we need to define integration and related terms as we will use them in this study:

- Because our focus is on VA, when we refer to *integrated system* or the *integration* without a modifier, we refer to the joining of two or more previously independent VA medical centers to one organizational entity.
- In VA, the term *integrated system* is an administrative designation, not a description of the structure and functioning of the system. VA medical centers (VAMC) are formally integrated when a single director is appointed, the databases are merged, and, of high importance in a bureaucracy, a single station number is assigned. Clearly this top-level administrative linking does not mean that all the functions within the two previously independent medical centers are merged and/or coordinated into one seamless system. Similarly, when we talk about "when the system was integrated," or "before or after integration," the reference point is the date on which the medical centers were formally designated as integrated. Clearly the actual integration of the structures and processes of the medical centers occurs over a period of months or years, not on a single day.
- The linkages between a VAMC and its affiliated medical school are very important and of great relevance to this study. In conducting our interviews, many people used the term integration to describe the close relationships between their VA and medical school rather than to describe the merger of the two VA medical centers. We do not use the term in that way. However, we use the term *integrated training programs,* as the sites do, to refer to medical school programs in which VA-funded residents are trained in the same program with the school's other residents rather than be trained in a separate VA track.
- Within the VA integrated system, the formerly independent VAMCs are often referred to as *campuses* or *divisions*.
- Within the VA integrated system, individual services, departments or sections can be integrated under different structures: a *consolidated* service brings all staff and care to one physical location; a *combined* service brings all staff and care under a single leadership for the system, but staff remain and care is provided at more than one campus. Services that have separate leadership and staff at different campuses, remaining relatively unchanged from the structure before integration, are not considered to be integrated.

- We do *not* use the term integration in this study to mean the coordination across services within the medical center, for example, by bringing traditionally separate services into service lines.

Methodology

This report presents case descriptions of the three systems based on our first round of site visits. Our goal in each system was to interview:

- At VA, the Director, Chief of Staff, Chiefs of Medicine, Surgery and Psychiatry, selected other clinical chiefs, Associate Chief of staff, ACOS for Research, ACOS for Education, and representatives of clinicians with faculty responsibilities, researchers, chief residents and residents.
- At the medical schools, the Dean, Associate Dean responsible for graduate medical education, senior person who works most closely with VA, senior person responsible for research, chairs of Medicine, Surgery, Psychiatry and key services being integrated. (We focused on the primary medical school affiliated with each campus – we did not investigate the affiliates that only train in one or two services, that train in dentistry, or that train allied health professionals.)

Because of conflicting schedules, we did not interview all of these people in each system, but were successful in meeting most. A list of people interviewed is attached in Appendix A. We interviewed senior VA officials and medical school representatives alone, or in a few cases in pairs. VA clinicians, researchers and residents were interviewed in small groups. The interviews were semi-structured. They were conducted between June and September 2000. The site visit teams are listed in Appendix B.

While the interviews were tailored to the position of the respondent, the common themes focused on the structure of the integrated system, the role of the medical school, the factors that affected integration and the perceived impact of integration on the academic missions of the VA health care systems.

Drafts of the case descriptions were reviewed by the director or his designee in each system. A draft of this report and the case descriptions were reviewed by the study steering committee which met in October 2000 to discuss the findings. Steering committee members are listed in Appendix C.

VA Context

Integration in all three systems studied is taking place in the local context of the medical centers and medical schools, as we will describe in the case studies. But all are also taking place in the context of national changes across the VA system. Among those changes are:

- *VA reorganization into networks*: In 1995, VA began to transform its healthcare system from a confederation of independent medical centers and outpatient clinics to an integrated system by organizing the medical centers and clinics into 22 Veterans Integrated Service Networks (VISNs). The VISNs represent a new point of control

over the medical centers. Medical center directors, for example, are held accountable for an extensive list of formal performance measures. VISN initiatives to create integrated delivery systems affect local service delivery and management. The VISN may create service lines to integrate care delivery across medical centers, or they may consolidate services the VISN level. In Chicago, for example, patients from the Lakeside division are referred to the Hines VA medical center for radiation therapy.

- *VERA system for allocating budgets*: In 1996, VA adopted a new system for distributing its $17 billion medical care budget to VISNs and then to medical centers. The new system, the Veterans Equitable Resource Allocation (VERA), replaced a system based on historical medical center costs with one based on the number of veterans having the highest priority for health care. The new system resulted in substantial shifts in the distribution of resources among VISNs, creating what are commonly referred to as VERA winners and losers. Although the new system was phased in over several years to cushion its impact, several VISNs saw substantial budget reductions under VERA. Boston, Chicago and New York are in VISNs that were among the highest losers under VERA. Table 1 (on page 11 at the end of this summary report) shows the allocations to their VISNs between fiscal year 1996, when the system began, and fiscal year 2000.
- *Models of organizing and delivering care*: As in the private sector, VA has substantially shifted its models of care over the last five years, by decreasing the focus on inpatient care, increasing the emphasis on outpatient care, and strengthening primary care that brings continuity and coordination to care delivery. To increase veteran access to care, many medical centers have opened community-based outpatient clients in areas distant from the medical center. These changes in service delivery models are sometimes intertwined with the efforts to integrate medical centers. In the New York Harbor Healthcare System, for example, Brooklyn's nursing and other allied health professionals are being reorganized under an interdisciplinary patient-centered care model, a model that Manhattan adopted three years ago.

It is often difficult to disentangle the impact of facility integration from these changes.

Case Summaries

Not surprisingly, the three systems studied are similar on broad dimensions but differ on closer inspection. A case description of each system is attached. We highlight some of the key findings from those descriptions here:

VA system and medical center characteristics

1. *All three systems include two highly-affiliated, relatively large and complex medical centers located in urban areas. As shown in Table 2 (page 12):*

- Patient counts in the medical centers in the year before they integrated ranged from 20,000 to 37,000, and complexity (rated in VA on a 0 to 100 scale with 100 being the highest complexity) ranged from 53 to 77.

- Budgets in the year before they integrated ranged from $54.3 million to $120.3 million. All three systems had to make substantial cuts to meet the lower budgets allocated under the new VERA system.

2. *Research funding in fiscal year 1999 ranged from $7.5 million in New York Harbor to $19.6 million in Boston, as shown in Table 3 (page 13). VA-funded research accounts for roughly one-third to one half of that total.*

3. *Both medical centers in each system are highly affiliated with their medical school. As shown in Table 4 (page 14):*

- In New York Harbor and Chicago, one medical school is a private institution ranked among the top 25 medical schools by US News and World Report, and the other medical school is a state institution that is not on the US News top list.
- In Boston, both medical schools are private institutions and both are in the top 35 of US News rankings.

Key features of integrated systems

1. *All three systems have multiple objectives in integrating. Most commonly they focus on improving care to the veterans by creating one standard of care across the system and achieving efficiencies.*

- In a survey conducted by the MDRC 18 months ago, directors in Boston and Chicago rated cost savings as their top objective, closely followed by one standard of care. In New York Harbor, the pattern was reversed.
- In their integration planning documents, all three systems include in their objectives variations on creating a single standard of care across the system and/or creating a continuum of care. New York Harbor and Chicago also have explicit objectives to maximize resources and eliminate redundancies to improve efficiency to reduce costs/achieve cost savings; Boston's similar objective is to realize cost avoidance.
- Within the systems in Chicago and New York Harbor, many staff seem unclear about integration objectives. Staff in Boston were less likely to question the objectives.

2. *All systems have integrated many or all of their administrative services but vary on integrating their clinical services.*

- In their written integration plans, Boston is the most specific about a structure for the integrated system. Boston's objectives specify consolidation of inpatient clinical programs to one location (West Roxbury) in order to deal with decreasing volume while maintaining quality. New York Harbor's objectives include elimination of duplicate clinical programs while improving quality and containing costs, and maintaining centers of excellence at each division; the plan does not specify which services fall in these groups. Chicago specifies a management plan that calls for reviewing all programs and determining appropriate efficiencies rather than identifying an integrated structure in advance.

- Boston has gone the farthest in organizationally integrating clinical services, but is still is the early stages of operationalizing the plan. The integration was premised on closing inpatient services on one campus. Systemwide chiefs and co-chiefs have been appointed, but not all are actively managing an integrated service yet. Services are being relocated – inpatient services to the West Roxbury campus and outpatient clinics to the Jamaica Plain campus -- as physical constraints permit. One major challenge is that the capital funding needed to renovate the campuses for their new functions is delayed. At the service level, the challenges are operational as chief and co-chiefs work out the details of their functions, sometimes with difficulty at first, and clinicians from both campuses get used to working together. A bigger problem is that the relocation of nurses and other staff has lagged the relocation of physicians because of union resistance, so that physicians in some services believe they are not adequately supported. Continued budget cuts and anticipated layoffs are of great concern among staff at all levels, including physicians.
- Chicago is the oldest integrated system of the three, but has only integrated two clinical services – and those integrated under single VA leadership because the affiliates withdrew their training programs. The system is still working to identify a viable model for integrating clinical services across campuses. At the same time, they are working on common policies across campuses in preparation for a Joint Commission survey. At the time of our visit, system leadership had decided to delay further structural changes until after their JCAHO survey in December 2000, Chicago's first survey as an integrated system. In the future, however, it intends to integrate more services.
- New York Harbor has integrated selected clinical and clinical support services, using an opportunistic strategy triggered primarily by the resignation of a service chief at one campus. The system will retain both campuses as full service hospitals, each with a few unique specialties; patients will be referred from one campus to another only in those specialty areas. However, the system has a single set of medical by-laws and has unified most policies across campuses in preparation for a Joint Commission survey. With both campuses maintaining full services, most teaching will remain separate. It is not clear that New York Harbor will try to integrate more clinical services. The director has stated that the integration is essentially complete.

1. *While all systems are strongly affiliated, relationships with medical schools vary across systems.*

- In Chicago, both divisions are very closely tied with their respective medical schools: the VA campuses are adjacent to the medical schools; most VA physicians have academic appointments and split their time between VA and the university hospital; the training programs are fully integrated with most medical students and residents rotating through VA.
- In New York, SUNY has historically a closer relationship with Brooklyn than NYU has with Manhattan. The SUNY training program is fully integrated with students and residents rotating through VA, the University Hospital and Kings County, a public hospital. Most VA physicians have faculty appointments, but generally are full-time VA employees. The Brooklyn campus and SUNY are physically separated,

12 miles apart through city traffic, which limits frequent interaction. NYU, in contrast, has had a separate VA residency track in Medicine and, despite being only a few blocks away from the Manhattan campus, has not had strong ties to VA. With the appointment of a new dean and a chair of medicine recruited from VA, NYU is now moving to strengthen it ties with VA. VA residents are being integrated with other residents in Medicine. There are, however, no ongoing discussions for integrating clinical activities or training across medical schools/VA campuses. The medical schools opposed one VA proposal for integrating a service in which both schools taught; VA dropped the proposal.

- In Boston, neither campus is co-located with its medical school. VA physicians at West Roxbury have Harvard appointments but are full-time at VA; most reportedly have a fairly distant relationship with the school. VA physicians at Jamaica Plain have BU appointments; many are only part-time VA. The two medical schools, faced with a firm VA decision to close inpatient care at one campus, collaborated to develop an acceptable model for sharing training sites. They agreed on a structure of service chiefs and co-chiefs with equal representation of Harvard-affiliated and BU-affiliated appointments, and on training together in the services.
- In all three systems, one medical school is more prestigious than the other, and in all three, the less prestigious school is perceived as being more dependent on VA as a training site. The discrepancy is least in Boston, judging both from rankings in US News and World Report and from interviews in the system. In New York and Chicago, the less prestigious schools are state schools.

Factors affecting integration

A variety of factors affect the integration process, structures and outcomes in the three case study systems. Among them:

- *Budget pressures both drive and complicate integration.* All three systems faced severe budget constraints when integration began. The need to reduce costs provides an impetus for integrating medical centers because system leaders expect savings from economies of scale and service consolidations. However, in some cases the real or anticipated cuts are so deep that some staff believe that integration is just an excuse to cut jobs. Moreover, with deep budget cuts, many of the people remaining are demoralized, believing that they have inadequate support and sometimes are required to take on the work of those who had left.
- *A sense of urgency facilitates change.* In Boston, the low census at both VAMCs, together with the budget reductions, seemed to create an urgency that led to the early agreement with the principle of consolidating inpatient care to one campus. In Chicago and New York Harbor, where they do not seem to feel the same immediacy of budget problems and low census, there is less urgency to further integrate the campuses.
- *Commitment to a master plan facilitates change.* Only Boston developed a plan for the structure of the integrated system before the integration was approved. Admittedly, it was a broad-brush plan with key details left to be negotiated, but the

basic decision to consolidate inpatient care at one campus was part of the approved integration plan. With public commitment to the plan, the VA had a firm position, and the medical schools, who supported the plan, came to the table to figure out how to make the integration work. In both Chicago and New York Harbor, basic structural decisions were left until after the system was designated as integrated, and the systems seem to have been less successful in getting agreement from the medical schools on the integration of key services.

- *Medical schools are key players in the integration of clinical services.* In Boston with its commitment to consolidate inpatient services, the medical schools decided not to run parallel services in one building; they developed a plan for sharing services equitably and presented it to VA. In New York, where leaders are following opportunities for integration rather than an overall plan, the medical schools have vetoed at least one plan for integrating a service which both schools considered important to their programs. In Chicago, the medical schools have not agreed on any services to be integrated – in the two clinical services that integrated, the integration resulted from the decision of one affiliate to withdraw its residents in that service. The willingness of medical center leadership to work with VA on the integration is essential.

- *The VA campus with the more prestigious medical school often dominates the integrated system.* In Chicago and New York Harbor, one campus is clearly perceived as the dominant campus. The theme of one campus being more influential and having staff who see themselves as more skilled and smarter comes up frequently. It is reinforced by the appointment of staff from that campus to the majority of key leadership positions, and by that campus' more active role in committees, for example when reviewing joint policies. Staff at the other campus, the one that considers itself the stepchild, are sometimes passive, for example, not speaking up in committees or even participating in discussions. They are anxious about their campus closing. The prestige of the medical school affiliated with each campus reinforces – and perhaps drives – these roles. Some of the same dynamic holds in Boston, but it is not nearly as strong.

- *Close linkage of a VA medical center with its academic affiliate makes integration with another VA medical center more difficult.* In Chicago, VA clinicians and medical school officials take pride in the close relationship between them. The VA facilities and the schools are within close walking distance and most clinicians split their time between VA and the university; and many have active research programs on the campus too. They talk about being able to maintain these multiple responsibilities because they are close geographically. But the very closeness of the VA/ medical school ties makes it more difficult for them to consider merging with another VA facility. A change in physical location, for example, would disrupt the existing balance of relationships.

- *A JCAHO survey facilitates but may also impede integration*. All three systems were preparing for JCAHO surveys this year. Since our site visits, both New York Harbor and Boston had their surveys and received high scores as integrated systems. Chicago's survey is scheduled for December. Preparing for JCAHO facilitated

integration by providing a strong external impetus to merge policies, create joint committees and create a single medical staff with single by-laws. It can also slow integration if a system puts off structural changes – like combining or consolidating services – until after the survey because they want to minimize system disruption leading into the survey. Chicago followed this pattern.

- *Geography sometimes impedes integration*. By definition, facility integration involves joining medical centers across locations. But distance is a bigger barrier in some systems than others. In New York Harbor, the travel between campuses may take 45 minutes to an hour because of traffic. Clinicians feel that the time required to move regularly between campuses is prohibitively long. Also Brooklyn and Manhattan veterans generally use only their "local" VAMC. Staff believe many would shift their care to the private sector before traveling to the other VA location. In Chicago, the travel distance is not great, but is seen as a major barrier because VA clinicians work part-time and they believe it would disrupt their schedules. For Chicago patients, according to staff, the barrier would not be distance but expensive parking. Distance is less of an issue for clinicians in Boston, probably because faculty and students already traveled some distance from the medical school/university hospital to VA. From a patient access point of view, however, location was a major debate in deciding which campus would be the inpatient campus, because one is much more accessible by public transportation and the other by car.
- *Many staff are unhappy*. Integrating two medical centers is a major organizational change that can be expected to make many staff unhappy in the short run. Change is disruptive and creates uncertainty that makes people anxious. Some people will always resist change. Some people will leave the system. Staff in the case study systems are no exception to these dynamics. Budget cuts and staff reductions have exacerbated the unhappiness. The key issues to track in an integrating system are whether enough staff resist change to delay progress, whether staff begin leaving the system in large numbers, and whether morale improves as the new system begins to stabilize.

Impact on academic missions of VA

1. *To date, teaching has been most affected in Boston, but joint training is just beginning.*

- In Boston, residents from Harvard and BU began working together in selected services in July without problem. Residents will be supervised by attendings affiliated with either school. Staff at the Jamaica Plain campus have more experience working with multiple medical schools than staff at West Roxbury because three medical schools (BU, Harvard and Tufts) used to train at Jamaica Plain.
- In New York and Chicago, integration has not directly affected training delivered because major affiliated clinical services have not been integrated.

- In Chicago, the discussions about closing West Side (together with the University of Illinois at Chicago medical school's own problems) hurt residency choices a few years ago.

2. *Research has not been notably affected beyond administrative changes.*

- New York Harbor has appointed a systemwide associate chief of staff for research (ACOSs/R), but has not made other changes.
- Boston has joined its IRBs but has kept separate ACOSs/R and R&D committees.
- Chicago has separate ACOSs/R but they share some administrative resources and both ACOSs sign proposals going out. IRBs are integrated with each medical school so there are arguments against merging them across VA. The medical schools are not interested in combining VA research offices because each university has different requirements and arrangements with VA.

Despite the lack of immediate impact of integration on teaching in two systems and research in all three systems, people are concerned about VA's academic mission. They believe that the academic mission is important to recruiting and retaining high quality clinicians, and thus to providing quality care to veterans. They are concerned that future integration efforts may cause one of the medical schools in a system to withdraw from VA. More broadly, they are concerned that with budget cutbacks, pressures on clinicians to spend more on direct patient care and continued uncertainty about the direction of the integrated systems, it will be difficult to recruit and retain top academic clinicians in VA.

Table 1
VERA Allocations to VISNs
(in millions)

	FY 1996	*FY 1997*	*FY 1998*	*FY 1999*	*FY 2000 Preliminary*	*Percent Change 1996 - 1999*	*Percent Change 1999 – 2000*
VISN 12 (Chicago)	$ 834	$ 828	$ 795	$ 781	$ 842	-6.4 %	7.8 %
VISN 1 (Boston)	$ 854	$ 845	$ 809	$ 785	$ 832	-8.1 %	6.0 %
VISN 3 (New York Harbor)	$ 1,022	$ 1,017	$ 974	$ 952	$ 919	-6.8 %	-3.5 %

Source: VA Allocation Resource Center

Table 2
Pre-Integration Characteristics of VA Medical Centers

	Chicago (FY96)		**Boston (FY98)**		**New York Harbor (FY98)**	
VA Medical Center:	*West Side*	*Lakeside*	*Jamaica Plain*	*Brockton/ West Roxbury*	*Brooklyn*	*Manhattan*
	26,532	20,359	36,933	24,052	36,335	31,109
PATIENT COUNT						
Total Recurring FTE	1375.1	988.2	1540	1687.2	1929.1	1684.3
Total Recurring FTE/ 1000 Adj. Workload	57.79	51.38	47.82	54.93	55.08	58.65
RN FTE	292.6	223.4	342.1	338.9	338.6	321.4
RN FTE/ 1000 Adj. Workload	12.3	11.62	10.62	11.03	9.67	11.19
MD FTE	99.1	77.5	143.2	102.3	109.3	121.2
MD FTE/ 1000 Adj. Workload	4.2	4	4.4	3.3	3.1	4.2
Total Direct Costs	$ 71,604,867	$ 54,304,039	$ 100,530,199	$ 108,224,336	$ 120,389,943	$107,393,387
Facility Complexity Score	59.41	55.42	76.80	52.75	67.68	73.15

Note: Complexity is calculated on a 100-point scale with 100 being the highest complexity.

Source: VHA Administrative Databases

Table 3
Research Funding

	FY 1998			FY 1999		
	VA	*Other*	*Total*	*VA*	*Other*	*Total*
Chicago	$ 4,343,486	$ 3,952,579	$ 8,296,065	$ 4,714,605	$ 7,553,006	$ 12,267,611
Boston	$ 9,103,852	$8,613,033	$ 17,716,885	$ 10,640,012	$ 8,916,955	$ 19,556,967
New York Harbor	$ 3,011,260	$ 5,672,283	$ 8,683,543	$ 5,054,107	$ 2,443,506	$ 7,497,613
Brooklyn	$ 637,281	$560,055	$ 1,197,336	$ 757,655	$ 422,792	$ 1,180,447
Manhattan	$ 2,373,979	$ 5,112,228	$ 7,486,207	$ 4,296,452	$ 2,020,714	$ 6,317,166

NOTE: CAMPUS BREAKDOWNS ARE ONLY AVAILABLE FOR NEW YORK HARBOR.

Source: VA Office of Research and Development

Table 4
Medical School Characteristics

	Rank	*Size*	*MCAT average*
Chicago			
University of Illinois at Chicago (UIC)	NA	1,221	9.8
Northwestern	22	689	10.9
Boston			
Boston University (BU)	33	616	9.9
Harvard	1	723	11.3
New York Harbor			
State University of New York at Brooklyn (SUNY)	NA	NA	NA
New York University (NYU)	27	676	11.3

NA = Not Available

Source: U.S. News and World Report web site of graduate school rankings. 1999-2000 academic year data.

Preliminary Case Descriptions:
VA Boston Healthcare System
September 2000

1.0 CONTEXT

The integration of the Boston VA Medical Center (referred to here as Jamaica Plain) and the West Roxbury campus of the Brockton/West Roxbury VA Medical Center was formally approved in December 1998 after several years of debate at the local and national levels. Initial plans focused only on West Roxbury merging with Jamaica Plain. To facilitate this integration, Brockton, which is primarily a psychiatric hospital, was temporarily separated from West Roxbury. It joined the VA Boston Healthcare System (VABHS) in April 2000.

The new VABHS is the only system of the three studied that began with a specific plan to consolidate inpatient services to one campus and most outpatient services to the other campus. Integration of administrative services is nearly complete. The new organizational structure of most clinical services is in place. The physical moves needed to implement the new structure have begun but are not complete. The physical restructuring needed to accommodate consolidated services faces challenges.

This case description is based primarily on interviews conducted in VABHS in July and August 2000. It reflects the status of integration at that time. The case description focuses primarily on the Jamaica Plain and West Roxbury campuses, with the exception of the discussion of psychiatry. However, the statistics on the medical centers prior to VABHS integration reflect combined figures for Brockton/West Roxbury because separate data are not available.

1.1 The medical centers:

The two VAMCs that made up the VABHS were large, highly-affiliated tertiary referral medical centers. While both medical centers offered a comprehensive array of services, Jamaica Plain offered special expertise in neurosurgery, radiation therapy and renal transplants, while Brockton/West Roxbury offered special expertise in open heart surgery and spinal cord injury. Both had sizable outpatient clinics at other sites.

Market studies found no major differences in the patient populations that used each VAMC. Use was predicted more along specialty lines, e.g., cardiology at one and neurosurgery at the other than by geography or demographics.

Prior to their integration, Jamaica Plain was the larger of the two facilities in terms of patients and physicians, having 36,933 patients and 143 physician full-time equivalent employees (FTEE), compared with Brockton/West Roxbury's 24,052 patients, and 102

physician FTEE. Jamaica Plain was also more complex with a score of 77 compared with Brockton/West Roxbury's 53, and more efficient with 48 adjusted FTEE per 1,000 adjusted workload compared with Brockton/West Roxbury's 55. Brockton/West Roxbury, on the other hand, had more employees overall and a larger budget, with 1,687 FTEE and patient care costs of $150.6 million at Brockton/West Roxbury compared with 1,540 FTEE and $140.9 million at Jamaica Plain. These comparisons are complicated by the combined Brockton and West Roxbury numbers since Brockton, primarily a psychiatric hospital, has different staffing and patient care requirements than an acute facility.

The Jamaica Plain and West Roxbury campuses are very different physically. The medical centers are about 7 miles apart, or about a 20-minute drive on an easy route. Boston is an urban medical center with a crowded campus. Parking is difficult but it is on electric trolley and bus lines. It is a high rise building with a new ambulatory care wing that opened last spring.

West Roxbury, though technically in Boston, has a more suburban feel. Comprised of three attached buildings, one of the buildings has special facilities for veterans with spinal cord injuries. The West Roxbury campus is difficult to reach by public transportation, but has more available parking than Jamaica Plain. The Brockton campus is about a 30 minute ride south of West Roxbury on a large campus with many buildings and ample parking.

Both of the medical centers had previous experience working with other institutions, but in different ways. West Roxbury and Brockton VA Medical Centers had merged, albeit under one academic affiliate (Harvard). Jamaica Plain had prior experience with multiple affiliates. At one time Boston University, Tufts Medical Schools and Harvard all had training programs at the medical center. In fact, a few Tufts trainees remained at the time of our study. Respondents commented, however, that previous experience with mergers and multiple academic affiliates had not prepared them for the current major integration that they were experiencing.

Respondents to our interviews described differences in management structure at the two campuses prior to integration. Jamaica Plain respondents viewed West Roxbury as almost totally connected with Harvard with authoritative management. Their view of themselves was more collaborative, both within their institution, and between themselves and their academic affiliate. On the other hand, several respondents from the West Roxbury campus believed that since most of them were full-time VA employees, they had more autonomy from their affiliate than their Boston campus counterparts, many of whom were part-time VA and part-time BU. Several West Roxbury respondents also noted cultural differences between the campuses, including the belief that West Roxbury was more efficient, nurses were more cooperative, and staff were more formal in following specific procedures than at Jamaica Plain.

In FY 1997, prior to integration, Jamaica Plain, with one of the most active research programs in the VA system, had research funding totaling $21.1 million annually, with

$11.3 million from VA and $9.8 million for other sources. In the same year, Brockton/West Roxbury also had an active research program with funding totaling $10 million, approximately half from VA and half from other sources.

1.2 The medical schools:

While both medical centers had several medical school affiliations, Jamaica Plain's primary affiliation was with Boston University (BU), and Brockton/West Roxbury's was with Harvard University. Both Harvard and BU were among the top-ranked medical schools by US News and World Report in 1999: Harvard was ranked 1 and BU ranked 33. Harvard's enrollment in 1999 was 723 and BU's was 616.

VA was one of two major teaching sites for BU. BU's primary affiliation was with the Boston Medical Center (BMC), with which it shared a campus. BMC was created when Boston City Hospital merged with BU's University Hospital. Some of the BU medical school leaders experienced that integration. The chairs of Medicine and Surgery at BU were the chiefs of Medicine and Surgery at BMC.

Harvard, one the largest medical schools in the county was decentralized with affiliated training sites at several major teaching hospitals in Boston. The VA's Harvard affiliation was only with Brigham and Women's Hospital. The chiefs of Medicine and Surgery at Brigham and Women's served as Harvard department chairs for that training site. Thus, the academic reporting for West Roxbury faculty was to the Brigham and Women's chiefs of Medicine and Surgery.

Psychiatry followed a different pattern. The department chairs at both BU and Harvard were based at VA.

Respondents from both campuses indicated that the VA was an extremely important component of both teaching programs. BU had roughly 60% more trainees at VA than Harvard, and had only one other major teaching hospital. Because Harvard had many training sites, some people argued that VA was more important to BU. We were told that Harvard valued VA highly because it had no other hospital that permitted as much independence. At the same time, we were also told about alternative teaching sites in community hospitals that both schools were developing.

Neither of the medical schools were on the same campus as the VA hospitals, but neither were they very far away. Harvard was closest to Jamaica Plain (5-minute drive) and about 20 minutes to West Roxbury. The BU medical school is also closer to Jamaica Plain than West Roxbury.

West Roxbury clinicians with Harvard faculty appointments were generally full-time at VA. In contrast, many Jamaica Plain faculty split their time between VA and BMC or private practice.

1.3 The integration process:

Formal planning for the integration began with a committee appointed by the Director of the VA New England Health Care System (VISN 1). The planning committee consisted of key leaders from both medical centers and from two other medical centers in VISN 1. The medical schools and VSOs were consulted but were not on the committee.

The intent in creating VISN 1 was to bring the nine previously independent medical centers in the VISN into a more coherent and integrated system across the Network. In this context, a key question was whether Boston needed two tertiary, acute inpatient facilities located six miles apart and with significant duplication of services.

The primary reason stated for considering integration was quality of care. The inpatient census at both medical centers was dropping to levels where it could be argued that patient care would be compromised. Hospital censuses were dropping for a variety of reasons, among them the declining veteran population and VA emphasis on moving care from the inpatient to outpatient setting. The Boston health care environment exacerbated the demographic trend of declining veterans. Boston as a center for major teaching hospitals offered many options for insured veterans to get care in other locations. Massachusetts was also an advanced managed care market with strong HMO presence, which limited veterans' options to use VA. The general consensus was that there was no longer a need for two tertiary VA medical centers in Boston.

Another pressing, but less publicly-emphasized, reason for considering integration was to achieve greater efficiency to realize cost savings. VISN 1 had severe financial problems under the new VERA system for allocating funds across the country. Staff reductions, through attrition and threats of reductions in force, continued as a major issue. Some staff reported to us during our interviews that they believed that the reason for the merger was "to get rid of people."

All parties within the planning committee quickly agreed to the guiding principle that inpatient care should be consolidated to one VA medical center, with the other serving as an outpatient service. The major debate was over which campus would be designated as the site for the inpatient facility. After considerable analysis by external consultants and debate among the committee, the Network Director recommended that Jamaica Plain serve as the inpatient campus.

By some measures, this seemed like a reasonable decision: Jamaica Plain was larger and more complex, with a larger training program and more research. It was also closer to both medical schools. However, Harvard, the Paralyzed Veterans of America (a powerful veterans service organization), and clinical staff at West Roxbury protested the decision, arguing that the analyses used for the decision were flawed. After two more planning committees and consultant studies, both initiated and led by VA national Headquarters, not the VISN 1 office, the final decision was to designate West Roxbury as the consolidated inpatient campus. Accompanying the decision was the agreement that substantial capital funding would be needed to renovate both campuses to suit their new missions.

According to the planning documents submitted to VA Headquarters to obtain formal approval for integration, the integration of Jamaica Plain and West Roxbury was intended to reorganize the two facilities into one comprehensive delivery system that would:

- Be responsible for coordinating the care delivery for all veterans in the Boston area and improve the referral of patients for tertiary services;
- Deal with anticipated reductions in demand for inpatient services by integrating inpatient clinical programs to consolidate their decreasing volume in one location with one staff providing all care in order to continue providing quality care and clinical expertise;
- Realize cost avoidance to offset the VISN's projected budget deficits and to enable several strategic initiatives to be carried out.

Interview respondents described the decision-making process as political and contentious on the parts of both the medical centers and the medical schools. The issue of giving up control of a service, traditionally defined in inpatient terms, by either of the VAMCs or the medical schools was extremely difficult. At the time of the decision, many people considered West Roxbury to be the winner and Jamaica Plain as the loser in the integration. In general, respondents from the Jamaica Plain campus were more skeptical about the fairness of the process than the West Roxbury respondents. In many interviews with Jamaica Plain respondents, we were told about the will and the power of Harvard to get "what it wants." They told us that the changes in decisions about how the integration would be structured -- that is, which campus would be the inpatient location -- were manipulated by Harvard's influence.

Once the decision to consolidate inpatient care to West Roxbury was made, the process to determine the operational structure of the integration began. On the clinical side, this process was led by medical school representatives over a two-year period. They developed guiding principles that included the involvement of both medical schools in every service and mixed faculty and students. They eventually arrived at a structure of Chiefs and Co-chiefs of major services and all sections with leadership split between medical schools, and with house staff shared within services. The discussions were not always easy. Not surprisingly, both schools were invested in maintaining the size and status of their programs. By some accounts, for example, Harvard representatives were concerned that since they had the smaller training program at VA, they would be eased out as they had been some years earlier at Boston City Hospital. However, the medical schools were able to negotiate most of the decisions about who would lead each service. In two cases, where they were at an impasse, the schools asked the Director to make the decision.

The medical schools continued to be highly involved in the integration process at the time of our visit. A joint dean's committee had been formed six months previously. It was described as inclusive of both VABHS campuses and medical schools, serving primarily in an advisory capacity. Initial decisions reportedly were made in a small group of Deans and the Director and taken to the larger committee for ratification. The medical schools also participated in oversight groups in Medicine and Surgery as described in the next section.

Although we were told about contentiousness between the two schools and among the schools and VA, we were also told about mutual respect and collaboration. The leadership across medical schools appeared to work productively with each other, once the basic integration was set. One instance of collaboration was a joint letter from the Deans to VA Headquarters expressing the need for administrative resources to assist with the integration. Medical school representatives viewed some of the externally-driven challenges as an opportunity for them to "fight a common enemy." Both VA and medical school leadership described the integration as a work in progress.

2.0 INTEGRATION PROFILE

The plan to consolidate inpatient services to West Roxbury and expand outpatient services at Jamaica Plain required both organizational and physical changes. While considerable progress had been made in integrating the two campuses over the last year, more work remained. At the time of our visit, virtually all major clinical services had been reorganized under a single system-wide chief and co-chief structure. However, many services had not all been physically moved or consolidated to their new location.

Organizational structure: The Director of VABHS was the previous Director of the West Roxbury VAMC, although he started his career at the Jamaica Plain VAMC. The Chief of Staff was recruited from the VA medical center in Little Rock, Arkansas, and was the only person in VABHS with a joint appointment at both medical schools.

The structure for integration of the major clinical services at the VABHS involved a Chief from one of the affiliated medical schools and a Co-Chief from the other medical school. In Medicine and Surgery, the Chiefs were expected to switch every five years. In practice, the Chief of Medicine of the VA Boston Healthcare System was affiliated with BU, with a Co-Chief affiliated with Harvard, and the Chief of Surgery was affiliated with Harvard, with a Co-Chief affiliated with BU. The Chief/Co-chief structure allowed each service to continue to have formal ties to both medical schools. The Chief and Co-Chief were expected to serve as the academic leader to his/her own school for faculty hiring and evaluation and for student evaluation; the Chief would be the operational leader. In order to keep the division of service leadership equal between schools, a few services were "horse-traded." In Neurology, for example, the Chief was from Harvard even though West Roxbury had a smaller service and no residents.

Medical students, residents, and fellows from both medical schools were planned to be mixed within the services. New residents arrived in July, but at the time of our visit, only a few services had Harvard and BU residents working side-by-side because of the constraints on the physical consolidation of services described below. As integration

moves forward, trainees were expected to be taught by attendings from either school at the bedside and in other clinical settings. Faculty would have an appointment at only one school, however. The attendings representing a specific medical school were expected to be responsible for training, including evaluations of students from their medical school. Two ACOS positions for Education and two ACOS positions for Research were still in place at the time of our visit. No decision had been made about integrating the Research Service, except for an integrated IRB. The reorganization of Psychiatry service had not been addressed. We heard a variety of opinions, many contradictory, about the potential future direction of this service.

Respondents reported that although the organizational structure was in place, the challenge to implement plans was just getting underway. Most of the respondents had "no idea" how it would work in practice.

Respondents varied in their opinions about the Chief/Co-Chief structure. They raised many concerns about the lack of specificity of a role or job description for the Co-chief. Many respondents considered the Co-Chief position to be a relatively weak position. Within some services, the arrangement was reported to work well, particularly if the Co-Chief had not been a strong competitor for the Chief position or did not have designs on being a Chief. One reportedly difficult situation was in the Medical service. Designated a BU position, the originally-designated Chief retired and the replacement appointed by BU had less seniority than the Harvard co-Chief, which was initially awkward. One proposal for carving out a role for the Co-Chief reportedly was to have him be in charge of those sections within Medicine that were led by a Harvard faculty member. The proposal was not accepted.

We were also told that the medical schools sought more oversight in certain circumstances. They were concerned that services not under their own school's direction would not keep their academic interests in mind. Two specific areas of concern were (1) assuring that students had enough practical experience and (2) determining a replacement process for staff who resigned or retired. Medical school representatives worked on helping to define the role for the Co-chiefs of services. They also established steering committees to oversee the implementation of the integration in Medicine and Surgery because they were concerned with early implementation problems. VA staff leaders expressed concern about balancing the needs of the medical schools with the needs of the VA. Respondents at the VABHS indicated a need to recognize the anxieties of the medical schools without their interference in day-to-day operations of clinical care.

Physical relocation: The integration plan approved by VA Headquarters depended on substantial capital renovations to change the missions of the Jamaica Plain and West Roxbury campuses. The initial capital funding request was for $23 million. In July 2000, VABHS was informed that it essentially had to start over and submit its capital requests through VA's new Capital Asset Realignment for Enhanced Services (CARES) process. Design planning funds were also rescinded but later re-awarded. Because of the funding delays, most renovations had not been made at the time of our visit. However, many smaller outpatient services were moved from West Roxbury to Jamaica

Plain, as planned, to free inpatient space at West Roxbury. Surgery and Cardiology, but not Medicine, had been recently consolidated to West Roxbury. The further consolidation of inpatient beds was delayed because construction funds that had been expected were withdrawn. [In November 2000, system leaders issued a notice that they were considering moving inpatient medical beds from Jamaica Plain as early as January 2001.]

Interview respondents expressed many concerns over the lack of continuity and threats to the quality of patient care caused by partial relocation of services. Of particular concern was the lack of support to the consolidated surgical service. The workability of consolidation without expanded surgical suites, ICUs, step-down units and telemetry reportedly depended on an expanded operating schedule. But there was a shortage of support staff, especially nurses, because they were not transferred from Jamaica Plain when surgeons were as a result of union objections. Consequently, the operating schedule was not expanded and patients were waiting in house for surgery for up to two weeks for surgery. A general nursing shortage in Boston and differences in cultures in the way staff work at the two campuses exacerbated these problems. Respondents were also concerned having Medicine and Surgery in different locations threatened the quality of care; for example, the lack of surgery and a 24-hour pharmacy at Jamaica Plain while inpatients were still there.

3.0 FACTORS AFFECTING INTEGRATION

VAMC and medical school buy-in. Early on in the process, the need to integrate was understood by many key participants. Too few patients to support all the medical centers in Boston was a widely-publicized phenomenon. Through all the planning processes, VA held firm to the principle of consolidating acute inpatient services to one campus. The medical schools appeared to accept this principle and focused their attention on "winning" the inpatient campus rather than arguing for the status quo.

Role of medical schools. Although the VA leadership did not want the medical school needs to override the needs of the VA, they gave the medical schools the opportunity to present a plan for integrating clinical services that would be acceptable to them. The medical schools, in turn, after an initial period of distrust, realized they had to work together. Given the mandate that integration would occur and the general guideline that inpatient and outpatient services would be consolidated at different campuses, the schools worked hard to develop a structure and plan that they thought was workable and asked for VA intervention when impasses occurred.

As mentioned earlier, some of the challenges that VABHS had to face, most notably obtaining adequate funding to support integration, served to build solidarity across the two medical schools as they perceived themselves fighting a common enemy.

Mutual respect among individuals. One of the facilitating factors between the medical schools and between campuses was a fair amount of respect between Harvard and BU faculty, though relationships were not without problems. The Deans and other senior medical school officials reportedly worked constructively with each other. Many of the clinicians at both campuses had trained together or worked with each other in the past. Where problems stemming from pride and reputation were brought to our attention, they related for the most part to the overall cultures of the institutions, rather to individual disagreements. Contentiousness between the VABHS campuses was reportedly about maintaining workloads and positions. The contentiousness between the medical schools related primarily to retaining their training slots and authority.

Staff buy in. Staff support for integration was mixed at best. While all the organizational pieces of the integrated system had been determined, our visit occurred on the cusp of implementation. Except for a few services, staff did not yet have much experience working in the integrated environment. Many respondents were unsure how things would work or if they were workable. Across services, we heard that experiences varied. Some sections were more integrated than others. Anxiety was reported by some respondents in sections where decision-making was not complete and in others where reportedly plans kept changing.

On one hand, we heard that morale was poor, that there were personality conflicts, that there were bad feelings about decisions, that authority had been taken away from section heads, that discussions with management about perceived problems was discouraged, and that there was resistance to change. A lack of cohesiveness was viewed as weakening the whole system. At the extreme, respondents expressed the belief that eventually one of the medical schools would pull out.

On the other hand, we also heard about positive experiences and services that were running smoothly. According to respondents, the smoothness of integration related to the relative seniority and career paths of the Chief and the Co-Chief, personalities, size of the section, amount of mutual respect, and pressures and/or uncertainties within the service. Several respondents indicated optimism, and the realization that the adjustment would take time.

Overall, respondents reported that they were eager to get to the other side of the integration process, have decisions made, and move ahead.

Operational constraints. The integration of VABHS had been substantially affected by multiple operational challenges. The fallout from the severe financial constraints resulting from the combination of substantial and continuing budget shortfalls and the lack of expected capital funding to support integration dominated most of our discussions. The financial constraints were further complicated by union resistance to staff movement across campuses and by a growing labor shortage in certain professions. One result of these challenges was that integration proceeded piecemeal with some services and staff moving long before others. This staggered implementation created problems in staffing and service continuity that many staff felt was compromising patient

care. A second result, stemming specifically from budget shortfalls, was high anxiety and preoccupation among many respondents with current and anticipated staffing cuts. People were unhappy about doubled-up workloads and about their fears that the best clinicians would leave the system.

4.0 IMPACT OF INTEGRATION

4.1 Impact on clinical care:

Our interviews revealed a number of concerns about clinical care during this time of transition for the VABHS. Staffing problems resulting from staff reductions and from labor resistance to transferring staff across campuses were, according to some respondents, compromising patient care. Specific shortages were for nurses, radiation therapists, and physical therapists. Problems related to an inadequate supply of beds for cardiac surgery (primarily due to nurse staffing issues) were mentioned, leading to long waits for surgery. Lack of surgery at night at the Boston campus while inpatients remained there was also a concern, as was the lack of a 24-hour pharmacy.

Difficulty with traveling between campuses was discussed as a difficulty by some respondents as were difficulties of seeing patients in one location as outpatients and admitting them in another location. A few respondents mentioned that patients were confused about the location of their care.

Some physicians commented that working side-by-side with physicians from the other campus was challenging but not insurmountable. Because of faculty shortages, some respondents indicated a concern about adequate supervision of residents in some services. An important challenge for the future, as some respondents highlighted, will be to downsize inpatient care. To date, the system is bringing services together, but as one respondent put it, “cohabitation doesn’t bring economies”. Facing multiple challenges – continuing budget constraints, higher staffing patterns here than in the rest of VA, changes in clinical practice away from inpatient care together with anticipated staffing shortages in nursing, pharmacy, anesthesiology, respiratory therapy and physical therapy – VABHS is expected to shrink, or at least shift resources from inpatient to other care settings.

4.2 Impact on the teaching mission:

At this very early stage of assessment (i.e., first joint residencies had just begun), comments were primarily positive about integrated house staff. Faculty, in general, indicated that they thought the integration would be stimulating for both faculty and trainees. Cardiology grand rounds was cited as an example of integration bringing a

larger audience and greater intellectual stimulation. Respondents reported that the house staff were working well together. The situation was not completely without problems, however. We were told of one complicated and contentious instance of transferring a resident that resulted in a new senior resident being brought in, some people thought unfairly, above residents already in the system.

Many respondents expressed concern about the effect of a decreasing patient load on availability of teaching subjects. Several respondents indicated that already there was not enough work within their sections for all the medical students and that they would also need to downsize their house staff. Inability to conduct a full complement of surgeries, primarily due to nursing shortages, was a current problem at the time of our interviews. Moreover, in some areas the problem reported was an inadequate number of faculty and preceptors for students, partially due to the hiring freeze.

Respondents indicated that they expected that one of the ACOS for education positions would be eliminated. They did not express concern about medical school affiliation for this position.

Many respondents talked, from different perspectives, about the continuing challenge of the appropriate size of the residency programs. By some accounts, there are too many residents in VABHS. With the shift to outpatient care in all sectors, and with the VISN moving to create an integrated network across New England, the need for residents will shift. In some opinions, these shifts also present an opportunity for VA because the affiliates' opportunities for training interns and first year residents are shrinking across their training sites, and VA therefore becomes an even more important training site.

4.3 Impact on the research mission:

At the time of our interviews, the research service was not fully integrated. The Institutional Review Board (IRB), including human subjects, animal studies, and safety, had been integrated. The IRB alternated sites and responsibilities for the meetings. Joint policies were developed to address the IRB's functions. Each campus continued to have its own Research and Development meeting to review new project submissions. Each campus had its own ACOS for research.

Many of the respondents indicated an uncomfortable uncertainty about the future of the research service. Several of them were resigned to thinking that the service would eventually merge, but did not know how or when. The purposes for maintaining two separate services were reported as to maximize funding from VA and appease the medical schools, who receive benefit from research conducted by VA researchers. Some respondents questioned that any savings would accrue from merging research, citing examples from other VA mergers. In addition, we were told that the West Roxbury campus had "worked hard" to develop an arrangement whereby Harvard gives a percent of overhead from NIH studies that are put through Harvard. BU does not have such an arrangement. Other reported advantages to separate organizations included the support that each office had provided to its researchers. Concerns were voiced that a single large

office would require more layers, be more cumbersome, and constrain close working relationships with researchers. It was suggested that local offices be maintained to support investigators at both campuses, even if the research service was merged. Interviewees noted that two-thirds of the research in the VA Boston Healthcare System was conducted by BU-affiliated staff.

Some of the researchers we interviewed commented about problems with the newly merged IRB. Not only were they required to use new forms, but also the meetings were extremely long, and there were reports about getting different feedback each time they resubmitted their information to the committee. Concerns about getting adequate safety support for labs were also voiced.

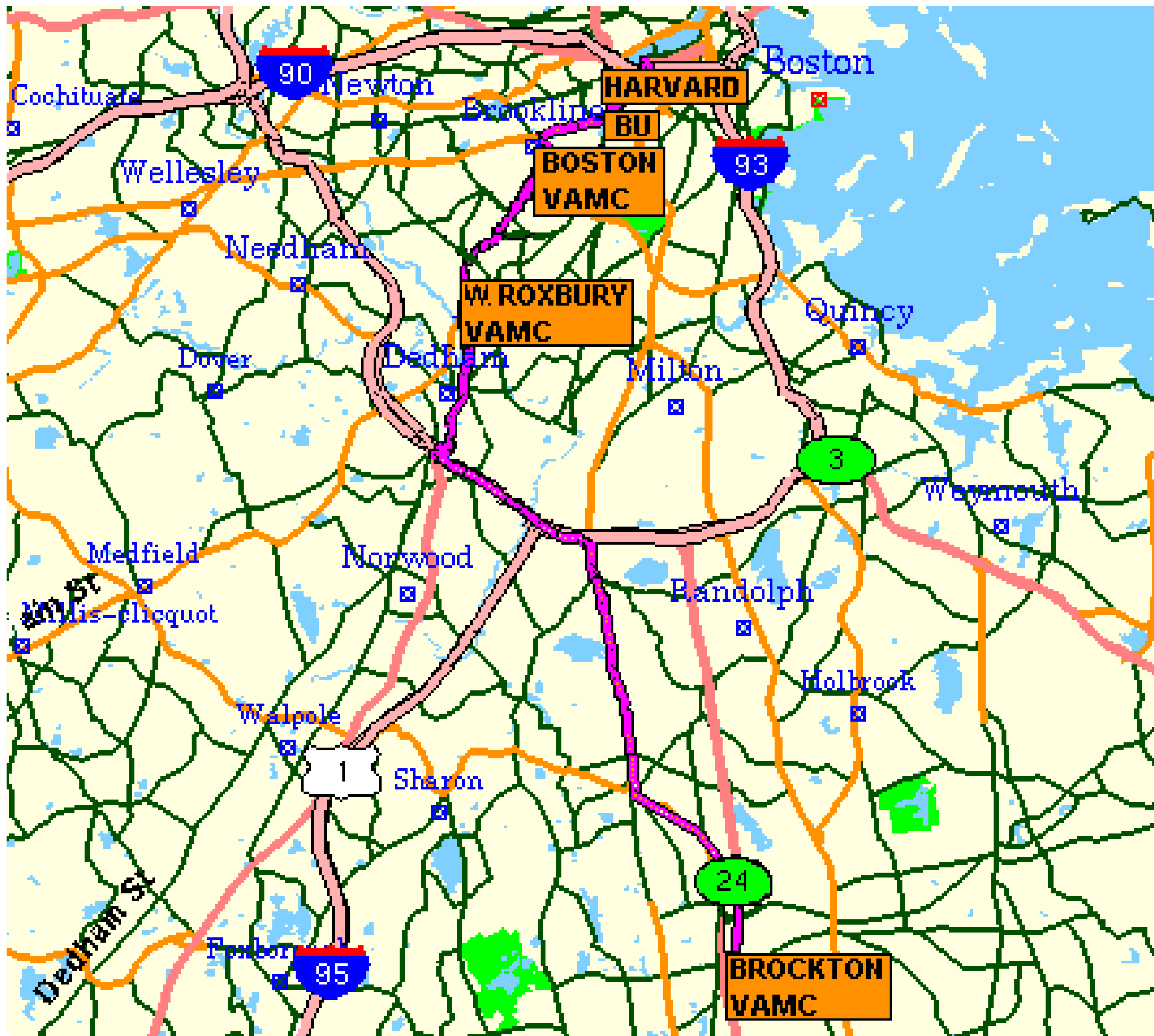
Many other respondents, particularly clinicians in medical and surgical services, reported problems that were affecting research productivity within the VABHS, only some of which were directly related to integration. The problems that were the most relevant to integration were time constraints for staff who had administrative responsibility for integration, decreases in physical research space, and fears about decreased support from the research office (particularly at the West Roxbury campus). Other reported problems were budget cuts, staff terminations, increased clinical productivity requirements, and inconsistency of funding (i.e., sometimes budgets are cut before awards or in subsequent years). Not only were these problems for current staff, but they were also reported as barriers to recruitment of clinicians, as well as clinical and Ph.D. researchers.

Researchers also noted the impact of integration on administrative services. For example, delays and lowered efficiency were observed regarding facility management and human resources, that researchers said made their jobs more difficult.

A number of positive impacts of integration on research were also noted. The two campuses were already involved prior to the integration in a few major joint research efforts that were viewed as highly successful. Respondents reported that they looked forward to possibilities for more joint research as well as larger research subject pools. The possibility of a larger medical student pool to assist with research was also attractive to some researchers.

Several respondents indicated that it was getting harder to maintain VA's academic mission in this era of diminishing resources. They also emphasized that the ability to start a research career was a strong incentive for clinicians and Ph.D.s to join the VA. Without supplemental support for clinical responsibilities, however, the ability to conduct research was already becoming limited.

BOSTON: SITE VISITS 2000



BOSTON INTERVIEW SITES:

Boston VA Medical Center
150 South Huntington Avenue
Boston, MA

Boston University (BU)
121 Bay State Road
Boston, MA

Harvard University
25 Shattuck Street
Boston, MA

West Roxbury
VA Medical Center
1400 VFW Parkway
West Roxbury, MA

Brockton VA Medical Center
940 Belmont Street
Brockton, MA

Preliminary Case Descriptions: VA Chicago Health Care System August 2000

1.0 Context

The integration of the West Side VA Medical Center (West Side) and the Lakeside VA Medical Center (Lakeside) is the oldest of the three cases studied, having been approved in June 1996. Despite this length of time, the VA Chicago Health Care System (VACHCS) and the VISN are still working to develop a viable plan for clinical integration. Multiple proposals have been offered, multiple studies have been conducted, and a variety of options have been considered, involving not only Lakeside and West Side, but also Hines VAMC, North Chicago VAMC, and nearby Wisconsin hospitals.

This case description is based primarily on interviews conducted in VACHCS in August 2000. We conducted 21 individual and 3 group interviews to obtain a wide range of perspectives at different levels of the organization across the West Side and Lakeside campuses and at the primary medical school affiliates.[1] The case description reflects the status of integration at the time of our interviews.

1.1 The medical centers:

Prior to their integration, the West Side VAMC was the larger of the two facilities with 26,532 patients, 1,375 full-time equivalent employees (FTEE), and patient care costs of $85.8 million, compared with Lakeside's 20,359 patients, 988 FTEE and patient care costs of $65.3 million. West Side also had more physician FTEE, both in terms of absolute numbers (99 versus 77.5 at Lakeside) and in terms of physician FTEE per 1,000 adjust workload (4.2 versus 4.0 at Lakeside). It was somewhat more complex with a complexity score[2] of 59 compared with Lakeside's 55. Lakeside was somewhat more efficient with 51 adjusted FTEE per 1,000 adjusted workload compared with West Side's 58. Both facilities had psychiatric beds but no nursing home or domicilliary beds.

The Lakeside campus is located in the Gold Coast area of downtown Chicago, within the Northwestern medical school campus, as shown in the map attached to this case description. It is in a prosperous, urban environment. Parking is difficult because outside parking and parking garages are expensive. West Side is also in a very urban setting. The immediate neighborhood is filled with the UIC campus and other hospitals. The contiguous residential and business neighborhoods are relatively poor. West Side has a new outpatient addition. No parking problems were mentioned. Probably because of its location, Lakeside has a reputation of serving a more well-off and less racially diverse patient population than West Side. Demographic studies of VA users revealed, however, that users of both divisions come from very similar areas of the city.

[1] We also conducted a day of interviews at Hines VAMC and at Loyola's medical school. The results of those interviews are not included in this case description.
[2] Complexity in VA is calculated on a 100 point scale with 100 being the highest complexity.

VACHCS received $12.3 million in research funding in fiscal year 1999, up from $8.3 million funded in fiscal year 1998. Of the 1999 total, $4.7 million was in VA funding and $7.6 million was from other sources. Historically, West Side has had less VA research funding than Lakeside, but in 1999, the funding levels were about even. In fiscal year 2000, West Side VA research funding rose to $3.2 million while Lakeside remained at about $2.4 million.

1.2 The medical schools:

Academic affiliations with VA have a long history in Chicago. The Hines VA medical center was the first academically affiliated VA in the country, with Northwestern, University of Illinois at Chicago (UIC) and Chicago Medical School all training at Hines. Some years later when VA was slated to build new hospitals, it built them next to the campuses of Northwestern and UIC, by some accounts as thanks for their early support to VA.

Northwestern, ranked 22nd by US News and World Report, is viewed as a medical school with top-level training and practice. It is part of a training consortium that involves several affiliated hospitals. Its major teaching site, Northwestern Memorial Hospital (NMH), is privately owned and operated and in a highly competitive position with other Chicago hospitals. Medical practice at NMH is becoming more demanding for faculty (e.g., twice a day rounds are required). Training at the VA is viewed as extremely positive since students and residents are able to spend more time with patients and are able to have more independence than in private hospitals. Northwestern has placed a strong emphasis on research and is trying to expand its research capacity. Northwestern has had two new deans since the VA integration began.

UIC is the largest state medical school in the country with campuses across Illinois, and has the second largest minority enrollment in the country. Chicago is the flagship campus with 1,221 students in 1999. VA and the University Hospital are its major teaching sites. It has a large residency program at VA. UIC had serious problems ten years ago when it tried to move its training programs to Michael Reiss hospital. The move failed and the school took several years to recover. More recently, there were IRB problems, but they have been resolved. UIC is proud of its social mission to serve poor patients and veterans, and is committed to providing high quality care and conducting excellent research.

The medical schools have not traditionally worked together, but the personal relationship between the UIC dean and the new Northwestern dean, in some opinions, may be beneficial to future cooperation.

Virtually all respondents emphasized the extremely strong relationship between each VA campus and its affiliated medical school, stemming in large measure from their close proximity, virtually across the street. They cited the sharing of physicians, VA's substantial support of residency slots, and joint IRB's to demonstrate the VAMCs' and medical schools' interdependency. Most VA physicians are part-time VA, spending the

rest of their time at the university hospital or in private practice. Many also have active research programs. Physicians talk about moving back and forth between VA and the university during the day. In many interviews with VACHCS clinicians, the distinction between the medical school and the VA was almost totally blurred. When a chief of a service used the term "we," for example, the medical school rather than the medical center was often the frame of reference. Likewise, the medical school respondents described the VAMC as being part of their campuses.

1.3 The integration process:

The decision to formally integrate West Side and Lakeside came from Headquarters. West Side and Lakeside VAMCs had been having discussions about coordinating and consolidating services for a number of years. The two medical centers, although only six miles apart and with identical missions, historically did not work together, and by some accounts represented battling fiefdoms. Looking ahead, however, it was clear that the two facilities would have to change to survive. Several factors brought pressures for change: Chicago was considered to be substantially overbedded in both the public and private sectors; VA was moving to create an integrated delivery network across VISN 12; and at the same time, was shifting from inpatient to outpatient care in response to VA eligibility reform and changing medical practices. The early discussions focused on coordination in order to reduce redundant services, not necessarily full facility integration. In 1994, a VHA Management Improvement Task Force evaluated potential savings from medical center integrations and consolidations nationally. The Task Force identified a number of potential integration sites, including West Side and Lakeside. West Side and Lakeside were not, however, on the first list of medical centers approved for integration in March 1995.

In October 1995, the VISN was established. One of its earliest priorities was to review tertiary facilities in VISN 12 for the most effective use of resources. VISN leaders held town hall meetings at each facility and meetings with the deans of the affiliated medical schools to discuss potential clinical and administrative efficiencies, including integration and consolidation of targeted services such as cardiac surgery, angioplasty and neurosurgery. Public resistance to these discussions was strong, among both VA employees and the affiliated medical schools. Reportedly, one of the medical schools, concerned that the discussions were headed toward integration and the closure of inpatient care at one facility, hired a public relations firm to lobby against integration with VA officials in HQ. By some accounts, the lobbying backfired: the Under Secretary for Health thought that the integration of the two medical centers was a good idea and ordered it be done, even though VISN 12 and the two medical centers had not been considering full facility integration.

The objectives of integration as finally approved were to:

- Eliminate redundancies and enhance operational efficiency;
- Conserve resources and maximize their utilization;
- Ensure continuation of high quality medical care to veterans during a period of declining resources; and

- Establish a continuum of care for veterans living within the geographic area of VISN 12.

LATER DOCUMENTS REDUCED THE OBJECTIVES TO THREE "ULTIMATE OBJECTIVES:"

- Cost reductions;
- Improved efficiencies; and
- Elevation and standardization of quality.

The early management plan was to:
- Review all clinical and administrative programs;
- Identify inefficiencies and unnecessary duplications;
- Determine appropriate efficiencies, including integrations and consolidations;
- Evaluate the potential for improvements in resource utilization and patient care; and
- Make no decisions without consulting stakeholders.

The document that lays out this plan also states that while there were no plans to close either West Side or Lakeside, functional changes were likely to occur at both sites.

Some services were consolidated across facilities before the integration was approved. In August 1995, for example, human resources for West Side, Lakeside and Hines were consolidated, with the new service located at Hines. West Side and Lakeside also shared programs in nuclear medicine, chaplain support and music therapy.

In Chicago, the integration was perceived by staff as a VISN directive, to be implemented by the Director of the VACHCS. The Director of Lakeside was chosen as the first Director of the VACHCS when the Director at West Side resigned to become the Director of the Hines VAMC. Many people thought that the new VACHCS Director had total authority to implement a pre-existing plan from the VISN. He was viewed as an extremely strong and authoritative leader. In the early phases of integration, the Director made decisions about integrating administrative services without an extensive planning or committee structure. For clinical services, however, he delegated planning to an Integrating Coordinating Council (ICC), chaired by the Chief of Staff in the VA New Jersey Healthcare System, which had recently undergone its own integration. The ICC included representatives of West Side and Lakeside and stakeholders, including medical schools, VSOs and unions. The ICC developed service-based work groups that were asked to create individual integration plans The plans came back with few recommendations for changes. Eventually the ICC was disbanded without developing plans for integrating most clinical services.

The Chicago integration has been highly politicized and publicized. From the beginning, there was a strong perception by many people in Chicago that the VISN had an agenda to close the West Side facility. Unions and clinicians protested publicly, including to their Congress members. At one point West Side constituents were bussed to Lakeside to

conduct demonstrations. As a result, the General Accounting Office (GAO) began a series of studies on the Chicago integration.

The VACHCS integration process has been complicated by continued attention to more general issues of excess capacity across all VA Medical Centers in the Chicago area. Several GAO and consultant studies had been conducted, many of which focused on the larger Chicago area. These studies also reinforced the possibility that West Side might be closed as an inpatient facility. These studies, particularly the one widely referred to as the Options Study, were generally thought to be very disruptive to the VACHCS. The reports from different sources were inconsistent and each time the results were presented, severe criticisms were lodged from a variety of sources. The options suggested included merging services within existing hospitals, consolidating in one and closing another, or closing two or more hospitals and building a new independent hospital. The Hines VAMC has been a focus of some of these studies. As part of VISN efforts to create an integrated delivery system, several administrative and clinical functions have been consolidated at Hines. At the time of our visit, however, no future plans to integrate Hines with Lakeside and/or West Side were being discussed.

After the first VACHCS Director retired in 1998, little internal planning occurred. In November of 1999, a new Director was hired from the VAMC at Murfreesboro. Generally he is viewed as a much more open and collaborative leader than the former Director.

Planning continues at both VACHCS and VISN levels to develop a plan to integrate more clinical services. No time deadline has been set for making decisions about a plan for further integration. In the short-run, according to the Director, the VACHCS was going to focus on successfully passing the JCAHO review. At the same time, they expected to continue a collaborative planning process with the medical schools to see what they could achieve in this forum. Many respondents reported that they thought that a new President (elections two months away) might change the emphasis of VA, and that they expected it would take another year and a half for anything to happen. Many respondents, including the Director, were extremely concerned about passing the JCAHO review.

2.0 Integration Profile

At the time of our visit to VACHCS, administrative functions of the Lakeside and West Side divisions were combined under a single structure, but only a few clinical services were combined. The Director maintained an office at both divisions, but reportedly used his Lakeside office as his primary base. The location of the Director, as well as other senior administrative staff at Lakeside, continued to give the impression to some staff that Lakeside was a favored site. Some of the major support services, i.e., human resources and laboratory services, were located at the Hines VAMC as VISN-wide functions.

Each campus had its own chief of staff, and the medical, surgical, anesthesiology, and neurology services were totally separate at each division. Two clinical services that were combined, psychiatry and rehabilitation, were combined because the medical schools

withdrew the training programs for reasons independent of the VA integration. Psychiatry came under the direction of the West Side division when the Department of Psychiatry at Northwestern University Medical School (Northwestern) withdrew their training program from Lakeside because of disagreements with the former Director. All inpatient psychiatric services were consolidated at West Side with consulting service at Lakeside and outpatient services remaining at both campuses. The Chief at West Side was appointed as the system chief of psychiatry, and the Lakeside chief lost his position but remains in the service with lead responsibility at one of the large outpatient clinics in the system. Similarly, the rehabilitation service had come under the leadership of Lakeside because UIC was no longer running a rehabilitation residency. Radiology was organizationally combined under a single chief, and the system was recruiting to fill the vacant chief's position. Social work and nursing were also combined under a single chief, though the services operated separately at each campus.

In addition to structural reorganization, another aspect of integration was to develop joint policies in order to create a single standard of care across campuses. In anticipation of the JCAHO survey later this year, VACHCS was preparing joint policies.

At the time of our visit, no decisions had been made about merging the major services of medicine, survey and anesthesiology. There was no consensus about the final form of the VACHCS system. None of the options proposed thus far were acceptable. In fact we heard about other potential options that they wanted to explore, ranging from a focus on real estate sharing agreements with the medical schools to the potential to recruit new patients to increase their census.

Many, but not all, respondents indicated that the new Director has done a lot to diminish the paranoia, defensiveness, and secrecy perceived previously. In leadership's view, significant progress has been made to improve and strengthen staff communication by holding town hall meetings, Dean's committee meetings and meetings with veteran service organizations and other stakeholders to provide current information on the budget and other important issues. Some respondents, however, especially at West Side, indicated that they had no idea how decisions were made, and generally felt out of the decision-making loop. Several respondents questioned the lack of data to support decision-making. For example, respondents mentioned that they were not aware of future projections of patient load nor any VA analyses to assess the number of residency slots VA would be able to support over time.

3.0 Factors Affecting Progress

- *Lack of urgency.* Although most respondents agreed that declining veteran populations and finite dollars ultimately would make integration necessary, relatively few felt any immediate pressure to combine or consolidate services. As one person put it, "Chicago is not in bad enough shape."

- *No acceptable options or perceived benefits.* Most respondents believed that merging clinical services was not feasible; a minority of respondents indicated that even if it

were "doable," it wasn't desirable. Most options for clinical integration turn on consolidating inpatient services to one campus, with Lakeside most frequently mentioned as the campus to retain inpatient care. Among the many objections to a single inpatient campus plan, the lack of access to the Lakeside campus and the close interdependency of each campus with its own medical school were the most frequently cited. Most clinicians on both campuses work for VA only part-time and need to be close to their other responsibilities at their affiliated medical schools, related hospitals, and research labs. Coping with these multiple demands on their time were viewed as feasible when the locations were within close walking distance, but impossible if the locations were an estimated 45 minutes apart (including walking to the car and parking). When we asked what would happen if a consolidation were to occur, led by either Lakeside or West Side, the response was that good staff would leave, and that within a short time, the medical school on whose site the campus was not based would withdraw from VA. Some respondents indicated that the medical schools would find a replacement for the VA training site, while others said that they might not even replace the training site.

- *Unequal power and stature.* Many respondents indicated that they, as well as others internal and external to VACHCS, perceived a substantial difference in the power and stature of the two divisions, primarily based on their academic affiliates. This inequality appears to have inhibited collaboration between the medical schools, and therefore delayed integration. By some accounts, Northwestern, with a stronger national reputation, did not need or want to share teaching and service delivery with its state school counterpart. Having Northwestern clinicians, faculty, and trainees was viewed as a positive benefit for VA, one that many people believed VA would not want to lose. In addition, finding new training sites was perceived to be easier for Northwestern than for UIC, suggesting that it was important to "keep Northwestern happy," at least until a plan had been developed. UIC was concerned that they were treated unfairly, as the stepchild in the system. UIC officials believe that they were not included in decision-making and ideas offered were rejected. Moreover, at this time both schools were happy with their arrangements with the VA and had no incentive to change them.

- *Toll of uncertain future.* Integration at the VACHCS has been in process for over four years, and no final plan is in sight. The process has been political and highly contentious. Both Lakeside and West Side respondents expressed uneasiness from the lack of certainty about future plans. One of the problems associated with uncertainty (some people experienced it; some feared it) were that good staff would resign and that recruitment would suffer.

- *Role of medical schools*. The same features that reflect a strong interdependency between the VAMCs and their medical schools were cited as reasons why integration between VA campuses is very difficult. The medical schools were described as highly vocal and adversarial during the past discussions of merging or closing services. Medical school respondents reported that merging certain services, e.g., rehab and psychiatry, where one of the medical schools did not have an interest, was

doable, but that merging key clinical programs, i.e., medicine, surgery, and anesthesiology, would be impossible. There appears to be no tangible incentive for the medical schools to support integration of the major services at this time. Medical school respondents suggested that they could provide high quality care using their own medical school affiliated hospitals to care for veterans, which would allow VA to close one or both facilities.

4.0 Impact of Integration

4.1 Impact on clinical care:

With the majority of clinical services still operating independently at each campus, the structural impact of integration on clinical care was limited. Nevertheless, respondents noted several impacts. The stress of the drawn-out integration process and the uncertainty of the final integration plan were mentioned. Reductions in staff, by design and by attrition, were discussed as negatively affecting morale and patient care. In psychiatry, specifically, concerns were raised about how the stress of integration may have affected staff's ability to provide highest quality care.

Working with services across distances, because of VISN changes as well as changes within VACHCS, caused problems. Several West Side respondents indicated that they experienced difficulty in coordinating services with Lakeside practitioners. In addition, Lakeside respondents reported that medical and surgical treatment of psychiatric patients at Lakeside was more difficult since psychiatric services were consolidated at West Side. The burden on patients cause by travelling between sites was also cited, not only between Lakeside and West Side, but for services that had been moved to Hines VAMC, e.g., radiation therapy. Respondents indicated that this type of service delivery was not in the best interest of patient care, since some of the services that would have been previously provided on an outpatient basis, were now provided on an inpatient basis because of distance. In general, respondents were more likely to favor integrating more completely with their medical school affiliates for services they could not provide themselves than transfer patients to a more distant VA location for those services.

4.2 Impact on the teaching mission:

No impact on training was described at the time of our interviews, although we were told that, previously, recruitment of residents at UIC was damaged because of the threat of closing West Side. Concerns about future travel time between Lakeside and West Side, however, were expressed. Respondents agreed that to combine both training programs would be difficult because of the large size of the training programs and the differences in cultures of the schools. Several respondents didn't think that it was feasible to supervise residents from the opposite school; others thought it would be possible.

Only a few respondents believed that the VA was backing away from its academic mission in Chicago. Many respondents reported that it was the academic mission that kept the quality of VA care above that of other indigent programs, such as state hospitals.

Although several respondents acknowledged that academic affiliations were more expensive, they also expressed a belief that quality of care for veterans required these affiliations.

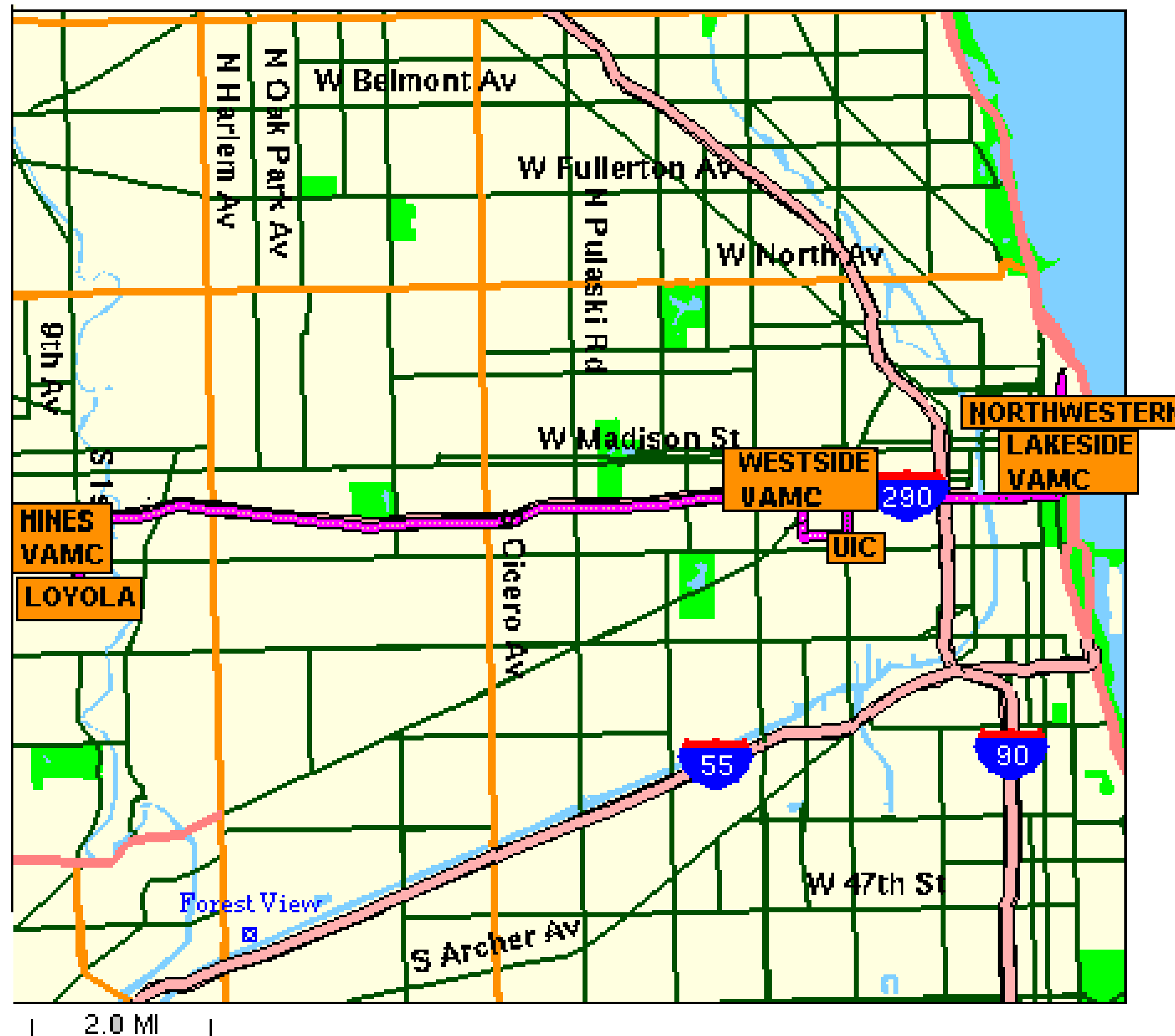
4.3 Impact on the research mission:

There had been no direct impact on research at the time of our interviews. We were told that research was seen as very important to both divisions and both medical schools and that all programs were interested in growth. Again, the integration between each medical school and its affiliated VA division was described as paramount.

Each division had a separate associate chief of staff (ACOS) for research, though some support functions had been combined and both ACOSs were required to sign off on grant applications. Each campus had its own IRB that operated jointly with its academic affiliate. A few collaborative research projects between the medical schools and their VA affiliates were described. No collaborations between Lakeside and West Side were reported.

Respondents reported that a few faculty with large grants at West Side had left because of uncertainties about the medical center's future. They reported that one ACOS responsible for such a large program would not be effective, given the size of the programs, and their close connections with the medical schools. One suggestion was that one ACOS be responsible for fiscal operations and the other take on programmatic development. Respondents reported that more collaborative research might take place as HSR&D research grows. Some research respondents indicated that they already knew that it was difficult to have a support service at another location, i.e., because human resources were located at Hines.

CHICAGO: SITE VISITS 2000



CHICAGO INTERVIEW SITES:

Hines VA Medical Center
5th & Roosevelt Road
Maywood, IL

Loyola University
2160 South 1st Avenue
Maywood, IL

West Side VA Medical Center
820 South Damen Road
Chicago, IL

University Of Illinois
At Chicago (UIC)
1740 West Taylor Street
Chicago, IL

Northwestern University
222 East Superior Street
Chicago, IL

Lakeside VA Medical Center
333 East Huron Street
Chicago, IL

Preliminary Case Descriptions:
VA New York Harbor Healthcare System
June 2000

1.0 Context

The integration of the Brooklyn VA Medical Center (Brooklyn) and the New York VA Medical Center (Manhattan) to form the VA New York Harbor Healthcare System (NYHHS) is the most recent of the three systems studied, having been approved in January 1999. Compared with the other systems, the NYHHS integration has been politically low key.

This case description is based primarily on interviews conducted in NYHHS in June 2000. We conducted 25 individual and 12 group interviews to obtain a wide range of perspectives from employees across the main campuses of the system and the primary medical school affiliates. Individual interviews were conducted with chiefs and managers of selected clinical and administrative services, union leadership and medical school leadership. Group interviews were conducted with clinical faculty, other clinical staff (including nurses, social workers, pharmacists, dieticians and others), residents, chief residents, and researchers. Group members were selected to represent a variety of services and a variety of opinions about integration. The study team met with the NYHHS leadership group at the beginning and end of the site visit. Some interview findings are augmented with results of a staff survey conducted in NYHHS by the MDRC in May 2000; 840 staff from all levels of the system responded to this mailed survey.

The case description reflects the status of integration at the time of our interviews. Since that time, NYHHS has progressed further in its integration efforts. Recently it passed its first JCAHO survey as an integrated system with high scores (95, 96, 97, 99) and no Type 1 recommendations.

1.1 The medical centers:

Prior to their integration, the Brooklyn VA Medical Center was the larger of the two facilities with 36,335 patients, 1929 full-time equivalent employees (FTEE), and a patient care budget of $172.7 million, compared to Manhattan's 31,109 patients, 1684 FTEE and budget of $151.1 million. Brooklyn was also somewhat more efficient than Manhattan with 55 adjusted FTEE per 1000 adjusted workload compared with Manhattan's 59. Manhattan, on the other hand, was more complex with a complexity score[3] of 73 compared with Brooklyn's 68. Manhattan also had more physician FTEE, both in terms of absolute numbers (121 versus 109 in Brooklyn) and in terms of physician FTEE per 1000 adjust workload (4.2 versus 3.1 in Brooklyn).

Brooklyn's main inpatient division is located in the Bay Ridge section at the southern end of Brooklyn near the Verrazano Bridge, as shown by the map at the end of the case

[3] Complexity in VA is calculated on a 100 point-scale with 100 being the highest complexity.

description. It is a large sprawling structure with a new ambulatory care wing. The St. Albans Primary and Extended Care Center in Queens is primarily a long-term care facility with primary care outpatient services, a dementia unit and a domicilliary. The Brooklyn VA operates two Veterans Health Care Centers: the Chapel Street Clinic in Downtown Brooklyn and the Staten Island community based outpatient clinic (CBOC) in Staten Island. Centers of excellence include a comprehensive cancer care program with full radiology oncology services, cardiac electrophysiology, and community-based primary mental health care, and rehabilitative and extended care services. Many staff at Brooklyn pride themselves on being a neighborhood hospital. Almost two-thirds of its patients come from Kings County.

The Manhattan campus is located on First Avenue and 23rd Street, a busy urban neighborhood in Manhattan, the southern link in a string of medical facilities on First Avenue. There are businesses across the street and an apartment complex next door. Manhattan provides outpatient services at the main site on 23rd street at First Avenue as well as through the Harlem Care CBOC in Harlem and the Compensation & Pension Unit in Soho, as well as substance abuse programs and readjustment counseling centers in Manhattan. The New York VA is a referral Level 2 tertiary care facility for cardiac surgery, neurosurgery, rehabilitative medicine, psychiatry and various other special treatments for the VISN and VAMC's nationwide such as HIV/AIDS, state-of-the-art urology treatment, and prosthetics.

The geographic distance between Brooklyn and Manhattan is 12.5 miles, but the travel time is considerable – anywhere between 20 minutes to over an hour depending on traffic. The two medical centers historically have drawn patients from different parts of the New York area. In 1999, for example, the Manhattan campus drew 36% of its patients from New York County (Manhattan), 22% from Queens, 14% from Kings County (Brooklyn) and 1.17% from Staten Island. The Brooklyn campus drew 61% of its patients from Kings County, 23% from Queens only 4% from New York and 8.23% from Staten Island.

Manhattan has historically had more funded research than Brooklyn. In FY99, Manhattan had research funding totaling over $6.3 million, with $4.5 million coming from VA and $2.0 million from other sources. In the same year, Brooklyn had approximately $1.18 million in research funding, with $758,000 in VA funding and $422,000 from other sources.

1.2 The medical schools:

The two medical schools, New York University (NYU) and the State University of New York, Downstate (SUNY) both indicated that VA was an important training site, although both schools also had other training sites with similar patient populations. Respondents from both campuses and the medical schools indicated that NYU had a much stronger reputation than SUNY and was a center of excellence in several important areas. We also heard that, at least in some people's perceptions, some services, such as ophthalmology, were stronger at SUNY.

Located about 12 miles away from the VA Brooklyn campus, SUNY also trains at its University Hospital and at Kings County Hospital, a public hospital, across the street from the medical school. SUNY officials report they are heavily invested in VA. Most VA clinicians with faculty appointments are full-time VA employees. VA service chiefs are typically active at the medical school, but because of the distance between VA and SUNY, many other clinicians are not. Some VA service and section chiefs perform duties at SUNY and are appropriately compensated. SUNY is in the midst of a substantial reorganization following the arrival of a new president.

NYU is a short walking distance from the VA. NYU is ranked 27th by US News and World Report and reported having 676 students in FY1999. NYU has traditionally had a separate track for VA Medical residents and reportedly did not have a strong investment in VA. However, with the recent appointment of a new dean and a new chair of medicine, the school plans to strengthen its relationship. The new Chair of Medicine has ties to VA and will use lab space at the VA to carry out his research. More important, NYU is in the process of developing a single residency program that would include VA. This change was reported as an indication both that NYU thought of the VA residencies as high quality placements and that VA would be getting higher quality residents from NYU. Because of the close proximity of VA and NYU, clinicians at all levels frequently move back and forth during the day.

1.3 The integration process:

The decision to integrate the Brooklyn VA Medical Center and the New York VA Medical Center was more low-key than the other systems. In 1997, the Director of the New York VA Medical Center was asked to serve as acting director of the Brooklyn VA Medical Center, while also continuing his position in Manhattan. While the most pressing reason for the appointment was to fill the immediate Brooklyn vacancy, the VISN director asked the New York director also to explore the potential for integrating the two medical centers. The key question, according to planning documents, was whether a consolidation would improve the quality of care provided to veterans in a seamless manner while achieving a more efficient and cost-effective health care organization. This was consistent with ongoing analyses in VISN 3 to identify efficiencies in the system – for example, services that could be streamlined by consolidating them. The VISN analyses were responding to questions from VA Headquarters and from Congress about whether New York City really needed three VA hospitals (the third is the Bronx), or whether one of them should be closed.

After internal discussions, analyses and consultation with major stakeholder groups, New York and Brooklyn submitted a plan to VA Headquarters to integrate the two medical centers to form the VA New York Harbor Healthcare System. The plan was approved and the new system was formed in January 1999. An integration steering committee made up of internal and external stakeholders was appointed to oversee the integration process. It continues to meet.

All stakeholders agreed that some form of partnership was necessary between the two institutions to ensure provision of VA health care in the area. The expectation was that the system could achieve efficiencies by consolidating or combining administrative and, at least some, clinical services. Some clinical services had already been regionalized with a network plan. The strategy for integration was to seek opportunities, created for example when the chief of service at one campus retired, rather to create a master plan for a final, fully-integrated organizational structure.

Anticipated benefits of integration, according to planning documents, were to:

- Create a single standard of care and standard of practice
- Support continued high quality care, increased access and expanded customer service
- Maximize available resources and capitalize on expertise
- Eliminate duplicate clinical programs while improving quality and containing costs
- Tap the best programs clinically and educationally through ties to two academic affiliates
- Consolidate duplicate administrative programs to achieve cost savings
- Coordinate opportunities for outreach.

These benefits would be achieved by:

- Defining a single strategic direction under one leader
- Providing complementary, and in some cases synergistic, services
- Maintaining centers of excellence at each division
- Combining medical staff
- Consolidating duplicate administrative programs
- Expanding access points.

2.0 Integration Profile

At the time of our visit, the NYHHS had integrated virtually all of its administrative services and selected clinical and clinical support services. The system is following an opportunistic strategy to integrating clinical services: more services will be integrated as the opportunities arise, for example, with the resignation of a service chief on one campus. The Director has stated his commitment to maintain acute inpatient services at both campuses.

Many of the top leadership in NYHHS are from Manhattan including the Director, the Deputy Director, the Executive Chief of Staff, the Associate Director for Patient Services and the Associate Director for Finance and Information. Members of the leadership team from Brooklyn include the acting Associate Director for Facilities and Human Resources, Performance Improvement Manager and the Compliance Officer.

Selected clinical services have been integrated. Prior to the creation of NYHHS, Radiation Oncology was consolidated to one campus and Physical and Rehabilitation Medicine was combined under one service chief. Prosthetics was consolidated to the New York campus with satellites at all VISN campuses. At the time of our visit, the integration of several other patient care services were underway or planned:

Anesthesiology; Dental; Mental Health; Pharmacy; Radiology; Research; Pathology/Lab; and Recreation Service. Most services were available in parallel across both campuses or had split functions between campuses. There are no immediate plans to integrate either Medical Service or Surgical Service across campuses at this time.

In addition, at the time of our visit, the nursing service and most allied health staff were being reorganized under a patient-centered care (PCC) model. Three years ago, nursing and allied health professionals at Manhattan were reorganized under this model. . With the appointment of the Manhattan Associate Director for Patient Services (ADPS) as the systemwide nurse executive, and following five months of planning and orientation by task forces and steering committees, the patient-centered care model was adopted systemwide. Care-line managers were appointed in April 2000 to begin the reorganization. At the time of our interviews in July, formal transfer of staff had begun in Brooklyn. The nursing service at St. Albans was not yet included in the reorganization because of pressure from the union to stay separate from the PCC model. Some staff coming under the model reported little change in their jobs and many in Brooklyn were not aware of the change. For others, the change was quite dramatic and there was intense frustration and anxiety about their roles and lines of authority. Many stated the close, cohesive culture that existed among Brooklyn staff before the reorganization had been damaged.

Other major integration-related efforts include the creation of a single set of medical by-laws, the integration of mandated committee and joint policy development in preparation for JCAHO review. All staff agreed that joint policy development was difficult. While some believed that working together on common policies in preparation for the JCAHO survey was beneficial in bringing the campuses together, others believed that it was a paper exercise that simply wasted resources and added no value to the organization. We were told that some services worked well together and had no problem determining joint policies, while others had enormous difficulty. In some cases, staff reported, the ways that the two campuses operated was so different that one would have to make a major change. In many cases we were told that both ways of operating were valid, just different. In other cases, we were told that the representative from one or the other campus was being difficult by being passive. Many Brooklyn staff perceived a preference for Manhattan policies over Brooklyn policies, even though they believed some Brooklyn policies were better for their campus. At the time of our interviews, many demands were being placed on services and managers to complete the integration of policies prior to the JCAHO survey in October.

Reactions to integration varied. Some respondents, primarily those in senior positions, were positive about it. Respondents who were more positive reported that they understood the reasons behind the need to integrate, even if they saw some problems in implementation. Most other respondents expressed considerable concern over the integration. They did not understand the reason for the integration. They reported that they were not aware of money saved from the experience, especially since they saw new management staff being hired. (According to system leadership, there has actually been a decrease of 24 management positions since integration.) Many respondents told us that

communication of their concerns with leadership was discouraged. A few respondents gave neutral responses, indicating that they felt that they had barely been affected by the integration.

Despite NYHHS management efforts to publish integration newsletters and updates, most respondents told us that they had no idea in what stage of integration they were. Other respondents told us they thought that they had just begun the process or that they were at the midpoint. Most respondents were unclear about the future and wanted to have more certainty so that they could plan. They reported that having parallel clinical services was most desirable from both the medical schools' points of view (to manage their own training and not lose training slots to the other site) and from a cultural point of view (each campus viewed its methods of operating as different and preferable from the other). Moreover, the large size of the population and the distance between sites were cited as important reasons to keep both campuses operating fully. To several respondents, the plan was to let time pass until one site drops out.

Although we were told that the fears and concerns about the future of Brooklyn were much improved since the previous year, they still existed. Brooklyn staff were sensitive to the appearance of favoritism for New York policies and practices over Brooklyn's. Several respondents told us that the fact that using the name and station number of the New York campus for the integrated system was evidence that the New York VA was favored. Some respondents reported that lower volume and some loss of surgeons at the Brooklyn campus made that campus vulnerable to closing all inpatient services, since they did not think that they could have inpatient medicine without surgery. The fact that a new ambulatory care building was going to open soon suggested to some respondents that Brooklyn would be an outpatient center, while New York would be the inpatient center.

At the time of our visit, morale was reportedly low at both campuses. Respondents were unable to distinguish clearly the influence of integration versus budget issues. Many of the clinicians reported that their jobs were much harder since the integration process began. One of the most common complaints was about reductions in staff and their belief that "high quality" support staff had terminated their employment, leaving less qualified people to handle more work.

The results of the survey of staff conducted by the MDRC in May 2000 provide a broader context for these comments. Among those results, 66% of the staff surveyed were at least somewhat satisfied with their jobs -- that is, they tended to agree with items that indicated that they have the support they need to do their jobs well, they are positive about their pay and opportunities in VA and they are positive about future improvements in their worklife; 28% of the staff surveyed were dissatisfied. Also, 71% of the staff surveyed were positive about system identification – that is, they tended to agree that staff are working together across campuses toward the same goals, have compatible ways of operating and provide excellent care, and that staff are committed to making the integration a success; 24% of the staff surveyed did not agree with these statements. Somewhat in contrast, only 45% of the staff surveyed felt that integration had a positive

effect on resources – that is, on the adequacy of available resources and their ability to operate efficiently to meet workload demands; 39% felt integration had a negative effect on resources and 16% felt the effect was neutral.

3.0 FACTORS AFFECTING INTEGRATION

Geographic barriers. The distance between campuses is not great as the crow flies, but in New York traffic, travel times can range from 20 minutes to over an hour. Clinicians feel that the time required to move regularly between campuses is prohibitively long. Also Brooklyn and Manhattan veterans generally use only their "local" VAMC. The assumption is that they would resist going to the other location for care, and that some would choose to get care in the private sector rather than travel to the other VA location.

Strong influence of the medical schools. Both medical schools were very involved in the process, and both schools have voiced strong opinions to try to protect their training programs. To date, integration is underway in some of services with small residency programs (laboratory medicine, mental health, dental and physical medicine). Reportedly, neither affiliate had major objections to integrating these services. However, hen NYHHS leadership proposed integrating a service in which both schools were heavily invested, the medical schools argued strongly against the plan and it did not move forward. Although we were only able to interview a few medical school representatives during our visit, we were told that they were uncertain about future VA plans. Respondents from SUNY reported that communication had been imperfect and had led to rumors and mistrust. Both medical schools are currently more focused on their own internal changes than on the merger of the NYHHS.

Impetus of JCAHO. Preparing for JCAHO provided a strong external impetus to merge policies, create joint committees and create a single medical staff with single by-laws. NYHHS staff has invested substantial energies working across campuses to develop joint policies.

Staff reductions. Staff were concerned both about good people leaving and about being expected to do work previously done by several people. They believe that patient care was adversely affected. Though in reality there were fewer managers than prior to integration, many staff questioned savings from the integration efforts because they perceived new layers of management had been added. These concerns were expressed at all staff levels but were stronger among line staff (both clinical and administrative) than senior managers.

Commitment to maintaining two acute inpatient campuses. Following their opportunistic approach, NYHHS has integrated only selected clinical and clinical support services.

Given the geographic barriers between the campuses and the lack of support from VA clinicians and the medical schools for integrating Medicine and Surgery, the system leadership plans to retain both campuses as full service hospitals, each with a few unique specialties; patients will be referred from one campus to another only in those specialty areas that have been consolidated.

4.0 IMPACT ON INTEGRATION

4.1 Impact on clinical care:

A few respondents told us that they had witnessed a slight improvement in access and continuity since the integration. Many respondents spoke highly of the newly integrated patient data system. Perceived problems related to the integration focussed primarily on the effects of integration of support services and inadequate staffing because of budget cuts. Several respondents reported difficulties since the integration of support services, e.g., getting lab results. Some respondents also believed that clinical care was being fragmented with the provision of some services only at New York. Respondents voiced concern about the lack of staffing to adequately treat patients.

4.2 Impact on the teaching mission:

Neither the medical schools nor their training programs had been strongly affected by the NYHHS integration to this point. People affiliated with NYU were much more focused on changes within the NYU system than on the VA integration across its campuses.

However, some people, especially those affiliated with Brooklyn, expressed concern about insufficient volume remaining to support training as more services are integrated, or about whole areas being consolidated and the training opportunities disappearing. Some of the residents interviewed, particularly those at Brooklyn, were concerned about reduced patient load and declines in specific surgical/procedural experiences. We were told, for example, that several types of cases are done only at the Manhattan campus. For patients referred to New York, the Brooklyn residents only were able to take care of patients after the procedure or if they had a post-procedure problem. These residents were very concerned about the deficits in their training experience.

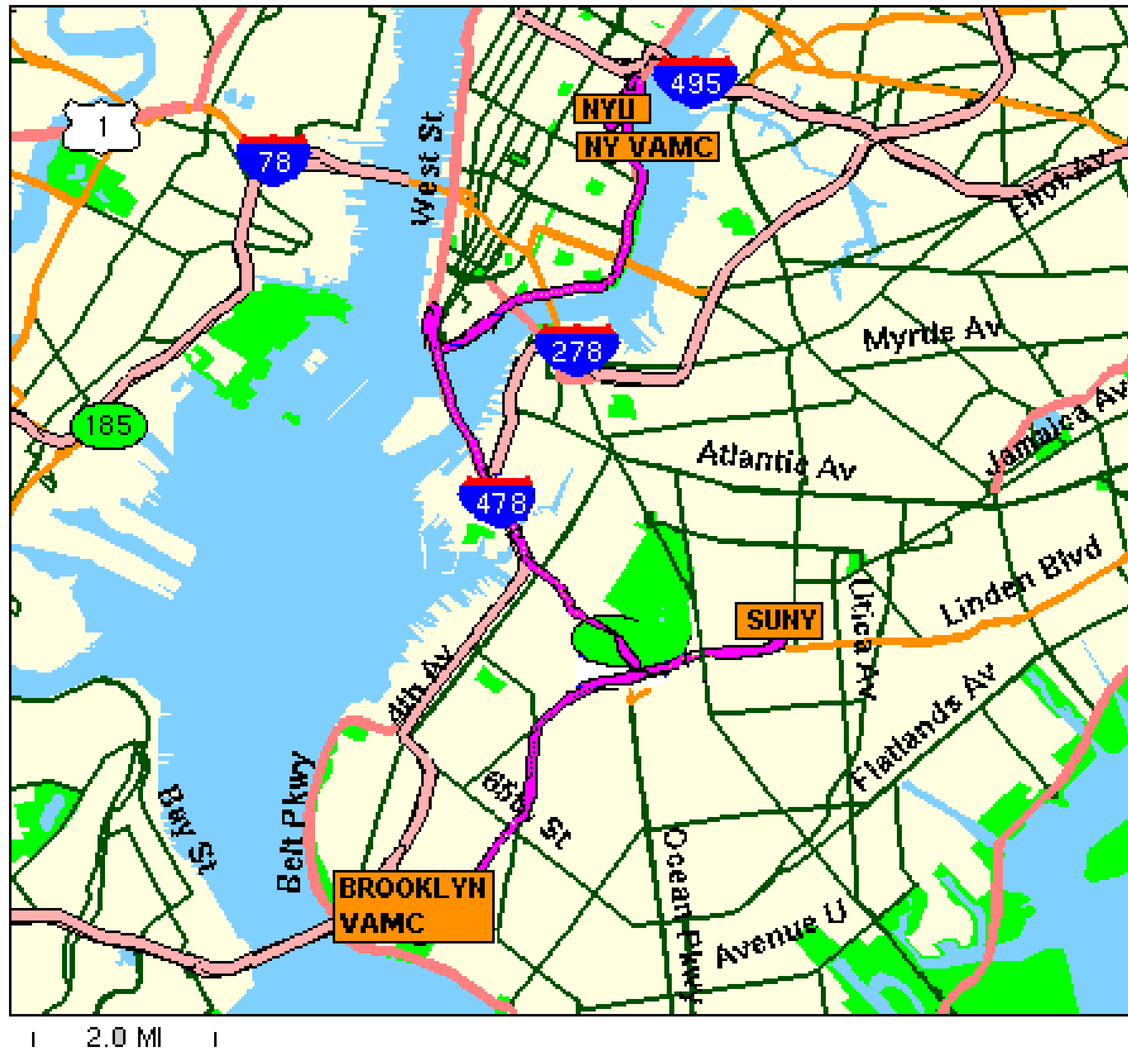
Whether because of the integration or other causes, many respondents indicated a decrease in their time available to train because of increased clinical responsibilities.

4.3 Impact on the research mission:

Although the NYHHS had a single Associate Chief of Staff (ACOS) for Research, none of the committees had been combined. We were told that they plan to have joint co-chairs of the research committees first and to combine the IRBs much later because of the complexity of both Research Services and the regulations that govern them. They have, however, included both IRBs under one Institutional Multiple Project Assurance (MPA) agreement, and have integrated R&D, IRB, Animal and Biosafety committee policies across the Harbor in a relatively short period of time. Some respondents reported that access to the ACOS for research was more difficult now that the leadership had been consolidated in one postion.

Many respondents described the leadership of the NYHHS as very supportive of research and that they were encouraged that this academic mission was valued. Several positive examples of collaboration were described including joint tumor boards, some specific collaborative research projects, and opportunities to include new patients in their studies. New collaborations with NYU researchers were also described as providing exciting opportunities to expand research. As with teaching, however, many researchers reported that budget cutbacks and increased patient caseloads had interfered with their ability to conduct research. Some researchers cited the push for policy integration and VERA cutbacks as having hindered support (personnel and resources) for research.

NEW YORK : SITE VISITS 2000



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New York, NY

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550 First Ave
New York, NY

SUNY Downstate
450 Clarkson Ave
Brooklyn, NY

NYHHS – Brooklyn Division
800 Poly Place
Brooklyn, NY

Appendices

Appendix A: People Interviewed

New York Harbor Healthcare System:

1. New York Harbor Healthcare System: Manhattan Division
   * Mr. Dan Downey, Chief, Fiscal Services
   * Mr. Mohammed Boutjdir, ACOS for Research
   * Mr. Karel Raneri-Vital, Manager, Specialty Care, Patient Services
   * Dr. Gurdip Sudhi, Chief, Department of Anatomic Pathology
   * Dr. Matthew Pincus, Chief, Department of Pathology
   * Dr. Adam Wolkin, Chief, Department of Integrated Mental Health
   * Dr. Thomas Gouge, Chief, Department of Surgery
   * Ms. Annie Brodie, President, AFGE
   * Dr. Robert Raicht, Chief, Department of Medicine
   * Ms. Catherine Benjamin-Bovell – Community Health Nurse Coordinator
   * Ms. Jan Hilley, Chief, IRM Service
   * Clinical Group
   * Resident Group
   * Chief Resident Group
   * Patient Group
   * Faculty Group

2. New York Harbor Healthcare System: Brooklyn Division
   * Ms. Rose Browne, Manager, Medical Care Service Line Brooklyn
   * Ms. Doris Quijano, Acting Chief, SWS
   * Dr. Edmund Bourke, Chief, Department of Medicine
   * Ms. Ena Thompson-Judd, AFGE Union President
   * Ms. Vilma Bailey, AFGE, Brooklyn Division
   * Dr. Bimal Ghosh, Chief, Department of Surgery
   * Dr. Alan Kantor, Chief, Department of Radiology
   * Administrative Group
   * Resident Group
   * Researcher Group
   * Patient Group
   * Chief Resident Group
   * Service Chief Group
   * Clinical Group

3. New York University, School of Medicine
   * Dr. Norman Chase, Chairman, Department of Radiology
   * Dr. Andrew Brotman, Vice Dean Clinical Affairs
   * Dr. Carol Bernstein, Director of Residency Training

4. State University of New York – Downstate Medical Center
   * Dr. Martin Kessleman, Interim Chair, Department of Psychiatry
   * Dr. David Gordon, Interim Chair, Department of Radiology
   * Dr. Roger Cracco, Vice Dean for Research of the College of Medicine, Professor and Chair, Department of Neurology
   * Dr. George Frangos, Associate Dean for Graduate Medical Education

VA Chicago Health Care System:

5. VA Chicago Health Care System: Lakeside Division
   * Mr. Richard Citron, Director
   * Dr. Brian Schmitt, Acting Chief, Department of Medicine
   * Dr. C. Raymond Zeiss, Chief of Staff
   * Dr. Robert Vanecko, Acting Chief, Department of Surgery
   * Dr. Ken Khuans, ACOS for Ambulatory Care
   * Dr. David Barch, ACOS for Research and Development
   * Mr. Hal Rhein, Special Assistant to the Director
   * Research Group

6. VA Chicago Health Care System: Westside Division
   * Dr. John Daugirdas, ACOS for Research
   * Dr. Surinder Nand, Chief, Department of Psychiatry
   * Dr. Prakash Desai, Chief of Staff
   * Dr. Robert Molokie, Attending Physician, Department of Medicine
   * Dr. Stuart Perlik, VISN Academics Compliance Informatics Officer, VISN Office
   * Chief Resident Group
   * Researcher Group

7. Hines VA Medical Center
   * Dr. Charles A. Andrus, Chief, Surgical Service
   * Dr. Rita Young, Associate Chief of Staff for Research
   * Dr. Elaine Adams, Chief, Medical Service
   * Ms. Josephine Jaycox, Acting Senior Manager, Education
   * Dr. Margaret M. Baumann, Interim Chief of Staff
   * Faculty Group

8. Loyola University Medical Center
   * Dr. Myles Sheehan, Associate Dean, Education
   * Dr. Patrick Fahey, Chair, Department of Medicine
   * Dr. Stephen Slogoff, Senior Vice President for Clinical Affairs,

DEAN STRITCH SCHOOL OF MEDICINE

   * Dr. Mamdough Bakhos, Chair, Department of Cardiovascular Surgery
   * Dr. Thomas C. Origitano, Co-Director, Department of Neurosurgery

9. Northwestern School Of Medicine
   * Dr. Donald Nutter, Associate Dean
   * Dr. Sheldon Miller, Chair, Department of Psychiatry
   * Dr. Richard H. Bell, Chair, Department of Surgery
   * Dr. J. Larry Jameson, Chair. Department of Medicine

10. University of Illinois at Chicago
   * Dr. Joseph Flaherty, Professor and Head, Department of Psychiatry
   * Dr. Lawerence A. Frohman, Edmund F. Foley Professor and Head
   * Dr. Gerald Moss, Dean, School of Medicine

* Dr. Leslie Sandlow, Senior Associate Dean, Educational Affairs and Head, Department of Medicine

VA Boston Healthcare System:

11. VA Boston Healthcare System – Brockton/West Roxbury Division
    * Dr. Raj Goyal, ACOS for Research
    * Mr. Michael Lawson, Director
    * Dr. Joseph Vita, Chief, Department of Medicine
    * Dr. Robert McCarley, Deputy Chief of Staff for Mental Health, Department of Psychiatry
    * Dr. Chester Swett, Chief, Department of Psychiatry
    * Dr. Michael Charness, Chief, Department of Neurology
    * Dr. Shukri Khuri, Chief, Department of Surgery
    * Dr. Gordon Strewler, Co-Chief, Department of Medicine
    * Dr. Peter Tishler, ACOS for Education
    * Faculty Group

12. VA Boston Healthcare System – Jamaica Plains Division
    * Dr. Robert Arbeit, ACOS for Research
    * Dr. Craig Karson, Chief of Staff
    * Dr. Michael Watkins, Co-Chief, Department of Surgery
    * Dr. Gordon Snider, Department of Medicine
    * Dr. Domenic Ciraulo, Chief, Department of Psychiatry
    * Dr. Joseph Jabre, Co-Chief, Department of Neurology
    * Dr. Fred Kanter, ACOS for Education
    * Faculty Group
    * Researcher Group

13. Harvard University
    * Dr. Raphael Dolin, Dean for Clinical Programs

14. Boston University
    * Dr. Aram Chobanian, Dean
    * Dr. Norman Levinsky, Provost
    * Dr. Joseph Loscalzo, Chair, Department of Medicine
    * Dr. James Becker, Chair, Department of Surgery

Network Directors

* Joan Cummings, MD
* James Farsetta
* Jeannette Chirico-Post, MD

Appendix B: Site Visit Teams

New York Harbor	Lois Camberg, Carol VanDeusen Lukas, Liz Adams, Martin Charns
Boston	Lois Camberg, Carol VanDeusen Lukas, Gary Young
Chicago	Lois Camberg, Carol VanDeusen Lukas, Geraldine McGlynn, Natalie Pobirsky
Clinical advisor	Daniel Deykin, MD
Program Support	Kim Bilbao

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