Transition Watch

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The Integration of Affiliated Medical Centers:

Challenges and Lessons from the VA Boston Healthcare System

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In the spring of 2000, John R. Feussner, MD, MPH commissioned researchers at HSR&D's Management Decision and Research Center to conduct a study of three VA health care systems (Chicago, New York Harbor, and Boston) that were integrating medical centers that had strong affiliations with different medical schools. The purpose of the study is to examine the impact of integration on the academic missions of these systems.

When we first reported on the progress of these three systems in *Transition Watch* in August 2001 (volume 4, issue 4), they shared many features but differed in their approaches to integrating clinical services: Chicago and New York maintained comprehensive clinical services at both campuses, generally under separate leadership, with New York moving toward creating specialized service niches at each campus. Boston, in contrast, consolidated its inpatient services to one campus.

This article provides a more detailed look at the Boston integration – its progress, challenges the system has faced, and implications for academic medicine.

Integration Progress

The organizing principles of the integration of the VA Boston Healthcare System (VABHS) were, first, that inpatient and outpatient care would be consolidated within separate campuses, and second, that all activities – clinical care, education and research – would be integrated. Boston has made significant progress in implementing both principles. Almost all structural changes have been made. Faculty, students and residents from both primary medical affiliates work and learn together in most services. The research service has combined R&D committees, though each campus still has its own ACOS for Research. The system successfully passed its Joint Commission review as an integrated system last year. System efficiency, measured by adjusted costs per workload and adjusted staff per workload, has increased.

Integration has been facilitated by the support of the primary medical affiliates, Boston University and Harvard University. The schools worked together to develop a plan for sharing services in the integrated system and continued their involvement as the new system was being implemented, for example, through Oversight Committees for Medicine and Surgery that have been important vehicles for resolving clinical and education issues.

Challenges to the Integrating System

Against this substantial progress, Boston faced serious challenges in developing its integrated system. The challenges, which offer lessons to other integrating systems, can be grouped under four headings:

1. *Transition issues: Working and learning together*
   Integration brings major organizational change that requires a transition period as people get to know each other and resolve differences in ways of doing things. In Boston, as in any system undergoing substantial change, there was resistance and some difficult spots as previously separate staff, faculty, and residents began to work, teach, and learn together. People had to accommodate different ways of operating. These transition issues were not seen as major problems in Boston given the other challenges the system faced, but they had to be addressed.

   While these issues are inevitable, they can be minimized. In addition to ongoing communication at all levels of the organization, opportunities should be created for staff to get to know their counterparts at other sites before changes take place. Getting acquainted can help people move beyond stereotypes so they can work more comfortably on tackling operational problems after integration.

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2. *Implementation challenges: Getting all the pieces in place*
   Reorganizing medical centers, especially if it involves restructuring reporting responsibilities and moving physical space, requires coordination. In surgery, the first service to consolidate its inpatient care to one campus, not all components were put into place simultaneously. Surgeons moved before labor negotiations were completed with the surgical nurses, and before renovations were completed on the operating rooms. Union resistance and movement of senior surgical nurses into non-surgical positions, compounded by nursing shortages, left the consolidated operating rooms and surgical intensive care units inadequately staffed. The reduced surgical workloads contributed to a lasting drop in caseload that compromised patient access and threatened residency programs. The CARES process review requirements continued to delay operating room renovations.

   Boston leaders recognized that moving surgeons before other pieces were in place would create problems, but felt it had to be done. Their challenge was to manage the personnel consequences once the consolidation was announced. In hindsight, they acknowledge that they underestimated the difficulty of retaining surgical nurses. Ideally, all pieces would be synchronized. In contrast with surgery, the transition in consolidating inpatient medicine went more smoothly because union negotiations were completed before changes were made, and renovations were less pressing.

3. *Structural challenges: Fallout from the organizational structure*
   Two structural features were challenging. First, inpatient and outpatient care were consolidated to different campuses. In the negotiations to create VABHS, this division made conceptual and practical sense. In practice, however, the division created a number of logistical and patient care problems that reportedly compromised patient care, diminished clinician efficiency, and interfered with teaching. For example, physicians were often not available – to patients, to residents, or to colleagues for consultation – because they were at the other campus. Some of these problems may be transitional and will be resolved as the system gains experience under the new structure. Others, however, may require modifications in the original structure of the integrated system. For example, VABHS recently moved three surgical clinics to the same campus as inpatient surgery.

   Second, the leadership of clinical services was shared equally, with the faculty from each affiliate serving as chiefs in half the services and co-chiefs in the other half. While this division appears to have been critical in launching clinical integration, it was professionally difficult for people who had to step back to a co-chief role and, in some opinions, created instability that will affect clinical recruitment and retention in the longer term. In some opinions, the selection of chiefs based on their affiliation should be phased out as the system matures.

   Both challenges suggest that some structural elements in an integrating system may be temporary, perhaps essential to gain support from staff and stakeholders at the beginning of integration, but not the best solution in the long term.

4. *Big-picture challenges: Budget shortfalls*
   Medical center integration is usually undertaken with the expectation of saving money. What is often overlooked is that integration requires an investment before savings can be expected. In Boston, severe budget shortfalls overshadowed integration. Many of the system's problems resulted not from integration per se, but from integrating without promised capital investments from Central Office, and from making staffing and resource cuts while integrating. The shortfalls are expected to continue. Staff morale is low, with staff leaving and vacancies not being filled.

From Boston's experience, trying to integrate and cut costs simultaneously does not work. This suggests that a system should not begin integration until funding is assured, so it does not get caught halfway down the integration path without necessary resources. Boston's experience also suggests that maintaining the academic mission should be an explicit goal in any integration of affiliated medical centers. In addition to making sufficient investments to maintain the quality of patient

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VISN 23: An Update on Integration

In January 2002, the Veterans Health Administration announced the merger of VISNs 13 and 14 to create a new, combined network, VISN 23. The aims of the merger, as stated in the Secretary's announcement on January 23, are "To increase efficiencies and to ensure high-quality medical care for about a million veterans in the Midwest...."

Dr. Robert A. Petzel, Director of VISN 13, was appointed Acting Director of VISN 23, and immediately held a joint leadership conference and appointed an Integration Council (IC). The IC, co-chaired by the Chief Operating Officers of VISNs 13 and 14, is charged with developing an integration strategy. The IC's challenge is to move quickly, so that VISN 23 can operate effectively, but also with deliberation, in order to gain input from staff and stakeholders, and to provide the permanent Network leaders (when they are appointed) with discretion in structuring the merged system.

By the end of April, the VISN 23 merger had progressed on several fronts:

- Governance and Network Office: A structure for an Interim Executive Leadership Council (ELC), consisting of leaders from former VISNs 13 and 14, was approved by VACO, and the Interim ELC had begun meeting. A structure for the core Network Office positions was submitted to VACO for approval. An approved organization chart is needed in order to post positions and hire for key Network positions.

- Communications: Dr. Petzel has been holding town meetings and meeting with Congressional and veteran stakeholders across the Network since his appointment. The IC is holding employee meetings at all facilities in VISN 23 to provide updates on the integration process and to seek input into the design of the VISN organizational structure. The process will continue at advisory meetings with veteran service organizations. The Network office also issues a regular newsletter on integration progress.

- Clinical collaborations: Clinical teams are collaborating across VISN 23 on task forces for cardiac services and telephone care, and on developing a proposal for a Mental Illness Research and Education Clinical Center.

At the request of Dr. Petzel, the MDRC is documenting the VISN 23 integration and will report on it further in upcoming issues of *Transition Watch*.

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care, integration plans and resource commitments should incorporate the resources needed to support the academic mission, such as investment in research labs and equipment.

Implications for Academic Medicine

The VA Boston Healthcare System can point to substantial successes in its integrated system, but it has also faced significant challenges. The biggest challenge has been the severe budget shortfalls.

In this context, academic medicine has not been the top priority for the system leadership at this time, as they readily admitted. In some opinions, VA's ability to attract top clinicians because of its strong research programs has been diminished, a trend that will affect patient care as well as research and teaching if it continues. The medical schools have continued to support the integrated system but are worried about the VA system if the budget crisis continues, and have lobbied for budget increases for Boston. Without a change in direction, many people fear, the academic mission of VABHS is in jeopardy.

Best Practices and Challenges Underlying the Initial Implementation of Service Lines

Timothy J. Hoff, PhD

Service line structures have been examined as a type of integrating mechanism that may achieve more fully than other structures the goals of an integrated delivery system.[1] However, less explored are: (a) the managerial, work-related, and cultural factors that accompany successful service line implementation and performance at different points in time, and (b) the manner in which successful implementation at one point in time creates further organizational challenges that must be addressed to assure continued functioning of the structure. These issues were explored through a nine-month, qualitative case study of the Behavioral Health Service Line within the VA Healthcare Network Upstate New York (VISN 2), recent winner of the Department of Veterans Affairs Carey Award for performance excellence in the VA system. Using almost any measure of performance improvement, the early life of the service line structure in VISN 2 has been extremely successful.

VISN 2 executives note that the service line structure, adopted in 1997, was and continues to be a central element in the VISN strategy. The structure consists of four distinct clinical service lines: Behavioral Health, Medical/Surgical Care, Geriatrics and Extended Care, and Diagnostics and Therapeutics. VISN 2's service line approach could best be described as a "modified service line division"(see *Transition Watch* Fall 1998 and Winter 2000). This type of integrated service line structure is characterized by: (a) shifting the basis of organization from the facility to the service line; (b) direct accountability of the facility-level service line managers to system-level service line directors; (c) authority for most clinical strategic decisions shifted to system-level service line leaders; (d) control of budget by VISN service line directors and facility service line managers; and (e) control over local facility site management and Public Relations/Congressional contacts retained by local hospital directors. This structure is a fairly "pure" form of service line approach and represents a strong commitment to the service integration ideal. Organizing all clinical activities in the VISN into service lines also represents a strong and clear commitment to the service line approach, reducing ambiguity among management and line staff regarding the organization's commitment to the service line approach. No other VISN has implemented service lines as extensively as VISN 2.

Transition Watch is a quarterly publication of the Office of Research and Development's Health Services Research and Development Service. Its goal is to provide timely, accessible health care change information and resources to aid VHA managers in their planning and decision making. Summaries and analysis of ongoing survey and management studies within VHA will be included, as well as organizational change resources from within and outside VA. For more information or to provide us with your questions or suggestions, please contact:

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Study Design

The Albany, NY and Buffalo, NY medical center sites were selected to examine service line operations, structure, and culture as they manifested themselves in two particular behavioral health programs, Homeless Outreach and Outpatient Mental Health. The Syracuse, NY medical center site was chosen as a comparison site. All levels of the organization, from the Network office down to program line staff working at the different sites, participated in the study.

The goal was to develop a data set that had more "depth" than "breadth", one in which a greater understanding could be gained of complex dynamics such as organizational culture and service delivery, within the context of a sub-organization (i.e., one entire program). This "drilling down" into the various levels of the service line enhanced the validity and reliability of the findings around both the best practices and emerging challenges. First, each level's perceptions could be compared and contrasted against each other. Second, the major strategic decisions made by top management could be viewed as they were implemented at the level of "production."

Facilitators of Service Line Implementation

Using organizational life cycle theory[2], the analysis identified specific factors accompanying effective service

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line performance success during the "entrepreneurial" or start-up stage of the structure's implementation (see Table 1). One factor that seemed to be a particularly important facilitator of service line implementation success was leader influence through entrepreneurial and decisive decision making. This finding is reinforced by the fact that VISN 2 was one of only three VISNs that had a reduction in "Bureaucratic / Hierarchical" culture in the MDRC National Quality Improvement Survey between 1997 and 2000. Other important facilitating factors include top management cohesion; organizational emphasis on achieving external legitimacy, and also using the legitimacy process as a motivational device within the service line; the establishment of an outcomes-focused culture, and, at times, the use of an "ad hoc" work approach at the professional line level that emphasized creative ways to deliver services in the absence of formal standards or guidelines. It is notable that these characteristics are not unique to the service line structure per se, but rather represent more general features of a total quality management approach within organizations. However, several features of the service line structure, in particular its ability to create more seamless ways of integrating clinical service delivery across geographic areas, its emphasis on creating holistic management decision making, and its program-driven (i.e., bottom-up) approach to budgeting create an atmosphere within which these best practices can be further reinforced, and which have resulted in outstanding outcomes.

Potential Threats to Continued Success

The study also identified emerging potential threats to the continued success of service line implementation in the Behavioral Health Care Line of VISN 2 (see Table 2). Consistent with life cycle theory, an organization's ability to develop into a more mature stage of existence depends upon its ability to solve problems generated in the entrepreneurial or start-up stage. The potential threats identified in Table 2 are facilitated by the extreme budget issues and rapidity of change necessary to achieve the dramatic turnaround that occurred in VISN 2. However, in order to maintain these gains the VISN must continue to evolve. Thus, it can be posited that the

Table 1. Factors Identified as Facilitating Service Line Implementation Success

Factor	Dimensions
Leader influence	• creating a culture of risk-taking among top management • filling key leadership positions with "new blood" based on competencies rather than historical VA roles or degrees • willingness to take personal career risks
Cohesion	• strong levels of trust and social integration among top management • flexibility regarding what comprises successful care line manager qualities
Strategic posture; developing a reputation	• sustained focus on achieving external legitimacy for care line programs • legitimizing management objectives through reference to performance measures and external organizations • using the pursuit of legitimacy as a motivational and staff unifying device
Resource acquisition	• strategic emphasis on pursuing growth opportunities • equating growth with survival at the strategic level of the service line
Establishment of an outcomes-focused culture	• centralization of performance monitoring at the top of the organization • emphasis on standardized performance data
Clear mission	• presence of a singular mission "bought into" throughout the service line • identical interpretation of meaning and value of performance measures at every level of the service line
Ad hoc approaches at the line staff levels	• high level of personal dedication of line staff to serving patients • customer-focused service orientation displayed by line staff
Informality	• rapid and open communication flows around performance data • use of e-mail and face-to-face communication modes to convey important issues and actions • informality in carrying out key work processes for new service initiatives

future success of the service line approach in VISN 2 depends, in part, upon strategically addressing the threats listed in Table 2.

Potential threats most strongly supported by the data include a decreased emphasis on learning within the programs of the service line. Although the Behavioral Health Care Line had proportionately more funds allocated for education than other care lines in the VISN, the available VISN funds had been reduced over time. Also strongly supported by the data was a decreased capacity for using organizational failure within programs as a means for self-examination and development of future process innovations. The potential for narrowing definitions of "appropriate" patients and services within the two service line programs studied, due to excessive pressures related to having to maintain and/or improve upon specific performance outcomes in the national performance measurement system was another potential threat strongly supported by the study data. Effectively addressing these threats must include cultivation of new organizational best practices that build on, and in some instances deviate from, the start-up best practices listed in Table 1.

Conclusion

VISN 2's level of commitment to service lines is unique in VA. Their very positive results stem not just from the service line structure alone, but also from numerous supporting practices. Since organizations are dynamic, the practices that facilitate change and high performance in one stage of the organizational life cycle may become challenges to future success. It is this dynamic understanding that prompted the leadership to request and support this study, so that its successes as well as its future threats could be identified and addressed proactively. Both local and national factors have been identified as facilitators and potential challenges. Overall, this study adds a layer of complexity onto the discussion of service lines, moving us beyond static or standardized notions of service line implementation and towards more contingent understandings that emphasize implementation requirements within the particular "life stage" of the structure.

[1]Parker VA, Charns MP, Young GJ. *Clinical service lines: an initial framework and empirical exploration*. Journal of Healthcare Management 2001 Jul-Aug;46(4):261-76.
[2]Quinn RE, Cameron K. *Organizational life cycles and shifting criteria of effectiveness: some preliminary evidence.* Management Science 1983;29:33-51.

Table 2. Emerging Threats Identified for the Behavioral Health Service Line's "Maturity" Stage

Threat	Causal factors
Decreased emphasis on "learning"	• lack of available funds for education and training* • process vs. outcome nature of evaluating learning in the care line* • presence of an externally-defined learning focus in the care line*
Underutilization of service line components such as clinical coordinating groups	• structural deficiencies of coordinating groups in the care line • insufficient top management attention paid to coordinating groups • insufficient resources and incentives given to coordinating groups*
Lack of viable motivators for professional line staff	• lack of modification of "Goalsharing" incentive program to emphasize process achievements in programs* • misdirected line input regarding design of rewards and incentives* • overemphasis on tying rewards to outcome performance targets
Decreased capacity for failure and innovation	• strong cultural norms for success contributing to reluctance to investigate and learn from failures in the care line • dominant emphasis on verifying and maintaining program outcomes • short turnaround times for correcting performance deficiencies
Overemphasis on program outcomes over processes	• insufficient creative dialogue and tension between care line management and professional line staff • short turnaround times for correcting performance deficiencies • informality over formalization and overly ambitious time frames with respect to implementing new performance initiatives
Narrowing definitions of "appropriate" patients and services	• dysfunctional effects of an overemphasis on outcome performance measurement and growth pressures on programs and professional line staff

* Factors influenced in part by VISN and/or national policies and imperatives