

# CHAPTER 2

## VHA Field Reorganization

### REPORT TO CONGRESS

Title 38 U.S.C. §510(b)

**I. Purpose:** This chapter describes the Department of Veterans Affairs’ plan to reorganize the field management structure of VHA. The plan flattens and decentralizes VHA’s field organization by replacing the four regions, 33 networks, and 159 independent VA medical centers with 22 Veterans Integrated Service Networks (VISNs) that report directly to the Office of the Under Secretary for Health. See **Figure 2.1** (page 23) and **Table 2.1** (pages 24-26) for planned VISN alignments, by map location and facility respectively.

**II. Background:** The delivery of health care in the U.S. is dramatically changing. If VHA is to remain a viable health care option for veterans, it needs to substantially change its approach to providing care. This planned reorganization provides the template for such change. When implemented, the proposed patient-centered structure will bring about improved integration of resources and service delivery, and it will increase efficiency. In order to achieve these goals, VHA must increase the autonomy, flexibility and accountability of its field management.

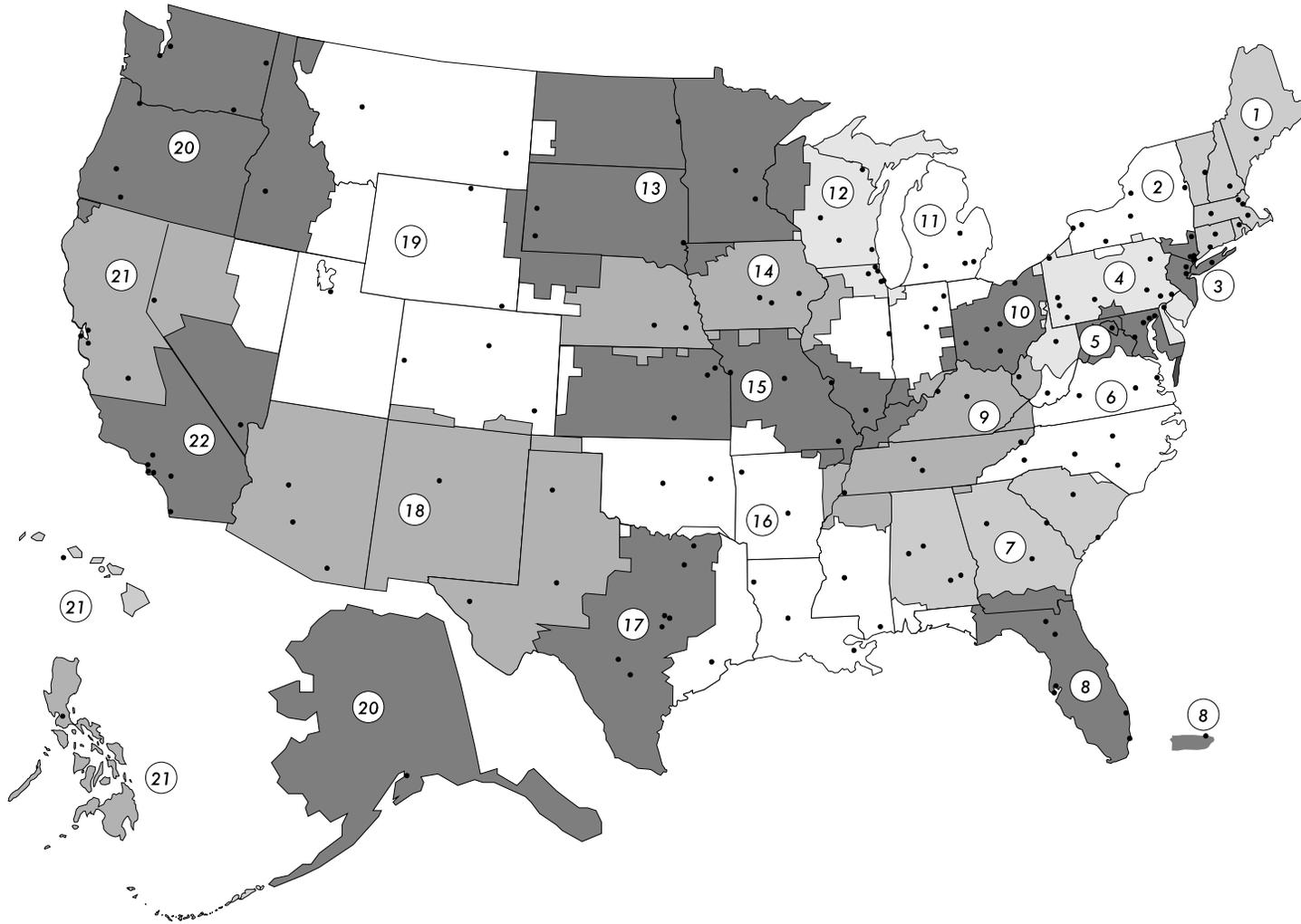
**III. Detailed Plan and Justification:** 38 U.S.C. §510(b) requires a Congressional report and a waiting period before VA implements any administrative reorganization of a field office or facility that reduces by 15% or more in one fiscal year the number of full-time equivalent employees with permanent duty stations at such office or facility, or reduces it by 25% or more over a two-year

period. Insofar as this reorganization will eliminate the current four regional field management offices and reassign those personnel and functions, this plan is subject to the 510(b) reporting requirements.

The following “detailed plan and justification” is submitted in accordance with and in the format specified by the statute (38 U.S.C. §510(f)(2)). It describes the planned reorganization of VA’s Veterans Health Administration field management structure and provides information on the current field organization (i.e., the regions), the rationale for the reorganization, the criteria underlying the selection of the VISN structure, and the alignments of VHA’s current health care facilities under the VISN structure.

Figure 2.1

## 22 Veterans Integrated Service Networks



**Table 2.1**

**Proposed Health Care Facility Components of the  
22 Veterans Integrated Service Networks (VISNs)**

**VAMCs**

***VISN # 1***

BEDFORD, MA  
BOSTON, MA  
BROCKTON, MA  
MANCHESTER, NH  
NEWINGTON, CT  
NORTHAMPTON, MA  
PROVIDENCE, RI  
TOGUS, ME  
WEST HAVEN, CT  
WHT RIVER JCT, VT

***VISN # 2***

ALBANY, NY  
BATAVIA, NY  
BATH, NY  
BUFFALO, NY  
CANANDAIGUA, NY  
SYRACUSE, NY

***VISN # 3***

BRONX, NY  
BROOKLYN, NY  
CASTLE POINT, NY  
EAST ORANGE, NJ  
LYONS, NJ  
MONTROSE, NY  
NEW YORK, NY  
NORTHPORT, NY

***VISN # 4***

ALTOONA, PA  
BUTLER, PA  
CLARKSBURG, WV  
COATESVILLE, PA  
ERIE, PA  
LEBANON, PA  
PHILADELPHIA, PA  
PITTSBURGH (HD), PA  
PITTSBURGH (UD), PA  
WILMINGTON, DE  
WILKES-BARRE, PA

**VAMCs**

***VISN # 5***

BALTIMORE, MD  
FORT HOWARD, MD  
MARTINSBURG, WV  
PERRY POINT, MD  
WASHINGTON, DC

***VISN # 6***

ASHEVILLE, NC  
BECKLEY, WV  
DURHAM, NC  
FAYETTEVILLE, NC  
HAMPTON, VA  
RICHMOND, VA  
SALEM, VA  
SALISBURY, NC

***VISN # 7***

ATLANTA, GA  
AUGUSTA, GA  
BIRMINGHAM, AL  
CHARLESTON, SC  
COLUMBIA, SC  
DUBLIN, GA  
MONTGOMERY, AL  
TUSCALOOSA, AL  
TUSKEGEE, AL

***VISN # 8***

BAY PINES, FL  
GAINESVILLE, FL  
LAKE CITY, FL  
MIAMI, FL  
SAN JUAN, PR  
TAMPA, FL  
WEST PALM BEACH, FL

**Proposed Health Care Facility Components of the  
22 Veterans Integrated Service Networks (VISNs)**

**VISN # 9**

HUNTINGTON, WV  
LEXINGTON, KY  
LOUISVILLE, KY  
MEMPHIS, TN  
MOUNTAIN HOME, TN  
MURFREESBORO, TN  
NASHVILLE, TN

**VISN # 10**

CHILLICOTHE, OH  
CINCINNATI, OH  
CLEVELAND, OH  
COLUMBUS, OH  
DAYTON, OH

**VISN # 11**

ALLEN PARK, MI  
ANN ARBOR, MI  
BATTLE CREEK, MI  
DANVILLE, IL  
FORT WAYNE, IN  
INDIANAPOLIS, IN  
MARION, IN  
SAGINAW, MI

**VISN # 12**

CHICAGO (LS), IL  
CHICAGO (WS), IL  
HINES, IL  
IRON MOUNTAIN, MI  
MADISON, WI  
MILWAUKEE, WI  
NORTH CHICAGO, IL  
TOMAH, WI

**VISN # 13**

FARGO, ND  
FORT MEADE, SD  
HOT SPRINGS, SD  
MINNEAPOLIS, MN  
SIOUX FALLS, SD  
ST. CLOUD, MN

**VISN # 14**

DES MOINES, IA  
GRAND ISLAND, NE  
IOWA CITY, IA  
KNOXVILLE, IA  
LINCOLN, NE  
OMAHA, NE

**VISN # 15**

COLUMBIA, MO  
KANSAS CITY, MO  
LEAVENWORTH, KS  
MARION, IL  
POPLAR BLUFF, MO  
ST. LOUIS, MO  
TOPEKA, KS  
WICHITA, KS

**VISN # 16**

ALEXANDRIA, LA  
BILOXI, MS  
FAYETTEVILLE, AR  
HOUSTON, TX  
JACKSON, MS  
LITTLE ROCK, AR  
MUSKOGEE, OK  
NEW ORLEANS, LA  
OKLAHOMA CITY, OK  
SHREVEPORT, LA

**VISN # 17**

BONHAM, TX  
DALLAS, TX  
KERRVILLE, TX  
MARLIN, TX  
SAN ANTONIO, TX  
TEMPLE, TX  
WACO, TX

continued

**Table 2.1**

**Proposed Health Care Facility Components of the  
22 Veterans Integrated Service Networks (VISNs)**

***VISN # 18***

ALBUQUERQUE, NM  
AMARILLO, TX  
BIG SPRING, TX  
EL PASO, TX  
PHOENIX, AZ  
PRESCOTT, AZ  
TUCSON, AZ

***VISN # 19***

CHEYENNE, WY  
DENVER, CO  
FORT HARRISON, MT  
FORT LYON, CO  
GRAND JUNCTION, CO  
MILES CITY, MT  
SALT LAKE CITY, UT  
SHERIDAN, WY

***VISN # 20***

AMERICAN LAKE/TACOMA, WA  
ANCHORAGE, AK  
BOISE, ID  
PORTLAND, OR  
ROSEBURG, OR  
SEATTLE, WA  
SPOKANE, WA  
WALLA WALLA, WA  
WHITE CITY, OR

***VISN # 21***

FRESNO, CA  
HONOLULU, HI  
MANILA, PI  
MARTINEZ, CA  
PALO ALTO, CA  
RENO, NV  
SAN FRANCISCO, CA

***VISN # 22***

LAS VEGAS, NV  
LOMA LINDA, CA  
LONG BEACH, CA  
LOS ANGELES, CA  
SAN DIEGO, CA  
SEPULVEDA, CA  
WEST LOS ANGELES, CA

## Detailed Plan and Justification

### 38 U.S.C. §510(f)(2)

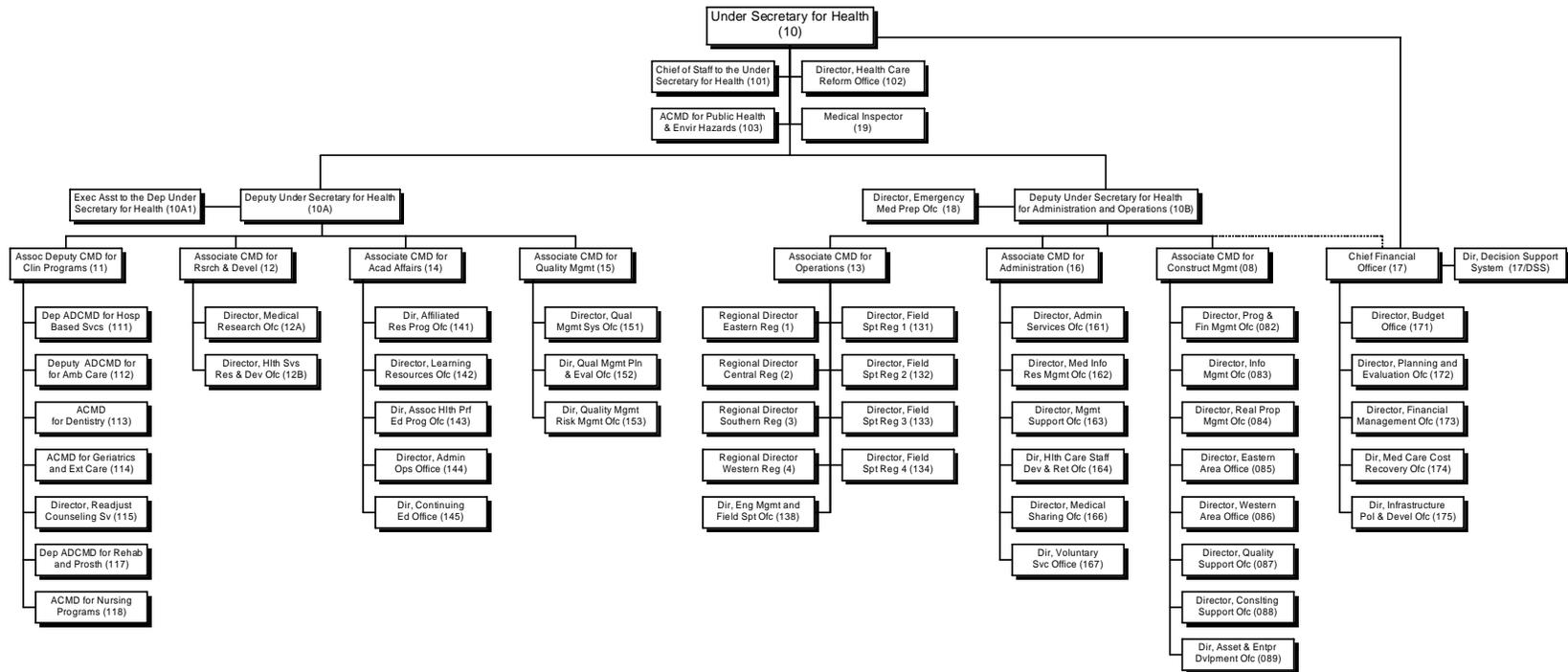
**A. Specification of the number of employees by which each covered office or facility affected is to be reduced, the responsibilities of those employees, and the means by which the reduction is to be accomplished.**

The existing organizational structure of VHA has been in place since 1990 and is shown on the organizational chart included as **Figure 2.2** (page 28). The Associate Chief Medical Director (AsCMD) for Operations, one of seven AsCMD positions, provides operational direction to and supervision of the four geographic regions. Each region is headed by a region director located in the field (Linthicum, MD; Ann Arbor, MI; Jackson, MS; and San Francisco, CA). The four region directors supervise the operation of the medical care facilities in their regions (which currently range from 36 to 45 facilities per region). The regions' employees have oversight responsibilities in the following areas: clinical programs, consolidated procurement, construction, emergency preparedness, human resources management, equal employment opportunity, public/consumer affairs, internal/external review, nursing, pharmacy, information management, women veterans programs, medical care cost recovery, planning, resource management, and quality management to include quality assurance, radiation safety, fire and safety, and industrial hygiene. **Figure 2.3** (page 29) provides a generic organizational chart for a region field office.

The FY 1995 budgeted staff level in the four VHA region offices totals 427 FTE, with 342 positions currently being occupied and there being a projected level of 330 by September 30, 1995. There will be a net reduction of 157 FTE as a result of the planned reorganization; these reductions will be accomplished by reassignments, early retirements and special placement initiatives for the affected employees. No employees are expected to be involuntarily separated

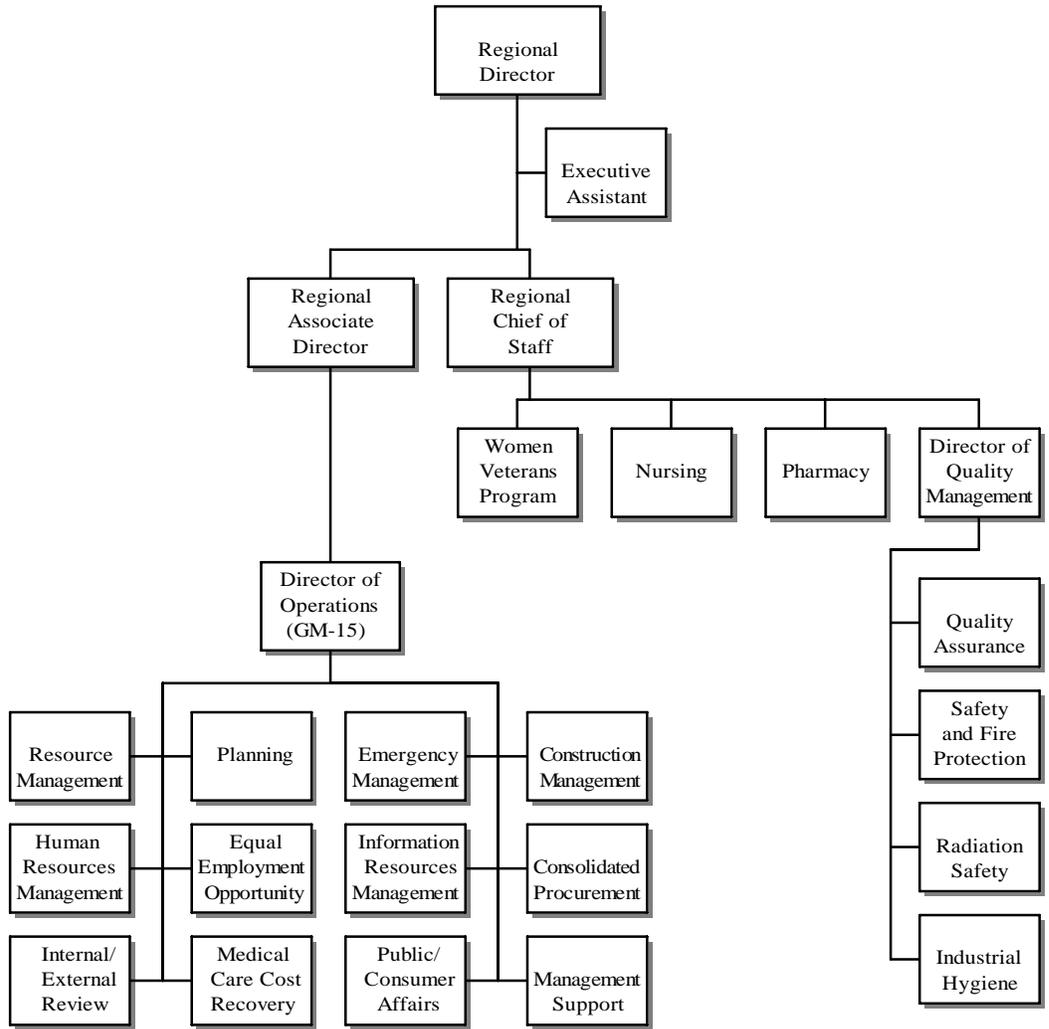
**FIGURE 2.2**

# Current Organizational Chart of the Veterans Health Administration



**FIGURE 2.3**

## Region Office Field Structure



because of this reorganization without first having received a bona fide job offer. Indeed, it is intended that affected employees will be given special consideration for vacant positions for which they qualify at a medical center, in a VISN office or at a Support Services Center (SSC). See **Tables 2.2** (page 42) and **2.3** (page 43) for details regarding the anticipated disposition of current region office staffs.

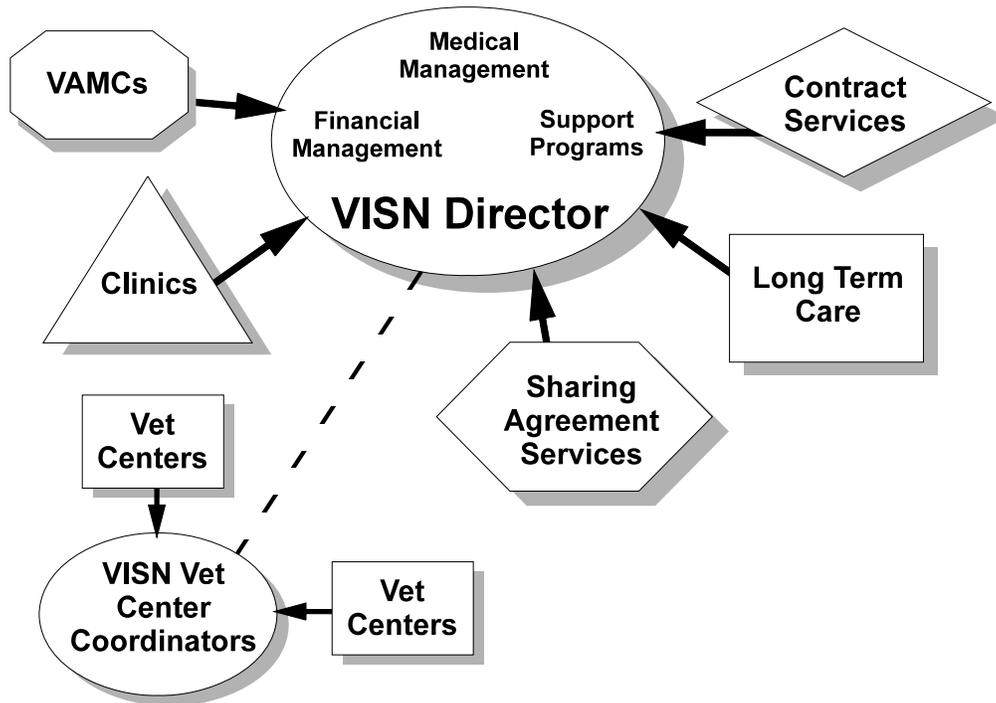
**B. Identification of any existing or planned office or facility at which the number of employees is to be increased and specification of the number and responsibilities of the additional employees at each such office or facility.**

VHA's field components will be organized into 22 Veterans Integrated Service Networks (VISNs). A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined on the basis of VHA's natural patient referral patterns; 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 VISN model, health care will be provided through strategic alliances among VA medical centers, clinics and other sites; contractual arrangements with private providers; sharing agreements with other government providers; and other such relationships. The VISN is designed to be the basic budgetary and planning unit of the veterans health care system. See **Figure 2.4** (page 31) for a schematic depiction of the VISN structure.

The proposed VISN organization structure was chosen after thorough review of numerous reports addressing VHA organizational structure (see **Appendix 7**), as well as a review of the field organizations of the Department of Defense and the U.S. Public Health Service. Likewise, consideration was given to the organizational structure of large private health care entities such as Kaiser Permanente and Columbia/HCA.

**FIGURE 2.4**

## A Schematic of the VISN Structure



Note: This chart is a schematic of the range of veterans health care and the methods for providing it that will occur in a VISN. It is not necessarily representative of the reporting relationships between the individual components and the VISN director.

The Under Secretary for Health played a very direct role in selecting the VISN structure. In addition to convening a group from within VHA to make broad-based recommendations on a new VHA field structure, he charged the group to base its recommendations on an evaluation of how the proposed new field structure would perform against 27 values that he personally developed (**Table 2.4**, pages 44-45). Ultimately, the group recommended a network structure because it approached most closely the Under Secretary's vision of satisfying the 27 values.

Each VISN will be led by a director who will report to the Chief Network Officer in the Office of the Under Secretary for Health (see **Chapter 3** and **Appendix 5** for a more detailed explanation of this position). VA medical center and other independent facility managers within a VISN, with the exception of Vet Center team leaders, will report to the VISN director. VISN directors will not serve concurrently as facility directors. Their attention must remain focused on the network. The location of the VISN office within a network will depend on several factors, including ease of access, existing staffing and cost considerations, but whenever economies can be achieved by locating VISN management on the grounds of an existing VA facility, to include VHA region or regional division office (RDO) or Veterans Benefits Administration regional office, this will be encouraged.

The allocation of staffing to each VISN office will be based on the size and complexity of the individual network. It is anticipated that the number of staff needed to manage a VISN will range between 7 and 10 FTE. For cost comparison purposes a figure of 10 FTE for each VISN office is used, although this may overstate the number that will be needed. The staffing complement for the 22 VISN offices is projected to be approximately 220 FTE.

In general, specific FTE by occupation or program area are not mandated in this plan in order to preserve the flexibility of the VISN director. Although no net increase in FTE or field SES

positions is anticipated, it is likely that job redesign and/or realignment will be required. Specifically, in addition to the director and clerical support, VISN management would be expected to include expertise in medical management, finance and budgeting, and planning. There may be other areas of expertise needed in a VISN from time to time that would not warrant a full-time staff person or collateral assignment. It is expected that the VISN director would draw such expertise on an ad hoc basis from employees of facilities within the VISN.

A Vet Center resource coordinator position will also be established at each VISN to manage vet center programs and facilitate collaborative efforts with other VHA facilities in the VISN. These positions will come from existing Office of Readjustment Counseling Services (RCS) staffing allocations, and the incumbents will not necessarily be located at the VISN office sites. The reporting line for these positions will be to the RCS Office at VHA headquarters. As part of the VISN implementation process, RCS will be reviewing its regional structure to determine how best to integrate its functions with those of the VISNs. In addition, regional coordinators for women veterans programs will be designated in accordance with 38 U.S.C. §108.

Another field organizational unit in the VISN model is the Support Services Center (SSC). SSCs will serve primarily as roll-up, data collection, and technical support centers for both the VISNs and VHA headquarters. Staffing for the SSCs will come from existing VHA region and national headquarters ceilings or be generated through management improvement initiatives at the VISN level. The primary function of the SSCs will be to support the staff needs of the VISNs. Therefore, some transition time will be required before the full scope of the support activities can be precisely defined. Consequently, rather than immediately abolish all the positions in the regions, which would be disruptive and costly, some core functions associated with economies of scale and roll-up and data collection activities will be retained in an SSC. Other field support

entities, such as the Cost Containment Center and the Consolidated Mail Out Pharmacy (CMOP) centers, will also be factored into the SSC concept.

Initially, four SSCs will be established at the present region director office sites. The number of staff serving in the SSCs will initially total approximately 100, but after 6 months this number is expected to decrease to about 50. The SSCs may be consolidated at fewer sites, too. The SSCs will be serviced by a local medical center (as the regions are now) for administrative support, and during the transition period they will be aligned under the Chief Network Officer in the Office of the Under Secretary for Health. After the transition period has been completed and the VISN directors have been appointed, the VISN directors will assume substantive supervision of the SSC functions to assure their responsiveness to the VISNs. This may be done through representative boards of VISN directors or through other means as determined effective by the VISN directors. To ensure that a consistent, systemwide perspective is maintained, the actions of all of these SSC-related boards will be accountable through the Chief Network Officer to the Under Secretary for Health.

See **Table 2.3** (page 43) for details regarding where VA expects to recruit VISN and SSC employees and **Paragraph (C), Support Functions**, for further discussion of SSCs.

**C. A description of the changes in the functions carried out at any existing office or facility and the functions to be assigned to an office or facility not in existence on the date that the plan and justification are submitted.**

## **Region Office Functions**

In general, the current functions of the regions will be absorbed by the VISNs, the SSCs or the component facilities of the VISNs, although there may be some functions that will be absorbed by VHA headquarters or discontinued because they no longer add value. Some functions will be

realigned at the time the VISNs are implemented; others will be realigned over a period of time. See **Table 2.5** (page 46) for examples of possible realignments of current region office functions.

## **VISN Functions**

The emphasis in the VISN will be markedly different from the regions. VISNs will focus on (1) integrating ambulatory services with acute and long term inpatient services, and (2) achieving the greatest possible health care value for the allocated resources provided. Specifically, each VISN director will be given the authority and be held accountable for:

- Ensuring that a full range of services is provided, to include specialized services and programs for disabled veterans;
- Developing and implementing the VISN budgets ;
- Areawide (population-based) planning;
- Consolidating and/or realigning institutional functions;
- Maximizing effectiveness of the human resources available to the VISN;
- Moving patients within and outside the VISN to ensure receipt of appropriate and timely care;
- Contracting with non-VA providers for medical and non-medical services, as needed; and
- Maintaining cooperative relationships with other VA field entities, such as Veterans Benefits regional offices and national cemeteries.

An important component of the VISN model is the requirement that each VISN establish a formalized structure to assure input from VHA's internal and external stakeholders. The recommended way to address this need is to establish a management assistance council. This

council would be comprised of representative facility directors, chiefs of staff, nurse executives, union representatives and others from within the VISN. External stakeholders, such as VSOs, state and local government officials, members of academic affiliates, and private sector health care entities would act as consultants to the council. They would be asked to regularly participate in meetings and to provide input into the operation of and planning for the VISN. Each council, working in concert with its external consultants, would formulate plans and recommendations to the VISN director. Those serving in the consultant role would not be compensated by VA.

## **Facility Functions**

While field facilities will remain the sites at which VA medical care is provided, the role and function of the medical center director will change as a result of the VISN structure. Decentralization of a broad range of authorities from headquarters to the field will increase the director's ability to effect changes within the facility. However, since the basic planning and budgetary unit will be the VISN rather than the individual facility, the role of the facility director in decisions affecting the delivery of patient care services will shift from one of independent action to one of collaboration within the network. It is anticipated that each VISN director will work closely and in a collegial fashion with representatives of all the facilities in the VISN to ensure that the views and concerns of facility managers are fully considered as decisions are made relative to the fulfillment of the goals and objectives of the VISN as a whole.

## **Support Functions**

There are a number of functions now performed at a region level that in the future will be performed at the VISN level (e.g., budgeting and planning). However, there are other functions which, because of economies of scale or expertise not needed in every network, are more

appropriately assigned to a Support Services Center. These include roll-up functions (e.g., ad hoc financial reports, high-cost equipment reports, survey reports), tracking functions (e.g., EEO reporting) and specific program expertise (e.g., major construction project support).

Details on the realignment of the many specific region functions can only be determined during the implementation planning process. As the regions are phased out and the VISN and SSC structures are phased in, the kinds of staff support required by the VISNs will become more clear. During this transition phase, decisions will be made as to where best to site the SSC staff in order to achieve the maximum return on these resources. The VISN directors will have a significant role in making these decisions, being mindful of the overall staffing levels described in this plan. As described in **Paragraph (A)**, staffing efficiencies are expected to accrue from this restructuring.

There are also other functions in support of a VISN that can be performed as a collateral assignment by facility employees. For example, certain functions in the areas of human resource management, pharmacy, or public and consumer affairs may not need dedicated staff in the VISN or SSC. Such decisions will be made by the VISN director in collaboration with the VISN facility directors. The manner in which these types of functions are accomplished is expected to vary from VISN to VISN and may vary within a VISN over time, depending on the specific circumstances prevalent in the VISN.

**D. An explanation of the reasons for the determination that the reorganization is appropriate and advisable in terms of the statutory missions and long-term goals of the Department.**

There are many reasons why this reorganization is vital to the fulfillment of VA's missions and long-term goals. Current trends and dynamics in health care and in government mandate that VA change. Many states have enacted legislation or are proposing reforms that are likely to

have consequences for the VA health care system. For VHA to survive and perform effectively in state and local markets, it will need an organizational structure that fosters patient-centered service delivery and allows for rapid decision making by giving authority to local management. VHA must become more “user friendly” and more efficient. It must promote a customer-centered culture that emphasizes continuous improvement of quality, consistency of quality, and the provision of the most cost-effective care possible. The plan will provide that needed structure.

VHA’s recent positive experience with the informal 33 network structure has demonstrated the soundness of the concept of facilities working together within a geographic area and has given added impetus to the development of the VISN structure. The network concept was based primarily on the existence of natural planning groups of two or more health care facilities that come together to assist one another based on historical working relationships, referral patterns, geographic proximity and ease of access. This informal network structure has fostered a sharing of both experience and talent among the network facilities.

The VISN plan embodies a fundamentally new way of thinking about providing VA health care services. The VISN structure encourages the pooling of resources and places a premium on process improvement, outcomes, cost management and value engineering. It recognizes that the hospital, while still an important component, is no longer the center of the health care delivery system, and it provides incentives for expanding community-based access points and primary care. The VISN model also places flexibility, authority and accountability at the true operating level.

The overarching goal of this reorganization is to improve VHA's ability to fulfill its patient care mission. In determining that the VISN model was best suited for achieving this goal, care was given to assure no disruption or diminution of VHA's ability to support its other missions.

**E. A description of the effects that the reorganization may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the Department not directly affected by the reorganization).**

The main effects of the field reorganization, combined with the restructuring of the central office, will be less bureaucracy, more timely decision making, easier access to care and greater consistency in the quality of care systemwide. The VISN director will have the authority and responsibility to manage the distribution of the network's resources to maximize the advantages to veterans within the VISN service area. This allocation will be achieved by VISN management working in collaboration with the directors of the component VISN facilities and the input of its management assistance council and other appropriate entities. In addition, there will be greater systemwide direction in strategic planning, quality improvement, clinical protocols and medical management. Also, since the VISN director will be able to structure the delivery of patient care services around the needs of the beneficiaries, the result should be better integration of and access to acute and long-term inpatient and ambulatory services.

In terms of the effects on benefits and services not directly affected by the reorganization, restructuring VHA is intended to facilitate more cooperative, mutually beneficial relationships between VA's health care system and its other administrations and staff offices. The Under Secretary for Health supports the concept of a unified Department of Veterans Affairs and wants a more responsive VHA that is able to provide better, more adaptable services to support local needs of the veteran.

Another effect of the reorganization is the flattening of the supervisory structure. Questions may be raised about the efficacy of the span of control with 22 VISNs reporting to the Office of the Under Secretary. However, the decentralization of many authorities to the VISN level coupled with planned improvements in performance measurements and systems monitoring will greatly reduce the kind of daily operational decision making and oversight now performed at the central office level. Consequently, headquarters will be able to refocus its attention to matters of governance, policy development and leadership. While the transition to a more corporate management role for headquarters and greater authority for the networks will take dedication and time, the end result will align VHA with the best practices of outstanding health care corporations.

**F. Estimates of the costs of the reorganization and of the cost impact of the reorganization, together with analyses supporting those estimates.**

Lower recurring costs for VISNs (compared to the current regions) should generate annual savings of over \$9 million, allowing these monies to be redirected for other high priority needs within VHA. See **Table 2.6** (page 47) for cost comparison between the region and VISN structures. Initially, there will be significant non-recurring costs in implementing the VISNs, especially those costs related to the relocation and displacement of current VHA region office staff. While staffing is the largest recurring cost associated with the reorganization, there will be other significant recurring costs, particularly leased space and employee relocation expenses. Important to note, though, is the fact that the recurring costs of the VISN management structure are substantially less than those associated with the current regional management structure. Also, while the VISN management will be separate and distinct from any medical center or other facility management, VHA will co-locate VISN management on the grounds of existing facilities or in currently leased sites, wherever possible, in order to minimize leasing and other support costs.

Also, in order not to underestimate the costs of staffing the office of the VISN director, a VISN staffing level of 10 FTE is assumed for cost comparison purposes, although it is unlikely that all of the VISN offices would receive this full staffing complement (see **Appendix 4** for details and list of assumptions).



**Table 2.2****Estimated Disposition of Current Region Office Staffs**

<b>Estimated Disposition</b>	<b>Transfer Required</b>	<b>Staffing Option 1<sup>1</sup></b>	<b>Staffing Option 2<sup>1</sup></b>
Staff for VISN offices at current region sites	No	40	40
Staff transferred to the other 18 VISN offices	Yes	90	108
Staff placed in local VA medical centers	No	70	66
Staff placed in Support Services Centers	No	100 <sup>2</sup>	50 <sup>2</sup>
Positions currently vacant that will be abolished	---	97 <sup>3</sup>	97 <sup>3</sup>
Staff transferred to existing VA medical centers that will require relocation funding	Yes	30	66
<b>Total</b>	—	<b>427<sup>4</sup></b>	<b>427<sup>4</sup></b>

**Note 1:** Using the projected total of 330 FTE for the region staffs as of Sept. 30, 1995, two staffing options are portrayed depending on the number of VISN staff coming from the region staffs and from the local area (see **Table 2.3's** assumptions).

**Note 2:** Initially, some 100 FTE will remain in the Regional Director offices for up to six months to assist during the transition period to VISNs. It is expected that by the end of the transition period the SSC staff will decrease to some 50 FTE and the four SSCs may be consolidated at fewer sites.

**Note 3:** These positions have remained unfilled pending the expected reorganization of the region offices.

**Note 4:** The derivation of the 157 FTE net reduction figure is as follows:

427 FTE current budgeted staff in regions  
 - 220 FTE projected staffing for the 22 VISNs  
 207 FTE  
 - 50 FTE projected staffing for the Support Services Centers  
 157 FTE projected staffing reduction after completion of the transition period

**Strategies to Staff VISN and SSC Offices**

<b>Staffing Category</b>	<b>Staffing Source</b>	<b>Transfer Required</b>	<b>Staffing Option 1</b>	<b>Staffing Option 2</b>
Professional and clerical staff at current region sites	Regions	No	40	40
Professional and clerical staff for 18 VISN offices	Regions	Yes	90	108
Professional staff for 18 VISN offices	VA-wide	Yes	0	18
Clerical staff for 18 VISN offices	Local	No	54	18
Professional staff for 18 VISN offices	Local	No	36	36
Professional and clerical staff for SSCs	Regions	No	50	50
<b>Total</b>	—	—	<b>270</b>	<b>270</b>

**Assumptions:**

1. The staffing complement for each VISN will equal 10 FTE.
2. In Staffing Option 1, the VISN directors at sites other than current region locations will pick five of the VISN staff from the existing region and the rest from local sources.
3. In Staffing Option 2, the VISN directors at sites other than current region locations will pick six of the VISN staff from the existing regions, one from another VA site, and the rest from local sources.
4. The initial staffing for the Support Services Centers will equal 100 FTE; this will be reduced to 50 FTE after the transition period.



**TABLE 2.4**

**The 27 Values Guiding the Establishment of  
Veterans Integrated Service Networks \***

**Patient care**

1. Enhance timely access to medical care and other VA services.
2. Maximize resource allocation to direct patient care services.
3. Facilitate health promotion, disease prevention and early diagnosis of disease.
4. Enhance appropriate patient referral and service utilization.
5. Keep patient care decision making as close as possible to the patient.
6. Promote horizontal, patient-focused processes.
7. Provide a community-based focus.
8. Minimize disruption of the system during implementation.

**Quality**

1. Facilitate the development of integrated systems of care.
2. Ensure systemwide consistency in quality and coverage.
3. Minimize fragmentation of functions.
4. Enhance capacity for continuous improvement.
5. Facilitate systemwide data acquisition and performance measurement.

**Flexibility**

1. Facilitate sharing and collaborative agreements.
2. Accommodate state and local health care reform initiatives.
3. Facilitate local flexibility and decision making.

## **Efficiency**

1. Promote innovation and creativity.
2. Provide clear lines of authority and responsibility and enhance managerial accountability.
3. Minimize organizational redundancies and maximize administrative efficiencies.
4. Maximize information flow and the timeliness of information flow to appropriate decision makers and internal and external stakeholders.
5. Enable decision making at all levels of the organization.
6. Maximize field organization control over support functions.
7. Ensure that each organizational layer or higher level oversight provides “added value.”

## **Responsiveness**

1. Maximize responsiveness to individual patient needs.
2. Maximize responsiveness to external stakeholders (e.g., VSOs, Congress).
3. Provide for a manageable span of control at all levels of the organization.
4. Enhance VA competitiveness with private and other government sponsored health care providers.

\* The values have been categorized according to their intended main result, although many of them overlap with other categories.



**TABLE 2.5****Examples of Possible Realignments of Region Office Operational Functions**

<i>Current Operational Functions Performed within the Regions involving:</i>	<i>Assignment of Function after Restructuring</i>			
	<i>VAMC/ Facility</i>	<i>VISN Office</i>	<i>SSC</i>	<i>National Headqtrs.</i>
<b>Clinical Programs, e.g.,</b>				
1. Eliminate overlaps/gaps in service		X		
2. Coordinate patient referrals	X	X		
3. Coordinate transplants				X
<b>Construction</b>	X		X	X
<b>Equal Employment Oppor.</b>	X		X	X
<b>Fire and Safety</b>	X		X	
<b>Industrial Hygiene</b>	X		X	
<b>Medical Care Cost Recovery</b>	X			X
<b>Planning</b>	X	X		X
<b>Public/Consumer Affairs</b>	X	X		X
<b>Radiation Safety</b>	X		X	
<b>Resource Management</b>	X	X		
<b>Women Veterans Program</b>	X			X

**\* General Note:**

The examples given in this table are illustrative of the realignments of region functions that may occur under VISNs. Although many of these functions will fall to the VISN director, they may not necessarily be performed specifically by the VISN staff. Final decisions regarding the possible alignments of the responsibility for the functions above together with the remaining region functions — including those relating to consolidated procurement, emergency preparedness, human resources management, information management, internal/external review, nursing, pharmacy and quality assurance — will be made during the implementation process. An implementation team will study all of the current region responsibilities, followed by a function-by-function analysis to ensure that only value-added functions continue to be performed.

A guiding principle that will be followed in reassigning region responsibilities is that most operational functions will be performed at the field level, i.e., health care facility, VISN office or SSC. VHA headquarters staffs will provide advice, national policy direction and technical expertise to support the field.

Although Chapter 2 lists the key functions on which the VISNs will focus, it is important to note that VHA will ensure, insofar as possible, that the VISN directors play a direct and significant part in making the decisions concerning the disposition of all of the current region functions. Many of these functions will have implications for the operation and ultimate success of the VISN structure; therefore, the direct involvement of VISN management is viewed as crucial.

**TABLE 2.6****Cost Comparison of VISN Structure with Current Region Structure<sup>1</sup>**

	<b>Recurring Cost</b>	<b>Non-recurring Cost</b>
Cost of current region structure	\$36,069,680	-----
Estimated cost of VISN structure (VISNs + SSCs)	\$26,746,000	\$6,990,000 - \$11,022,000 <sup>2</sup>
Funds available for redirection	\$9,323,680 <sup>3</sup>	-----

**Footnotes:**

1. A detailed cost analysis of the region versus the VISN structure is included in **Appendix 4**.
2. An estimated one-time expenditure of \$7 to 11 million will be needed to implement the VISN structure. These costs are projected as a range as they will be variable depending on the number of employees requiring relocation funding.
3. Implementation of the VISN structure frees \$9.3 million in administrative cost which can be redirected for patient-care needs.