Implementing Service Lines
A Case Study

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The 1995 reorganization of the Veterans Health Administration into twenty-two Veterans Integrated Service Networks, or VISNs, created a significant opportunity to observe trends and innovations in healthcare delivery. One area where networks have substantially diverged has been in the development of service line structures. While some networks have moved forward rapidly in this area, others have utilized service lines only tangentially.

The following case study is the second in a series of three *Transition Watch* articles in which we examine networks that have made the most extensive changes through implementation of service lines. All three networks featured in the series utilized service lines, although each network differed in the types of service line structures selected (e.g. teams, matrix or divisional forms) and in the manner in which service lines were deployed. VISN 10, the VA Healthcare System of Ohio and the subject of this case study, took a gradual path in service line implementation, moving through a number of organizational stages along the way. Similarly, VISN 13 (VA Upper Midwest Health Care Network) did not rapidly institute service lines, but rather approached their organizational changes in a more steady, step-wise progression. The subject of the first *Transition Watch* article in this series, VISN 2 (VA Healthcare Network Upstate New York), quickly implemented a service line structure that entrusted each network-level service line with a great deal of authority. The comparisons among these VISNs may be informative for those considering developing a service line structure.

Initial Steps

VISN 10 serves an estimated veteran population of 1.1 million from Ohio and neighboring states. Most VISN 10 facilities are located in Ohio, although it does have some community-based outpatient clinics (CBOCs) in Kentucky and Indiana and a nursing home in Kentucky. In contrast to some other networks, when VISN 10 was created none of the individual facilities within the VISN utilized a service line structure.

VISN 10 began its service line structure by creating six VISN-wide clinical care councils soon after the

network was created in 1996. The clinical care councils were: 1) Primary Care; 2) Extended Care; 3) Mental Health; 4) Medical/Surgical Specialties; 5) Rehabilitation; and 6) Clinical Support Services. These six areas would correspond with the six service lines that the VISN would later develop.

In July 1997 the VISN held a retreat at which its leadership decided on a plan for restructuring into care lines. After further refinement, the VISN submitted its reorganization plan to Headquarters in June 1998. The goals of the care line reorganization, as described in the proposal to Headquarters were to:

1. Further enhance the VISN as the new operating unit of the VA
2. Develop multi-disciplinary teams for patient information, communication and feedback
3. Reduce duplication
4. Develop network-wide practice guidelines and referral patterns
5. Re-engineer administrative activities
6. More rationally distribute scarce resources
7. Establish additional points of care
8. Fully deploy primary care across the network

In this proposal the VISN defined care lines as:

…a set of related clinical services, facilities and caregivers who are linked together to achieve optimal sharing of resources, ideas and operations.

The restructuring plan involved the creation of a care line office within each care line, consisting of a care line manager (CLM) and a business manager. The CLMs were made full voting members of the network's Executive Leadership Council, the network's senior management group that previously had included

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the Network Director and the six medical center directors. Many of the care line managers had collateral duties within the VISN. Two of the six care line managers were also medical center directors, while three more were Chiefs of Staff at a facility within the VISN. This contrasted with VISN 2, where the care line managers came from other positions within the organization.

Structural Form
VISN 10 approached the structural form of its service lines in a unique manner, not only by choosing to reorganize into a matrix structure, but also by separating budget from personnel authority. In general, budget and personnel authority are paired in organizational structures. For example, in a traditional network structure, facility leadership has both personnel and budget authority, while in a network service line divisional structure, such as that in VISN 2, network service line directors have both personnel and budget authority. In comparison, a matrix structure balances authority between facilities and network-level service lines. The literature on matrix organizations suggests that budget authority would be shared between the two sides of the matrix, and similarly that personnel authority would be shared. In VISN 10, however, leadership chose a different approach to achieve the balance between network-level service lines and facilities. They kept personnel authority with the facilities by maintaining the reporting relationships between local service line managers and their facility leadership, while giving budget authority to the network-level service line directors.

The division of responsibilities at the network (i.e. Care Line) versus local (i.e. Medical Center) level, was established by the network in its July 1997 retreat:

- *Care Line Managers: All policy and planning, resource shifts, maintaining/increasing workloads.*

- *Medical Center Management: Implementation and operations, integration of Care Line policies and plans at the facility level*

Dr. Richard McCormick, the Mental Health Care Line Director, described how he saw the care lines functioning:

"I didn't view the Mental Health Care Line as consisting of the five facilities, but rather as five regions covering the entire VISN territory. The initial shift resulting from the care line reorganization was that we took responsibility for the clinical service delivery decisions. The facility directors need to insure coordination among the different care lines, such as Primary Care and Mental Health."

Care Line Implementation
Rather than roll out all six care lines simultaneously, the Ohio network introduced care lines incrementally. The process of granting budget control to the care lines illustrates how and why the network took this evolutionary approach. In 1997, the network relied upon a traditional facility-based budget. In 1998, care lines were given "shadow" budgets – budgets were developed by the care lines, but resources were managed along traditional lines, through the facilities. In 1999, Mental Health and Clinical Support Services were given their own budgets, while the remaining care lines were given budget control in 2000. The VISN benefited from the experience of allocating budget authority first only to Mental Health and Clinical Support. By granting budget authority incrementally over time, the network was able to apply the lessons learned before giving budget authority to the rest of the care lines.

The Medical/Surgical Care Line and the Primary Care Line lagged structurally behind the rest of the care lines, due in part to the more complex nature of these care lines. In most facilities, the Mental Health Care Lines were implemented earlier than were the Primary Care Lines. By 2000, though, a majority of the care lines had reached the same point of development, including budgetary control.

Giving each care line its own budget meant that, in essence, there were thirty-six budget lines. Each of the six care lines in VISN 10 had five budget lines – one for each of the facilities. Additionally, each facility manager still controlled a budget, including funds for maintenance and pharmacy, which represented about 45 percent of the total budget assigned to a medical center. The final budget line consisted of dollars retained at the network level for network-wide activities and emergency funds.

Challenges of the Change Process
One major challenge that arose in the reorganization was categorizing services into the Medical/Surgical and Primary Care Lines, respectively. Distinguishing

which patients fell into these care lines was not an easy task. Dr. Steve Cohen, Director of the Dayton VAMC and the Network Extended Care Line Manager, discussed how the Medical/Surgical and Primary Care Lines needed to be treated differently than the others:

"There are some areas that are natural for care lines, like Mental Health and Extended Care. The demarcation lines are easy to identify. You can run those care lines easily even if there are some parochial issues. For areas like Primary Care and Medical/Surgical, however, I think that those issues need to be managed more locally."

The relationships between the medical facilities and medical schools further complicated the issue of organizing primary care and specialty medical services, and was a challenge for highly affiliated VA medical centers (VAMCs) nationally. Historically, the organizations of the VAMCs and their medical school affiliates had strong parallels, with the medical schools' clinical departments (Medicine, Surgery, Psychiatry, Radiology, etc.) corresponding to VAMC services (Medical Service, Surgical Service, etc.). With reorganization into separate primary care and specialty medical/surgical care lines, this parallel structure was disrupted. For example, physicians in a medical school Department of Medicine could now find themselves in separate structures at the VAMC: some in the Primary Care Line and some in the Medical/Surgical Care Line. Several physicians expressed concern that this structure might have negative effects on professional issues such as residency training, as well as potentially contributing to fragmentation of care between primary and specialty care. To respond to this challenge local leaders at each medical center made adjustments to meet their particular local needs.

Facilitators of the Change Process

A number of individuals referred to the gradual pace of change as enabling them to keep moving forward with the care line structure. The importance of network leadership was also cited as an integral component of the change process in VISN 10. One collateral network care line manager discussed these topics:

"The most significant step was the development of the clinical councils… this was very important. For the first time, these councils brought together people who had been competitors, in an environment where they learned collaboration and cooperation. This was

crucial to later steps such as developing a VISN-wide care line budget. The second key was how Laura [Miller] first facilitated the debate about care lines, then made a decision to implement them. Both the debate, and the fact that a decision was made without consensus, were important."

Conclusion

VISN 10 is currently the only network to have implemented a matrix organizational structure throughout the network. This structure is theoretically one of the most challenging structures to implement, due to the difficulty of maintaining the balance in influence between facilities and network care lines.

While VISN 10 continues to move forward with its care line reorganization, several future challenges remain for the network. One particular area of interest will be whether splitting personnel and budget authority, as VISN 10 has done, will help the VISN better manage its matrix structure. Also, monitoring and addressing the tensions intrinsic to the Medical/Surgical and Primary Care Lines will be instructive for other networks considering similar organizational arrangements.

Creating an Integrated Delivery System

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VISNs across VA are striving to create integrated delivery systems in their networks. Network leaders generally expect integration to add value to their organizations by enabling them to provide higher quality care at lower costs, while maintaining or improving the health and satisfaction of their patients. Networks make structural and process changes on the assumption that those changes will lead to greater integration and that integration in turn will lead to improved system performance. Within this broad framework of system integration, networks are following a variety of paths for change and are using a variety of organizational structures.

These varied efforts at creating integrated delivery systems provide a natural laboratory for examining the progress of integration. Data from integration surveys administered to staff in three VISNs suggest that there are common patterns of integration across these networks. This article explores those patterns.

As described in the Fall 1999 issue of *Transition Watch* (vol. 3, no. 1), the MDRC developed an integration survey for VISN 13 to be used as part of an integrated system scorecard to measure the progress of system integration. VISNs 14 and 1 are also now using the integration survey. In all three systems, the survey has been administered to samples of managers, clinicians and general staff with good response rates. The survey asks staff about their experiences with different aspects of integration across facilities within the network. Working with the survey data, we created scales from items whose responses clustered statistically. Higher scale scores indicate greater system integration experienced by staff.

Looking at data from the integration surveys administered in 2000 in VISNs 13, 14, and 1, we find a consistent ordering of the five primary integration scales – that is, the same scales are high and low in each network. Figure 1 shows the scale scores for VISN 13 from its 2000 survey. The scores for VISNs 1 and 14 for 2000 are in the same range on each scale. Equally important for this discussion, the order of the scales is the same in each network, when the scales are ranked from high to low by their average scores.

We assume that scales with higher scores reflect dimensions that are easier to accomplish or come earlier in the integration process. The consistent ordering of integration scales across networks indicates a common pattern – that despite different structures and strategies for change, the same dimensions are easy and difficult across networks. Figure 2 offers a model for considering the common pattern that the scales suggest.

Looking at the scales in order of their average scores, we can consider these dimensions in more detail. The definition of each scale, developed from the items that comprise it, is shown in italics.

Leadership: *System and facility leaders articulate clearly the system goals and objectives; staff understand their role in furthering those objectives and work together toward them.*

The higher score on this scale suggests that communication from leadership comes early in the process of integration. Communicating goals and objectives is an important starting point in any organizational change, and is an imperative of virtually all change theories.[1] Having staff understand how their work fits the plan is also an important early step in change. But as necessary as clear and frequent communication is, it does not by itself represent an integrated system.

Staff cooperation: *Individual staff cooperate across facilities: I know whom to call when I need assistance, others are willing to help, we share the same goals and standards.*

Individual efforts to work together appear to be another early step in creating an integrated delivery system – building on personal relationships that may well pre-date formal attempts at integration. Individual staff very likely have developed their own contacts at other facilities, even without a formal move toward integration. VA operations, like those in many systems,

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[1] For example, JP Kotter, *Leading Change*, Harvard Business School Press, 1996.

are enhanced by personal relationships – knowing whom to call to get things done. This does not necessarily mean that the organizations move together, but that individuals have personal contacts.

Clinical coordination: *Patient care is well managed across facilities; reliable, timely patient data are provided.*

Clinical coordination falls in the middle of the scales. In part, it may reflect referral practices among medical centers that predate the move toward formal system integration. Many facilities have some referral relationships with other VAMCs, particularly in their network. In part, this scale may also reflect a step toward improved organizational coordination as the facilities adopt a common data system that can be accessed across the system and as they standardize policies so everyone is operating by the same ground rules.

Alignment: *Facility leadership and priorities are aligned with network goals, yet local needs and priorities do not get lost.*

Good communication, personal relationships and referral practices, while important, can occur without creating an integrated delivery system. If deeper changes are expected in order to increase the value of the system and achieve the benefits of improved quality and cost efficiency, we would expect priorities in the system to shift – local priorities would have to change to align with network priorities. Changing priorities may affect resource allocations, organizational responsibilities and possibly work assignments. Since change is often seen as threatening, we might expect to see some resistance in this area. The lower scale score suggests that this dimension is more difficult for staff. Looking at the items in this scale, many respondents indicated that the needs and priorities of their service often get lost when network-wide planning is the focus and conversely, that facility priorities usually outweigh network goals or process improvement when making decisions about the service.

Service cooperation: *Services share problem solving, benchmark their performance, and coordinate administrative and support efforts across facilities.*

This scale most clearly reflects efforts to systematically integrate services across facilities. The average scores are the lowest, between rarely and sometimes. Perhaps equally important, the responses are spread fairly evenly across response categories, indicating that staff have widely varying experiences in coordinating efforts across facilities. Clearly this is a dimension on which integration is more difficult, or at least slower than others.

Implications

Strong leadership with a clear vision is necessary to organizational change. Personal interactions among individual staff are important, both because that's the way many things are done in an organization and because individual relationships can be building blocks for larger organizational change. At the same time, these are the easy parts – and even here, the integration scores are not at the top of the scale, indicating that more work is needed. The real challenges in creating an integrated delivery system, however, come when systematic change is required in the way work is organized – when people have to do things differently, when communication and reporting relationships change, and when established local priorities come up against new priorities from the network. The interesting question in our VA natural experiment is whether our model describes a time progression – that over time, the scores on the last three scales will rise as networks tackle the difficult organizational issues – or whether it describes a more lasting state – that it will be hard for networks to move beyond the easy changes in a facility-based system.

Figure 1. System Integration Scores for Network 13 (n=1110)

Higher scale scores indicate greater system integration. A score of 4.0, for example, means that the average employee experienced the features described in the scale definition about half the time.
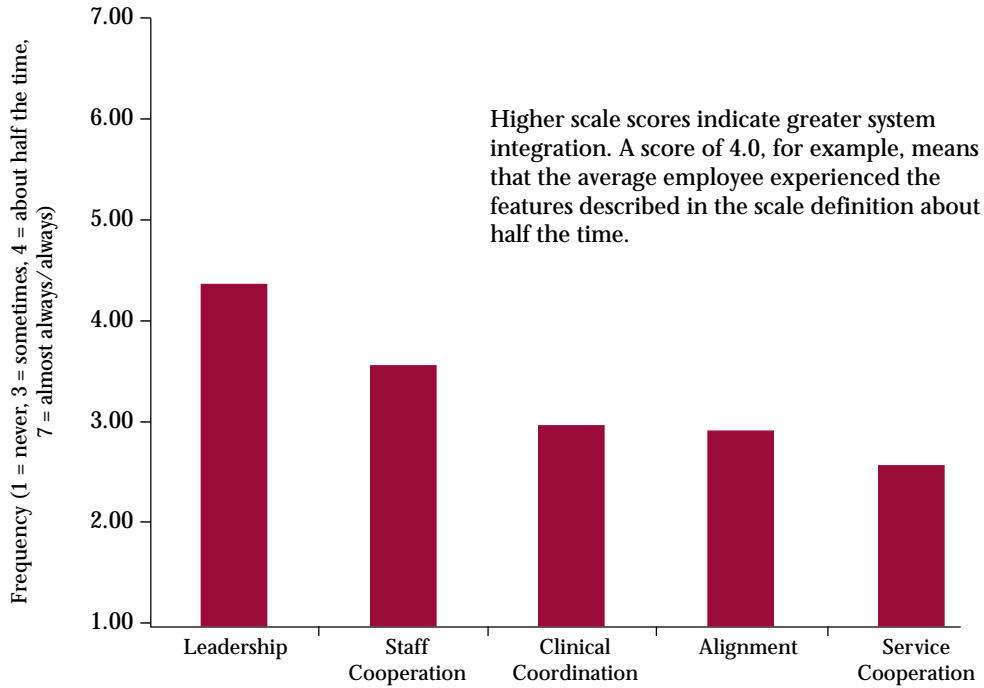
Figure 2. Patterns of System Integration