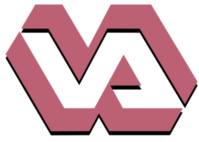

Transition Watch

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VISN Task Force and Service Line Implementation: Who's Doing What Now?

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Introduction

MDRC continues to study the process of clinical service line implementation at Veterans Integrated Service Networks (VISNs). Network clinical service lines are intended to integrate multiple disciplines and activities at multiple sites. Among the types of service lines:

Care lines provide services directly to patients and focus on outputs of the care process. These outputs can be conceptualized in terms of any of the following:

- *Intervention:* interventions, such as surgery, or organ transplantation;
- *Disease:* disease-related groupings, such as comprehensive cancer care or heart disease;
- *Population:* care to and/or maintaining health of identifiable segments of the population (e.g., geriatrics, mentally ill).

Support service lines also integrate across both multiple disciplines and sites, but — in contrast to care lines — do not themselves provide comprehensive and integrated services directly to patients. Rather, support service lines produce intermediate services and products that in turn are used as inputs by the care lines (e.g., laboratory, pharmacy).

Service lines represent some of a variety of ways to organize for interdisciplinary and inter-facility coordination. Among the broader range of organizational alternatives, of which service lines are a subset, we identified five models during site visits and in telephone calls to VISNs:

- **Integrators** are individuals who serve as internal consultants to the VISN with regard to a particular clinical area such as mental health or primary care.
- **Task Forces** bring together a group of people with a variety of perspectives for what is usually a limited period to complete a defined activity. They are not service lines themselves, but often serve as precursors to service lines. Task Forces vary in name (e.g., working group, standing committee, sub-council or advisory board), and reporting relationship (e.g., a Task Force that reports to a clinical advisory council which in turn reports to the Executive Leadership Council, or an advisory board that reports directly to the Network Director). Only those Task Forces that focus on a particular population, disease, or intervention, are listed in the table on pages 2 and 3.
- **Facilities are reorganized into service lines** and facility service line managers represent their facilities in corresponding VISN Task Forces.
- **Service Line Teams/Councils** are more established interdisciplinary, inter-facility organizational arrangements with broader management and clinical responsibilities than Task Forces. Teams/Councils have VISN-level service line directors (SLDs) and facility-level service line managers (SLMs) who serve in either a full time or collateral capacity. SLMs report to their respective medical centers and SLDs have input into their performance evaluations. Teams/councils may or may

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Look for *Transition Watch* on the Web at www.va.gov/resdev/prt

VISN Service Line Implementation as of October, 1998*

VISN#	VISN Name	Clinical Area	Organization Arrangement		Budget Authority	
			Current	Projected	Current	Projected
1	New England Health Care System	Mental Health	Task Force	SL Division	No	Yes
		Extended Care	Task Force	Undecided	No	Undecided
		Ambulatory Care	SL Division	SL Division	No	Yes
		Laboratory*	SL Division	SL Division	No	Yes
2	Upstate New York Healthcare Network	VA Behavioral Care	SL Division	SL Division	Yes	Yes
		Geriatrics/Extended Care	SL Division	SL Division	Yes	Yes
		VA Medical Care	SL Division	SL Division	Yes	Yes
		Diagnostics/Therapeutics*	SL Division	SL Division	Yes	Yes
3	New York – New Jersey	Mental Health	Task Force[1]	Task Force	No	No
		Geriatrics/Extended Care	Task Force	Task Force	No	No
		Spinal Cord Injury	SL Division	SL Division	Yes	Yes
		Prosthetics	SL Division	SL Division	Yes	Yes
4	VA Stars and Stripes Network	Primary Care & Consultative Medicine	Task Force	Task Force	No	No
		Geriatrics & Long Term Care	Task Force	Task Force	No	No
		Surgery	Task Force	Task Force	No	No
		Behavioral Medicine	Task Force	Task Force	No	No
5	VA Capital Network	Mental Health	Reorganize Facilities	SL Division	No	Yes
		Geriatrics/Extended Care	Reorganize Facilities	SL Division	No	Yes
		Women's Health	Reorganize Facilities	SL Division	No	Yes
		Pathology and Lab*	Reorganize Facilities	SL Division	No	Yes
6	Mid-Atlantic Network	Mental Health	SL Team/Council	SL Division	No	Yes
		Primary Care	SL Team/Council	SL Division	No	Yes
		Spinal Cord Injury	SL Team/Council	SL Division	No	Yes
		Extended Care	Task Force	Undecided[2]	No	Undecided
		Acute Care	Task Force	Undecided[2]	No	Undecided
7	Atlanta Network	Mental Health	Reorganize Facilities	SL Team/Council	No	Yes
		Primary Care	Reorganize Facilities	SL Team/Council	No	Yes
		Extended Care	Reorganize Facilities	SL Team/Council	No	Yes
		Clinical Support*	Reorganize Facilities	SL Team/Council	No	Yes
8	VA Sunshine Healthcare Network	Mental Health	Task Force	Task Force	No	No
		Extended Care/Geriatrics	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
9	Mid South Health Care Network	Primary Care & Ambulatory Care	Task Force	Task Force	No	No
		Mental Health	Task Force	Task Force	No	No
10	Veterans Health Care System of Ohio	Mental Health	SL Team/Council	SL Team/Council	Yes	Yes
		Primary Care	Reorganize Facilities	SL Team/Council	No	Yes
		Extended Care	SL Team/Council	SL Team/Council	No	Yes
		Medical/Surgical	Reorganize Facilities	SL Team/Council	No	Yes
		Rehabilitation	SL Team/Council	SL Team/Council	No	Yes
		Clinical Support*	SL Team/Council	SL Team/Council	Yes	Yes
11	Veterans In Partnership (VIP) Network	Mental Health	Task Force [3]	Undecided	No	Undecided
		Extended Care	Task force [4]	Undecided	No	Undecided

VISN Task Force and Service Line Implementation

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not have network-wide budget authority.

- **Service Line Divisions** are permanent interdisciplinary, inter-facility organizational arrangements led by a SLD with direct line responsibility over the local SLMs. Additionally, SLDs usually have budget control. In this arrangement, the basis of the organization shifts from the facility to the VISN service line. The medical center leadership (i.e., Director and Chief of Staff) may retain input into performance evaluations, but not final authority over, local SLMs.

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VISN Service Line Implementation as of October, 1998, *continued*

VISN#	VISN Name	Clinical Area	Organization Arrangement Current	Organization Arrangement Projected	Budget Authority Current	Budget Authority Projected
12	Great Lakes Health Care System	Primary Care	Task Force	Task Force	No	No
		Mental Health	Task Force	Task Force	No	No
		Prosthetics	Task Force	Task Force	No	No
		Pathology & Laboratory*	Task Force	Task Force	No	Yes
		Imaging*	Task Force	Task Force	No	No
13	VA Upper Midwest Network	Mental Health	Reorganize Facilities	SL Division	No	Yes
		Primary Care	Reorganize Facilities	SL Division	No	Yes
		Long Term/Extended Care	Reorganize Facilities	SL Division	No	Yes
		Specialty Care	Reorganize Facilities	SL Division	No	Yes
14	VA Central Plains Network	Mental Health	Task Force	Undecided	No	Undecided
		Primary Care	Task Force	Undecided	No	Undecided
		Acute Specialty	Task Force	Undecided	No	Undecided
		Long Term Care	Task Force	Undecided	No	Undecided
15	Heartland Network	Mental Health	Integrator [5]	Undecided	No	Undecided
		Primary Care	Integrator [5]	Undecided	No	Undecided
16	VISN 16	Mental Health	SL Team/Council	SL Division	No	No
		Primary Care	Task Force	Task Force	No	No
		Extended Care	Task Force	Task Force	No	No
		Tertiary Care	Task Force	Task Force	No	No
17	Heart of Texas Health System	Hepatitis C	Task Force	Task Force	No	No
		Severely Mentally Ill	Task Force	Task Force	No	No
		Cardiac Catheterization	Task Force	Task Force	No	No
18	VA Southwest Network	Mental Health	Task Force	Task Force	No	No
		Care Management	Task Force	Task Force	No	No
		Geriatrics/Extended Care	Task Force	Task Force	No	No
		Rehabilitation/Prosthetics	Task Force	Task Force	No	No
		Diagnostics*	Task Force	Task Force	No	No
19	Rocky Mountain	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Task Force	No	No
		Dental Health	Task Force	Task Force	No	No
		Home Care	Task Force	Task Force	No	No
20	Northwest Network	Mental Health	Task Force	Undecided	No	Undecided
		Primary Care	Task Force	Undecided	No	Undecided
		Long Term Care	Task Force	Undecided	No	Undecided
		Same Day Surgery	Task Force	Undecided	No	Undecided
		Medical Specialties	Task Force	Undecided	No	Undecided
21	VA Sierra Pacific Network	Mental Health	Task Force	Task Force	No	No
		Primary Care	Task Force	Undecided	No	Undecided
		Extended Care	Task Force	Task Force	No	No
22	Desert Pacific Health Care Network	Cancer	Task Force	Undecided	No	No
		Women's Health	Task Force	Task Force	No	No
		Homelessness	Task Force	Undecided	No	No
		Prosthetics	SL Division	SL Division	Yes	Yes

Footnotes

*an asterisk denotes a "support" service line.

1 VISN 3 This Task Force made its recommendation in September 1998 and subsequently dissolved.

2 VISN 6 Extended Care and Acute Care will be considered for further development after assessment of current service lines, as per negotiated agreement with unions.

3 VISN 11 Full time Director for Mental Health

4 VISN 11 Full time Director for Extended Care

5 VISN 15 Former SLDs for Mental Health and Primary Care now advisors to Network Director

Of these models only teams/councils and divisions are considered to be service lines within VA. The other models, especially Task Forces, represent important and common stages in the process of developing service lines. In this article we report on the whole range of interdisciplinary, inter-facility organizational models from Integrators through Service Line Divisions.

Where VISNs are Today

As shown in the table on pages 2 and 3, the majority of the 22 VISNs continues to employ Task Forces as the primary vehicle for clinical coordination across their facilities. Fourteen VISNs use network-wide Task Forces to achieve clinical coordination. Four VISNs have directed their facilities to reorganize into service lines that correspond to existing Task Forces. All four of these VISNs are reorganizing in order to implement VISN-level Service Lines, either as Service Line Teams/ Councils or as Service Line Divisions. Additionally, two VISNs have three or more Service Line Teams/Councils in place. Finally, VISN 2 (Upstate New York Healthcare System) has implemented Service Line Divisions and VISN 15 (Heartland Network) has engaged integrators, who function as Primary Care and Mental Health specialists, to advise the Network Director in future planning.

Where VISNs are headed

Ten VISNs intend to continue employing Task Forces as the primary means for achieving clinical integration across facilities. Five VISNs plan to implement Service Line Divisions for all or most of their health services delivery, while two VISNs plan to use Service Line Teams/Councils. The remaining five VISNs are undecided as to how they will pursue clinical integration in the future. Below are three examples of interdisciplinary, inter-facility organizational arrangements: Task Forces, Service Line Teams/Councils, and Service Line Divisions.

Task Forces

VISN 3 (New York/New Jersey) is a classic example of the use of Task Forces for clinical integration across facilities. These Task Forces, termed "Product Line Task Forces" by the VISN, are time-bound and address a specific area of concern. Once a Task Force makes recommendations to the Network Director, it is disbanded.

VISN 3 convened Task Forces in the summer of 1996 to develop recommendations for consolidation of clinical areas and to create standardized performance benchmarks across facilities. The Task Forces were also given the task of proposing measures to improve efficiency in the areas of: 1) Mental Health; 2) Primary Care; 3) Geriatrics/Extended Care; 4) Operative/ Invasive Procedures; and 5) Diagnostic Services. In December of 1996, they reported their findings to the Network Director and were disbanded. After obtaining the medical center directors' input, the Network Director presented the measures for each medical center's clinical and business areas based on the Task Forces' recommendations.

In the spring of 1998, the Mental Health and Geriatrics/Extended Care Task Forces were reconstituted with approximately the same membership and representation as the previous Task Forces. Two-thirds of the original members participated in the second round of Mental Health Task Force deliberations. The Task Forces were charged with updating overall recommendations concerning the network's mental health and extended care services, and developing local performance measures for holding medical center directors accountable. During the second round, the Mental Health Task Force identified the need for better coordination of homelessness programs across the VISN to fill gaps in certain regions and reduce duplication in others. The Mental Health Task Force has now made its recommendations to the Network Director and has

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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:

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Facility Integration: Managing Across Distances

Carol VanDeusen Lukas, EdD

One of the key challenges in designing an integrated, efficient, multi-campus health care system is developing a management structure that is effective across distances. This is true not only when integrating two or three previously separate facilities but also more broadly when creating an integrated delivery system. In the first issue of *Transition Watch* (Fall 1997), we highlighted the difficulties of working across the usually long distances between the VHA integrating facilities. Our subsequent analyses have broadened our understanding of the issues of managing across distances, from the perspectives of both the system-level structures and the department-level structures and operations. This article continues our efforts to share lessons from our analyses of 14 VHA integrated systems.

System-Level Management

In VA, the structure of an integrated system is heavily influenced by the similarity of the integrating facilities in terms of size, complexity and academic affiliation. In systems with dissimilar facilities, the larger tertiary facility is the ***dominant partner***. In comparison with ***equal-partner*** systems, these dominant-partner systems are likely to integrate more quickly, especially in clinical departments. They are also likely to offer acute inpatient care only at the tertiary campus.

Both dominant-partner and equal-partner systems need to determine where the system managers will be located, and how to manage the campus(es) where top management is not located .

System Headquarters: Dominant-partner systems create clear system headquarters, with headquarters defined as the campus where top management and all or most service chiefs are based. In nine of the 10 dominant-partner systems we studied, the headquarters was the larger, tertiary campus. In the remaining system, Pittsburgh, the headquarters was located at a neutral location rather than one of the major medical centers in the system. System leaders felt this choice diffused the perception that one facility was taking over the other.

Five of the dominant-partner systems located all service chiefs at the headquarters campus (Connecticut, Palo Alto, Southern California, South Texas and Western New York). While the arrangement offered management efficiencies, it heightened the sense at the small campus that it had been taken over and it created a management vacuum at the smaller campus.

In the remaining five dominant-partner systems, the majority of chiefs were at the tertiary facility – but some were spread across campuses. In Puget Sound and Pittsburgh, the chiefs at the smaller campus headed integrated services. In New Jersey and Central Texas, the spread of chiefs primarily reflected services that had not integrated at the time of our study. Maryland had a mixture of chiefs of separate and integrated services at its smaller campuses.

The four equal-partner systems designated a lead campus for administrative communications with VHA Headquarters, although it did not serve the same strong headquarters functions as in dominant-partner systems. Usually top management was located at the lead campus but service chiefs are spread across campuses.

Campus Management: Careful attention is needed to manage the campus where top management is not located, particularly in dominant-partner systems. Integration was difficult for smaller campuses, especially when as a result they lost their acute inpatient services. Staff felt a strong loss of status and autonomy – even when they recognized that joining a larger system would bring new security and access to new resources.

This sense was heightened when few or no top- or middle-managers were based at the smaller campus. Reliance on department-level management by non-resident service chiefs as the sole means of managing the smaller campus was generally inadequate for two reasons. First, staff at the smaller campus often did not know their new chiefs well, and, in some cases, found them inaccessible. Second, service chiefs focused — appropriately — on their service responsibilities, not on

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Facility Integration Report Available

The MDRC/Sepulveda study team recently completed its first comprehensive report on the integration of 14 VHA systems. Copies of the report were sent to each VISN director and medical center director. The report is also available on the VA intranet at vaww.va.gov/resdev/integrt.htm.

Facility Integration: Managing Across Distances

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assuming new campus-wide responsibilities.

In all systems, top management spent time at both campuses, sometimes formally scheduled to be at the smaller campus one or two days a week. This offered the advantage to campus staff of having senior staff presence and to the senior managers of maintaining direct contact with all campuses. It did not guarantee a daily management presence to deal with crises and operational issues.

Six of the 10 dominant-partner systems dealt with this problem by designating a site manager, often an associate director for the system. Site managers provided day-to-day supervision and advocated for the campus on systemwide issues. However, staff sometimes found themselves in the middle of conflicting decisions and directives from site managers and service chiefs. Care needs to be taken to clearly delineate and communicate the responsibilities of site managers in relation to service chiefs.

In addition, system leadership needs to make an effort to recognize and incorporate the strengths of the smaller campus into the new system, rather than simply assume that the practices and policies of the larger facility are best for the system. For example, several systems reported that their smaller campuses had superior primary care service delivery models and practices.

Different Models For Managing Across Campuses

Puget Sound and Pittsburgh are both dominant-partner systems with strong headquarters. They differ, however, in their approaches to managing across campuses. At the time of our study, Pittsburgh focused on managing at the site level while Puget Sound managed at the level of the individual services. Pittsburgh had a site manager for the smaller campus; Puget Sound did not. The individual services in Puget Sound appeared to be more operationally integrated. Almost all of the combined services with staff at both campuses had shared policies across campuses (93%) and most used regular video- and tele-conferencing to communicate among service staff across services (78%). In Pittsburgh, fewer than half of the combined services staff had the same policies (48%) and less than one-third used regular video- and teleconferencing (30%). The Pittsburgh site manager was an associate director for the system and seen as a strong advocate for her campus.

Department-level Management

Within the framework of system-level management, department structures are also key to managing across campuses. As we described in an earlier *Transition Watch* article, departments integrated either by *consolidating* staff and services to one campus, or by *combining* under a single systemwide chief or service-line manager with staff remaining at several locations. While consolidated departments must work across campuses to refer and transfer patients, the staff and managers by definition are located on the same campus. For combined departments, however, managing across campuses is close to the heart of their operation as an integrated system.

Across the 14 systems we studied, the majority of departments (60%) integrated by combining services. In order to meet the integration objectives of creating a single standard of care and improving clinical coordination across the system, combined departments need to develop shared policies and clinical protocols. For service chiefs trying to manage the combined service, good mechanisms for communicating are important.

Policies and clinical protocols: Among the 14 systems, those with high proportions of combined departments were also likely to be operationally integrated with shared policies, and to a lesser extent, common clinical protocols. Among the eight systems with at least two-thirds of their departments combined, seven had more than 85% of their departments with the same policies across campuses. With two exceptions, each of these systems also reported more than 70% of their combined clinical departments shared clinical protocols. Developing standard policies and clinical protocols across campuses is an important step toward operational integration, and thus toward creating a single standard of care and a coordinated delivery system.

Service chief management across distances: In managing a department with staff in multiple locations, often many miles apart, chiefs needed to balance the need for communication and interaction with staff in all locations with the strains of physically traveling back and forth. The interactions in early phases of integration were often complicated as new relationships took

shape. The staff at the campus where the chief was not based usually did not know the chief well and in some cases found him or her inaccessible. At the same time, staff at the campus where the chief was based—and where frequently he or she was the chief prior to integration—also sometimes found the chief inaccessible because now he or she was splitting time between both campuses, and often with added systemwide responsibilities.

Across the 14 systems, less than one-third of the chiefs spent ten hours a week or more at each campus. Clinical chiefs on average were much less likely (23%) than administrative chiefs (42%) to spend time regularly at each campus. More chiefs relied on meetings with supervisors across campuses at least monthly, and on periodic tele- or videoconferencing with staff.

While many department chiefs tried to both split their time between campuses and use video/teleconferencing to meet with staff, most chiefs tended to use one method more than the other. The tradeoff depended on the type of service (administrative chiefs were more likely than were clinical chiefs to spend time at each campus), and, not surprisingly, on the distance between campuses. Despite these efforts, staff at some systems felt that they received inadequate attention from their chiefs.

In a multi-campus system, broad-based communication is particularly important. It is not enough, however, to tell service chiefs that they should communicate well. System leadership needs to work with chiefs to plan and carry out effective mechanisms and processes to support communication, decision-making, and accountability across campuses.

Typically, organizations neglect management structures and communications that cross sites and organizational divisions, especially when they are used to functioning as independent medical centers. To become an integrated delivery system, and not just separate hospitals linked by a common administration, systems must build in processes and structures that support coordinated, efficient services across locations at all levels of the system. ■

Hasselbein, F, Goldsmith M, Beckhard R. The Organization of the Future. San Francisco: Jossey-Bass, 1997.

VISN Task Force and Service Line Implementation

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again been disbanded. The reconstituted Geriatrics/Extended Care Task Force continues its deliberations.

Service Line Teams/Councils

VISN 10 (Veterans Healthcare System of Ohio) is implementing Service Line Teams/Councils for the following six clinical areas:

1. Mental Health
2. Clinical Support
3. Extended Care
4. Rehabilitation
5. Primary Care
6. Medical-Surgical

With the exception of the Mental Health Service Line Council, which has a full-time director, the Service Line Director (SLD) positions are collateral duties for either chiefs of staff or medical center directors. Currently, the VISN is undecided as to whether these remaining SLD positions will continue as collateral duties or become full-time responsibilities.

Strategic plans for Mental Health and Clinical Support are approved by the Executive Leadership Council and are well along on implementation. Extended Care and Rehabilitation are also approved, but in their start-up phase. VISN 10 has intentionally delayed presentation and approval for the Primary Care and Medical-Surgical SLs in order to work through the issue of division of authority for these inter-related areas of patient care.

Each SL has/will have a Service Line Council consisting of the VISN SLD, local SLMs from each facility, and union representation. This council meets on a monthly basis to monitor and evaluate the performance of the Service Line. The day-to-day operation of the SL takes place through ongoing communications between the SLD and the local SLMs.

All five medical centers in VISN 10 will be reorganized into corresponding SLs. The local Service Line Managers (SLMs) were/will be selected by the respective SLD in conjunction with the medical center director. For Mental Health Service Lines, all five SLMs are in place and have been charged with the task of preparing a plan for Mental Health Services at their respective facilities. These five Mental Health SLMs convene with the SLD weekly via tele-conference and monthly in person. SLMs will continue to report directly to medi-

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cal center directors or chiefs of staff, with a dotted line relationship to the SLDs. In turn, SLDs will have input into the SLM performance evaluation.

The Mental Health and Clinical Support SLDs received full budget authority at the beginning of FY99. The Extended Care and Rehabilitation SLs are projected to have budget authority beginning six months into FY99. When fully implemented, the VISN expects to have a total of 36 budget categories in the network — one at the VISN-level (for items such as case management, IRM support, video-conferencing, office of resolution management, and support for Community-Based Outpatient Clinics) and seven categories (six clinical and one business SL) at each of the VISN's five facilities.

Service Line Divisions

VISN 2 (Upstate New York Healthcare Network) has implemented a Service Line Division structure. They have delineated the following four clinical service lines (three care lines and one clinical support line):

1. VA Behavioral Health
2. Geriatrics/Extended Care
3. VA Medical Care
4. Diagnostic/Therapeutics

All four of these clinical Service Line Divisions, along with a business support service line[1], were officially operational as of October 1997, and have full budget authority effective October of 1998. Each of these SLs has a full-time Physician Director, Chief Operating Officer (COO), and a secretary. All of these positions were recruited internally, with the Service Line Director (SLD) positions structured as three-year appointments, at which time the SLDs will be reappointed based on their performance.

All of the local Service Line Managers (SLMs) serve this role as a collateral assignment. They were selected by their respective SLD, with recommendations provided by the local medical center director. These local SLMs report directly to the SLD/COOs, who also are primarily responsible for their performance evaluations, with input from the local medical center director.

The local SL leadership structure varies from single managers to teams (i.e., dyads, triads, quadrads), based on the particular service line and/or medical center. The leadership for the VA Medical Care Line at the Syracuse VAMC, for example, is a triad (comprised of an administrator, Chief of Medicine, and ACOS for Patient Care Services), whereas one individual manages the Geriatrics/Extended Care Line for the Bath VAMC.

The effect of this reorganization has been to transfer the clinical policy decision-making authority from the local medical centers to the VISN. As a result, the role of the local medical center director addresses the administrative (i.e., business) aspects of managing the facility, with a greater focus on external/community stakeholder relationships.

Conclusion

This year, we are seeing more highly integrated forms of Service Lines employed by a greater number of VISNs. An important component of VISN-level Service Line strategy is the reorganization of facilities into a Service Line structure which corresponds with network-level Task Forces. MDRC will continue monitoring this dynamic change process and report back its findings in subsequent issues of *Transition Watch*. Future articles will report on Service Line structures implemented at the local medical center level. ■

[1] This business support service line, called "Service Line" by the VISN, supports all business, administrative, facility, and management operations for the network.