



## Works in Progress

### Integrating Highly Affiliated VA Medical Centers

Carol VanDeusen Lukas, EdD

Over the past six years, VA has integrated 54 medical facilities into 26 health care systems. In most, academic affiliates did not play a major role in the integration process because there was only one major affiliate or no affiliate. In a few systems, however, integration brings together two or more medical centers with strong affiliations with different medical schools. These multiple affiliations add complexity to the integration process.

The MDRC is tracking the progress of three affiliated systems for a study commissioned by Dr. John R. Feussner, VA's Chief Research and Development Officer: Chicago, approved for integration in June 1996; Boston, approved in December 1998; and New York Harbor, approved in January 1999. This article offers highlights of each system's efforts to bring historically independent medical centers with strong ties to different medical schools together in an integrated delivery system. These are stories of works in progress.

On one level, the three systems share many features. Their formal integration objectives are similar: All set out, first, to create a single standard and/or continuum of care across the system and, second, to achieve cost savings or cost avoidance. All three systems have attained substantial success: They have integrated their administrative functions and some clinical support services under single system-wide leaders, and have achieved efficiencies as a result. All have integrated their policies, committees, and medical by-laws in preparation for Joint Commission surveys in the last year, and all passed with high scores.

But beyond these shared features, the three systems are following different paths in integrating clinical services across campuses.

**VA Chicago Health Care System (VACHCS):** Structurally, most clinical services remain separate, running in parallel at the two campuses – West Side and Lakeside. The system recently appointed a new Chief of Staff and Associate Chief of Surgery for the Lakeside campus, with responsibilities only for that campus. Joint recruitment of system-wide chiefs from outside VACHCS has not been successful, reportedly because of both uncertainty about

VACHCS' future and lack of medical school enthusiasm for recruiting for a position without full control of resources or clear lines of authority. At both campuses, VA and the affiliates are investigating Enhanced Lease Use options to upgrade physical plants and generate revenue, options that would build even closer ties between each campus and its affiliates. VACHCS leadership is still striving for a viable plan for further consolidation of the two campuses.

Two factors appear important to VACHCS' integration challenges. First, both campuses are very closely linked with their respective medical schools. The VA campuses are adjacent to the schools, and most VA physicians also practice at the university hospital. Further, VA physicians are augmented by many university physicians who work without compensation (WOC) at VA because they consider VA patients to be part of their service. These valued relationships between VA and the affiliates are given as reasons why VACHCS cannot further consolidate services to one campus. Any move would reportedly threaten the withdrawal of one affiliate. Neither campus could absorb the caseload of the other campus without that campus's physicians, especially without the WOC contribution.

Second, the extensive political attention and continued outside studies by the GAO and consulting firms have stalled progress. Several groups have made recommendations for restructuring the VA system in Chicago. Expecting a structure to be externally imposed, VACHCS leaders are reluctant to further restructure the system because such changes might run counter to an external plan. With VA not making decisions, the affiliates seem more opposed to more clinical integration than they did a year ago.

**New York Harbor Healthcare System:** New York Harbor has integrated selected clinical and clinical support services, using an opportu-

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nistic strategy triggered primarily by the resignation of a service chief at one campus. The integration has been low key. The system retains both campuses as full-service hospitals, with the expectation that each will develop specialized niches. Each campus has its own medicine and surgery services. In the last few months, budget shortfalls have accelerated integration steps. Inpatient psychiatry was consolidated to the New York campus, and other consolidations, including some surgical specialties, are also being considered.

Both affiliates are heavily invested in keeping their core teaching services at “their” campus. At the New York campus, virtually all VA faculty teach at the medical school and NYU-affiliated hospitals as well as at VA, relationships fostered by the walking distance between institutions. Faculty based at NYU-affiliated hospitals come regularly to VA to teach. The State University of New York (Downstate) also has close ties with VA, but the 12-mile distance between Downstate and the Brooklyn campus makes daily interactions far less frequent. Affiliated faculty at Brooklyn teach when students and residents rotate through VA, but only a minority travels to Downstate to teach. To date, the Harbor has integrated services that are not central to the medical schools, and dropped one plan the schools opposed. Now with more severe budget pressures, the Harbor is more actively pursuing consolidation initiatives, though the medical school response reportedly has been lukewarm.

Geography also favors maintaining full-service hospitals at both campuses. Travel between campuses takes from 20 minutes to over an hour depending on city traffic, and historically the campuses have drawn patients from different parts of the New York area. It is argued, therefore, that it is difficult to consolidate services to one campus while maintaining patient access and workable schedules for clinicians and students.

**VA Boston Healthcare System (VABHS):** Only Boston has made structural changes to consolidate its core inpatient services to one campus. An early principle in considering integration of the Brockton/West Roxbury and Boston medical centers was that inpatient tertiary care would be consolidated to one campus. It took several years and multiple planning committees to determine on which campus the inpatient tertiary services would be located, but the principle held. The primary affiliates, Boston University and Harvard,

showed their strong commitment to VA by collaborating to develop a model for sharing training sites in the consolidated system. 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.

VABHS is now working to implement this shared structure, with inpatient surgery and medicine consolidated to the West Roxbury campus, though it is not easy. Clinicians have had to create new working relationships and overcome differences in operating practices. As former chiefs became co-chiefs, some clinical leaders had to substantially re-orient their professional goals. Plans were needed for physician recruitment and replacement to maintain balance between the medical schools. Some physicians left the system. These typical implementation problems have been compounded by severe budget constraints, including potential downsizing of clinical staff, and by operational problems with other staff, including nursing shortages and the delayed transfer of union staff to West Roxbury to support the inpatient medicine and surgery consolidation. The affiliates are concerned that the general surgical caseload has dropped in the consolidated service. To further complicate integration efforts, VABHS must shift its structure to accommodate VISN service lines and, most recently, may have to delay some of its clinical integration while waiting for the Capital Asset Realignment for Enhanced Services (CARES) process to be completed.

## Summary Notes

The experience of these three systems underscores the strong influence of affiliate stakeholders in shaping these integrated systems. As we would expect, the medical schools are at best reluctant partners in integration, arguing for keeping the major services separate and operational at both campuses. Consolidation of services to one campus means either sharing or giving up a service. Chicago’s experience suggests that close ties between VA and the affiliate sometimes make the integration between the two VA medical centers more difficult. In Boston, where VA held to its decision to close inpatient services at one campus, the affiliates are to be commended for working together to create a plan for sharing services. But agreeing on the plan was only the first step. A new set of issues arises when the plan is implemented. Separate from the role of the affiliates, severe budget constraints add urgency to integration: on one hand, the urgency facilitates integration by forcing decisions and actions; on the other, it heightens tension and competition between campuses.

# VHA Reorganization and Quality of Inpatient Care

Gary Young, JD, PhD

Beginning in 1995 the Veterans Health Administration (VHA) embarked on a major reorganization to improve the efficiency and quality of its services. The reorganization entailed major shifts in financial and human resources from inpatient to outpatient care. While this reallocation of resources has been associated with many positive results, it also has raised issues about the continued quality and accessibility of inpatient programs. Indeed, healthcare analysts often point out that when one service area of a healthcare organization receives increased resources and attention, other service areas will lose resources and may experience a decline in quality. We undertook a study to assess whether the VHA reorganization affected the quality of care in nursing home units. Specifically, we focused on pressure ulcer development among nursing home patients. Our study compared pressure ulcer development over time both before and after the reorganization. We found that during the early 1990s VHA was successful in reducing the rate of pressure ulcers but that the rate of pressure ulcer development increased following the reorganization. In this issue of *Transition Watch*, we present an overview of this study.

## VHA's Quality Improvement Initiative for Pressure Ulcers

With respect to the background for the study, it is important to know that VHA has had a long-standing commitment to improving pressure ulcer preventive care. In 1990 VHA redesigned its quality management program to emphasize continuous quality improvement and the use of system-wide databases as a source of information on key processes and outcomes of care. As part of this initiative, information on performance was to be provided as feedback to medical centers to stimulate improvements in care. The first system-wide outcome measure selected for this program was the rate of pressure ulcer development in long-term care. The outcome was selected for the following reasons: long-term care has been an important program for VHA, pressure ulcers have been a significant clinical problem in VHA nursing units, there has been ongoing development of clinical guidelines describing best practices to prevent pressure ulcers, and data sources exist for monitoring pressure ulcer development in VHA.

Rates of pressure ulcer development were calcu-

lated from an administrative database, the Patient Assessment File, which was originally developed for case mix-based reimbursements in nursing homes. Since 1991, rates of pressure ulcer development in long-term care have been sent semiannually to all medical centers. These reports included the medical center rate in addition to regional and national rates for use in benchmarking. Initially, only unadjusted rates of pressure ulcer development were reported, although subsequent reports considered case mix using a validated risk-adjustment model. These reports generated considerable attention from managers and clinicians throughout VHA. Regional managers requested plans for improving care from medical centers with persistently high rates of pressure ulcer development. As a result, innovative programs for improving care were implemented at individual VHA medical centers in response to poor performance in this measure.

The emphasis on pressure ulcers ostensibly declined following the reorganization that began in 1995. Although VHA continued to measure and disseminate rates of pressure ulcer development in long-term care to medical centers, pressure ulcer rates were not included in the performance agreements of network

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GERALDINE MCGLYNN, EDITOR  
INFORMATION DISSEMINATION PROGRAM  
MANAGEMENT DECISION AND RESEARCH CENTER (152-M)  
VA BOSTON HEALTHCARE SYSTEM  
150 SOUTH HUNTINGTON AVENUE, BOSTON, MA 02130-4893  
PHONE: (617) 278-4433  
FAX: (617) 278-4438 EMAIL: geraldine.mcglynn@med.va.gov

*Transition Watch* is available on the internet at [www.va.gov/resdev/prt](http://www.va.gov/resdev/prt) or intranet at [vaww.va.gov/resdev/prt](http://vaww.va.gov/resdev/prt)  
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## VHA Reorganization

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directors. Additionally, an increasing primary care orientation of VHA called into question the role of long-term care and many long-term beds were closed. Thus the issue of pressure ulcer performance has received considerably less attention from managers and quality assurance personnel since the reorganization.

### Analysis of Pressure Ulcer Rates Over Time

We evaluated eight years of pressure ulcer development among residents of VHA long-term care units. We used the Patient Assessment File (PAF) as the primary database. The PAF contains information on a variety of patient characteristics including demographics, specific diagnoses, therapies received, and activities of daily living. The stage of the largest pressure ulcer present is also recorded. The stages range from 1 (superficial erythema) to four or five (ulcer extends through the fascia into muscle or bone). Information is collected on all residents at the time of admission to a long-term care unit and semi-annually on April 1 and October 1. No information is collected at the time of discharge. Assessments are performed by registered nurses familiar with the patient. We included only residents of VHA owned nursing units (i.e., no residents in contract facilities were included).

We defined pressure ulcer development as present when a patient without a pressure ulcer on an index assessment had a stage 2 or higher-stage ulcer at a subsequent outcome assessment. The outcome assessment was always a semi-annual evaluation that occurred on either April 1 or October 1. We evaluated the six-month period ending April 1, 1990 through the six-month period ending October 1, 1997, which resulted in rates of pressure ulcer development for 16 six-month periods.

A patient-level risk-adjustment model was used to account for clinical factors that can affect pressure ulcer development. The model included the same 11 patient characteristics identified as important by the study team in a previous research project. These characteristics included activities of daily living, terminal illness, and urinary tract infection. We calculated three rates for each time period: an observed rate, an expected rate, and a risk-adjusted rate.

The primary results of the analysis were the following:

- Risk-adjusted rates of pressure ulcer development were initially high, with a value of 4.5 percent in the first half of 1990. Rates declined to a low of 3.3 percent in the first half of 1992 and remained stable through 1994. This represented a 27 percent reduction in the risk-adjusted rate.
- However, starting in 1995, rates of pressure ulcer development increased, and in 1997 they were similar to those observed in 1990. The expected rate of pressure ulcer development calculated from the risk-adjustment model was 4.1 percent in 1991 and declined to 3.7 percent in 1997, which indicates that VHA residents have been at a lower risk of pressure ulcer development in more recent years.
- A total of 41 percent of pressure ulcers that developed among patients were stages 3 or 4. The percentage of ulcers that were deep was relatively constant between 1990 and 1995. However, the three time periods with the highest percentage of deep ulcers, averaging 45 percent, were the last half of 1996 and all of 1997. This resulted in a significant trend toward ulcers becoming more severe in VHA over time.

Although we do not know with any certainty the reasons for the initial improvements in pressure ulcer care, it may well have been related to the implementation of the previously discussed VHA quality improvement initiative. Other factors such as the 1992 publication of the Agency for Health Care Policy and Research clinical practice guideline on pressure ulcers also may have contributed to improvements in pressure ulcer preventive care. The increase in the rate of pressure ulcer development that began in 1995 occurred during a time of significant reorganization within VHA. As noted, during this period resources were shifted from inpatient to outpatient settings. We do not know whether other areas of inpatient care have experienced declines in quality since the reorganization. As the reorganization continues, it may be important for VHA officials to carefully consider how resource allocation decisions are likely to affect quality of care.

*For complete details of the study, see Dan Berlowitz, Gary Young, Gary Brandeis, Boris Kader, and Jennifer Anderson, Health Care Reorganization and Quality of Care: Unintended Effects on Pressure Ulcer Prevention, Medical Care 39(2): 138-146.*