



National VA Quality Improvement Project (NVAQIS): Interpreting the Data

Gary J. Young, J.D., Ph.D. and Kamal R. Desai, Ph.D.

The web site reporting the results from the second round of the NVAQIS survey will be available on the KLF menu by early June 1999. The reporting of the survey results marks the completion of the second round of the survey. In this *Transition Watch* article we provide background information about the survey to facilitate interpretation of survey results.

What is the study purpose?

In 1995, VHA, under new leadership, embarked upon a major transformation effort designed to improve the quality of services delivered to our nation's veterans. Staff members of VHA's Management Decision and Research Center (within the Health Services Research and Development Service, Office of Research and Development) are documenting this transformation effort and studying the organizational and managerial factors that appear to facilitate the effort. Data collection efforts include employee surveys and interviews with VHA managers. The project will serve as a source of timely and relevant internal information for top VHA managers. Additionally, it will serve as an important case study for private- and other public-sector organizations undergoing transformations. The project is supported by grants from HSR&D and the National Science Foundation (NSF).

We have completed two rounds of employee surveys. We conducted the first round of survey distribution during the first half of fiscal year 1997, and the second round during the last half of fiscal year 1998. Survey content and procedures have been consistent for each round to allow managers to compare survey results over time. We are planning a third round of surveys to be distributed during the first half of fiscal year

2000. The remaining sections of this report discuss survey content and procedures, and report facility-level results.

Who is surveyed?

A random sample of up to 150 employees was drawn from each participating VHA facility. The larger the facility workforce, the greater the number of employees sampled. The sample was stratified by service (e.g., Fiscal, MAS) and administrative level (e.g., non-managerial employee, service chief). For the first round of surveys, 161 facilities met the reporting requirements for participation. For the second round of surveys, 147 facilities met the reporting requirements for participation. The decline in participating facilities is due to facility integrations.

What is the response rate?

For the first round of employee surveys, the overall VHA national response rate was approximately 70 percent. At the facility level, the response rate varied from 44 to 98 percent.

For the second round of employee surveys, the overall VHA national response rate was approximately 62 percent. At the facility level, the response rate varied from 37 to 98 percent.

What is measured?

Four aspects, described below, of a facility's potential for and commitment to service quality and customer satisfaction were measured. To measure these aspects, we used survey instruments for which evidence exists supporting their reliability and validity. (see Exhibit 1)

1. Facility Culture:

Employees were asked to complete a questionnaire on organizational culture. The questionnaire asked employees to distribute 100 points among four cultural attributes in accordance with the extent to which they believe each attribute characterizes their facility. The

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four attributes pertain to innovation, team work, bureaucracy and task orientation. We report the number of points employees assigned to two of the four attributes — innovation and team work, since these attributes appear to be most relevant to VHA's ongoing effort to improve service quality and customer satisfaction. The more points assigned (up to a maximum of 100) to an attribute, the more employees believe that attribute characterizes their facility. Employees typically did not allocate all 100 points to any one attribute.

To help interpret the results, comparative results from a sample of private-sector hospitals are provided in the interpretation section. The private-sector sample is not representative of all U.S. hospitals, but the general characteristics are in line with most private-sector hospitals.

2. Overall Facility Commitment to Quality Improvement:

Employees were asked to complete a modified version of the Quality System Survey, an instrument that has been used in VHA for several years to assess facility commitment to service quality. The modified instrument consists of forty-two questions that each have a scale of one-to-five. The higher the score, the stronger the perceived commitment.

3. Top Management Commitment:

Mid-level managers were asked a series of questions about whether they believe their facility's top management team is involved in and committed to continuous quality improvement. Ten questions, each on a scale of one-to-five, were presented. The higher the score, the stronger the perceived commitment.

4. Relationship Between Job Characteristic and Service Quality:

Employees were asked a series of questions about whether they believe:

- their own performance goals are related to service quality (three questions, one-to-five scale)
- they receive adequate feedback about their performance (six questions, one-to-five scale)

- efforts to improve service quality are rewarded and recognized (four questions, one-to-five scale)

The higher the score on each of these scales, the stronger the perception that the job characteristic supports service quality.

Can survey results be benchmarked?

Information has been provided for benchmarking a facility's survey results to 1) overall VHA performance (for each round of surveys), and 2) its own baseline performance (second round of surveys to the first round of surveys). As for benchmarking to VHA overall performance, information has been provided in the report indicating whether or not a facility's score on a given survey indicator was significantly higher or lower (*t-test*) than the VHA overall mean (the mean of all participating facilities). A facility score was reported to be significantly above (or below) the VHA overall mean if its 95 percent confidence interval was above (or below) the VHA overall mean.

As for benchmarking to baseline performance, information has been provided about whether a facility's score on a given indicator for the second round of surveys is significantly different (*t-test*) from its score for the first round of surveys.

What was the general pattern of results for the first and second rounds of the survey?

Among the seven survey indicators, the overall balance of high and low outlier facilities remained fairly comparable across the two rounds of surveys. Specifically, for the first round of surveys between 7 and 17 percent of facilities were high outliers on a given survey indicator, and between 2 and 16 percent of facilities were low outliers on a given survey indicator. For the second round of surveys, between 7 and 16 percent of facilities were high outliers on a given survey indicator, and between 7 and 13 percent of facilities were low outliers on a given survey indicator. Across the two surveys, there were some substantial shifts in the balance of high and low outliers for specific survey indicators. No facility increased its score significantly on any of the indicators between the first and second rounds of the survey. Some facilities did experience a decrease on particular indicators between the first and second round of surveys.

Thus, overall, VHA facilities did not exhibit any signs of substantial quality improvement between the

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Managers' Perceptions of Service Lines

by Maria Fonseca, M.A., M.P.H., William Wubbenhorst, M.B.A., Victoria A. Parker, D.B.A., Linda Pucci, M.P.H. and Martin P. Charns, D.B.A.

In last quarter's *Transition Watch*, we reviewed facility-level service lines throughout VHA. In this issue, we focus on facility-level service line managers (SLMs): who they are, their skills and backgrounds. We also look at the expectations and observations of facility leadership (i.e., facility directors (FDs) and Chiefs of Staff (COSs) for their SLMs.

Over 90% of VA medical centers and integrated systems implemented at least one clinical service line or task force.¹ Primary Care and Mental Health service lines have been implemented more widely than others such as Long Term Care/Extended Care, Tertiary Care/Medical Specialties, Ambulatory Care, Spinal Cord Injury, and Rehab and Physical Medicine. Here we focus on the role of SLMs in the Service Line Divisional form referred to in the last issue.¹

The following data and quotes are interview data gathered from site visits conducted in 1997 - 1998 with managers (SLMs, FDs, and COSs) at more than 80 facilities. To feel the full effect of service line reorganization, we limited our analysis to only VA medical centers where two or more service lines had been implemented. Thus, the interviews drawn on do not represent all of the facilities we interviewed that had implemented service lines. Data were drawn from twenty four (24) facilities where forty seven (47) SLMs were interviewed.

Who are Service Line Managers?

We learned the following about SLMs:

- Of the forty-seven (47) SLMs we interviewed, sixty-six percent (66%) were physicians; twenty-nine percent (29%) were clinicians (i.e., nurses, psychologists); and five percent (5%) were non-clinicians (i.e., administrative).
- Of the thirty-six (36) SLMs who provided us with background information, seventy-eight percent (78%) came from within VA. Twenty-two percent (22%) came from outside VA.
- Of the thirty-one (31) SLMs who provided us with information about their previous positions, sixty-one percent (61%) had been either COS, ACOS or Service Chief; twenty-five percent (25%) had

previously served clinical roles (including physicians in private practice); six percent (6%) previously held administrative positions; three percent (3%) came from private sector management; and three percent (3%) came from academia/research.

What Relevant Backgrounds Emerged?

VA Management

A little more than half the SLMs who were, or continued to be, Chiefs of Staff, Associate Chiefs of Staff, or Clinical Service Chiefs indicated the importance of that experience in terms of knowing how the "old" system operated.

"My long history in the VA has been very valuable. My understanding of the old system as well as three years as ACOS were very useful."

"My background as COS in several facilities has given me a good idea of how the system works."

Private Sector Experience

Service line managers coming from the outside thought their outsider status put them at an advantage. They lacked VA knowledge in designing and planning this new organizational form.

"I have created programs in both the private and public sector. And I bring lots of experience working on interdisciplinary teams. I have come with a non-VA view of the world and, hence, can think outside the box."

Communication Tops List of Relevant Skills

Interpersonal Communication Skills

The skill cited by more than half of the SLM respondents was talent in interpersonal communication.

"I enjoy compromise and I spend time listening to people, hearing their opinions and input."

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¹ As discussed in *Transition Watch*, Winter 1999, Vol. 2, No. 2, pp. 1-2, a task force is often a precursor to a service line, but is not considered to be a service line.

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

In particular, SLMs pointed to the importance of these interpersonal skills during the service line implementation process.

"At the inception of service lines, a lot of personal interaction was required, both with service chiefs and with line staff. The first six months were spent meeting informally with staff to smooth the transition."

"Mediation skills are important. I have taken over some programs that were once warring factions that historically fought each other for space, people, and money."

Organizational/Leadership Skills

Almost one third of respondents indicated that organizational/leadership skills were key in their SLM role. In contrast to the more informal interpersonal skills, organizational skills indicate how service line staff work as an organization. The following quotes show these organizational skills often parallel the interpersonal skills.

"My background in organizational structure, mentoring, coaching and communicating has proven beneficial."

"I am left-brained and think in terms of diagrams and arrows and how things relate to one another. Besides people skills, I know how to delegate to make things happen."

Administrative Skills

About one quarter of SLM respondents cited administrative experience such as fiscal and personnel management. Administrative skills are useful on practical matters (i.e., personnel/budget management) and also for understanding the larger context of VA's health delivery system.

"I developed a global perspective from working in the front office on budgetary and training issues and have gained the big picture perspective from those experiences."

"My broad background in the management aspects of a department left me familiar with the details of residencies and medical school affiliations."

Other

Respondents mentioned a broad range of other skills.

"Knowledge of internal politics, including knowledge of how information flows, who holds power, and the ability to give 'Atta-boys' have served me well."

"I have had no training in management but draw from my collective experience in medicine. There has been a lot of on-the-job training in terms of management. I use the team concept to eliminate fortresses and skirmishes. And I use common sense."

"It is arguable whether I bring any skills that apply to this situation. My life-long management of systems of various sizes both within VA medical centers and HQ has served me well."

Respondents mentioned clinical skills as relevant, but did not elaborate on just how clinical skills served them.

Facility Leadership Expectations

Facilities implementing the Service Line Divisional Form,² by definition, have already transferred all or most of the personnel authority for service line staff to these managers. In addition, most of the facilities have either transferred, or planned to transfer, budgetary control to the SLMs. Facility Directors and Chiefs of Staff stated:

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

"Hiring, firing and personnel evaluations are left to the SLMs. They can hire and do anything they want with the dollars, but they have to stay within budget; they are held accountable."

"I expect the SLMs to be fairly autonomous."

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² Please refer to *Transition Watch*, Winter 1999, Figure 1, points 8 and 9.

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Facility Leadership Observations

Variability of SLMs' Management/Administrative Skills

Some senior managers noted substantial variability among SLMs in terms of management and administrative skills. The delegation of personnel and budgetary authority revealed a skill gap among some SLMs in personnel and fiscal management.

Some service line managers experienced steep learning curves and required on-the-job training.

"Some SLMs were brought in without budget and/or program experience. Innovative candidates were sought who would bring the right attitude, who were familiar with the VISN, and who were able to embrace and support VISN activities. The required skill set could be taught but the mind set could not."

"Some SLMs are still struggling to meet the requirements placed upon them. For some there has been no intermediate experience to prepare them for this new and challenging role. They are challenged to gain a skill set that would enable them to transition from their previous/collateral position to that of service line manager. Learning curve issues will continue to surface without a safety net."

Administrative Skills Gaps

Facility leadership generally responded in one of two ways to close the administrative skill gaps.

Some facilities have assigned a business manager to support the SLM, or organized the service line under a dyad structure where the co-leaders have complementary management/operations skills.

"In most service lines there will be a business manager to ensure that the business aspects are being handled in a business-like way. The business manager reports to the SLM on day-to-day issues. Tension between the two promotes quality care and fiscal responsibility. The tension has worked quite well."

"Dyads are broken down by personality and relative strengths. One person surfaces as the strategic leader, the other serves as the operations leader."

The other approach was to recruit SLMs with both clinical and administrative skills or to provide on-the-job training to meet these dual responsibilities.

"Non-administrative people are watched, shepherded, etc. until they can demonstrate that they can handle a budget. Day-to-day management is left at the service line level."

"I am looking for clinical expertise as well as business and managerial savvy."

"Since the SLMs are being groomed to take over the management of the medical center, I have had to be very direct in mentoring, training and educating."

SLMs' Role in Overall Facility Management

SLMs' role in overall facility management is often as important as their role in managing within their service line. Many facilities use the SLMs as their Executive Leadership Council (ELC), often functioning as a self-directed work team as it relates to the operation of the medical center as a whole. The emphasis on SLMs managing horizontally (i.e., as a team) also offsets the tendency of service lines to become isolated vertical silos within a facility.

"There are no lines on the organizational chart above the service lines. The management team is oval. The FD and COS maintain liaison to 5 service lines with administrative issues going to the FD and clinical issues going to the COS... Each SLM now takes on things never taken on before, thus broadening their scope. They have had to deal with broader issues by moving outside the discipline box. More is expected of them."

Concluding Thoughts

Interview findings suggest that SLMs need to apply both "soft" skills (i.e., interpersonal) and "hard" skills (i.e., organizational, clinical) in operating a clinical service line. Key issues for facility leadership concerns both the recruitment and training of SLMs and whether to provide administrative support with a business manager.

The comments of many FDs and COSs in facilities that have reorganized along service lines suggest that service lines are more than simply a consolidation of traditional services. For many of these facilities, SLMs comprise a new approach to facility leadership based simultaneously upon team-building and delegation of operational authority to patient-focused clinical service lines. ■

Updates on Integration Analyses

Carol VanDeusen Lukas, Ed.D.

Work on facility integrations continues with three additional projects:

1. *Analysis of facility integration.* The MDRC is continuing the work it began on facility integration in collaboration with the HSR&D Center of Excellence at Sepulveda. Our current analyses focus in two areas. First, we are updating and extending the analysis of the status, structure and perceived impacts of integration. The analysis is based on a survey of directors and managers in integrated systems conducted last fall as part of the larger National Quality Improvement Survey the MDRC sent to all medical centers. The survey administration was completed in January 1999. Second, we are analyzing the effects of facility integration on dimensions such as patient satisfaction, patient

access, redirection of resources to clinical areas, operating efficiency and employee perceptions of service quality. Both analyses should be completed in the next few months.

2. *Analysis of the New York Harbor integration.* At the request of VISN 3, we have begun a new 30-month project to study the integration of the New York and Brooklyn VA Medical Centers. Working with the leadership of the New York Harbor Health Care System, we will look at the process, structure and effects of integration with particular attention to the system's academic affiliations. Both medical centers are highly-affiliated, but with different medical schools. We will look, first, at how integra-

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first and second rounds of the survey. These results need not be interpreted pessimistically, however. During the early stages of a transformation effort it is common for the transforming organizations to experience some decline in performance due to the disrup-

tion surrounding the transformation, before improvements in performance are realized.

How do I access the results on the KLFMENU web site?

The results for both first and second administration of surveys are available at the site: <http://152.125.190.53/qm/qimprove/qa1998.htm> To access the results online, you will need access to the *intranet* (VA's internal network) as above site is accessible to VA employees only. ■

Exhibit 1: Variables, Definitions and Possible Range of Scores

<i>Variable</i>	<i>Definition</i>	<i>Range</i>
Risk Taking Culture	Do employees believe their facility's culture promotes innovation and risk taking	0-100
Group Culture	Do employees believe their facility's culture promotes teamwork and cooperation	0-100
QSS Score	Do employees believe their facility is committed to Continuous Quality Improvement	1-5
Leadership	Do employees believe their facility's top managers are personally committed to service quality goals	1-5
Performance Goals	Do employees believe their job performance goals are related to service quality improvement	1-5
Evaluation & Feedback	Do employees believe they receive sufficient feedback about their performance	1-5
Reward & Recognition	Do employees believe their facility rewards and recognizes efforts to improve service quality.	1-5

Keep Up on Transition Watch Topics — News You Can Use

Elaine C. Alligood, MLS

We put together a selection of current information resources from the web and journal literature on integrating health systems, quality improvement, and service lines. Selected for their relevant content and quality, these sites provide access to QI tools and techniques, classic documents in the QI arena and an interesting site focusing on the wisdom and successes of teamwork. We hope you find these to be useful resources.

Quality Tools

Have you ever wanted to quickly put your hands on Quality Tools and clear definitions on when and how to use them? This site will help by providing clear definitions and guidance on the use of various quality tools. Traditional quality tools available on the sites include: Histograms, Cause and Effect Diagrams, Pareto Diagrams, Control Charts, Scatter Diagrams, Flow Charts, and Run Charts.

Visit the Seven Quality Control Tools - GOAL/QPC Research site at:

<http://www.goalqpc.com/RESEARCH/7qc.html>

Health Care CQI Documents from Clemson University's CQI Program

- Don Berwick's classic letter on quality in health care
- Surveying Customer Needs, not Satisfaction, is Critical to CQI
- TQM: Health Care Can Learn From Other Fields, by Armand V. Feigenbaum

<http://deming.eng.clemson.edu/pub/tqmbbs/health-care/>

A Few Lessons on Teamwork from the Team Players Academy

People who share a common direction and sense of community can get where they are going quicker and easier because they are traveling on the thrust of one another. <http://www.tpa.org/geese.htm>

Recent Citations

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2. Burns, LR. Polarity management: the key challenge for integrated health systems. *Journal of Healthcare Management* 1999;44(1):14-31; discussion 31-3.
3. Byrne, MM, Ashton, CM. Incentives for vertical integration in healthcare: the effect of reimbursement systems. *Journal of Healthcare Management* 1999;44(1):34-44; discussion 45-6.
4. Hatch, SW. Rumors of the death of integrated systems are greatly exaggerated. *Health Care Strategic Management* 1999;17(5):16-17.
5. Pavia, L. Health care's top 10 trends that should ride into next decade. *Health Care Strategic Management* 1999;17(4):12-13.
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7. Taylor, PL. Clinical integration and new options for academic medical institutions in network development. *Academic Medicine* 1999;74(3):213-20. ■

Transition Watch is a quarterly publication of the Office of Research and Development's Health Service Research and Development Service that highlights important information and learnings from the organizational change processes underway within the Veterans Health Administration. Special focus will be given particularly to findings from three organizational studies: the Service Line Implementation Study, the Facility Integration Study and the National Quality Improvement Study. The goal of *Transition Watch* is to provide timely and supportive feedback to VHA management throughout the change processes being studied as well as to draw on the change literature to assist managers in their decision making. *Transition Watch* is available on the web at www.va.gov/resdev/prt and on our Fax service by calling (617) 278-4492 and following voice prompts. For more information or to provide us with your questions or suggestions, please contact:

GERALDINE MCGLYNN, EDITOR

INFORMATION DISSEMINATION PROGRAM
 MANAGEMENT DECISION AND RESEARCH CENTER (152-M)
 VETERANS AFFAIRS MEDICAL CENTER
 150 SOUTH HUNTINGTON AVENUE, BOSTON, MA 02130-4893

PHONE: COM (617) 278-4433 OR FTS 839-4433
 FAX: (617) 278-4438 EMAIL: geraldine.mcglynn@med.va.gov

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tion affects the organization of the health care system in terms of delivery of care to veterans and of staff responsibilities and reporting relationships from the perspectives of facility staff, affiliates and trainees. We will also look at how these changes in staffing and service delivery affect quality of care, patient satisfaction, teaching and research, and staff and affiliate satisfaction.

3. *Development of VISN 13 integration scorecard.* At the request of VISN 13, we are working with their Integration Council to create a tool for monitoring their progress in creating a network-wide integrated delivery system. The scorecard is being built from

three components: 1) *integrated structures*, which are standard descriptions of the functions, activities and authorities of the network's integrated structures including the patient service lines (primary care, mental and behavioral health, extended care, specialty care), product lines (research and education) and, integrated services (Fiscal, IRM, DSS, purchasing and contracting, prosthetics); 2) *system operations*, which measure dimensions on which the network operates as an integrated system (e.g., transferring patients, sharing medical records), using data from surveys of staff across the network and 3) *system performance* in four domains: customer service, growth, cost and health of the population, drawn primarily from measures the network is already using. The first full scorecard will be reviewed by the Integration Council this summer. ■