



Service Line Management Study

If You Are Confused About the Definition of Service Line Management, You Are Not Alone.

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While service line management structures have been around in the private sector (initially in manufacturing consumer products) for decades, no agreement exists in the literature or in practice on its essential characteristics. In general, service line management in health care is an organizational model based upon providing:

- a comprehensive set of services to meet the needs of a particular segment of the market (for example, women, geriatrics), **or**
- an integrated set of services (e.g. cancer, heart or diabetes centers) distinguished from other services by the technology or specialty employed.

The objective of service line management is to focus management and clinical efforts on outputs, in contrast to traditional organizations, which are built around inputs to the management and care processes. Examples of outputs include comprehensive care delivered to a geriatric population, or the diagnosis, treatment, rehabilitation and prevention of heart disease. By focusing on outputs, service line structures are intended to increase managers' and clinical staff's awareness of the broad range of patient and customer needs and place a priority on meeting those needs. Service line reporting relationships are intended to place authority lower in the organization, empower

staff, and aggregate responsibilities to facilitate responsiveness to customers.

In some organizations, support services (i.e., laboratory and radiology) or business/administrative functions (i.e., facilities management, human resources, information management) are called "service lines." Sometimes different terms are used to distinguish patient care services from support services. Examples of the terminology used are listed in the table below. However, those listed are all local adaptations. There is no consistency in use of the various terms. In general, the support services and business functions do not meet the definitions of service line presented here earlier. Using service line terminology for support and/or business functions is thought to promote the "customer focus" of service lines and avoid creating a feeling of subordination to service lines that deliver medical care.

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Examples of Local Adaptations of Service Line Terminology

Patient Care Functions	Patient Support Functions	Business Support Functions
<i>(i.e., mental health, primary care, and geriatrics and extended care)</i>	<i>(i.e., laboratory and radiology)</i>	<i>(i.e., facilities, human resources, and information management)</i>
service lines care lines clinical product lines patient-centered care lines	service lines patient care services	service lines administrative product lines support operations product lines

What kinds of service lines do we find in VA?

Among the variety of service line options, VA facilities and VISNs cluster around three variations: (1) task forces, (2) teams that draw members from existing services, and (3) service line divisions where traditional services are replaced and staff from various disciplines report directly to the service line management structure. In theory, these variations make a difference in the level of integration achieved among staff and – at the VISN level – among facilities.

SERVICE LINE IMPLEMENTATION STUDY

VHA is continuing to support improvement in the delivery of veterans health care by restructuring organization and management practices to increase efficiencies and responsiveness to veterans. VHA's move toward Service Line Management is one aspect of this restructuring.

Nineteen of the 22 VISNs indicated an intent to implement service line management. In collaboration with the Houston Center for Quality of Care and Utilization Studies, MDRC is conducting a study of VISN service line management implementation to look at the process of change and the actual effectiveness of service lines. Study objectives are to evaluate service line management using both qualitative and quantitative techniques to identify specific characteristics of the various forms of service line management and to measure its impact on a wide range of patient and organizational variables. The study design is based on comparisons of pre- and post-measurement of service line implementations within each VISN and across VISNs.

At the writing of this article, base line data collection for the Service Line Implementation Study was completed at the VA networks listed below. We have used examples from these sites to illustrate the three service line variations discussed in the article.

- Albany, NY – VISN 2, Upstate New York Healthcare Network
- Bronx, NY – VISN 3, Veterans Integrated Network of New York and New Jersey
- Pittsburgh – VISN 4, Stars and Stripes Healthcare Network
- Durham, NC – VISN 6, VA Mid-Atlantic Network
- Chicago, IL – VISN 12, Great Lakes Health Care System

Task forces are a collection of people with a variety of perspectives and expertise who are brought together to complete an activity over a limited timeframe. Most task forces are used for planning and are then disbanded. Facility level task forces are usually multidisciplinary, and may be charged with improving a process, such as admitting or discharge; shifting practice from inpatient to ambulatory care; or planning new services or access points. At the network level, task forces or councils, comprised of representatives from each facility in the network, typically plan for a discrete set of network-wide services. A fundamental characteristic of these task forces is that members do not report formally to the task force leader. Rather, task force members are still accountable to their facility-based supervisors.

Many service line task forces are currently being used for planning network-wide and within medical centers. For example, the Great Lakes Health Care System (VISN 12) has established 19 task groups to address standardization issues and to meet group communication and reporting needs within the network. Thirteen of the task groups are clinical in nature and include cardiac surgery, community based outpatient clinics, compensation and pension, dental, homeless, long term care, medicine, mental health, neurosurgery, pathology and laboratory, primary care, prosthetics and orthotics, and surgery. All of the clinical task groups refer their clinical standardization issues to the Network's Clinical Advisory Council (CAC) for review and subsequent forwarding to the Executive Leadership Council.

The Veterans Integrated Network of New York and New Jersey (VISN 3) is also using network-level task forces as one step in its incremental approach to service line implementation. Seven task forces have been charged to analyze the current delivery of services and to generate ideas for service line initiatives that would improve access, quality, customer satisfaction and cost effectiveness. The task forces include operative/invasive procedures, diagnostic services, primary care, geriatric and extended care, mental health services, support services, and spinal cord injury services.

Teams are groups that are more permanent in nature and have broader management and clinical responsibilities than task forces. Because team members interact with each other more frequently over longer periods of time than do task force members, there is greater potential for coordinating services. Like task forces, team members do not formally report

to their team leader. However, team leaders often have input into members' performance evaluations. While some teams are functioning at the facility level, to date, service line teams have not been found at the network level.

Richmond's VA medical center, in the Mid-Atlantic Network (VISN 6), created multi-disciplinary, service line teams in primary care to provide continuous patient care. Three clinical chiefs coordinate and manage the care teams that are referred to as "primary care group practices." Members of the group practices have a primary or "solid line" relationship to their traditional, discipline-based service chief and a "dotted line" relationship to their group practice manager.

It is important to note that both teams and task forces are matrix-like structures where members have a primary reporting relationship to their traditional service and facility and a secondary reporting relationship to their team or task force. Organizational theorists would not characterize these arrangements as true matrix organizations, for in the true matrix the reporting relationships would be dual (i.e. two solid lines rather than one solid and one dotted line) and the influence of the service lines and the traditional services would be balanced and equal.

Service line divisions, in theory, contain all of the key clinical and administrative functions needed for providing care to the patients of the service line. In this model, service line managers hold full budget and personnel authority, where traditional reporting relationships are **replaced** with reporting relationships to service line managers. For example, nurses in this model report to a nurse manager, who in turn reports to a service line manager. In some cases new multi-skill employee positions, consisting of responsibilities that traditionally are part of several services, are created and report also to the service line.

In practice, it is too complicated and expensive to duplicate all of the functional departments needed in each service line. In addition, most health care leaders do not want to lose all of the benefits and functions of the traditional organization based on disciplines and facilities. So, variations to the model exist where an individual or a group is assigned responsibility for integrating specific functions across service line divisions (i.e., a Nurse Executive or Professional Nursing Board is appointed to oversee professional nursing issues).

Several VISNs and many medical centers have implemented or are planning to implement service line divisions. The Upstate New York Healthcare

Network (VISN 2) is in the process of establishing network-level "care lines." Each network-level care line manager will establish a care line office and a multidisciplinary team of advisors to the care line office. Each of VISN 2's facilities will have similar care lines that are managed by a local care line manager. The local care line manager will report directly to the network care manager and will oversee the local care lines' day-to-day operations. Facility directors will become Chief Operation Officers (COO) who will be responsible for the day-to-day general business activities of the medical center. In addition, the COO will provide local leadership for public relations, congressional and external affairs, and related affiliation matters.

The VA Pittsburgh Healthcare System's three facilities, which are part of the Stars and Stripes Network (VISN 4), have organized patient care functions and support into 13 product lines. The 13 product lines were further organized into four units: (1) Care Management Organizations that include primary care, mental health programs, and geriatrics and extended care; (2) Specialty Care Organizations that include medical specialty care, surgical specialty care, and critical care; (3) Patient Care Support Organizations that include clinical support services, patient care services, and community support services; and (4) Administrative Support Organizations that include facilities management support, business service center and information management.

The multi-disciplinary staff within each of the Care Management Organizations' three product lines are responsible for ensuing quality care and managing the health care needs of their patients. Each Product Line Manager reports to the Director of the three facilities that make up the VA Pittsburgh Healthcare System and the Healthcare System's Operations Board. By mid-to-late FY 1998, all Product Line Managers will manage their budget and staff, work with other product lines, ensure that standards of care are met, and act in the best interests of the VA Pittsburgh Healthcare System. The six product lines in the Specialty Care and Patient Care Support Organizations will provide specialty and support services to the patients of the three care management organizations.

From the information gathered from just five networks, it quickly becomes apparent that a myriad of approaches are being taken to reorganize and integrate health care delivery. The study team expects to complete initial site visits by Fall 1997 and will continue to provide additional information through *Transition Watch* on how VHA's 22 Networks are organizing and implementing the many facets of service lines. ■

Analysis of Facility Integrations

Carol Van Deusen Lukas, Ed.D

The MDRC, in collaboration with the HSR&D Center for the Study of Healthcare Provider Behavior, at Sepulveda, is analyzing facility integrations at the request of Dr. Kenneth W. Kizer. The study is being conducted in 14 VA systems that have integrated, or are in the process of integrating, since January 1995 (See Figure 1). The first component of the study looks at the process of integration, including the factors that facilitated or hindered the process, and the structure of the resulting integrated system, taking into account the length of time each integration has been operational. The second component assesses the effects of integration on patient satisfaction, cost, access and quality enhancement. Effects will be measured over the next two years so that integrations have time to reach stability. The primary objective of both components is to identify the management lessons that can be drawn to assist newer and future integrations.

The study team will finish its two-day visits to the study sites in August and plans to report on its first findings in early fall. With analyses still underway, it is premature to draw extensive conclusions from the study. However, we offer a few early observations.

Few VA integrations are between facilities that are comparable in size, mission and complexity. VA integrations tend to be between large hospitals and small or medium hospitals, between very complex hospitals and medium or low complexity facilities or between medium complexity and low complexity hospitals. Usually the differences in size and complexity are associated with differences in mission; for example, tertiary, academic facilities integrating with specialty or community facilities. In some respects, these differences make integration easier because the facilities complement rather than duplicate each other's services before integration. Each facility, therefore, can develop a distinct mission and service niche in the new system more easily than if the facilities provided very similar services before integration. On the other hand, these same differences may hinder the integration by exacerbating the perception that one hospital is taking over the other. Among the facilities we visited, there was frequently a feeling among staff at the smaller facility that the larger facility was taking over and that staff at the larger facility did not recognize the smaller facility's strengths and potential contributions. Smaller facility

14 Systems Participating in the Facility Integration Study

Figure 1

<i>Separate Facilities</i>	<i>New Integrated Systems</i>	<i>Separate Facilities</i>	<i>New Integrated Systems</i>
VAMC Ft. Meade VAMC Hot Springs	VA Black Hills Health Care System	VAMC Ft. Wayne VAMC Marion	VA Northern Indiana Health Care System
VAMC Montgomery VAMC Tuskegee	VA Central Alabama Health Care System	VAMC Livermore VAMC Palo Alto	VA Palo Alto Health Care System
VAMC Marlin VAMC Temple VAMC Waco	VA Central Texas Health Care System	VAMC Highland Drive VAMC University Drive	VA Pittsburgh Health Care System
VAMC Lakeside VAMC Westside	VA Chicago Health Care System	VAMC American Lake VAMC Seattle	VA Puget Sound Health Care System
VAMC Newington VAMC West Haven	VA Connecticut Health Care System	VAMC Kerrville VAMC San Antonio	VA South Texas Health Care System
VAMC Baltimore VAMC Ft. Howard VAMC Perry Point	VA Maryland Health Care System	VAMC Sepulveda Los Angeles OPC Bakersfield OPC Santa Barbara OPC	Southern California System of Clinics
VAMC East Orange VAMC Lyons	VA New Jersey Health Care System	VAMC Batavia VAMC Buffalo	VA Western New York Health Care System

staff spoke of lost autonomy and having to do everything the larger facility's way. The feeling of take over prevailed even when staff at the smaller facility realized their facility might have closed otherwise and that they were receiving new resources as a result of being part of a larger system.

The majority of integrating facilities are between 25 and 50 miles apart. Among the integrations we visited, staff generally recognize the benefits of integration but find it very difficult to work across the long distances between facilities. One set of difficulties arises from the long commute required of staff who are reassigned to work at the "other" facility. Many of these staff are in low-paid positions so the longer commute is a financial hardship; in some cases they must negotiate public transportation between cities. There are also perceived inequities between reassigned staff who are expected to travel on their own time and detailed staff who are allowed to travel on work time. The differences are exacerbated when the locality pay scales differ among facilities. The sense of burden is increased when the majority of reassignments are in one direction. For example, when functions are consolidated to a corporate headquarters, usually at the larger, tertiary facility, most of the people reassigned formerly worked at the smaller facility. Some systems have done less reassignment than others, either by keeping portions of departments, sometimes with specialized functions, at each campus, or by finding positions for staff at their home facility even if their departments are changed or eliminated. A few systems haven't done any reassignments because of union objections.

A second set of difficulties stems from trying to maintain personal communication and management across the long distances. Staff in most facilities talked of spending a lot of time "burning up the highway" between campuses, especially during the planning and early development of the integrated system. In most systems, people believed that face-to-face meetings during these early phases were worth the travel time because they provided an important opportunity for them to get to know each other in a way not possible on the telephone or video-conference. In all systems, staff rely more on telephone and video-conferencing for regular meetings as the integration matures. For managers and staff with ongoing responsibilities at all campuses, the traveling usually continues after the integration has stabilized. However, there are differences among managers, both within and among systems, between those who regularly appear at each

campus – often at least one day a week — and those who rarely or never go to the facility that is not their home base – typically the smaller facility – even though they are responsible for those staff. Not surprisingly, the departments where managers regularly appear at each campus appear to be more functionally integrated.

Distance between facilities within integrations	
DISTANCE*	INTEGRATION
Less than 10 miles	Chicago Pittsburgh
10-25 miles	New Jersey
26-50 miles	Alabama Central Texas Connecticut Maryland Northern Indiana Palo Alto Puget Sound Western New York
51-80 miles	Black Hills South Texas
Greater than 80 miles	Southern California
<i>* Distance is measured in linear miles from the facility coordinates.</i>	

Some integrating facilities are reorganizing along service lines. Among the integration sites included in this study, there is a mix of systems that are maintaining a traditional organizational structure in the integrated facilities and systems that are moving to a service line or partial service line structure. Several systems, such as Maryland, reorganized into partial service lines when they integrated. Generally two reasons are given for aligning integration and service lines. First, the leadership believe that while the system was being disrupted to bring two or three facilities together, they should seize the opportunity to do more far reaching reorganization. Second, they believe that service lines offer a promising structure for managing across long distances. Other systems, in contrast, maintained the traditional, discipline-based structure because they felt their organizations could not absorb additional change. In some cases, like Puget Sound, they are now moving to service lines in selected areas, but believe they were wise

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to change “step-wise,” focusing first on bringing existing departments together – consolidating management, unifying policies and procedures and getting to know each other – and later moving to service lines which require additional ‘integration’ across disciplines.

JCAHO surveys can facilitate integration. Depending on the timing of the Joint Commission survey, it has either impeded or facilitated integration. When the survey was scheduled shortly after the initial integration date, some facilities chose to be surveyed separately. In this situation, the survey impeded the integration because the facilities had to hold off integrating policies, medical by-laws and committees, for example, until after the survey. In contrast, for those facilities that chose or were required to do joint surveys, the survey served to facilitate integration in two ways. First, the deadline of the survey forced systems to develop their joint policies, procedures and infrastructures at a faster rate than they would have without the external deadline. Second, the survey provided a common ‘enemy’ around which the clinicians and staff in different parts of the system could come together. By working together on shared tasks in the face of immovable deadlines and an external threat, staff from different campuses grew to know and appreciate each other.

When is an integration complete? At one level, a facility integration is easily defined and observed. In VA, an integration is considered to be operational when a single director is appointed and the information systems are merged. In some cases, integration can stop there – as simply an administrative integration. In most cases, however — and in all the systems we have visited to date — the systems are going beyond administrative integration to structural and functional integration in order to meet objectives of increased efficiency and improved patient care.

When we asked about the status of the integration, we sometimes heard different answers in the same system. In several sites, the leadership has declared the integration complete. Complete in these cases means the structure of the integrated system is in place with a revised organization chart, new top leadership appointed, chiefs and department heads in place, and staff assigned to their position in the new organization. In some cases, the department-level policies and procedures have been rewritten for the full system. (In other cases, they were still working on their policies and procedures, or had integrated them for some depart-

ments but not others.) In systems where leadership declared the integration completed, their reasoning was that they wanted a clear conclusion to the integration process so that their system could move on to other challenges. The notion of having an end point to integration is appealing. Most integrations have strong emotional connotations. Being able to declare that stage of the system’s development complete may free staff to move on to other challenges. Moreover, some directors feel that disassociating other initiatives from integration may defuse negative emotions and resistance to them.

Even when the system leadership has declared an integration structurally complete, they agree with their staff who almost uniformly state that the integration is still evolving. Staff particularly consider integration to be a work in progress in two ways. First, they state that they have not reached full functional integration where they consider themselves part of one system. In all integrations, staff cite cultural differences — and simply not knowing each other well — as an impediment to smooth working relationships. Where cultures were perceived to be very different, staff believe that developing good relationships between the campuses will take years. Second, staff recognize that in a changing health care environment, all health care systems need to change continuously to look for better ways of delivering care. In this context, an integration may be complete, but the resulting system is not in that it needs to keep changing to deliver quality care and to be competitive in the health care market. ■

Transition Watch is a new quarterly publication of the Office of Research and Development that will highlight 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. For more information or to provide us with your questions or suggestions, please contact:

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Survey Data Disseminated from the National VA Quality Improvement Study

Gary Young, J.D., Ph.D

MDRC staff disseminated the first round of employee survey data from the National VA Quality Improvement Study (NVAQIS), which is supported both through HSR&D funding and by a grant from the National Science Foundation. The study, which is a three-year project, is both examining and supporting VHA's transformation through a variety of data collection strategies, including employee surveys, interviews with Headquarters' staff and network directors, and site visits to facilities. Approximately 12,500 VHA employees responded to the first round of surveys that was used to obtain information on a variety of indicators pertaining to quality improvement, customer service orientation, and organizational culture.

MDRC disseminated the survey results to Headquarters staff and all network directors. Plans are underway to place the data on the KLF menu. Because the survey will be repeated in 1998 and 1999, it will be possible to assess VA's progress over time on the survey indicators. The 1998 and 1999 survey will also be used to collect information associated with specific structural changes occurring in VHA such as service lines and facility integrations.

MDRC staff are available to answer questions about the survey. VHA staff are also encouraged to call with suggestions for the second round of the survey, which is scheduled to begin late fall. Gary Young, the project director, can be reached at (617) 278-4433 or FTS 700 839-4614. In addition, MDRC staff will use *Transition Watch* as a vehicle to address commonly asked questions from the network offices and facilities. In this *Transition Watch*, MDRC staff address one question that has been frequently asked since the first round of employee survey data were disseminated.

Question: In the MDRC report, some facilities that have been identified as high outliers relative to the VA national average score on a particular indicator actually have lower scores than facilities that were not given such a designation. How can this be?

Answer: For purposes of the report, the identification of an outlier did not depend on whether or not a facility's reported score (which is the average of the employee scores for a given facility) fell above or below the VA national average score per se. Rather it de-

pendent on both the **average of** and **variation in** a facility's employee scores relative to the VA national average score. The variation in a facility's score may be thought of as a gauge of how much consensus exists among the facility's employees regarding a particular survey indicator. Less variation means more consensus among the facility's employees. To quantify the amount of variation around the average facility score for each survey indicator, we calculated a 95 percent confidence interval. If the lower bound of the facility's confidence interval was **above** the VA national average score, then the facility was identified as a high outlier. If the upper bound of the facility's confidence interval was **below** the VA national average score, then the facility was identified as a low outlier.

For example, Figure 2 presents results from VISN 2 for one of the NVAQIS indicators. Syracuse has a higher score than Albany, yet Albany is identified as a positive outlier and Syracuse is not. This is because the lower bound of Albany's 95 percent confidence interval is 15.08, which is above the VA national mean for this particular NVAQIS indicator. Syracuse's lower bound is 14.44, which is not above the VA national mean. ■

Figure 2

Do Employees Believe Their Facility's Culture Promotes Innovation and Risk Taking?	
Scale: (0-100)	
VA National Average Score:	14.8932
VISN Average Score:	15.4861
Private Sector Score:	15.0000*
FACILITY	SCORE
ALBANY, NY	17.4627+
BATH, NY	15.5482
BUFFALO, NY	11.7646-
CANANDAIGUA, NY	14.3773
SYRACUSE, NY	17.8476

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