4. FINDINGS

4.1 VISN-level descriptive findings

In this section we present descriptive information about VISN-level service lines and their development. This section includes:

– Information about the clinical focus of service lines

– Descriptions of service line structures and their change over time

– Different patterns of use of service lines in different VISNs

– VISN managers' perceptions of service line effects.

All VISNs used service lines in some form, but the VISNs differed in their emphasis on service lines and in the service lines' organizational structures and authority, clinical focus, and pattern of implementation.

Service lines were most frequently implemented in mental health, primary care, and geriatrics/extended care during the period 1997-1999. Exhibit 5 presents the clinical focus of service lines in the twenty-two VISNs for each of the three years, 1997 through 1999. In 1999 twenty-one VISNs had mental health service lines, seventeen had primary care service lines, and sixteen had geriatrics/extended care service lines. Only one VISN did not have a mental health service line, and that VISN did have a more narrowly focused service line for "severely mentally ill." Although they are less numerous, service lines were also implemented in prosthetics in eight VISNs, in spinal cord injury in five VISNs, and in acute care in four VISNs. Thirteen VISNs also had VISN-level consolidated diagnostic services (consolidated services do not fit the service line definition because they are not organized around outputs of care for specific diseases or populations).

The task force structure was the most frequently used structure for service lines in all three of these clinical areas. Exhibit 6 presents the distribution of organizational forms for the three most frequently implemented service lines, mental health, primary care, and geriatrics/extended care, in 1999. More than half of the service lines in each of the three clinical areas were structured as task forces. Teams were the second most frequently used structure, followed by service line divisions. The matrix structure was used in all three clinical areas in one VISN and in one clinical area in another VISN; this will be discussed in more detail below.

Exhibit 5: Clinical Focus of VISN Services Lines 1997-1999

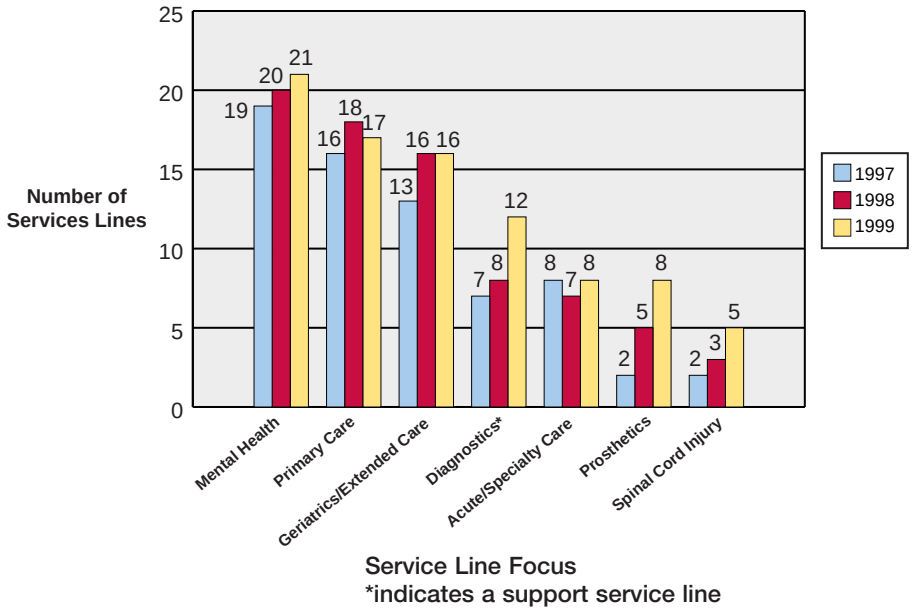
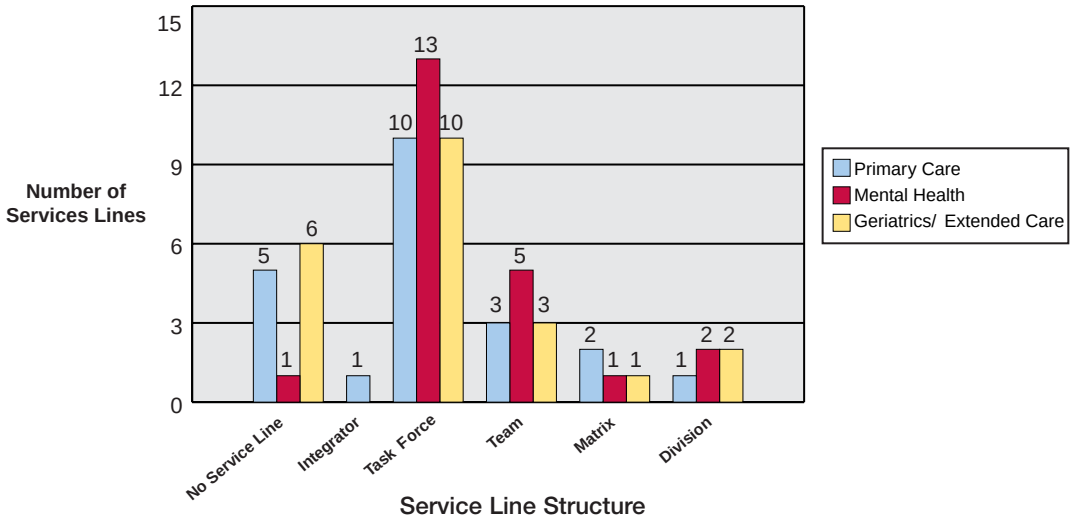
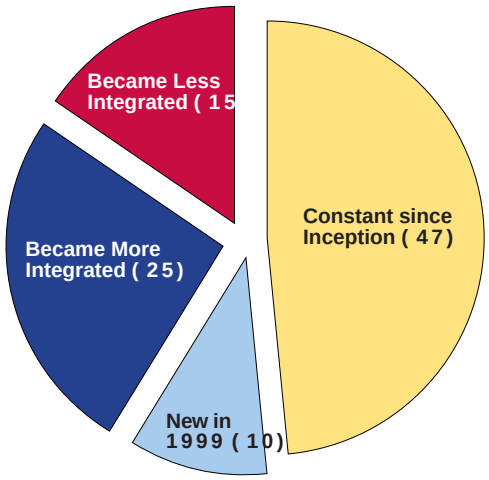


Exhibit 6: 1999 Network-Level Service Structure



Of the 97 VISN-level service lines reported, 47, or nearly half, had the same organizational form from the time of their inception through 1999. Over the period 1997 through 1999, a total of 97 service lines were established in the twenty-two VISNs. Seventy-nine of these service lines were initially established in 1997, eight in 1998, and ten in 1999. The distribution of patterns of change in structure for the 97 service lines is shown in Exhibit 7. Twenty-five, or 26% of the total, had evolved from less- to more-integrative forms; i.e. they had changed from structures on the left side of the continuum of Exhibit 3 to forms further to the right. Most of these changes were service lines that had originated as task forces and then changed to teams. Others evolved further from teams into matrix or divisional structures. Four, all in VISN 2, initially were established as task forces and were restructured directly into divisional structures. Fifteen of the 97 service lines restructured from more-integrative to less-integrative forms. Eleven of the fifteen were task forces that developed recommendations and then ceased operations. The remaining four service lines were teams that were restructured into task forces.

Exhibit 7: Changes in Structure Among Network-Level Clinical Service Lines, 1997-1999



Different networks have adopted different approaches to their use of service lines. VISN 2 was the only VISN to have completely reorganized into service line divisions, and did so in 1998. VISN 5 also implemented some service line divisions in 1999. In both VISNs 2 and 5, service line directors had budget control for the areas covered by their service lines. VISN 1 was in the process of reorganizing in late 1999, but did not yet meet the criteria for the division category. VISN 10 implemented a matrix structure in 1999. VISN 10 in 1998 first developed VISN-level teams, together with facility-level service lines in which service line managers retained their reporting relationships to the facility senior management. In 1999 VISN 10 then assigned control over service line budgets to VISN service line directors. We have classified these arrangements as a matrix organization because they are balancing facility and VISN-level service line influence in decision making.[3] VISN 13 was pursuing the same pattern of development of service lines as VISN 10. They had implemented VISN-level service line teams and indicated that their intention was to provide budget control to VISN service line directors.

A number of other networks had implemented several service line teams. These teams functioned as mechanisms to share information, as well as to recommend network-wide policies for implementation by the VISNs' executive leadership councils. In one VISN, the leadership reported that multiple state jurisdictions, a complex union situation, and a number of facility mergers made tightly integrated network service line divisions seem impractical. Instead, the network director convened service line teams/councils charged with determining and implementing best practices in specific clinical areas, and reported that these groups were very successful in meeting their objectives.

Some VISNs implemented service line task forces in primary care, mental health, and/or geriatrics/extended care, and one or two service line divisions in spinal cord injury and/or prosthetics. In such cases network leadership indicated that it was easier to implement the divisional structure in service lines having a narrower focus than those with a broad range of services, and they moved forward with the divisional structure in those areas.

In four networks, VISN-level task forces were formed and disbanded. Individuals within the networks gave different reasons for why the task forces disbanded. In one network, the Network Director cited the lack of line authority or budget control as the reason some task forces were not successful at achieving integration. In another network, a change in leadership was cited as being partially responsible. The current Network Director stated, "Most of the network service lines are non-existent; they were created by the previous Chief Medical Officer and Network Director… They really weren't accomplishing anything; there was no effort to try to reinvigorate them. We were cutting our losses." In a third VISN, task forces were set up early on to "determine if this idea [service lines] had any merit." After nearly three years of meetings, the task forces were discontinued. Interviewees in that VISN explained that committee members had "gotten busy with other things" and that the network was "too geographically dispersed to meaningfully integrate any services."

The process of VISN service line development has been slow in comparison with development at the facility level. As described above, as of the end of 1999 very few VISN-level service lines of the divisional form had been in place for a year or more, and most service lines were organized as task forces (Exhibit 6). One reason frequently reported for the slowness in implementing network-level service lines was barriers in personnel practices. Interviewees in several networks remarked that appropriate job levels and position descriptions for network-level service line directors who would have authority over facility-level service line managers did not exist and reportedly were difficult to create. Thus, networks that went ahead with extensive reorganizations did so by mechanisms such as developing the service line director positions as time-limited appointments pegged to the incumbents' pre-existing grade levels or as collateral responsibilities. VISN 13, which was emphasizing service lines as a central element of their integration strategy, had requested senior executive service (SES) level positions for its service line directors, and this request was not approved until late 2000.

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[3] Strictly speaking, a matrix organization distributes both personnel and budget authority equally in two dimensions to attain the balance in decision making, rather than allocating personnel authority to one and budget authority to the other. There are no examples of network matrix organizations in the literature to which we can directly compare. By referring to the arrangements in VISN 10 as "matrix" we are able to differentiate them from teams/councils and from divisional structures, as well as reflect the intent of the designers of structure, the VISN leadership.

As of the end of 2000, VISN-level service lines had not been in place long enough to investigate their relationships to outcomes. Since few network service line divisions have been implemented for more than a year, we would not expect to be able to detect positive effects on outcomes related to VA performance measures. While there are many VISN-level service line task forces, task forces are not considered to be service lines within VA and also would not be expected to have a very large effect on outcomes. From the time that service lines are implemented, we expect one to two years before the initial turbulence of the change process subsides. Following that period, one year of post-implementation outcomes data needs to be compiled and compared to the pre-implementation period. For those service lines implemented in 1999, the outcomes for 2002 to 2003 are needed to investigate relationships between service lines and outcomes. We believe that using data from an earlier period would yield misleading results.

Although we could not examine quantitative outcomes associated with VISN-level service lines, we coded the interviews from the ten VISNs that we visited in 1999 for positive and negative attributions of process and outcomes associated with service lines. These attributes were coded in nine categories (Guideline Implementation, Uniformity of Care, Care Coordination, Cost and Utilization, Access and Enrollment, Communication, Competition, Staff Motivation, and Professional Issues). The average number of negative comments per interviewee in every VISN was less than 1. There was not enough variation in negative responses to provide useful comparisons among VISNs. The average number of categories (of the nine categories coded) in which respondents made positive comments are presented for the ten VISNs in Exhibit 8.

Networks' perceptions of positive attributes of service lines varied with service line structural form. The networks with only task forces had the lowest average number of positively coded categories. In addition, the task force structure characterizes the four VISNs having the lowest number of positively coded categories. However, task forces were also used by VISNs ranking second and fifth of the ten VISNs. The highest ranking VISN structured its service lines in a divisional structure; it was the only one visited in 1999 that used divisions extensively. The two VISNs having teams and the one having a matrix had a higher average number of positively coded categories than the average of the VISNs using task forces and lower than the one using divisions. Representative quotes from interviewees for each category are presented in Exhibit 9 (on Page 14).

Exhibit 8: Average Number of Positive Effects Attributed to Network Service Lines Reported by VISN Staff From 10 VISNs Site Visited in 1999

VISN	Average Number of Positive Effects Attributed to Network Service Lines	Type of Network Level Service Lines Implemented
A	4.0	Divisions
B	3.2	Task Forces
C	3.2	Teams
D	2.7	Matrix
E	2.6	Task Forces
F	2.3	Teams
G	2.0	Task Forces
H	2.0	Task Forces
I	0.6	Task Forces
J	0.3	Task Forces

Service Line Structure	Number of VISNs with Service Line Structure	Average Number of Positively Coded Categories per VISN
Task Forces	6	1.8
Teams	2	2.75
Matrix	1	2.7
Divisions	1	4.0

Exhibit 9: Representative Quotes From Network Staff Regarding Positive Impacts Of VISN-Level Service Lines

Category	Respondent's Job Title	Quotation
Guideline Implementation	Network Director	"We've had a very positive effect with guidelines – we've implemented a number of them, and done some great standardization. Our performance scores have improved significantly, as have our outcome measures."
	Chief Fiscal Officer	"Clinical policy development has been helped by bringing together groups that are knowledgeable and representative of all groups in particular area."
Uniformity of Care	Network Director	"Service lines have been very effective in reducing the variation of practice, leading to better and more cost effective care. The primary care service line has been very effective in standardizing delivery and way we do our work."
	Chief Medical Officer	"Care councils are impacting the uniformity of care across the VISN. This is why they are there. Like the policy for nursing home care. Another example is Hepatitis C where we make sure that the same level of knowledge is driving care at all care sites."
Care Coordination	Chief Medical Officer	"One of the problems in the past was that patients would be bounced from specialty to specialty – no internal communication. Now with one care line like med/ surg, the one administrative officer can coordinate everything."
	Chief Information Officer	"Our patient satisfaction scores for coordination of care have gone up. We've made efforts, but it is the service line model that provided impetus to move things faster."
Cost and Utilization	Network Director	"People are looking at cost and utilization of mental health. Teams at some facilities are doing great work, and they are feeling supported by the emphasis on mental health [from the service line]."
	Service Line Director	"We have dropped our costs per patient below the national average. Inpatient costs came down more quickly; there is no question that we have become more outpatient based. Our unit costs are all going down and we are becoming more efficient."
Access and Enrollment	Service Line Director	"In population coverage/ access for general and specialized services, no network is doing as well. We have expanded access and continue to do well on these measures."
	Service Line Director	"We have increased utilization at our facility – an increased volume of patients and an increased number of patients in adult day health care."
Communication	Chief Medical Officer	"The change to me is that the groups that we have gotten together are working – two years ago they would have said, 'buzz off'."
	Chief Information Officer	"VISN service lines have enhanced our services immensely. We have communication and strategic planning at our finger tips. We are reducing duplication of services."
Competition	Service Line Director	"We took up a collection to bail out [a facility in financial trouble]. It meant $500, 000 from us."
	Chief Medical Officer	"Effectiveness of our structure? A lot of contribution has been the breaking down of culturalbarriers…as barriers come down, there is mileage to be gained."
Staff Motivation	Chief Financial Officer	"At the very basic level, we are having discussions that three years ago would have amazed me. At the strategic level there is unity of mission and awareness of interdependence – more patient focused than it was before."
	Facility Director	"When I came here in 1994 I would have said we would never make the changes we have. It has to do with the commitment of the people… The only way to gain control is to give up control. This is a difficult lesson for anyone who has been schooled in the VA. I am convinced that if I said we needed to move the building six inches, within a week I would have a committee who would have figured out how to do it."
Professional Issues	Network Director	"When special initiatives come, I am much better able to capitalize because I am now selecting the best people in network rather than the best in medical center; therefore, there is greatly improved professional development training."
	Service Line Director	"There is now an education council which is a resource to us. Their recommendations are based on the network's needs and not the individual staff person."

4.2 Facility-level descriptive findings

In this section we report findings based on our site visits to facilities and from the survey of facility directors. We will describe:

– when service lines were implemented at the facility level

– what forms they take

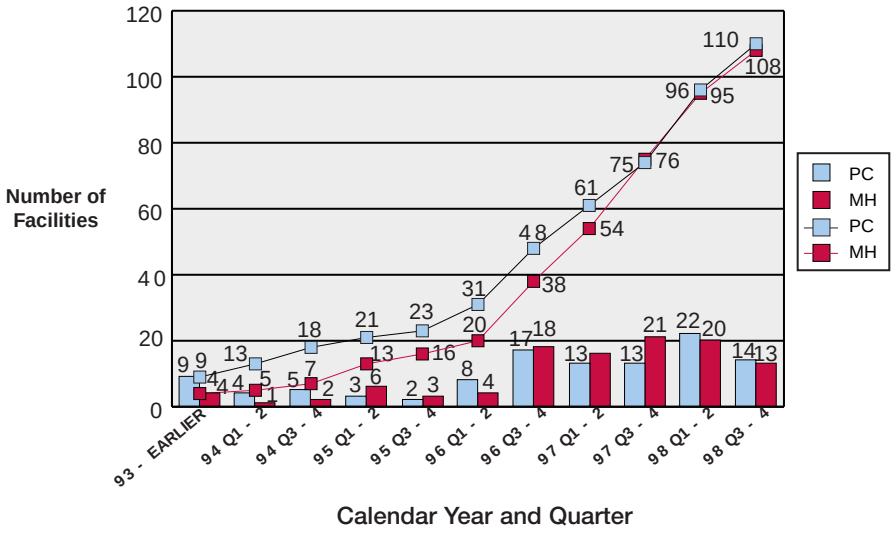
– their clinical focus

– the disciplines of the managers who lead them

– managers' perceptions of facility-level service lines.

In a small, but important, number of cases, the implementation of service lines at the facility level predated the reorganization of VHA and the formation of networks. Beginning in 1996, the numbers sharply increased. As is evident in Exhibit 10, several mental health and primary care service lines had been implemented by 1993, and service lines were implemented in a small number of additional facilities each quarter thereafter. Primary care and mental health service lines had each been implemented by over 100 facilities by the end of 1998, and only a small number of facilities had not implemented either type. This sharp upturn in 1996 is consistent with the accounts of many interviewees, who reported perceiving a "mandate" for service lines in Headquarters' policies and reports released at around that time.

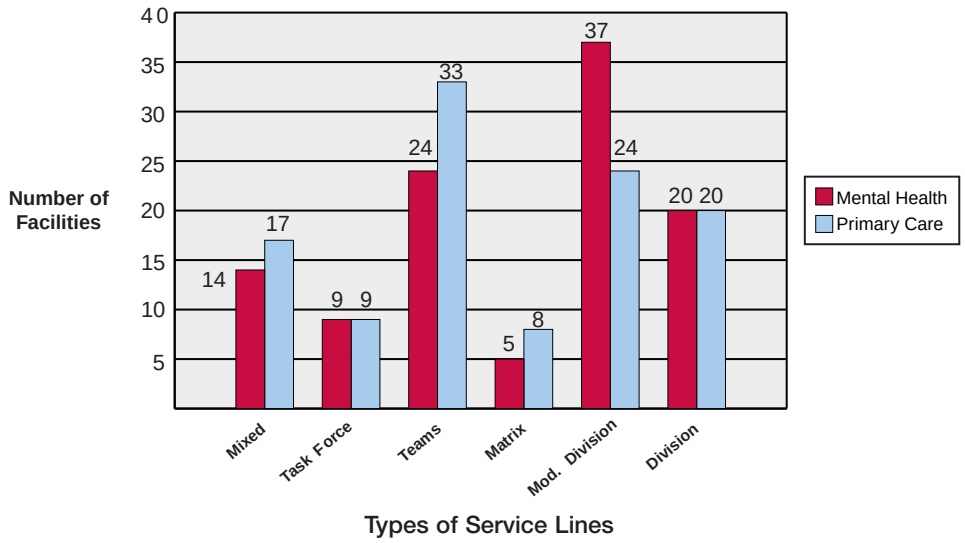
Exhibit 10: Start Dates of Mental Health and Primary Care Service Lines



We found wide variation in the organization of primary care and specialty care in service lines. In many facilities, these two areas were reported as separate service lines. In contrast, in others they were both part of a single ambulatory care service line or a medical/surgical service line. Thus, when comparing primary care service lines, it should not be assumed that all relate to specialty care in the same way.

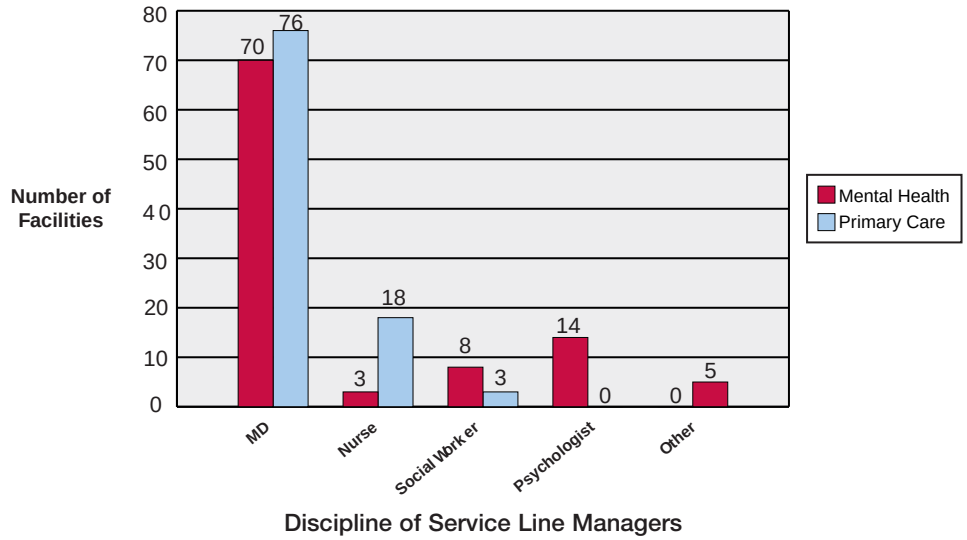
As expected, service line forms falling all along the Charns and Tewksbury (1993) continuum were reported. The distribution of different service line forms is depicted in Exhibit 11. Teams and modified divisions were the organizational forms reported most frequently, with mental health exceeding primary care in the use of the two most integrative service line forms. A number of facilities had service lines that could not be classified on the Charns and Tewksbury continuum because the reporting relationships of different disciplines within the service line varied substantially. We called these "mixed."

Exhibit 11: Structure of Facility-Level Mental Health and Primary Care Service Lines in 1998



Service lines also varied in terms of their leadership. Most service lines had a single individual serving in the position of service line manager. Fourteen of the 109 mental health service lines and nine of the 111 primary care service lines, however, were led by a dyad or by a larger group of individuals. Most often dyads consisted of a physician-nurse pairing, or a clinician-administrator pairing. Two reasons were reported for this: a desire to spread the workload of what was usually structured as a collateral duty, and an attempt to address skill coverage by choosing co-managers with complementary skills. The professions of service line managers in mental health and primary care service lines having single managers are shown in Exhibit 12. The greatest number of service line managers in both clinical areas were physicians. In mental health, there were also some psychologists and social workers in these roles. In primary care, the second most frequent disciplinary background for service line managers was nursing. The dominance of physicians in service line manager roles was consistent with the widespread belief expressed by many interview respondents that physicians are best suited to such roles.

Exhibit 12: Disciplines of Facility Primary Care and Mental Health Service Line Managers in 1998



In our site visits we found that service lines were often perceived positively by managers in the facilities. As the quotes in Exhibit 13 below suggest, managers believed that service lines improved communication, the dissemination of best practices, and financial accountability.

Exhibit 13: Facility Managers' Positive Perceptions of Service Lines

"I have the ability to communicate with people at a practical and direct level. I can facilitate communication and assimilate people's concerns."

"Dissemination of best practices is much quicker because information is no longer filtering down through the layers."

"It gives us a broader perspective and newer ideas."

"Service lines are empowered by having their own people and their own dollars. Each has a business manager to help run the service line."

"The business manager reports to the service line manager on day-to-day issues. Tension between the two promotes quality care and fiscal responsibility. The tension has worked quite well."

"It's a big change. Once you know there's not a blank check, rather than immediately replacing people you look to see if you can do it cheaper."

"I have had a social worker and a registered nurse who were trained in the addiction severity index (ASI) after the redesign. We now have had 100% and 99% compliance. Both of these people worked very hard to bring that about. I believe that it happened because of the shift - that they felt the incentive to perform."

"We've improved our relationship with the affiliate. Regardless of the changes, they are still able to hire high quality staff through medical school affiliations. We've made it better for our patients, even with the loss of staff."

However, such positive perceptions were not universal. Some managers were concerned that service line forms of organization could have unintended negative consequences. Such concerns are illustrated by the comments in Exhibit 14 below. These unintended byproducts might also cancel out any potential benefits.

Exhibit 14: Facility Managers' Negative Perceptions of Service Lines

"My theoretical concern is that you substitute one set of rivalries for another."

"We are losing our talent base because there is no training and development in specific functional areas like there used to be."

"Professional standards is one potential casualty of going over to care lines."

"I don't know that they [service lines] have had a major impact on practice. The professional staff has seen reductions in staff, which has resulted in service not being given in as timely a way as before. Since we have been able to retrain people … things have gotten better."

"When the shift happened to service lines, there was a lot of confusion and chaos in the process. There also was some reluctance to take on and respond to these new roles. Adding staff onto mid-level managers is a very challenging and almost unreasonable scope of responsibility. Under service lines you don't have the flexibility and economies of scale for coverage as under the other [traditional] organizational structure."

In some sites people felt that while a service line organization might be appropriate for the facility, problems in implementing service lines had undermined their efforts. For example, at one site service line managers indicated that Medical Administration Service (MAS) had assigned the poor performing and problem employees to the service lines, and kept the best employees for the core MAS function. Service line managers felt that this had handicapped them from the start. Ultimately, service lines were eliminated at this site. Thus, the effects of service line forms of organization often seemed to be confounded, at least in view of some facility managers, with the effects of the organizational change process undertaken to achieve service line implementation.

Many interviewees also indicated that service line managers did not have the training or skills in general management and in financial management needed for these new positions. Many of the physician leaders, who constituted the majority of service line managers, reportedly did not have extensive management experience or training. They were not sufficiently prepared to manage the multiple disciplines in their service lines, a skill that is generally developed through years of progressively increasing management responsibilities. Although some service line managers did obtain some management training, this was generally perceived as being insufficient for the requirements of the position.

Although several interviewees indicated that they were concerned that service lines would have a negative impact on professional standards and professional development, we did not have any direct evidence of this occurring. We did note ambiguity about some responsibilities in several instances when facilities eliminated professional departments and implemented service lines. For example, in one site Nursing Service had been responsible for maintaining the crash cart, and it was not clear where in the service line structure this responsibility should be assigned. We also observed a number of sites that implemented service line divisional structures, eliminating professional departments, only to reestablish lead professionals (e.g. lead social worker, nurse executive) or professional councils. Interviewees in those facilities indicated that the resulting modified divisional structures provided vehicles for addressing professional issues that could not adequately be addressed when they were structured in the pure service line divisional form.

4.3 Facility-level outcomes analysis findings

After excluding three sites that provided no inpatient care and one site that did not provide information on its service line structure, we were able to analyze data from 140 sites. Regression analyses were done, as well as descriptive statistics on improvements in outcome measures. The findings discussed below will first examine the effect of primary care service lines on patient-centered outcomes from Austin administrative databases and on customer satisfaction. Next, the effect of mental health service lines on the outcomes of users of psychiatric care in VA will be described.

4.3.1 Primary care service lines

We first examined the correlation between hospital characteristics and primary care service line structures. Two significant correlations were found. Teaching status was negatively correlated with presence of a service line divisional structure ($r = -.19$, $p<.02$), indicating that teaching hospitals tend not to be organized into divisional structures. Hospital size was negatively correlated with a service line manager having control over the service line's personnel budget ($r = -.17$, $p<.04$), indicating that such control occurs more often in smaller hospitals.

Organizational theory implies that as service lines become more highly developed, control by the service line manager over all facets of operations related to the service would increase. To explore whether this was true in VA medical centers, we compared service line continuum scores to control over budget. Only 25 of 110 facilities with primary care service lines indicated that the service line manager had control over the personnel budget; and, contrary to what theory would predict, control over the personnel budget was not correlated with the Charns and Tewksbury organizational continuum score.

Between FY97 and FY98 all measured primary care outcomes that we collected from the Austin databases as well as patient satisfaction improved nationally in VA. Primary care enrollment was up, bed days of care were reduced and other important measures also showed marked improvement. Regression analyses were then used to determine whether the presence or type of service line had an accelerative effect on the improvement in outcomes. We controlled for factors such as patient severity and hospital characteristics in these analyses.

Facilities that implemented primary care service lines did not have significantly greater improvement in primary care outcome measures than facilities that did not implement primary care service lines. In comparing all sites with service lines to all sites without service lines, we found no statistically significant positive differences in primary care outcome measures from the Austin databases. However, facilities with service lines had significantly less improvement than facilities without service lines on three measures: ambulatory care sensitive (ACS) condition hospitalization rates, urgent care visit rates, and the ratio of urgent care visits to total visits. We also found no statistically significant differences in improvement in patient satisfaction measures between sites with service lines and those without service lines.

When we took into account the specific organizational form and the duration of service lines, we found mostly negative effects of service lines on improvement in outcomes. As noted earlier, service lines differ greatly both in structural form and duration. Thus, we conducted a second set of regression analyses to account for these differences. The detailed regression results are reported in Appendix G and are summarized in Exhibit 15.

In these regressions we found that specific types of service lines had one positive significant effect on outcome measures from the Austin databases. Those facilities with a longer-duration (LD) service line team had significantly greater improvement in primary care enrollment than did facilities with no service line. However, we found that specific forms of service lines also had significantly detrimental effects on the improvements in other outcome variables. Specifically, shorter-duration (SD) service line task forces had significantly less improvement in reducing discharge rates. Facilities with SD service lines of team and division forms had significantly less improvement in the ratio of urgent care to total visit rates. Facilities with SD division and mixed service line forms reduced their ACS hospitalization rates less than facilities without service lines. Also, LD mixed service lines had reduced their specialty visit rate significantly less than facilities without service lines.

Service lines of different structural forms and duration had inconsistent effects on improvements in patient satisfaction. Facilities with LD mixed-evaluation service lines had significantly worse outcomes on six satisfaction scores, and a significantly better outcome on one score, "courtesy" (see Exhibit 15). All other types of LD service lines each had significantly better outcomes on one satisfaction measure. Finally, the effect of SD service lines was inconsistent, but mostly not significant, with SD task forces having significantly less improvement on emotional support, SD teams having significantly less improvement on overall coordination, and SD divisions having significantly more improvement on patient preferences.

Exhibit 15: Summary of Statistically Significant Findings Between Service Line Form and Duration and Hospital Outcomes

Service Line Duration	Service Line Form	Primary Care Quality and Utilization Outcomes	Mental Health Quality and Utilization Outcomes	Patient Satisfaction
Short-duration	**Task Force**	**(-)** Discharge rates	**(-)** Psychiatric Bed Day Rates **(-)** Acute Bed Day Rates **(-)** Hospitalizations with no prior primary care visit w/in 30 days	**(-)** Emotional Support
	Team	**(-)** Urgent care visits/total visits		**(-)** Overall coordination
	Division	**(-)** Ambulatory care sensitive hospitalization rates **(-)** Urgent care visits/total visits	**(-)** Urgent care visit rates	**(+)** Patient preferences
	"Mixed"	**(-)** Ambulatory care sensitive hospitalization rates		
Long-duration	**Task Force**			**(+)** Continuity of care
	Team	**(+)** Primary care enrollment		**(+)** Courtesy
	Division			**(+)** Patient preferences
	"Mixed"	**(-)** Specialty visit rates	**(-)** Readmission after hospitalization rates **(+)** Proportion of primary care visits after hospital discharge	**(-)** Access **(-)** Emotional support **(-)** Patient preferences **(-)** Patient education **(-)** Visit coordination **(-)** Overall coordination **(+)** Courtesy

(+) Indicates statistically significant finding of greater improvement in service line
(-) Indicates statistically significant finding of less improvement in service line

4.3.2 Mental health service lines

As in our analysis of primary care, we began analysis of mental health service lines by examining the correlations between hospital characteristics and mental health service line structures. We found statistically significant correlations between facilities located in VISNs experiencing a 5 percent gain in VERA allocation from FY97 to FY98 and the following variables: existence of a mental health service line ($r=.24$, $p<.01$), service line duration ($r=.18$, $p<.05$), existence of a team or committee ($r=.23$, $p<.01$), and divisional structure ($r=.32$, $p<.001$). These findings indicate that facilities in VISNs having the VERA gain were more likely to have mental health service lines, to have established them earlier, to use a team or committee to manage or advise the service line manager, and to be structured in a divisional form. In addition, the correlation between use of the team or committee and number of hospital FTEEs was significant ($r=.21$, $p<.05$), indicating that this approach was used more often in large hospitals. We also noted that in 27 facilities mental health service line managers had control over budget.

In contrast to the primary care outcomes, mental health patient-centered outcomes did not all improve between FY97 and FY98. Psychiatric and total acute bed day rates were reduced overall, and the proportion of psychiatric hospitalizations followed by a primary care visit within 30 days increased. However, fewer psychiatric hospitalizations were preceded by a primary care visit within 30 days in FY98 than in FY97, and urgent care visit rates for the psychiatric cohort were higher in FY98.

Facilities with mental health service lines did not have significantly different mental health outcomes than facilities without mental health service lines. However, several specific types of mental health service lines did have significant, and mostly negative, effects on these outcomes. As shown in Exhibit 15, facilities with SD service line task forces had significantly less reduction in both psychiatric and total acute bed day rates, and also had a significantly greater increase in the proportion of hospitalizations not preceded by an outpatient visit. Facilities with SD divisional service line forms had significantly less reduction in urgent care visit rates. Facilities with LD mixed evaluation service lines had significantly greater increases in readmission rates than did facilities without service lines, but also had a significantly greater increase than facilities without service lines in the proportion of hospitalizations followed within 30 days by a primary care visit.