

Vision for Change

A Plan to Restructure the Veterans Health Administration

March 17, 1995

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Under Secretary for Health

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PREFACE

The reorganization plan presented in this document should be viewed as the first step in transforming the Veterans Health Administration (VHA) to a more efficient and patient-centered health care system.

The organizational model described in this document has been conceived with the intent of providing a structure that will facilitate the changes that need to occur, while at the same time retaining the many good things the system already does. The proposed structure optimizes VHA's ability to function as both an integrated and a virtual health care organization; it provides structural incentives for efficiency, quality and improved access; it builds in a formal means of ensuring a high degree of stakeholder involvement; and it provides for a level of accountability not typical of government agencies. Once operational, it should be apparent to our patients, Congress and the public that this is not only a better model than the present structure, but that it is also better than the various alternatives that call for doing away with VHA.

Important to note, however, is that in and of itself, the planned organizational structure merely provides a template upon which new attitudes and behavior will be encouraged and rewarded, and around which a new organizational culture can grow. This transformation will take time, and the difficulty of changing a decades-old culture in the second largest bureaucracy in the federal government should not be underestimated. The change will be neither easy nor painless. Nonetheless, if the veterans health care system is to remain viable it must fundamentally change its approach to providing care.

And while the need for structural change is acute, it must be understood that this reorganization alone cannot heal all of the maladies of the veterans health care system. A number of other remedies are also needed. Among these are the development and use of systemwide clinical protocols and practice guidelines, a major Departmental commitment to providing more and better training for the VA workforce, and an overhaul of the veterans health care eligibility criteria. Moreover, VA needs to explore opportunities to open up the system to additional users, within available resources, when that will enhance both the access to care and the quality of care provided to veterans.

This plan is, of necessity, somewhat general. Once approved, the detailed work of implementation can begin. Implementation will take several months, but it is my hope that operation of the system under this new model can be underway by October 1, 1995. As this transformation progresses from planning to implementation and operation, we remain committed to collaborating and working openly with interested stakeholders to ensure continuous improvement in the quality of health care provided to this nation's veterans.

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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I wish to acknowledge and express my gratitude to the "510 Team" that worked with me to craft this report. Working within a very tight time line, the team fleshed out my ideas and thoughts, along with those expressed by so many others who believe we can improve the veterans health care system. The team reviewed several thousand pages of comments from drafts of this report, developed ideas expressed in other reports, and synthesized myriad opinions into this final document. Hopefully, through their efforts, this plan represents the best thinking of those who know the most about veterans health care. The members of the "510 Team" are as follows:

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They have my heartfelt thanks.

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CHAPTER 1

Introduction and Executive Summary

I. Purpose: This report presents a plan to reorganize the Veterans Health Administration's (VHA) central office and field operations. This is being done to improve the access to and quality and efficiency of care provided to the nation's veterans. This reorganization will also strengthen VHA's ability to accomplish its other missions of education and training, research and contingency support during war or national emergency.

II. The Scope of VHA: Since colonial days, the United States has provided some type of medical care and other support to persons who suffered untoward effects resulting from service in the nation's uniformed services. The veterans health care system was originally established to treat combat-related injuries and to help rehabilitate veterans with service-connected disabilities. Over the years, the system has greatly expanded. Today, VHA is the largest integrated health care provider in the nation, with more than 200,000 employees and an annual medical care budget over \$16 billion.

During 1994, there were over 700,000 acute medical and surgical, 37,000 intermediate, and almost 200,000 psychiatric admissions¹ for care in VA facilities. In addition, over 20,000 veterans received acute inpatient care in community hospitals at VA expense. Also in 1994, over 104,000 veterans received long term care in VA and non-VA domiciliaries and nursing homes. Likewise, last year, VHA provided more than 25 million outpatient clinic visits, nearly 2 million prostheses and sensory aids, 192 million laboratory tests, 6.3 million radiological studies and 400,000¹

¹ Admissions is used here to refer to all inpatients treated during fiscal year 1994.

inpatient and ambulatory surgical procedures. Between 1989 and 1994 inclusive, VHA provided care to approximately 4.7 million veterans, or approximately 40 percent of those veterans having the highest priority for medical care.

Historically, VA patients have largely been men. And as a group, VA patients are older, sicker, poorer and more likely to have social problems and mental illness than persons using private health care facilities.

Concomitant with changes in the composition of the military forces, VHA has cared for a growing population of women veterans in recent years. Last year, nearly 120,000 women veterans sought outpatient care and almost 20,000 sought inpatient care at VHA facilities, although even now less than 3 percent of VA admissions are for women. Only recently have VHA facilities endeavored to meet the gender-specific needs of female veterans.

In 1995, VHA will operate 159 medical centers², 375 ambulatory clinics³, 133 nursing homes, 39 domiciliaries and 202 readjustment counseling centers (Vet Centers). Six more outpatient clinics are scheduled for activation during FY 1995. The recently promulgated VHA policy on activating new access points is expected to improve the availability of care for current VA users.

Appendices 1 to 3 provide additional details regarding the VHA budget and facilities.

² Of this total, 13 have two or more facilities reporting to the same director.

³ Of this total, 172 are managerially and geographically associated with Veterans Affairs medical centers (VAMCs) and 183 are managerially associated but geographically remote from a VAMC (75 are outreach, 58 are satellite, and 50 are community-based clinics). In addition, one outpatient clinic is associated with a freestanding domiciliary, three outpatient clinics are co-located with veterans benefits regional offices, and four outpatient clinics are completely independent. Further, VHA operates six mobile clinics that regularly schedule visits at 54 separate locations. The 1995 Congressional Appropriation provides funding for five clinics. These clinics are among several possible new clinic sites currently under development.

In addition to providing medical care, VHA is also the nation's largest trainer of health care professionals. During 1994, VHA sponsored more than 9,100 medical resident positions, and over 33,000 medical residents from affiliated universities rotated through VA facilities. Approximately 22,000 medical and dental students, 26,000 nursing students and 27,000 allied health trainees from more than 1,000 universities, colleges or other institutions of higher education also received training at VA last year.

Through its affiliations with 105 medical schools and academic medical centers, as well as other research institutions, VHA also continues to be a major national research asset conducting basic, clinical, epidemiological and behavioral studies across the entire spectrum of scientific disciplines. Indeed, nearly 10,000 VA clinicians had academic appointments with one or more affiliated institutions, and a similar number of faculty from the same academic affiliates taught, directed or provided hands-on care for veteran patients at VHA facilities.

VHA further serves as a contingency back-up to Department of Defense (DOD) medical services, and during national emergencies it supports the National Disaster Medical System (NDMS).

III. The Changing Health Care Environment: In addition to a Departmental commitment to improving the quality of veterans health care, other factors are prompting change within VHA. Chief among these is the profound change in the way health care is being provided in the United States. Technological advances, economic factors, demographic changes and the rise of managed health care, among other things, are causing a dramatic shift away from inpatient care and a corresponding increase in ambulatory care. VHA needs to adapt its service delivery to align with the changes occurring in the larger health care environment.

President Clinton's initiative to reinvent and streamline government also mandates that VHA examine its organizational practices and become a more agile and cost-efficient health care delivery system.

Further, in recent years, numerous government and non-government reports have consistently concluded that fundamental changes are needed in the VHA health care system to make it more patient responsive and efficient. Among the principal changes that have been recommended for VHA are:

- redistribution of VHA health care resources to better meet veterans' needs;
- use of innovative approaches to improve veterans' access to VHA health care; and
- decentralization of decision making and operations.

IV. The Under Secretary for Health's Vision: This reorganization plan embraces a "Patients First" focus for the organization's structure and delivery of services. In addition to being the guiding principle for patient care, this focus will be further extended into all the major VHA missions, including education, research, Department of Defense support and response to domestic emergencies.

The Department of Veterans Affairs (VA) has adopted the concept of "Putting Veterans First," and now it is time to update and restructure the VA health care delivery system to accomplish this goal. To that end, this plan will do much more than change boxes on organizational charts. It will fundamentally change the way that veterans health care is provided. This will include increasing ambulatory care access points, emphasizing primary care, decentralizing decision making, and integrating the delivery assets to provide an interdependent, interlocking system of care. The structural vehicle to do this will be the Veterans Integrated Service Network (VISN).

This restructuring includes a new distribution of VHA headquarters and field responsibilities. Headquarters' purview will include the development of systemwide policies, clinical protocols and critical pathways, definition of expected levels of performance and monitoring of outcomes. Whenever feasible, implementation of policies and control of processes, operations and decision making will be vested with the field. The authority and responsibility to accomplish these functions will be similarly vested in the field leadership who will be held accountable for meeting defined levels of patient satisfaction, access, quality and efficiency.

V. The Plan in Brief: This plan details both a restructuring of VHA's field operations and its central office management. The new structure is based on the concept of coordinating and integrating VHA's health care delivery assets and the creation of 22 Veterans Integrated Service Networks. The VISN structure is derived from a model of organizational management that emphasizes quality patient care, customer satisfaction, innovation, personal initiative and accountability.

The planned central office and field reorganization embodies a fundamentally new approach toward the delivery of veterans health care services. Under the proposed strategy, the basic budgetary and planning unit of health care delivery shifts from individual medical centers to integrated service networks providing for populations of veteran beneficiaries in defined geographic areas. Decision-making authority is shifted closer to those affected by the decision. These network service areas and their veteran populations are defined on the basis of VHA's natural patient referral patterns; aggregate numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders.

Under the new VHA organizational paradigm, services will be provided via better integrated VA resources and through strategic alliances among neighboring VA medical centers, sharing agreements with other government providers, direct purchase of services from the private sector and other such relationships. The model promotes the benefits of both an integrated and a virtual health care system (see **Section VI** below).

The new VISN structure places a premium on improved patient services, rigorous cost management, process improvement, outcomes and “best value” care. As an integrated system of care, the VISN model promotes a pooling of resources and an expansion of community-based access points for primary care. In this scheme, the hospital will remain an important, albeit less central, component of a larger, more coordinated community-based network of care. In such a system, emphasis is placed on the integration of ambulatory care and acute and extended inpatient services so as to provide a coordinated continuum of care.

VI. About Integrated and Virtual Health Care Organizations: The concept of an integrated health care organization is based on the success of various manufacturing and retailing firms that used horizontal and vertical integration to improve their market position. The fundamental business concept is that if an entity controls and coordinates (i.e., integrates) supply, production, distribution, marketing and all other facets of the enterprise, then it will be able to incorporate all the profits of the otherwise necessary “middlemen” into the parent organization, and thereby accrue cost and service advantages over less integrated competitors. Said in a more health care relevant way, the basic concept of an integrated health care organization is that it is one which will be accountable for providing a coordinated range of physician, hospital and other medical care services for a defined population, and generally for a fixed amount. The assumption is that it

will be easier and more efficient to provide for all the needs of the population if all the pieces of the health care system needed to provide the care are integrated into and under the control of a single entity.

In an integrated health care system, physicians, hospitals and all other components share the risks and rewards and support one another. In doing so they blend their talents and pool their resources; they focus on delivering “best value” care. To be successful, the integrated health care system requires management of total costs; a focus on populations rather than individuals; and a data-driven, process-focused customer orientation. Private health care providers started to emulate these business concepts in the 1970s (with some notable earlier efforts), and this is now being pursued in the private sector at a frenzied pace.

Another organizational model that arose in the 1980s, based largely on the experience of the biotechnology industry, is the “virtual health care organization.” Under this model, integration is achieved by a wide array of discrete corporate arrangements to develop and market specific products. These arrangements are “tailor made” to individual products, markets or corporate competencies of strategic allies.

A number of private health care companies have formed virtual organizations and experienced great success as reflected in market share and profitability. What holds these virtual organizations together are : (1) the operating framework (i.e., the aggregate of agreements and protocols that governs how patients are cared for and the information systems that monitor patient flow) and (2) the framework of incentives that governs how physicians and hospitals are paid. Both frameworks are “learning systems” which evolve and change as more is learned about how to

improve the provision of care, conserve resources and manage the system. Virtual health care systems invest substantial resources in developing and maintaining their provider networks, focusing on community-based networks of physicians participating in the plan.

The Veterans Health Administration has the relatively unique advantage of being able to function as both an integrated and a virtual health care organization, although it has not been organizationally aligned and managed as such in the past.

VII. The Report In Brief: Following this brief introduction are chapters designed to meet the requirements of Title 38, as well as to address key issues relevant to the basic reorganization.

Chapter 2 meets the stipulations of 38 U.S.C. §510(b), which requires a report to Congress for certain reorganization proposals. In fulfillment of this requirement, Chapter 2 outlines the plan to convert the VHA field organization to 22 VISNs. It also provides cost estimates for the field reorganization, discusses the transition process and delineates a plan to establish Support Services Centers (SSCs), a new VHA organizational component designed to assist the VISNs and headquarters in the transition from larger regions to smaller, more cohesive integrated service networks.

Chapter 3 describes the restructuring of VHA Central Office into a new VHA National Headquarters. While the headquarters reorganization does not require a report pursuant to 38 U.S.C. §510, the chapter nevertheless provides information similar to that required by law for the field reorganization. It describes a flatter and less hierarchical headquarters having reduced day-to-day operational involvement, but increased responsibility for providing leadership, guidance

and systemwide quality monitoring. The chapter also describes the new behaviors and values that will be expected for successful performance by the headquarters staff.

Chapter 4 briefly describes the new performance measurement and monitoring system that will ensure accountability in the new organization. The chapter discusses performance contracts for network directors, and includes examples of specific performance criteria that can be used to establish more consistency of care and service delivery across the VISNs. Performance contracts will be a critical aspect of the proposed reorganization.

Chapter 5 addresses additional implementation issues and priorities, and also discusses the Under Secretary's vision for the future of the Veterans Health Administration.

Finally, a number of appendices are included that amplify upon concepts or provide supplemental details to material contained in the text.