

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

ACKNOWLEDGMENT

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.

Kenneth W. Kizer, M.D., M.P.H.

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.

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.

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)

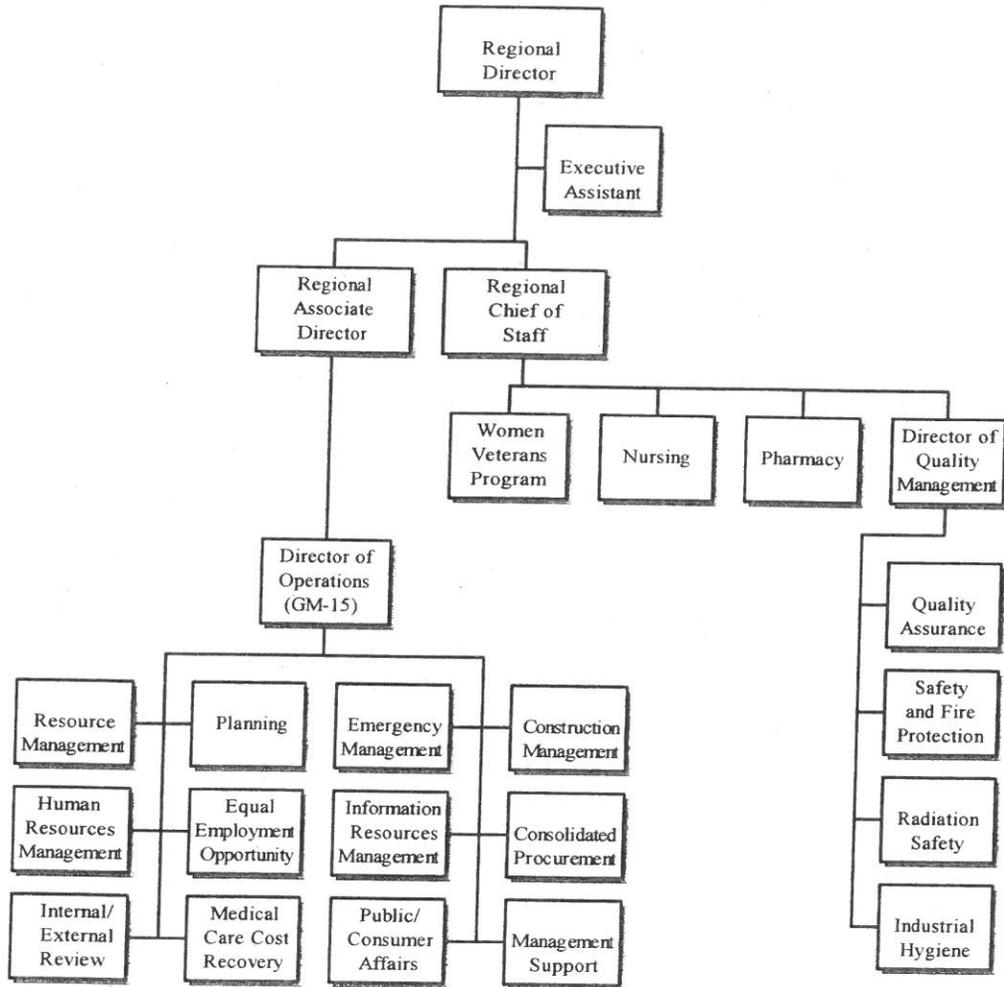
- A. Specification of the number of employees by which each covered office or facility affected is to be reduced, the responsibilities of those employees, and the means by which the reduction is to be accomplished.**

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 2.3

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.

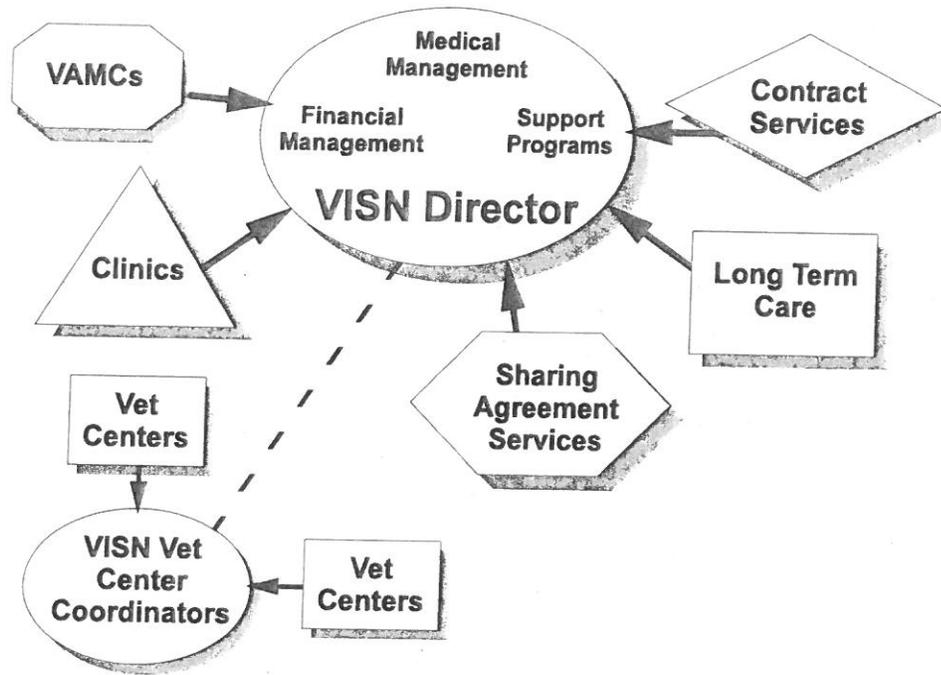
B. Identification of any existing or planned office or facility at which the number of employees is to be increased and specification of the number and responsibilities of the additional employees at each such office or facility.

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**

Estimated Disposition	Transfer Required	Staffing Option 1¹	Staffing Option 2¹
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 ²	50 ²
Positions currently vacant that will be abolished	---	97 ³	97 ³
Staff transferred to existing VA medical centers that will require relocation funding	Yes	30	66
Total	—	427⁴	427⁴

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

Staffing Category	Staffing Source	Transfer Required	Staffing Option 1	Staffing Option 2
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
Total	—	—	270	270

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>
Clinical Programs, e.g.,				
1. Eliminate overlaps/gaps in service		X		
2. Coordinate patient referrals	X	X		
3. Coordinate transplants				X
Construction	X		X	X
Equal Employment Oppor.	X		X	X
Fire and Safety	X		X	
Industrial Hygiene	X		X	
Medical Care Cost Recovery	X			X
Planning	X	X		X
Public/Consumer Affairs	X	X		X
Radiation Safety	X		X	
Resource Management	X	X		
Women Veterans Program	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 Structure¹

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

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.

CHAPTER 3

VHA Central Office Reorganization

I. Purpose: This chapter describes the Under Secretary's plan to restructure VHA's central office, which will be essential to the success of VHA's new field structure, as well as the system's long-term success. It should be noted that the scope and impact of the central office reorganization do not require a report to Congress under 38 U.S.C. §510, because the VHA headquarters staff will not be reduced by 50 percent or more in a fiscal year (38 U.S.C. §510(d)(2)). However, because the headquarters and field reorganizations are designed to complement each other, it is appropriate to provide information on the headquarters reorganization as an integral part of this report.

II. Background: The increased integration and flexibility in the field needs to be matched by a headquarters organization that is also more integrated and more flexible. Just as the field will become more patient-focused, so will VHA headquarters become more focused on systemwide issues that will improve the quality of care and the efficiency of care delivery.

In the past, the role of central office has been to manage the delivery of health care to veterans through a system of 159 largely independent, and often competing, medical centers. Central office has been very much "hands-on" and has promoted highly centralized decision making and process oversight. As described in the previous chapter, the field structure is being changed to 22 VISNs with substantial autonomy in operational decision making. Under this management scenario VHA headquarters will change its focus from operations and management control to the critical role of governing the overall veterans health care system and leading it through the

challenging times ahead. The Under Secretary intends that the reorganization embrace this new focus, actualize it, and create a supportive environment that ultimately produces real, measurable improvements in the health care provided to America's veterans.

III. Current Central Office Organization: The existing central office structure is shown in **Figure 2.2** (page 28). This structure, which has been in place since 1990, is hierarchical and supports a long-standing command and control environment. There is a line operations function, as well as clinical and administrative program groups. The latter two organizations include independent services that parallel the services in the VA medical centers, e.g., medicine, surgery, medical administration and environmental management. Traditionally, these headquarters services have developed and issued policy and provided operational guidance that are discipline-specific for their counterpart services in the field.

IV. Description and Rationale for Proposed Organization: Numerous reports have recommended significant changes to the central office structure and function (see **Appendix 7**). The current VHA central office structure has been criticized for being too narrowly focused and overly parochial. It is discipline specific rather than interdisciplinary, even though the latter have been shown to be more effective in delivering patient-focused care. Because patient care delivery patterns in the field have changed, central office must be restructured to better support the new delivery paradigm. The new headquarters needs to provide support for specific groups of patients or functions rather than advocacy for specific medical or technical disciplines. This concept is applied across the new organization to the extent that, whenever possible, offices are organized by function or "product line" rather than by discipline. However, headquarters will remain responsible for providing national leadership and representation for the many clinical,

technical and administrative disciplines represented in the VHA workforce. The specific day-to-day mechanisms for assuring the continuation of this important function will be developed during the implementation phase of the headquarters reorganization.

An important feature of the new organization is its flatness. The Under Secretary specifically wants to avoid creating layers of supervision in the organization. The location of a single Deputy Under Secretary within a unified Office of the Under Secretary, as opposed to the establishment of a distinct organizational layer for the Deputy, clearly demonstrates departure from the traditional hierarchical and compartmentalized organization. Also, the re-establishment of a single Deputy Under Secretary position shows the Under Secretary's intent that the administrative support, clinical, academic and research staffs are all part of one headquarters team. The lack of a tiered organizational structure and limitation of line authority to the Office of the Under Secretary also signals a new management philosophy for the headquarters, i.e., specific location on the organization chart should be a secondary consideration to the function one has. Important concerns for the headquarters will be how it works collegially on matters that affect service delivery in the field, and how it involves representatives from the networks and the medical centers in policy development and other activities affecting the field. In fact, the large number of offices having a direct reporting relationship to the Office of the Under Secretary will require a higher degree of cooperation and interdependence among headquarters staffs. The stovepipe organizations of the past and the bifurcation of the clinical and administrative offices will be replaced by an organizational structure that fosters teamwork and coordination.

The new headquarters organization will evolve through a three-step process. First, the headquarters staff will be reorganized as outlined in the new organizational charts and functional descriptions in **Figures 3.1 through 3.5** (pages 58-60) and **Appendix 5** respectively.

Next, the staff will identify those operational activities that can be decentralized to the field, and will make the necessary changes to policy manuals and directives. And third, the new core values and behaviors described at the end of this chapter will begin to become institutionalized so that the new VHA headquarters can provide the kind of leadership and direction the field will need and has a right to expect. Importantly, a significant part of this process will be to identify new functions the headquarters should perform that have not been done in the past due to the press of operational business. Among these will be a heightened emphasis on strategic planning, development of clinical guidelines and practice parameters, quality improvement and systemwide information management.

V. Criteria Underlying the Selection of the Proposed Structure: The primary criterion for changing the structure of central office is to enable and support change in the field that will improve the quality of care and the efficiency of the delivery of care provided to veterans.

However, there are unrelated government-wide changes in process whose objectives are congruous with this reorganization, e.g., the Vice President's National Performance Review and the Department's Streamlining Plan as presented to the Office of Management and Budget. The National Performance Review includes key principles that are clearly evident in the proposed organization. These include cutting red tape and micro-management, putting customers first, and empowering employees to get results by delegating authority and responsibility. The stated objectives of the VA Streamlining Plan include reducing the number of supervisors, eliminating some headquarters functions, positioning VA to deliver quality services in a competitive health care market, and flattening the organization. The proposed organization for VHA headquarters incorporates all of these overarching principles and demonstrates the Under Secretary's commitment to set the example for effective change that truly makes a difference in the way services are delivered throughout the system.

VI. Functional Responsibilities within the New Organization: The Under Secretary for Health will function as the Chief Executive Officer (CEO) and the Deputy Under Secretary for Health as the Chief Operating Officer (COO) of the Veterans Health Administration. All the organizational components in headquarters, including the Chief Network Officer, report to the CEO through the COO. The VISNs report to the Chief Network Officer who is located in the Office of the Under Secretary and is responsible for line management and coordination of network activities.

Functional descriptions for the new organization are included in **Appendix 5**. It is important to note that these descriptions provide a general overview of the new organization. More detailed information about the internal organization of each major office and staffing levels will be included in separate, more detailed implementation plans. The Under Secretary intends to establish an implementation team and work groups to complete the fine details of the blueprint for the headquarters reorganization.

VII. Staffing Requirements: No additional staffing is required to implement the new organization. The decentralization process that accompanies the reorganization will allow reallocation of existing staff to non-operational activities and create opportunities for achieving efficiencies in the future. Present central office employees whose positions are abolished as a result of the reorganization will be offered comparable positions in the new organization, transfers to the field, or early retirements if eligible. No employees are expected to be involuntarily separated because of this reorganization without first having received a bona fide job offer.

VIII. Resource Implications: No additional resources are needed to complete the reorganization in Fiscal Year 1995. There may be some costs associated with relocating

headquarters employees to the field to achieve future staffing reductions, but these costs will be absorbed within existing appropriations.

IX. Other Significant Issues: This reorganization will be unlike previous ones in that it is predicated on achieving a real change in organizational culture and values, operational delivery and accountability. Specific issues in this regard are discussed below.

- A. **Span of Control:** As with the field reorganization, it may appear that the reporting relationships to the Office of the Under Secretary are overly demanding. However, much of the operational activity that is currently brought to the Under Secretary's office will be decentralized or managed through the Chief Network Officer. Furthermore, the decentralization of operational activities and the headquarters emphasis on policy, guidelines and outcomes, together with changed behaviors and cultural values, will reduce the number of issues coming into the Office of the Under Secretary for action.

- B. **Decentralization and Restructuring Plan:** The Under Secretary will direct all VHA headquarters offices to identify all operational activities either performed in or controlled by headquarters that reasonably can be decentralized to the field. In conjunction with non-VHA offices that have parallel responsibilities at the Department level (e.g., the Office of Human Resources Management), decisions on decentralization will be made and the appropriate policy manuals and directives will be issued to effect the changes. The proposed time to complete this activity is 60 to 90 days from the date of the Under Secretary's initial directive.

Concurrent with this process, the program offices will reaffirm the need to retain those functions related to policy and governance, and they will identify activities that should be

assumed by headquarters to provide better support to the field. Once the decisions are made on this phase of the headquarters reorganization, it will be possible to reassess and redefine staffing needs within individual program offices. It is likely that some staffing efficiencies will result from this process.

- C. Accountability and Oversight:** In a decentralized environment, the traditional VHA forms of oversight of processes and inputs must give way to a more realistic and modern system that focuses on outcomes and bottom lines. As described in **Chapter 4**, the method and means of measuring the performance and assuring the accountability of the VISN directors in the future will be significantly different from the practices of today. In a similar manner, as the functions of headquarters change, so too will the performance requirements and measures. A detailed review of the existing system and development of performance contracts for headquarters executives and program officials will be accomplished by an implementation team. Emphasis will be placed on policy development and governance activities that support and facilitate the VISNs' ability to serve patients.
- D. Executive Titles:** The existing titles for central office executives reflect the hierarchical, highly centralized organization of the past. They also convey the perception of sharing in the line authority of the Under Secretary (formerly Chief Medical Director) — e.g., Associate Chief Medical Director and Assistant Chief Medical Director. Reorganization implementation activities will include proposals for new titles that will signify the staff relationship of all program officials in headquarters. The only line management to the VISNs will be the Office of the Under Secretary for Health (i.e., the Under Secretary, the Deputy Under Secretary and the Chief Network Officer).

E. Special Programs: There always has been a need in VHA to designate certain clinical activities for “special program” status. Typically, these are clinical services that address service-connected illnesses that are highly specific to the veteran population. Generally, these services have been ones that are unlikely to be adequately served by a market-driven system and ones for which VHA has developed unique expertise and resources. Congress has generally recognized these programs by targeting funding or taking other specific actions to emphasize their importance. The Under Secretary has designated a group of services as special programs, with the understanding that the list is likely to evolve over time. For example, at the beginning of the AIDS epidemic it was necessary to establish and develop the VHA's ability to treat growing numbers of AIDS patients. Special funding was identified, special tracking mechanisms were put in place and special training programs were developed. These actions gave AIDS “special program” status. The result of those efforts now — fifteen years into the AIDS epidemic — is that care for AIDS patients is an ongoing, integrated part of our health care delivery system. However, other urgent problems have emerged to replace it on the list of activities needing unique support. Two such examples are homelessness and the medical problems of Persian Gulf veterans. Each identified special program is different and requires different attention by management in the field and in headquarters. Transition implementation activities will include development of special measures that will be put in place for each designated program. The list of special programs is shown in **Table 3.1**.

A critically important aspect of the development of performance measures and evaluation monitors for the special programs will be involving not only expert VHA staff, but also interested stakeholders e.g., veterans service organizations and non-VA experts and professional organizations with expertise in the various programs. The goal is to ensure the broadest possible input into the development process.

VHA Special Programs

1. Blind Rehabilitation
2. Geriatrics and Long Term Care*
3. Homelessness
4. Persian Gulf Veterans Programs
5. Post Traumatic Stress Disorder
6. Preservation Amputation Care and Treatment (PACT)
7. Prosthetics and Orthotics
8. Readjustment Counseling
9. Seriously Mentally Ill
10. Spinal Cord Dysfunction
11. Substance Abuse
12. Women Veterans Programs

***NOTE:**

This includes the following specific geriatrics programs: Geriatrics Research, Evaluation and Clinical Centers (GRECCs); Community Contract Nursing Home Program; Hospital Based Home Care; and the State Home Program.

- F. **New Core Values and Behavior for VHA:** The benefits of the reorganization described in this chapter will be manifested only insofar as the values and behavior of those working in headquarters change. Some key aspects of the culture shift needed to make change work in headquarters are moving from micro-management to providing leadership, shifting from input control to output measurement, maintaining a customer focus all the way down the line to the patient, moving from specialization and independence to cooperation and interdependence, moving from standard operating procedures to value-added activities and striving to become "THE" place to work. **Chapter 5** includes further discussion about the cultural changes envisioned for VHA.

Figure 3.1

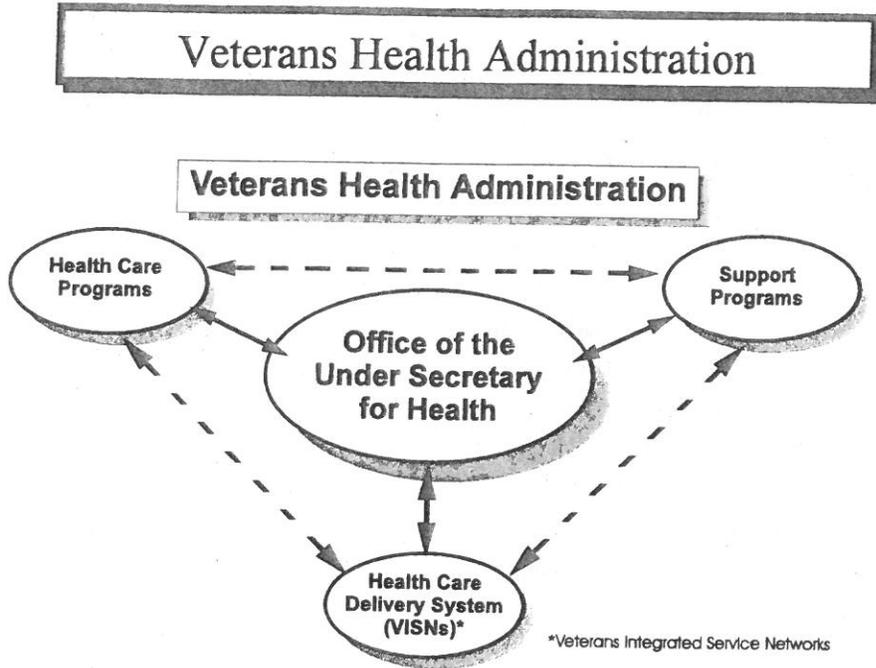


Figure 3.2

Veterans Health Administration:
Office of the Under Secretary for Health

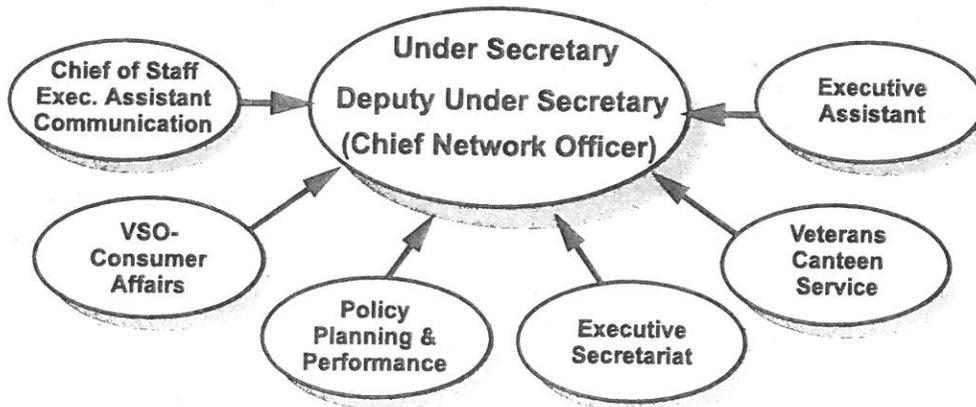


Figure 3.3

**Veterans Health Administration:
*Veterans Integrated Service Networks***

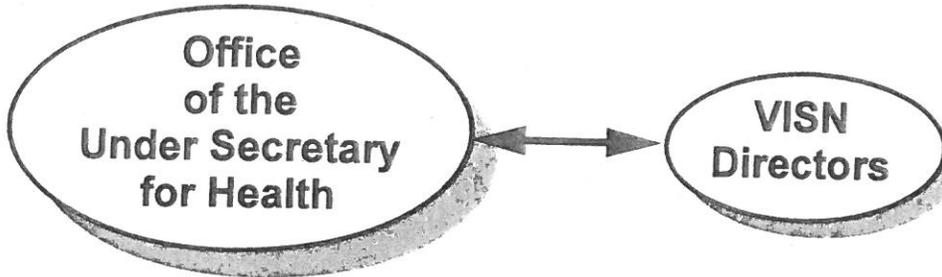


Figure 3.4

**Veterans Health Administration:
*Health Care Programs***

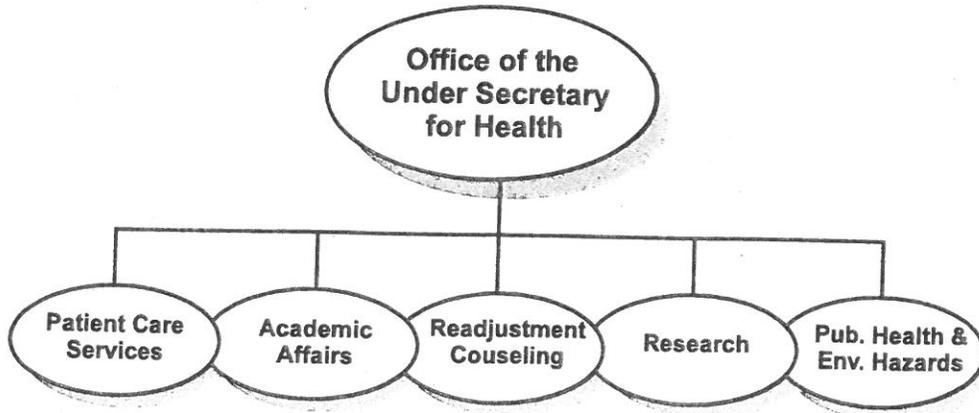
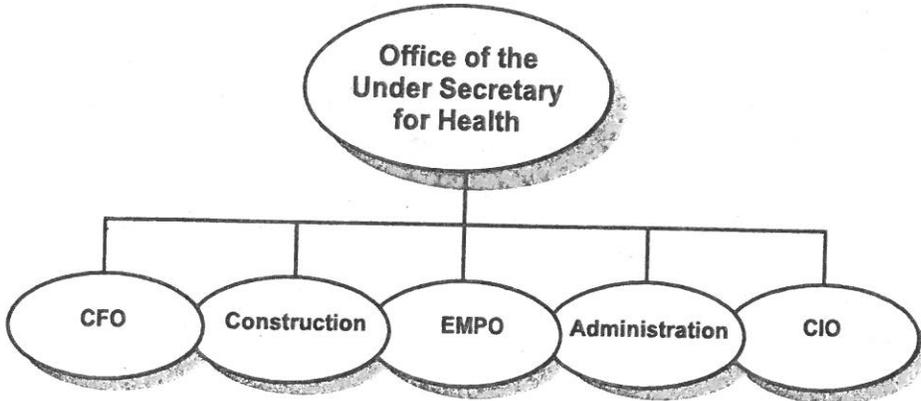


Figure 3.5

**Veterans Health Administration:
*Support Programs***



Chapter 4

VISN Performance Measurement and Systems Monitoring

I. Purpose: This chapter espouses a performance measurement and systems monitoring approach for VISN directors. Many of these measures can also be used for evaluating the consistency of performance systemwide. While this chapter focuses on performance contracts for VISN directors, the same approach will be applied to performance contracts for facility directors and headquarters executives as well.

II. Background -- The Need For A New Way of Performance Assessment: With decentralization of authority to the field comes a concomitant responsibility for ensuring accountability. For VHA, this means assuring that the organization's operating elements (i.e., the VISNs) are consistently providing high quality and efficient care, and achieving the goal of "Patients First."

Historically, VHA manager performance has been evaluated by a wide variety of inconsistent, often changing indices that were frequently subjective, not measurable and focused more on process than outcome. Empowerment of field managers and measurement of their performance by objective standards are crucial to a successful reorganization of VHA. Indeed, the Under Secretary envisions a negotiated performance contract with each VISN director as the mechanism for ensuring accountability in the new organization.

III. A Brief Overview: Performance monitoring of a large system such as VHA requires neither the development of a large number of measures nor the reporting of repeated measurements of large volume. Most large organizations, including private health care systems similar to VHA, effectively monitor and manage their systems using a modest number of key measures.

Important features of these key measures are that they are tightly linked to the organization's goals and its strategic plan for meeting those goals, that they are clearly understood throughout the organization, and that they are related to aspects or activities that can be changed. Usually, the best such measures are related to outcomes that are desired by the organization. Indeed, it has often been observed that people and systems pay attention to what is measured.

As part of the implementation of the VISN structure, policy will be developed to clearly define the methodology, scope and requirements of VHA's performance measurement and monitoring system. Included as part of this process will be the actual structure and verbiage of such contracts. At this time, it is expected that each contract will cover three general areas: (1) systemwide needs and tasks that all VISNs will be expected to complete (e.g., in the first year, the development of a 5 year strategic plan for meeting the needs of the VISN); (2) VISN specific efficiency and service delivery objectives predicated on past performance of that VISN or its component facilities, as directed by headquarters; and (3) VISN specific objectives as developed by VISN management.

A critical planning assumption for VHA is that it will be increasingly important to demonstrate to Congress and the public that VHA health care meets or exceeds community standards for patient satisfaction, access, quality and efficiency applicable to the specific communities in which VA facilities operate. For this reason, VHA plans to emphasize performance measures

that

allow for comparison with national and local private sector measures, as well as comparison with current performance evaluation trends supported by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The key performance monitors will be selected, as well, to be in concert with Secretary Brown's Performance Agreement with President Clinton, and will emphasize a climate of innovation not found at the present time. The data necessary to measure these categories are within existing VHA databases, and much of the information is comparable to that collected and analyzed by other health care organizations.

Because VHA will be expected to achieve improvements in all of these areas within the constraints of existing resources, it is important that the VISNs be held accountable for financial management and cost controls. Simple goals of improvement by 'x' percent or reduction by 'x' dollars should provide VHA with meaningful efficiencies in VISN operations. Some of the savings from improved operations will be reallocated by the Under Secretary to other VISNs or other systemwide priorities. Others will be used to improve access or delivery of services within that VISN.

Performance contracts will also address the support of education and research, as these partnerships have been a major factor in VA's achieving excellence in patient care. For more than 40 years, VHA has trained new health professionals to meet the changing patient care needs of the nation. Likewise, medical knowledge has been significantly expanded through VA-sponsored research. For these reasons, indices will be included to monitor the overall performance of VHA and the VISN directors for the appropriate balance and effectiveness of support for the education and research missions. As the fourth mission, emergency preparedness also will be included as a part of the performance contract with each VISN director.

Public policy and other organizational goals also will be monitored through performance contracts. For example, improvements in workforce diversity, labor-management partnerships, and education and training of staff will be addressed this way.

During the first year of implementation, each VISN will be required to develop a 5 year strategic plan that will have as its goal achieving the optimal alignment of VHA resources with service demand. The plan will be developed with the active participation of relevant stakeholders and submitted to the Office of the Under Secretary for approval. The plan will focus on all aspects of service delivery within the VISN, as well as the cultivation of a climate of cooperation and teamwork among VISNs. This atmosphere of collaboration must be fostered and supported by performance measures and must permeate all relationships, internal and external. The 5 year strategic plan will pay particular attention to establishing ambulatory care sites, such as community-based clinics and vet centers. Likewise, the use of non-physician primary care providers will be specifically addressed as a method to expand patient access and decrease waiting times, while also reducing VISN costs per patient. The plan will further review information management needs (particularly, ensuring timely availability of patient information throughout the VISN) and it will reassess the future need for existing scarce medical resource contracts based on VISN needs rather than on individual facility strengths and capabilities. And to assure uniformity of services throughout the VISN, the VISN director will establish average and major category baseline expenditure levels that transcend facility boundaries.

In summary, field units and senior managers will be held accountable for measurable achievements that will result in an improved veterans health care system. The resulting efficiencies will allow VHA to invest in new ways of providing high quality, efficient ambulatory and inpatient care to better meet veterans' expectations.

IV. Some Additional Details on Performance Measurement: The key areas of focus for the development of VHA performance measures include patient satisfaction, ease of access, quality and efficiency. These can be measured together in an interrelated manner to provide meaningful information that will allow improvement in one or more of the parameters while ensuring that the others do not suffer. These measures, varying from circumstance to circumstance, can be applied to product lines as well as to cohorts of patients. Although many potential measures exist, only a relatively few actually need be used in each of the specific areas.

The product line measures will reflect activity in such areas as ambulatory care, acute inpatient care, long term care, health promotion and disease prevention, rehabilitation or surgical care. Here, specific measures of patient feedback (e.g., satisfaction with timeliness of care, emotional support provided by caregivers, attention to transition between settings, etc.) could be obtained. Also measured could be costs of that type of care and the outcomes obtained for those costs. Outcome measures could include specific reflections of the type of care, such as evaluation of drug therapy in outpatients, frequency of need for hospitalization, functional recovery following rehabilitation, the mortality and morbidity rates following surgical procedures, or the acquired pressure sore rate for bedridden patients.

While product line measures can assess a major part of VHA activity, there are two other types of measures which can add significant information to the assessment of performance at all levels of the system. The first of these is the use of the measures mentioned above in specific cohorts of patients such as those with a chronic disease (e.g., diabetes, chronic obstructive lung disease or ulcers). Such patients are expected to be users of the system and will generate multiple encounters for evaluation. Further, their care will naturally cut across the product lines as they move from outpatient status to inpatient status, back to outpatient, to

rehabilitation, etc. Using measures of patient satisfaction, outcomes (including mortality and morbidity rates, number of admissions, number of outpatient visits, etc.) and costs in such cohorts will give VHA information about how well the system is handling the patients needing a continuum of care (as opposed to focusing on measures that reflect only episodic care). Many of the measures would be similar to those described above.

And while measures for assessing care across product lines and for cohorts of patients are necessary and important, they are insufficient to assess the system as a whole. There must be a second set of organizational measures which complement the outcomes assessment. These organizational measures are more structure and process oriented and include certain elements of the accreditation process carried out by the JCAHO. Other appropriate measures include employee satisfaction surveys, measures of the ease of access patients have to entering the system, specific output measures (e.g., volume of patients treated or the proportion of surgery performed in an ambulatory setting), overall patient satisfaction, and targeted measures of the value of educational, research and DoD backup activities.

Although a fairly broad range of measures are currently monitored by VHA, it is anticipated that only 12 to 20 select ones would be used for each of the performance contracts. Those chosen would be selected on the basis of the prior performance of the VISN or its component facilities. National experience is known in most of these measures, and VISNs or facilities positioned on the poor performance end of the scale would be expected to place emphasis on those areas and create improvement. Performance levels in each activity can be compared to national non-VA activity where that information exists; likewise, local information can be sought and used for comparison.

In recent years, VHA has gained fairly extensive experience with the measurement of outcomes and patient satisfaction. Several programs have provided useful information for local facilities to identify areas of excellence and areas where improvement is needed. A number of significant improvements have occurred throughout the system as a result of disseminating this information to all facilities. The recent measurement programs which have had an impact on improving care are the Quality Improvement Checklist and the External Peer Review Program. Although not perfect instruments, these programs are a strong first step toward meaningful, reliable measures. They are likely to serve as a foundation for a future comprehensive instrument that will more accurately measure what is intended.

Of note, two additional programs have recently been developed and are beginning to add patient level information to the local capability for change. These are the Surgical Quality Improvement Program and the Patient Feedback Program. For additional information about these programs, see Appendix 6.

Tables 4.1 through 4.9 (pages 68-72) provide examples of the kinds of performance data that the VHA is currently monitoring and for which it has sufficient baseline or background data to have established norms. This list is far from all inclusive and is intended to reflect a sample of the kinds of measurements likely to be considered as part of a performance measurement system. VHA has reasonable expectations that these data can be delineated in performance contracts that should result in overall systemwide improvement. This process will be refined further during the initial stages of implementation. It is important to note that the process will also be an evolving one which will continue to be refined as additional experience is gained.



Table 4.1

Examples of Performance Measures of Patient Satisfaction

I. General Indices of Patient Satisfaction

1. How satisfied were you with the care you received at this facility?
2. How would you evaluate the level of service you received at this facility?
3. Would you choose to receive your care at this facility again in the future?
4. Did you feel like you were treated with dignity and respect?

II. Timeliness as a Measure of Satisfaction

1. The number of days to enroll in a primary care program.
2. The number of days to get an appointment with a primary care provider.
3. The number of days to get an appointment in a specialty clinic.
4. The time to be seen by a caregiver after registering.
5. The time to obtain an outpatient prescription.

III. Ease of Access as a Measure of Satisfaction: The Availability of Community-based Access Points

1. The availability of community-based clinics within 30 minutes average travel time.
2. The availability of acute inpatient care within 30 to 60 minutes average travel time.
3. The availability of long term care within 30 to 60 minutes average travel time.

IV. Meeting Patient Concerns as a Measure of Satisfaction

1. Patient preferences, e.g., what were patients' perceptions about whether their wishes concerning diagnostic or treatment options were honored by the practitioners.
2. Providing emotional support, e.g., what were patients' perceptions about whether they could talk to their caregivers about their concerns.
3. Coordination of care, e.g., what were patients' perceptions about whether the treatment team communicated with each other and the patient.
4. Providing comfort, e.g., what were patients' perceptions of how well caregivers did in responding to requests for pain relief.
5. Transition to other forms of care, e.g., what were patients' perceptions about whether such movement was well planned.

Table 4.2

Examples of Performance Measures of Inpatient and Ambulatory Quality of Care

1. The percentage of patients seen within 30 days of hospital discharge.
2. The risk-adjusted cardiac surgery mortality rate.
3. The rate of acquired pressure sores in nursing home care units.
4. The number of outpatients being prescribed more than two neuroleptics.
5. The average time to begin thrombolytic therapy for patients with acute myocardial infarction.
6. The number of unplanned returns to the operating room.
7. The risk-adjusted length of stay for the 12 most common VHA Diagnosis-related Groups.

Table 4.3

Examples of Performance Measures of Financial Management and Efficiency

1. The ratio of inpatient to outpatient care costs.
2. The actual cost per inpatient stay.
3. The cost per outpatient visit.
4. The ratio of veterans receiving outpatient care to those receiving inpatient care.
5. The nursing home per patient direct and indirect cost.
6. The percentage of patients with multiple visits to the emergency room.
7. The pre-operative length of stay for all and for specific surgical procedures.
8. The average length of stay on acute care services.
9. The percentage of surgeries done as an outpatient.
10. The percent of MCCR payment denials.

Table 4.4

**Examples of Quality of Improvement Checklist (QUIC)
Performance Measures**

1. Incidence of nosocomial pneumonia in patients on mechanical ventilators per 1000 patient days of care.
2. Average time to administer thrombolytic therapy.
3. Incidence of employee needlestick injuries.
4. Readmission rate for alcohol and drug-related disorders.
5. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of upper gastrointestinal hemorrhage.
6. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of chronic obstructive pulmonary disease.
7. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of diabetic ketoacidosis.
8. Number of cardiac catheterization procedures.
9. Mortality rate within 24 hours of cardiac catheterization.
10. Number of percutaneous transluminal coronary angioplasty procedures.
11. Mortality rate within 24 hours of percutaneous coronary angioplasty.
12. Number of bronchoscopies.
13. Mortality rate within 24 hours of bronchoscopy.

Table 4.5

**Examples of External Peer Review Program (EPRP)
Performance Measures**

1. The accuracy of diagnosis for:
 - appendicitis
 - acute myocardial infarction
 - gastrointestinal obstruction
 - lung cancer
 - colon cancer
2. Adherence to established treatment guidelines for:
 - acute myocardial infarction
 - upper gastrointestinal hemorrhage
 - lower gastrointestinal hemorrhage
 - gastrointestinal obstruction
 - major depressive disorder
3. The incidence of complications or untoward outcomes following:
 - cholecystectomy
 - transurethral resection of the prostate
 - coronary artery bypass graft
 - carotid endarterectomy
 - abdominal aortic aneurysm repair

Table 4.6

Examples of Education and Research Specific Performance Measures

1. The number of individuals trained in the health professions by VISN facilities in collaboration with affiliated health professions schools.
2. The ratio of trainees in primary care disciplines to total trainees.
3. The research funding received by VISN facilities from non-VA sources.
4. The proportion of research funds that are devoted to clinical conditions that are of particular concern to veterans and that are consistent with the strategic goals of VHA.

Table 4.7

Examples of Public Policy and Organizational Goals for Performance Measures

1. The number of outreach activities to minorities and women.
2. The number of labor-management issues resolved through non-traditional labor-management processes (for example, partnership councils, interest based bargaining).
3. The number of employees completing the VISN training plan.
4. The average number of hours of education and training completed by VISN workforce.

Table 4.8

Examples of Special Program Performance Measures

1. The percentage of veterans with spinal cord dysfunction who receive annual examinations at a spinal cord injury center.
2. The incidence of grade II or worse hospital acquired decubitus ulcers.
3. The percent of newly injured veterans with spinal cord dysfunction who meet the functional expectations for their level of injury within one year of injury.
4. The number of blind patients who move from dependency to independent living within one year of entering rehabilitation.
5. The interval between initial contact and completion of a Persian Gulf War-related examination.
6. The percent of geriatric fellows who are practicing geriatrics or who have academic appointments two years after completion of training.

Table 4.9

Examples of Emergency Preparedness Performance Measures

1. Utilization of the VA Medical Center Emergency Preparedness Plan in conducting internal emergency operations and exercises.
2. Number of personnel trained, by job specialty, in selected emergency preparedness plans/areas.
3. Percentage of accuracy in quarterly VA/DoD contingency bed reporting.

CHAPTER 5

Implementation and Transition

I. Purpose: This chapter briefly addresses some issues related to the implementation of the national headquarters and field reorganizations, and identifies priorities for the future.

II. Background -- ‘Think Global, Act Local’: This restructuring plan provides the impetus for a profound paradigm shift in the provision of health care services to veterans. Central to this shift is the creation of a powerful interdependence that has not previously existed between field operations and central office. Now is the time to fully integrate all of VHA’s critical functions and re-focus each on the most important customer -- the veteran patient.

This reorganization is not a simple realignment of 159 independent medical centers, 33 networks and four regions into 22 VISNs. Nor is it a re-shuffling of bureaucratic boxes on a central office organizational chart. Rather, it is a fundamental change in the way responsibility is spread across many decision points in order to imbue the organization with a common sense of purpose. VHA will become less like a mega-corporation and more like a system of federated networks that are bound together by a determination to provide quality patient care. If roles are properly defined and executed, and if power, authority and accountability are balanced and dispersed throughout the organization, then the result will be an interdependent and interlocking system whose whole is greater than the sum of its parts.

“Think global, act local” is a fashionable slogan that embodies how VHA intends to function in the future. Strategic planning will become integrated with quality improvement in order to assure that the changing demands of the national health care environment are reflected in the

consistent delivery of local services. Patient care services, and most importantly VHA's recognized special programs, will benefit from a new way of thinking in which multi-functional teams will collaborate and offer expert consultative services for clinicians at the point of service delivery. Health care delivery will be shifted away from institutional inpatient modalities to network-based ambulatory solutions. And a renewed emphasis on data capture and information management will provide the vehicle for meaningful performance measurement and resultant accountability. VHA also recognizes the importance of maintaining its education and research activities. The responsibility to the next generation of clinicians will be best met if education, training and research efforts are supported by the restructuring of the delivery system.

III. Organizational Culture: At the VISN level, the bricks and mortar of individual institutions will no longer be the central point of patient services. While there will be additional flexibility and autonomy for local managers, independent decision making and parochial interests must be subsumed for the greater good of the geographic network. Community involvement and resource sharing will become the vehicles for outreach and expanded services. Program and resource decisions will be built on the shared vision of improved customer satisfaction, quality care, access and cost-effectiveness.

At the national headquarters level, the focus will move from a centralized organization that exercises a traditionally hierarchical mode of operational control toward a headquarters that supports the field, through governance and leadership, in its critical role of serving patients. Patient-care decision making will be exercised as close to the patient as possible, allowing headquarters to concentrate on leading the system through the dynamic and turbulent changes ahead. Ultimately, the goal is that the field will seek advice and counsel from headquarters

because headquarters has expertise to offer and adds value to field decision making, not because it is holding operational decisions hostage.

While this reorganization is dramatic in scope, the implementation of the new structure will be relatively simple when compared with the cultural change needed to make the operation truly effective. The Under Secretary recognizes that the inherent value and strength of VHA lie in the individuals who comprise the organization. The Under Secretary also acknowledges that, over time, VHA has instilled certain behaviors and attitudes in its employees that are not compatible with this new direction. VHA's responsibilities for two-way communication, job re-engineering, education and training are tremendous, and the Under Secretary is committed to providing the tools necessary to assure a smooth, orderly and compassionate transition. Additionally, the entire organization needs to demonstrate greater sensitivity to its various stakeholders, including veterans service organizations, employee unions, affiliated medical schools, and state and local health care entities.

IV. Education and Training: Change of this magnitude does not come quickly or easily, and changing an organization's culture is not a task for the fainthearted. Key to managing the change process and facilitating the acquisition of new skills is education and training. As part of the implementation plan, comprehensive education and training needs will be identified and options to meet those needs will be developed. For example, the VISN directors will need an orientation on the scope of responsibilities for this new position. New sets of skills, such as business planning, and performance measurement and systems monitoring, will need to be acquired.

V. Communication: Communication of both the spirit and the specifics of the transition plan to internal and external audiences is one of extreme importance. The internal VHA audience,

including both field and headquarters employees and volunteers, has been kept informed as the reorganization plan has been formulated. Senior managers at all levels, as well as employee representatives, have been given the opportunity to comment on two reorganization foundation documents as well as a draft of this reorganization report. The Under Secretary's vision for this transformation and its inherent culture change was also outlined in January during the annual VHA Senior Management Conference.

A comprehensive communication plan has been developed to assure that information is provided in a meaningful and timely manner. For example, a bulletin updating all VHA employees on the progress of the transition development group will be disseminated periodically, with copies also being sent to veterans service organizations and employee unions. Extensive use of the national VA magazine, VANGUARD, as well as satellite teleconferences, electronic mail and conference calls are integral parts of the communication strategy. Special briefings for congressional committee staffs, VSOs, top VA staff and others have been presented by the Under Secretary in an effort to personally convey the vision for the future VHA. Feature stories have run in U.S. Medicine, Modern Healthcare, AHA News and other publications, including VSO magazines. These have provided important insight into the impending changes transforming VHA. Local medical facilities are being encouraged to inform their individual communities of the changes that are planned and the benefits that will accrue to veteran beneficiaries in their service areas.

VI. Information Systems Management: Central to the success of this plan is the future development of financial and information management systems that support integrated networks. Modifications will be required to the current resource allocation model, known as Resource Planning and Management (RPM), in order to refine funding distribution at the VISN level, to accurately measure the financial needs of new programs and access points, and to

ensure that the model will meet the requirements of a financial monitoring system. Further, leadership of the

new structure will have tremendous demands for accurate and real-time information to aid decision making and monitor performance. These modifications and resources for the development of new models will have high priority.

VII. Implementation Plans: Many of the specific plans that are required to effect this transition are in various stages of formulation. The Under Secretary intends to establish an implementation team and various work groups to further develop and refine this plan to the level of detail necessary to effect its implementation at both the headquarters and field levels. This implementation team will consist of staff from headquarters and field elements and will have specific functional assignments. The team will work in close collaboration with internal and external stakeholders, such as employee unions and VSOs, and will seek expertise from outside consultants as necessary. Examples of issues to be addressed are:

- The selection process for VISN directors and other key VISN staff;
- Identification of the VISN office locations;
- Development of systems for resource allocation to VISNs;
- Reallocation of current region personnel, programs and functions;
- Development of policy for performance measurement and systems monitoring and the attendant performance contracts for field and headquarters executives;
- Development of education and training programs to support the organizational transformation;
- Integration of patient care databases for VISN management;
- Development of policies for supporting the special medical programs;
- Further definition of the functions of the support services centers;
- Further refinement of headquarters' functions; and
- Identification of functions to be decentralized.

VIII. The Transition: An extremely important aspect of this plan is its flexibility. For example, while the VISN boundaries are largely defined by patient referral patterns and natural planning groups, they can be altered over time, if warranted. State level health care reform is continuing in many parts of the country, and if state legislation dictates that a network be organized around state borders, the change can be implemented with little disruption to the system as a whole. Or if, after implementation, it becomes clear that a VISN is unwieldy because of its size, complexity or other factors, then alignment can be adjusted. The provision of health care services is a dynamic field, and the integrated networks must retain the agility necessary to thrive. VHA must also recognize that improvement comes from knowledge, knowledge from experience, experience from action, and action from planning and evaluation. Failure and paralysis are predictable when the status quo is blindly defended; success and growth are realized when initiative is valued and honest mistakes are tolerated.

The transition period poses special challenges because change of this magnitude is often accompanied by organizational anxiety and disruption of existing systems. The Under Secretary is committed, however, to minimizing these untoward effects through effective communication and education and by building on the enthusiasm and momentum this new vision creates. An important goal of the restructuring is that VHA become an employer of choice, an organization that thrives on the growth and development of its most important asset - its people.

The transition must be orderly and visible to all of our customers -- veterans, their families, employees, volunteers, vendors, academic affiliates, sharing partners, etc. The Under Secretary intends that in the first year after implementation, significant improvements will begin to catch the attention of our various publics in such a way that they energize the system for even more positive change in the future.

Appendices

Medical Care
Appropriation & Medical Consumer Price Index

FISCAL YEARS 1980 - 1995

MEDICAL CARE APPROPRIATION AND MEDICAL CONSUMER PRICE INDEX
FISCAL YEARS 1980 - 1995

FISCAL YEAR	ACTUAL APPROPRIATION (\$ 000)	MEDICAL CPI-U	MED. CPI-U ADJUSTED APPROP. 1/	UNIQUE INDIVIDUALS 2/	INPATIENT EPISODES 3/	OUTPAT. VISITS	TOTAL EPISODES	FTE	NUMBER OF FACILITIES			
									HOSP 5/	NURSING	DOM	OP. CLINICS
1980	5,832,039	10.73%	5,832,039		1,159,028	18,204,000	19,363,028	185,698	172	92	16	227
1981	6,339,396	10.33%	6,434,489		1,159,287	18,165,000	19,324,287	184,865	172	96	16	226
1982	7,101,028	11.89%	7,199,550		1,159,317	18,202,000	19,361,317	186,836	172	98	16	226
1983	7,773,254	9.78%	7,903,666		1,199,434	18,754,000	19,953,434	188,713	172	99	16	226
1984	8,244,414	6.37%	8,407,130		1,207,690	18,836,000	20,043,690	190,463	172	105	16	226
1985	8,971,169	6.11%	8,920,806		1,224,010	19,831,000	21,055,010	193,828	172	115	16	226
1986	9,130,137	7.25%	9,567,564		1,248,010	20,437,000	21,685,010	194,453	172	117	16	229
1987	9,728,303	7.05%	10,242,077		1,247,595	21,890,000	23,137,595	194,459	172	117	17	228
1988	10,151,387	6.34%	10,891,425		1,263,235	23,232,000	24,495,235	193,798	172	119	26	233
1989	10,887,671	7.22%	11,677,786	2,690,194	1,186,840	22,643,000	23,829,840	191,801	172	122	28	339
1990	11,436,306	8.84%	12,710,102	2,654,512	1,148,652	22,602,000	23,750,652	193,821	172	126	32	339
1991	12,335,330	9.11%	13,867,992	2,645,860	1,105,576	23,039,000	24,144,576	196,103	172	127	35	341
1992	13,625,685	7.67%	14,931,667	2,726,899	1,085,126	24,195,000	25,280,126	199,811	171	129	35	362
1993	14,642,723	6.29%	15,870,869	2,764,858	1,075,111	24,406,000	25,481,111	204,527	172	128	37	354
1994	15,640,150	4.95%	16,656,477	2,793,920	1,066,534	25,442,000	26,508,534	203,884	172	128	37	366
1995	16,214,684	5.00%	17,489,301	2,822,584	1,061,741	25,900,000	26,961,741	200,987	173	133	39	376
Change '80 to '95	\$10,382,645		\$11,657,262	132,390	(97,287)	7,696,000	7,598,713	15,289	1	41	23	149

1/ This column starts with a 1980 appropriation base and adds the annual Medical CPI percentage increase to it for each fiscal year.
2/ Validated data prior to 1989 not available.

3/ This includes both acute and long term care discharges plus those inpatients remaining in the VAMC at the end of the fiscal year (end of year census); Some patients are admitted more than once in the fiscal year.

4/ The change in unique individuals is for 1989 to 1995.

5/ The numbers in this column are derived from prior year budget documents. Please see footnote 2, page 12.

The Medical Care appropriation for the years 1981 to 1995 is short \$10.5 billion from an appropriation for this period adjusted by the Bureau of Labor Statistics Medical Consumer Price Index (MCPI). In 1995 alone, the shortfall is \$1.27 billion. Also, since 1980 there have been significant VA program expansions. That is, new programs have been added or expanded such as PTSD, Persian Gulf services, Ionizing radiation, Agent Orange and other health services that are unique to veterans. In addition, new installations have been constructed and activated including hospitals, nursing homes, domiciliarys and outpatient clinics. The chart provides some indicators of program growth as measured by increases in the number of individual veterans receiving VA health care, staffing, and episodes of care (outpatient and in total reflecting a shift from inpatient to ambulatory care).

Type of VHA Access Point

Hospital, Nursing Home,
Domiciliary, Outpatient Site

Facility Type Abbreviated in the Appendix

DOM	VA domiciliaries co-located with a VA hospital
IDM	Independent Domiciliary
IOC	Independent Outpatient Clinic (clinic has its own Director and Chief of Staff)
NHC	VA Nursing Home Care units co-located with a VA hospital
OPC(CBC)	Outpatient Clinic (Community-based Clinic)
OPC(MobileClinic)	Outpatient Clinic (Mobile Outpatient Clinic)
OPC(ORC)	Outpatient Clinic (Outreach Clinic)
OPC(ROC)	Outpatient Clinic (Outpatient Clinic located at a Veterans Benefit Regional Office)
OPC(SOC)	Outpatient Clinic (Satellite Outpatient Clinic)
RCS	Readjustment Counseling Center
VAMC	Veterans Affairs Medical Center
VAM&ROC	VA Medical and Regional Office Center

Type of VHA Access Point Hospital, Nursing Home, Domiciliary, Outpatient Site

<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
1	TOGUS(1), ME	VAM&ROC	NHC
1	Bangor	OPC (ORC)	
1	Calais	OPC(MobileClinic)	
1	Caribou	OPC (CBC)	
1	Machias	OPC(MobileClinic)	
1	Portland	OPC (ORC)	
1	WHITE RIVER JCT(1), VT	VAM&ROC	NHC
1	Burlington	OPC(MobileClinic)	
1	Keene	OPC (ORC)	
1	Montpelier	OPC (ORC)	
1	Newport	OPC (ORC)	
1	Rutland	OPC (ORC)	
1	St. Johnsbury	OPC (ORC)	
1	Wilder	OPC (ORC)	
1	North Troy	OPC(MobileClinic)	
1	St. Albans	OPC(MobileClinic)	
1	BEDFORD, MA	VAMC	NHC/DOM
1	Lowell Veterans Community Center (2)	OPC (CBC)	
1	Winchenden Day Care Center (2)	OPC (CBC)	
1	BOSTON, MA	VAMC	
1	Boston	OPC (SOC)	
1	Lowell	OPC (SOC)	
1	BROCKTON, MA	VAMC	NHC/DOM
1	WEST ROXBURY, MA	VAMC	
1	Worcester	OPC (SOC)	
1	MANCHESTER, NH	VAMC	NHC
1	NEWINGTON, CT	VAMC	
1	Willimantic (2)	OPC (ORC)	
1	Windham (2)	OPC (ORC)	
1	NORTHAMPTON, MA	VAMC	NHC
1	Greenfield	OPC (ORC)	
1	Northampton	OPC (CBC)	
1	Pittsfield	OPC (ORC)	
1	Springfield	OPC (SOC)	
1	Springfield	OPC (CBC)	
1	PROVIDENCE, RI	VAMC	
1	New Bedford	OPC (CBC)	
1	WEST HAVEN, CT	VAMC	NHC
2	ALBANY, NY	VAMC	NHC
2	Albany	OPC (CBC)	
2	Elizabethtown	OPC (ORC)	
2	Plattsburg	OPC (ORC)	
2	Sidney (Southern)	OPC (ORC)	
2	BATAVIA, NY	VAMC	NHC

1. Mobil Clinic parent facility.
2. Clinic under development or station number not assigned.

<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
2	Rochester	OPC (SOC)	
2	BATH, NY	VAMC	NHC/DOM
2	BUFFALO, NY	VAMC	NHC
2	Buffalo	OPC (ORC)	
2	Buffalo	OPC (CBC)	
2	CANANDAIGUA, NY	VAMC	NHC/DOM
2	Geneva	OPC (ORC)	
2	Ithaca (PTSD)	OPC (ORC)	
2	Ithaca (SATP)	OPC (ORC)	
2	Lyons	OPC (ORC)	
2	Sonyea	OPC (ORC)	
2	SYRACUSE, NY	VAMC	NHC
2	Fort Drum	OPC (CBC)	
2	Massena	OPC (CBC)	
3	BRONX, NY	VAMC	NHC
3	BROOKLYN (Poly Pl.), NY	VAMC	
3	BROOKLYN(St Albans-Div), NY	VAMC	NHC/DOM
3	Brooklyn	OPC (SOC)	
3	CASTLE POINT, NY	VAMC	NHC
3	EAST ORANGE, NJ	VAMC	NHC
3	Brick	OPC (SOC)	
3	LYONS, NJ	VAMC	NHC/DOM
3	Jamesburg	OPC (ORC)	
3	MONTROSE, NY	VAMC	NHC/DOM
3	Carmel	OPC (ORC)	
3	White Plains	OPC (ORC)	
3	NEW YORK, NY	VAMC	
3	New York	OPC (SOC)	
3	NORTHPORT, NY	VAMC	NHC
3	Hicksville	OPC (ORC)	
3	Islip	OPC (ORC)	
3	Lindenhurst	OPC (ORC)	
3	Lynbrook	OPC (ORC)	
3	Mt. Sinai	OPC (ORC)	
3	Patchogue	OPC (ORC)	
3	Riverhead	OPC (ORC)	
3	Sayville	OPC (ORC)	
4	WILMINGTON, DE	VAMC	NHC
4	Linwood	OPC (ORC)	
4	Vineland	OPC (ORC)	
4	ALTOONA, PA	VAMC	NHC
4	BUTLER, PA	VAMC	NHC/DOM
4	CLARKSBURG, WV	VAMC	
4	Tucker (2)	OPC (CBC)	
4	Wood (2)	OPC (CBC)	
4	COATESVILLE, PA	VAMC	NHC/DOM

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<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
4	Philadelphia	OPC (CBC)	
4	Springfield	OPC (CBC)	
4	ERIE, PA	VAMC	NHC
4	LEBANON, PA	VAMC	NHC
4	Harrisburg	OPC (CBC)	
4	PHILADELPHIA, PA	VAMC	NHC
4	PITTSBURGH (Highland Drive), PA	VAMC	DOM
4	PITTSBURGH (University Drive), PA	VAMC	NHC
4	St. Clairsville	OPC (CBC)	
4	PITTSBURGH (Aspinwall-Div), PA	VAMC	
4	WILKES BARRE, PA	VAMC	NHC
4	Allentown	OPC (SOC)	
4	Sayre	OPC (CBC)	
5	BALTIMORE, MD	VAMC	
5	FORT HOWARD, MD	VAMC	NHC
5	MARTINSBURG, WV	VAMC	NHC/DOM
5	Cumberland	OPC (CBC)	
5	PERRY POINT, MD	VAMC	NHC
5	Cambridge	OPC (CBC)	
5	WASHINGTON, DC	VAMC	NHC
5	Washington	OPC (ORC)	
6	BECKLEY, WV	VAMC	NHC
6	DURHAM, NC	VAMC	NHC
6	FAYETTEVILLE, NC(1)	VAMC	NHC
6	Beaufort	OPC(MobileClinic)	
6	Belhaven	OPC(MobileClinic)	
6	Greenville	OPC(MobileClinic)	
6	Jacksonville	OPC(MobileClinic)	
6	Kill Devil Hills	OPC(MobileClinic)	
6	Kinston	OPC(MobileClinic)	
6	New Bern	OPC(MobileClinic)	
6	Shalotte	OPC(MobileClinic)	
6	Whiteville	OPC(MobileClinic)	
6	Willmington	OPC(MobileClinic)	
6	HAMPTON, VA	VAMC	NHC/DOM
6	Norfolk	OPC (CBC)	
6	ASHEVILLE, NC	VAMC	NHC
6	RICHMOND, VA	VAMC	NHC
6	SALEM, VA	VAMC	NHC
6	Covington	OPC (ORC)	
6	Danville	OPC (ORC)	
6	Hillsville	OPC (ORC)	
6	Lynchburg	OPC (ORC)	
6	Marion	OPC (ORC)	
6	Martinsville	OPC (ORC)	

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<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
6	Pulaski	OPC (ORC)	
6	Stuarts Draft	OPC (ORC)	
6	SALISBURY, NC	VAMC	NHC
6	Winston-Salem	OPC (SOC)	
7	ATLANTA, GA	VAMC	NHC
7	AUGUSTA (Downtown-Div), GA	VAMC	
7	AUGUSTA (Uptown), GA	VAMC	NHC
7	BIRMINGHAM, AL	VAMC	
7	Huntsville (B)	OPC (CBC)	
7	CHARLESTON, SC	VAMC	
7	Savannah	OPC (SOC)	
7	COLUMBIA, SC	VAMC	NHC
7	Greenville	OPC (SOC)	
7	DUBLIN, GA	VAMC	NHC/DOM
7	MONTGOMERY, AL	VAMC	
7	TUSCALOOSA, AL	VAMC	NHC
7	Anniston	OPC (ORC)	
7	Decatur	OPC (ORC)	
7	Florence	OPC (ORC)	
7	Gadsden	OPC (ORC)	
7	Huntsville	OPC (ORC)	
7	TUSKEGEE, AL	VAMC	NHC
7	Columbus	OPC (CBC)	
8	BAY PINES, FL	VAMC	NHC/DOM
8	Fort Myers	OPC (SOC)	
8	MIAMI, FL	VAMC	NHC
8	Key West	OPC (CBC)	
8	Miami	OPC (CBC)	
8	Oakland Park	OPC (SOC)	
8	WEST PALM BEACH, CA	VAMC	
8	Riviera Beach	OPC (SOC)	
8	GAINESVILLE, FL	VAMC	NHC
8	Daytona Beach	OPC (SOC)	
8	Jacksonville	OPC (SOC)	
8	LAKE CITY, FL	VAMC	NHC
8	Tallahassee	OPC (SOC)	
8	SAN JUAN, PR	VAMC	NHC
8	Mayaguez	OPC (SOC)	
8	Ponce	OPC (SOC)	
8	St. Croix	OPC (CBC)	
8	St. Thomas	OPC (CBC)	
8	TAMPA, FL	VAMC	NHC
8	Orlando	OPC (SOC)	
8	Port Richey	OPC (SOC)	
9	HUNTINGTON, WV	VAMC	

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<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
9	Prestonsburg	OPC (CBC)	
9	LEXINGTON (Cooper Drive-Div), KY	VAMC	
9	LEXINGTON (Leestown-Div), KY	VAMC	NHC
9	Campton	OPC(MobileClinic)	
9	Harrisburg	OPC(MobileClinic)	
9	London	OPC(MobileClinic)	
9	Millersburg	OPC(MobileClinic)	
9	Morehead	OPC(MobileClinic)	
9	Mt. Sterling	OPC(MobileClinic)	
9	Ravenna	OPC(MobileClinic)	
9	Slemmingsburg	OPC(MobileClinic)	
9	Sommerset	OPC(MobileClinic)	
9	Stanford	OPC(MobileClinic)	
9	Lexington Multi-site	OPC (ORC)	
9	LOUISVILLE, KY	VAMC	
9	MEMPHIS, TN	VAMC	NHC
9	MOUNTAIN HOME, TN	VAMC	NHC/DOM
9	MURFREESBORO, TN	VAMC	NHC
9	Chattanooga	OPC (SOC)	
9	Cookeville	OPC (ORC)	
9	Tullahoma	OPC (CBC)	
9	NASHVILLE, TN	VAMC	
9	Knoxville	OPC (SOC)	
10	CHILLICOTHE, OH	VAMC	NHC
10	Columbus	OPC (ORC)	
10	CINCINNATI, OH	VAMC	
10	CINCINNATI (Ft. Thomas), OH		NHC/DOM
10	CLEVELAND, OH	VAMC	
10	CLEVELAND (Brecksville-Div), OH	VAMC	NHC/DOM
10	Canton	OPC (SOC)	
10	Youngstown	OPC (SOC)	
10	DAYTON, OH	VAMC	NHC/DOM
10	Springfield	OPC (ORC)	
10	COLUMBUS, OH	IOC	
11	ANN ARBOR, MI	VAMC	NHC
11	Toledo	OPC (SOC)	
11	BATTLE CREEK, MI	VAMC	NHC
11	Grand Rapids	OPC (SOC)	
11	DANVILLE, IL	VAMC	NHC
11	Decatur	OPC (CBC)	
11	Peoria	OPC (SOC)	
11	ALLEN PARK, MI	VAMC	NHC
11	FORT WAYNE, IN	VAMC	NHC
11	INDIANAPOLIS (10th St.-Div), IN	VAMC	
11	INDIANAPOLIS (Cold Spring Rd.), IN	VAMC	NHC

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<i>VISN</i>	<i>FACILITY</i>		<i>ACUTE</i>	<i>LTC</i>
11	MARION, IN		VAMC	NHC
11	SAGINAW, MI		VAMC	NHC
11	Gaylord		OPC (CBC)	
12	CHICAGO (Lakeside), IL		VAMC	
12	Crown Point		OPC (SOC)	
12	CHICAGO (West Side), IL		VAMC	
12	NORTH CHICAGO, IL		VAMC	NHC/DOM
12	Rockford		OPC (ORC)	
12	HINES, IL		VAMC	NHC
12	Joliet	(2)	OPC (ORC)	
12	IRON MOUNTAIN, MI		VAMC	NHC
12	Marquette		OPC (ORC)	
12	MADISON, WI		VAMC	
12	TOMAH, WI		VAMC	NHC
12	Eau Clair	(2)	OPC (ORC)	
12	Loyal		OPC (ORC)	
12	Wautoma		OPC (ORC)	
12	MILWAUKEE, WI		VAMC	NHC/DOM
12	Fox Valley		OPC (SOC)	
13	FARGO, ND		VAM&ROC	NHC
13	SIOUX FALLS, SD		VAM&ROC	NHC
13	FORT MEADE, SD		VAMC	NHC
13	HOT SPRINGS, SD		VAMC	DOM
13	Alliance		OPC (ORC)	
13	Kyle		OPC (ORC)	
13	Newcastle		OPC (ORC)	
13	Pine Ridge		OPC (ORC)	
13	Rushville		OPC (ORC)	
13	MINNEAPOLIS, MI		VAMC	NHC
13	Superior		OPC (SOC)	
13	ST CLOUD, MN		VAMC	NHC/DOM
13	Hibbing	(2)	OPC (ORC)	
13	Virginia	(2)	OPC (ORC)	
14	DES MOINES, IA		VAMC	DOM
14	Mason City		OPC (ORC)	
14	GRAND ISLAND, NE		VAMC	NHC
14	IOWA CITY, IA		VAMC	
14	Bettendorf(Quad Cities)		OPC (SOC)	
14	Quincy		OPC (CBC)	
14	KNOXVILLE, IA		VAMC	NHC/DOM
14	Marshalltown (K)		OPC (ORC)	
14	Ottumwa		OPC (ORC)	
14	LINCOLN, NE		VAMC	
14	OMAHA, NE		VAMC	
15	WICHITA, KS		VAM&ROC	NHC

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<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
15	COLUMBIA, MO	VAMC	NHC
15	KANSAS CITY, MO	VAMC	
15	MARION, IL	VAMC	NHC
15	Evansville	OPC (SOC)	
15	POPLAR BLUFF(1), MO	VAMC	NHC
15	Hayti	OPC(Mobile Clinic)	
15	Houston	OPC(Mobile Clinic)	
15	Ironton	OPC(Mobile Clinic)	
15	Lebanon	OPC(Mobile Clinic)	
15	Paragould	OPC(Mobile Clinic)	
15	Perryville	OPC(Mobile Clinic)	
15	Salem	OPC(Mobile Clinic)	
15	West Plain	OPC(Mobile Clinic)	
15	West Plains	OPC(Mobile Clinic)	
15	ST LOUIS (Jefferson Baracks-Div), MO	VAMC	NHC/DOM
15	ST LOUIS (John Cochran), MO	VAMC	
15	TOPEKA, KS	VAMC	NHC
15	Abelene (2)	OPC (ORC)	
15	Chanute (2)	OPC (ORC)	
15	Emporia (2)	OPC (ORC)	
15	Garnet (2)	OPC (ORC)	
15	Junction City (2)	OPC (ORC)	
15	Lawrence (2)	OPC (ORC)	
15	Russell (2)	OPC (ORC)	
15	Seneca (2)	OPC (ORC)	
15	Topeka Multi-site	OPC (ORC)	
15	LEAVENWORTH, KS	VAMC	NHC/DOM
16	ALEXANDRIA, LA	VAMC	NHC
16	Jennings	OPC (CBC)	
16	BILOXI , MS	VAMC	
16	BILOXI (Gulfport-Div), MS	VAMC	NHC/DOM
16	Mobile	OPC (CBC)	
16	Pensacola	OPC (SOC)	
16	FAYETTEVILLE, AR	VAMC	
16	Mt. Vernon	OPC (SOC)	
16	HOUSTON, TX	VAMC	NHC
16	Beaumont	OPC (SOC)	
16	Lufkin	OPC (SOC)	
16	JACKSON, MS	VAMC	NHC
16	LITTLE ROCK, AR	VAMC	
16	NORTH LITTLE ROCK, AR	VAMC	NHC/DOM
16	MUSKOGEE, OK	VAMC	
16	Talihina	OPC (ORC)	
16	Tulsa	OPC (SOC)	
16	NEW ORLEANS, LA	VAMC	NHC

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<i>VISN</i>	<i>FACILITY</i>		<i>ACUTE</i>	<i>LTC</i>
16	Baton Rouge		OPC (SOC)	
16	OKLAHOMA CITY, OK		VAMC	
16	Ardmore		OPC (ORC)	
16	Clinton		OPC (ORC)	
16	Lawton		OPC (CBC)	
16	SHREVEPORT, LA		VAMC	
16	Texarkana		OPC (CBC)	
17	BONHAM, TX		VAMC	NHC/DOM
17	DALLAS, TX		VAMC	NHC/DOM
17	Fort Worth		OPC (SOC)	
17	KERRVILLE, TX		VAMC	NHC
17	MARLIN, TX		VAMC	
17	SAN ANTONIO, TX		VAMC	NHC
17	Corpus Christi		OPC (SOC)	
17	Laredo		OPC (CBC)	
17	McAllen		OPC (SOC)	
17	San Antonio		OPC (SOC)	
17	Victoria		OPC (CBC)	
17	TEMPLE, TX		VAMC	NHC/DOM
17	Austin		OPC (SOC)	
17	WACO, TX		VAMC	NHC/DOM
17	Hamilton	(2)	OPC (ORC)	
18	ALBUQUERQUE, NM		VAMC	NHC
18	Artesia		OPC (CBC)	
18	Farmington		OPC (CBC)	
18	Gallup		OPC (ORC)	
18	Las Vegas	(2)	OPC (ORC)	
18	Raton		OPC (ORC)	
18	Silver City		OPC (CBC)	
18	AMARILLO, TX		VAMC	NHC
18	Clayton, NM		OPC (CBC)	
18	Clovis		OPC (SOC)	
18	Lubbock		OPC (SOC)	
18	Memphis		OPC (CBC)	
18	Stratford	(2)	OPC (ORC)	
18	BIG SPRING, TX		VAMC	NHC
18	PHOENIX, AZ		VAMC	NHC
18	Sun City (NorthWest)		OPC (CBC)	
18	Willams AFB (Mesa)		OPC (SOC)	
18	PRESCOTT(1), AZ		VAMC	NHC/DOM
18	Bullhead City		OPC(MobileClinic)	
18	Flagstaff		OPC(Mobile Clinic)	
18	Kingman		OPC(MobileClinic)	
18	Lake Havasu City		OPC(MobileClinic)	
18	Parker		OPC(MobileClinic)	

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<i>VISN</i>	<i>FACILITY</i>		<i>ACUTE</i>	<i>LTC</i>
18	Show Low		OPC(MobileClinic)	
18	Winslow		OPC(MobileClinic)	
18	Yuma		OPC(MobileClinic)	
18	TUCSON, AZ		VAMC	NHC
18	EL PASO, TX		IOC	
18	Las Cruces		OPC (CBC)	
19	FORT HARRISON, MT		VAM&ROC	
19	Browning	(2)	OPC (ORC)	
19	Columbia Falls	(2)	OPC (ORC)	
19	CHEYENNE, WY		VAM&ROC	NHC
19	DENVER, CO		VAMC	NHC
19	Colorado Springs		OPC (CBC)	
19	Fort Collins	(2)	OPC (CBC)	
19	Fort Morgan	(2)	OPC (CBC)	
19	Pueblo	(2)	OPC (ORC)	
19	Denver Multi-site		OPC (ORC)	
19	FORT LYON, CO		VAMC	NHC
19	La Junta		OPC (ORC)	
19	GRAND JUNCTION, CO		VAMC	NHC
19	MILES CITY, MT		VAMC	NHC
19	Billings		OPC (CBC)	
19	SALT LAKE CITY, UT		VAMC	
19	Pocatello		OPC (CBC)	
19	SHERIDAN, WY		VAMC	NHC
19	Gillette		OPC (CBC)	
19	Casper	(2)	OPC (CBC)	
20	ANCHORAGE, AK		OPC (ROC)	DOM
20	AMERICAN LAKE, WA		VAMC	NHC/DOM
20	BOISE, ID		VAMC	NHC
20	PORTLAND, OR		VAMC	
20	PORTLAND (Vancouver-Div), OR		VAMC	NHC/DOM
20	Portland		OPC (SOC)	
20	ROSEBURG, OR		VAMC	NHC
20	Bandon		OPC (CBC)	
20	Eugene		OPC (SOC)	
20	SEATTLE, WA		VAMC	NHC
20	Retsil	(2)	OPC (ORC)	
20	SPOKANE(1), WA		VAMC	NHC
20	Bonniers Ferry		OPC(MobileClinic)	
20	Coulee Dam		OPC(MobileClinic)	
20	East Wenatchee		OPC(MobileClinic)	
20	Kettle Falls		OPC(MobileClinic)	
20	Lewiston		OPC(MobileClinic)	
20	Libby		OPC(MobileClinic)	
20	Moscow		OPC(MobileClinic)	

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<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
20	Moses Lake	OPC(MobileClinic)	
20	Okanogan	OPC(MobileClinic)	
20	Osborn	OPC(MobileClinic)	
20	Plummer	OPC(MobileClinic)	
20	Republic	OPC(MobileClinic)	
20	WALLA WALLA, WA	VAMC	NHC
20	Yakima	OPC (ORC)	
20	WHITE CITY, OR		IDM
21	MANILA, Republic of the Philippines	OPC (ROC)	
21	HONOLULU, HI	OPC (ROC)	
21	Agana (Guam)	OPC (CBC)	
21	Hilo	OPC (CBC)	
21	Kailua-Kona	OPC (CBC)	
21	Lihue	OPC (CBC)	
21	Wailuku	OPC (CBC)	
21	FRESNO, CA	VAMC	NHC
21	PALO ALTO (Livermore-Div), CA	VAMC	NHC
21	Modesto	OPC (ORC)	
21	Stockton	OPC (ORC)	
21	MARTINEZ(NCSC), CA	IOC	
21	Berkeley	OPC (CBC)	
21	Martinez (Day Hospital)	OPC (CBC)	
21	Oakland	OPC (SOC)	
21	Redding	OPC (SOC)	
21	Sacramento	OPC (SOC)	
21	Martinez	OPC (SOC)	
21	PALO ALTO, CA	VAMC	
21	PALO ALTO (Menlo Park-Div), CA	VAMC	NHC/DOM
21	Marina (2)	OPC (ORC)	
21	San Jose (Mental Hyg.)	OPC (SOC)	
21	RENO, NV	VAMC	NHC
21	SAN FRANCISCO, CA	VAMC	NHC
21	Eureka (2)	OPC (ORC)	
21	Lakeport (2)	OPC (ORC)	
21	Ukiah (2)	OPC (ORC)	
21	Yountville	OPC (ORC)	
22	LAS VEGAS, NV	VAMC	
22	LONG BEACH, CA	VAMC	NHC
22	LOMA LINDA, CA	VAMC	NHC
22	SAN DIEGO, CA	VAMC	NHC
22	San Diego(Mission Valley)	OPC (SOC)	
22	SEPULVEDA, CA	VAMC	NHC
22	Bakersfield	OPC (SOC)	
22	WEST LOS ANGELES, CA	VAMC	
22	WEST LOS ANGELES (Brentwood-Div), CA	VAMC	NHC/DOM

1. Mobil Clinic parent facility.
2. Clinic under development or station number not assigned.

<i>VISN</i>	<i>FACILITY</i>	<i>ACUTE</i>	<i>LTC</i>
22	Los Angeles	OPC (CBC)	
22	Santa Barbara	OPC (SOC)	
22	LOS ANGELES, CA	IOC	
22	East Los Angeles	OPC (CBC)	
22	Weingart (2)	OPC (ORC)	

1. Mobil Clinic parent facility.
2. Clinic under development or station number not assigned.

A List of VHA
Vet Centers

A List of VHA Vet Centers

<i>Place</i>	<i>Region</i>	<i>State</i>
Regional Manager Office-1A	Providence	RI
Hartford	1A	CT
New Haven	1A	CT
Norwich	1A	CT
Avon	1A	MA
Boston	1A	MA
Lowell	1A	MA
New Bedford	1A	MA
Springfield	1A	MA
Worcester	1A	MA
Bangor	1A	MA
Caribou	1A	ME
Lewiston	1A	ME
Portland	1A	ME
Sanford	1A	ME
Manchester	1A	ME
Jersey City	1A	NH
Newark	1A	NJ
Trenton	1A	NJ
Albany	1A	NJ
Bronx	1A	NY
Brooklyn	1A	NY
Buffalo	1A	NY
Harlem	1A	NY
Long Island	1A	NY
Manhattan	1A	NY
Queens	1A	NY
Rochester	1A	NY
Staten Island	1A	NY
Syracuse	1A	NY
White Plains	1A	NY
Providence	1A	RI
S. Burlington	1A	VT
White River Junction	1A	VT

Appendix 3.

A List of VHA Vet Centers

<i>Place</i>	<i>Region</i>	<i>State</i>
Regional Manager Office-1B	Baltimore	MD
Washington, DC	1B	DC
Wilmington	1B	DE
Lexington	1B	KY
Louisville	1B	KY
Baltimore	1B	MD
Elkton	1B	MD
Silver Spring	1B	MD
Linwood	1B	NJ
Cincinnati	1B	OH
Cleveland-East	1B	OH
Cleveland-West	1B	OH
Columbus	1B	OH
Dayton	1B	OH
Erie	1B	PA
Harrisburg	1B	PA
McKeesport	1B	PA
Philadelphia-2	1B	PA
Philadelphia-1	1B	PA
Pittsburgh	1B	PA
Scranton	1B	PA
Norfolk	1B	VA
Richmond	1B	VA
Roanoke	1B	VA
Springfield	1B	VA
Beckley	1B	WVA
Charleston	1B	WVA
Huntington	1B	WVA
Martinsburg	1B	WVA
Morgantown	1B	WVA
Princeton	1B	WVA
Wheeling	1B	WVA

Appendix 3.

A List of VHA Vet Centers

<i>Place</i>	<i>Region</i>	<i>State</i>
Regional Manager Office-2	Chicago	IL
Chicago Heights	2	IL
Chicago-HP	2	IL
Chicago-OP	2	IL
East St. Louis	2	IL
Moline	2	IL
North Chicago	2	IL
Peoria	2	IL
Springfield	2	IL
Evansville	2	IN
Fort Wayne	2	IN
Gary	2	IN
Indianapolis	2	IN
Cedar Rapids	2	IW
Des Moines	2	IW
Sioux City	2	IW
Wichita	2	KS
Detroit-L.Park	2	MI
Detroit-O.Park	2	MI
Grand Rapids	2	MI
Duluth	2	MN
St. Paul	2	MN
Kansas City	2	MO
St. Louis	2	MO
Fargo	2	ND
Minot	2	ND
Lincoln	2	NE
Omaha	2	NE
Rapid City	2	SD
Sioux Falls	2	SD
Madison	2	WI
Milwaukee	2	WI

**Appendix 3.
A List of VHA Vet Centers**

<i>Place</i>	<i>Region</i>	<i>State</i>
Regional Manager Office-3A	Bay Pines	FL
Birmingham	3A	AL
Mobile	3A	AL
Ft. Lauderdale	3A	FL
Jacksonville	3A	FL
Miami	3A	FL
Orlando	3A	FL
Palm Beach	3A	FL
Pensacola	3A	FL
Sarasota	3A	FL
St. Petersburg	3A	FL
Tallahassee	3A	FL
Tampa	3A	FL
Atlanta	3A	GA
Savannah	3A	GA
Biloxi	3A	MS
Charlotte	3A	NC
Fayetteville	3A	NC
Greensboro	3A	NC
Greenville	3A	NC
Arecibo	3A	PR
Ponce	3A	PR
San Juan	3A	PR
Columbia	3A	SC
Greenville	3A	SC
N. Charleston	3A	SC
St. Croix	3A	VI
St. Thomas	3A	VI
Regional Manager Office-3B	Dallas	TX
Little Rock	3B	AR
New Orleans	3B	LA
Shreveport	3B	LA
Jackson	3B	MS
Oklahoma City	3B	OK
Tulsa	3B	OK
Chattanooga	3B	TN
Johnson City	3B	TN
Knoxville	3B	TN
Memphis	3B	TN

A List of VHA Vet Centers

<i>Place</i>	<i>Region</i>	<i>State</i>
Amarillo	3B	TX
Austin	3B	TX
Corpus Christi	3B	TX
Dallas	3B	TX
El Paso	3B	TX
Fort Worth	3B	TX
Houston	3B	TX
Houston	3B	TX
Laredo	3B	TX
Lubbock	3B	TX
McAllen	3B	TX
Midland	3B	TX
San Antonio	3B	TX
Regional Manager Office-4A	Denver	CO
Anchorage	4A	AK
Fairbanks	4A	AK
Kenai	4A	AK
Wasila	4A	AK
Phoenix	4A	AZ
Prescott	4A	AZ
Tucson	4A	AZ
Boulder	4A	AZ
Colorado Springs	4A	CO
Denver	4A	CO
Boise	4A	CO
Pocatello	4A	ID
Billings	4A	ID
Missoula	4A	MT
Albuquerque	4A	MT
Farmington	4A	NM
Santa Fe	4A	NM
Las Vegas	4A	NM
Reno	4A	NV
Provo	4A	NV
Salt Lake City	4A	UT
Seattle	4A	UT
Spokane	4A	WA
Tacoma	4A	WA
Casper	4A	WA
Cheyenne	4A	WY

Appendix 3.

A List of VHA Vet Centers

<i>Place</i>	<i>Region</i>	<i>State</i>
Regional Manager Office-4B	San Francisco	CA
Anaheim	4B	CA
Burlingame	4B	CA
Chico	4B	CA
Concord	4B	CA
Eureka	4B	CA
Fresno	4B	CA
Los Angeles-East	4B	CA
Los Angeles-S.C.	4B	CA
Los Angeles-West	4B	CA
Marin County	4B	CA
Marina	4B	CA
Oakland	4B	CA
Riverside	4B	CA
Sacramento	4B	CA
San Diego	4B	CA
San Francisco	4B	CA
San Jose	4B	CA
Santa Barbara	4B	CA
Sepulveda	4B	CA
Upland	4B	CA
Vista	4B	CA
Guam	4B	GU
Hilo	4B	HI
Honolulu	4B	HI
Kauai	4B	HI
Kona	4B	HI
Maui	4B	HI
Eugene	4B	OR
Grants Pass	4B	OR
Portland	4B	OR
Salem	4B	OR

VHA Field Reorganization Budget
Estimates and Comparisons

**VHA Field Reorganization Budget Estimates and Comparisons
Veterans Integrated Service Networks (VISNs)
and Support Services Centers (SSCs)
Compared to Current VHA Region Structure**

Recurring Budget Estimates	Per Office	Total Estimate
VISN		
FTEE	10	220
AVERAGE PAYROLL	\$ 80,730	
PERSONAL SERVICES	\$ 807,300	\$ 17,760,600
ALL OTHER	\$ 260,100	\$ 5,722,200
VISN Estimate	\$ 1,067,400	\$ 23,482,800
SSC		
FTEE		50
AVERAGE PAYROLL		\$ 43,350
PERSONAL SERVICES		\$ 2,167,500
ALL OTHER		\$ 1,095,700
Support Services Center Estimate		\$ 3,263,200

Total Recurring Budget Estimate-VISN & SSC

FTEE	270
FUNDING	\$ 26,746,000

Region Organization Structure

FTEE	106/107	427
AVERAGE PAYROLL	\$ 60,490	
PERSONAL SERVICES	\$ 6,457,308	\$ 25,829,230
ALL OTHER	\$ 2,560,113	\$ 10,240,450
Region Budget Estimate	\$ 9,017,421	\$ 36,069,680

Estimated Resources Available for Redirection

FTEE	157
FUNDING	\$ 9,323,680

Non Recurring Budget Estimates

VISN & SSC		
TRANSPORTATION OF FURNITURE/EQUIPMENT (18 VISN @ \$15,000)		\$ 270,000
EMPLOYEE RELOCATION (120 FTE @ \$56,000 per move*)		\$ 6,720,000
VISN Estimate		\$ 6,990,000

*Maximum relocation (192 FTE @ \$56,000 = 10,752,000)

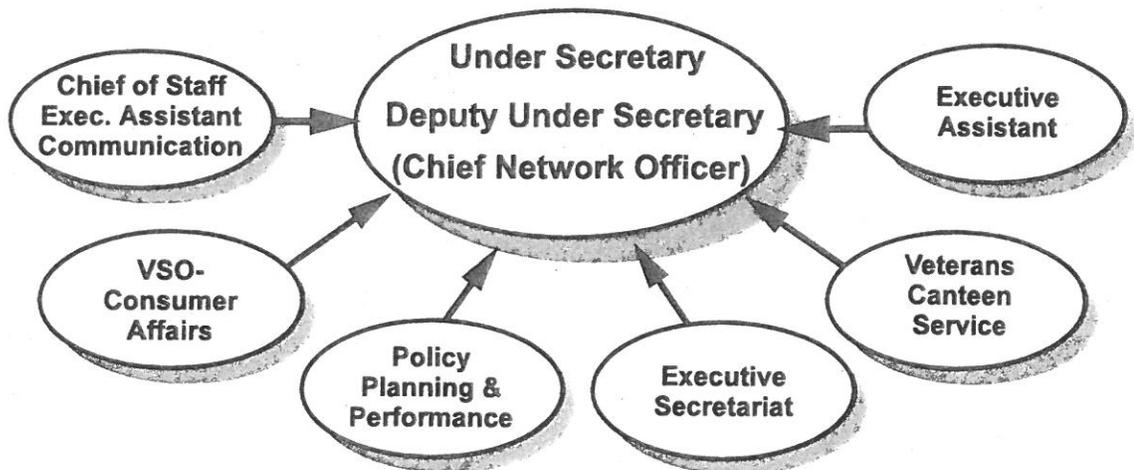
Assumptions

- Each VISN cost estimate is calculated on 10 FTE (22 VISNs)
- SSCs' cost estimate is calculated on 50 FTE
- Four VISNs and SSCs will be located at current Region Office sites
- Lease space at the present region offices will be used for VISNs and SSCs
- VISNs and SSCs will not require the purchase of additional furniture and equipment

Functional Statements for VHA
Headquarters

The Office of the Under Secretary for Health

Veterans Health Administration: *Office of the Under Secretary for Health*



This office is responsible for the overall executive leadership and direction of the Veterans Health Administration. The office includes the Under Secretary for Health (USH), the Deputy Under Secretary for Health (DUSH), the Chief Network Officer (CNO), and their immediate staffs. The Under Secretary has statutory responsibility for operation of the Veterans Health Administration and serves as its Chief Executive Officer. The Deputy Under Secretary serves as Chief Operating Officer. The Chief Network Officer provides

line supervision for the VISN Directors. These three executives are the only headquarters officials in the direct chain of command above the networks and field medical facilities. The Under Secretary and the Deputy Under Secretary share executive responsibilities and divide day-to-day activities as determined by the Under Secretary.

CHIEF NETWORK OFFICER: This official will be a headquarters change agent to help activate the VISNs, support them as they develop and mature, serve as a primary point of contact between national headquarters staff and the field and, in conjunction with the USH/DUSH, monitor and evaluate the VISN directors' progress on their performance contracts. A cadre of network support specialists will provide general administrative support for the network directors and their staffs. The specialists will coordinate with the emerging support services centers to ensure that various tracking and roll-up functions are accomplished and that needed information is available to the headquarters offices. Essentially, this office replaces the operations function in headquarters. The programmatic activities formerly performed in operations (i.e., budget, planning, engineering and quality management) will be decentralized or absorbed by the appropriate headquarters offices.

CHIEF OF STAFF: This official is responsible for the administrative management of the Office of the Under Secretary, including liaison with the Offices of the Secretary and Deputy Secretary, the Assistant Secretaries, Veterans Benefits Administration, National Cemetery System and other executive offices in headquarters. The Chief of Staff also provides first line supervision for the legislative programs function, the communications/public affairs function and the IG/GAO liaison function, which will be reassigned from the Office of the Chief Financial Officer.

EXECUTIVE ASSISTANT TO THE UNDER SECRETARY: This official provides direct support to the Under Secretary for a variety of special projects and emergent priority matters of interest to the Under Secretary.

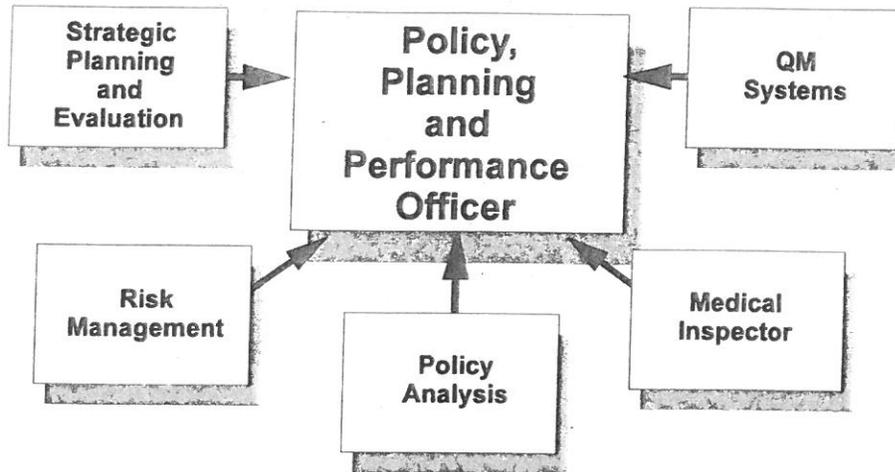
EXECUTIVE ASSISTANT TO THE DEPUTY UNDER SECRETARY: This official provides executive and administrative support to the Deputy Under Secretary and supervises other staff in the office.

VETERAN SERVICE ORGANIZATION/CONSUMER AFFAIRS STAFF: This office provides ongoing communications with the veterans organizations. This includes arranging regular and special briefings, ad hoc projects, and other events involving Veterans Service Organizations.

EXECUTIVE SECRETARIAT: This office administers the VHA correspondence management program, establishes VHA correspondence policy, and reviews all written communications prepared for the signature of the Secretary, Deputy Secretary, Under Secretary, and Deputy Under Secretary. The office serves as VHA liaison with the Secretary's office and other VA offices on all correspondence issues. The office also analyzes and processes VHA correspondence and maintains the official files for the Under Secretary.

VETERANS CANTEEN SERVICE: This office manages a self-sustaining business which provides reasonably priced goods and services to veteran patients and caregivers. The service has been reassigned to VHA from the Office of the Assistant Secretary for Acquisition and Facilities.

Office of Policy, Planning and Performance

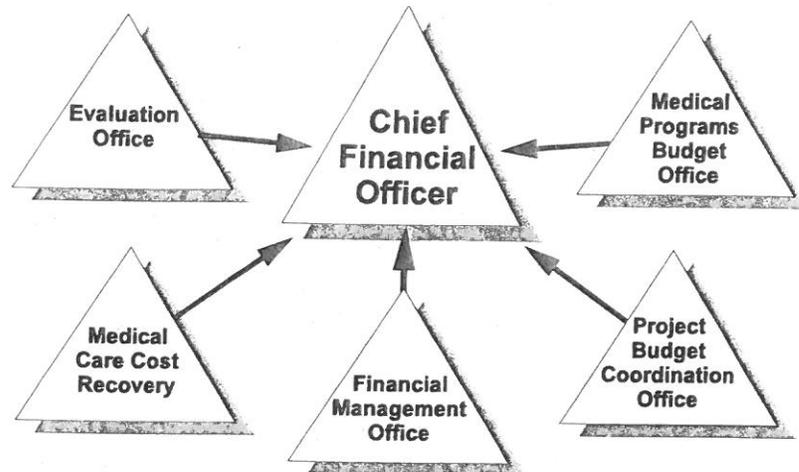


This office is responsible for the integration of VHA's strategic planning and performance measurement activities with policy implications to ensure that quality management considerations drive the planning activities and underlie all ongoing operations. The new organization combines the present office and functions of the Associate Chief Medical Director for Quality Management with strategic planning functions now located in the Chief Financial Officer's organization, the Office of the Medical Inspector and the Office of Policy Analysis (formerly the Health Care Reform Office). In conjunction with the appropriate headquarters program offices, the quality management function will focus on the development of appropriate measures for use at all levels of the organization to reflect performance and progress toward system goals. Planning functions will include forecasting of need and changes in the technical environment of health care as well as the

development of a responsive plan for the evolution of the organization through the next decade. Education of staff in the mechanism of developing local plans will also be carried out. Policy Analysis will evaluate alternatives and strategies for access and care for VA's patients, provide support and recommendations to the Under Secretary regarding health care policy and reform issues, monitor state reform initiatives, maintain an information clearinghouse, and provide liaison with other federal and non-federal agencies on health policy issues. Inspection capability from the Medical Inspector functions will be maintained for specially warranted circumstances; other functions of the Medical Inspector will be folded into ongoing quality management activities.

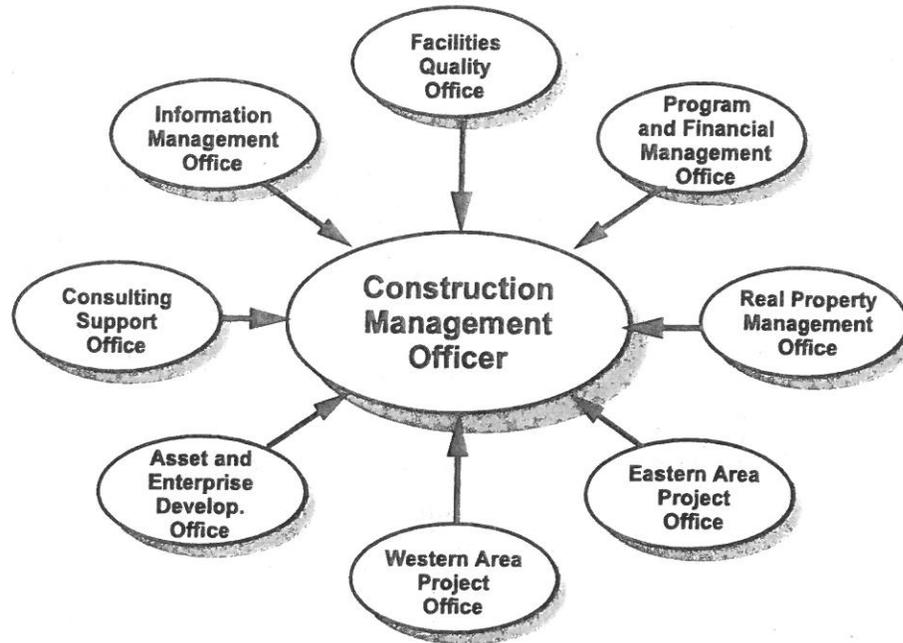
Support Programs

Office of the Chief Financial Officer



This office serves as the principal advisor to the Office of the Under Secretary on resource management and financial matters. This includes identifying and monitoring financial performance measures; formulating, defending, and administering the VHA budget; directing the MCCR program; developing policies for implementation of recoveries from non-appropriated sources; and performing program financial management evaluations. As described above, the strategic planning function will move to the Office of Policy, Planning and Performance. The IG/GAO liaison function will move to the Office of the Under Secretary. Also, all construction-related functions and staff located in the present Infrastructure Policy and Development Office and the former Construction Project Coordination and Budget Office, with the exception of the activation budget coordination activity and the post occupancy evaluation function, will move to the Office of Construction Management. The CFO office will retain responsibility for formulation and execution of the construction budget.

Office of Construction Management



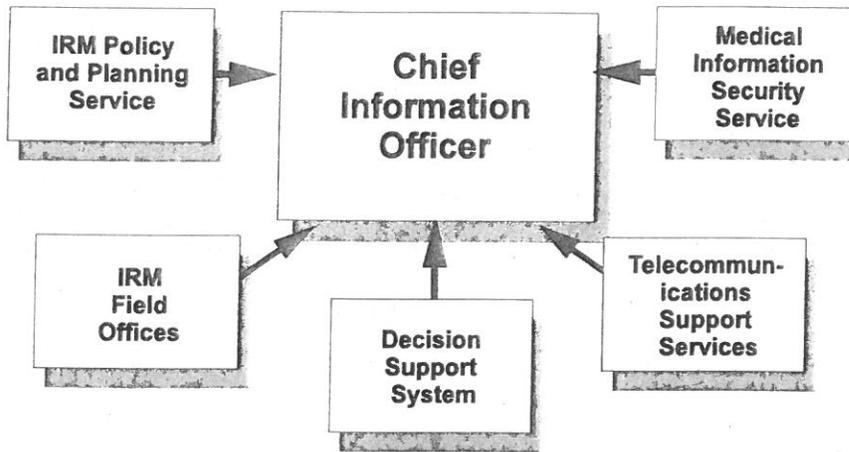
This office houses VHA's major construction and capital project programs and serves as the principal advisor to the Office of the Under Secretary for construction, capital project management, systemwide architectural and engineering design policy and consultation, real property, leasing and land acquisition activities. In addition, the office re-integrates the functions and associated staff being transferred from the CFO office, as described in the CFO's functional statement on the previous page.

Office of Emergency Medical Preparedness



This office serves as VHA's primary policy, planning, training and management organization for internal and external medical emergencies. It supervises the development and coordination of the agency-wide emergency medical preparedness program and the overall emergency management program for VHA.

Office of the Chief Information Officer



This office is the principal advisor to the Office of the Under Secretary on information resources management and telecommunications. It is responsible for the integration of all VHA information functions. The functions formerly performed by the Medical Information Resources Management Office (MIRMO) and the Decision Support System (DSS) Office will be incorporated into this new office. The CIO will play a critical role in seeing that business and information strategies are carefully coordinated, and will act as a change agent to implement information systems that achieve service and productivity objectives. The CIO will ensure that a strong medical informatics support structure is in place to assist the VISNs in delivering high quality, cost effective care, and to support VHA's corporate policy, planning and performance management functions.

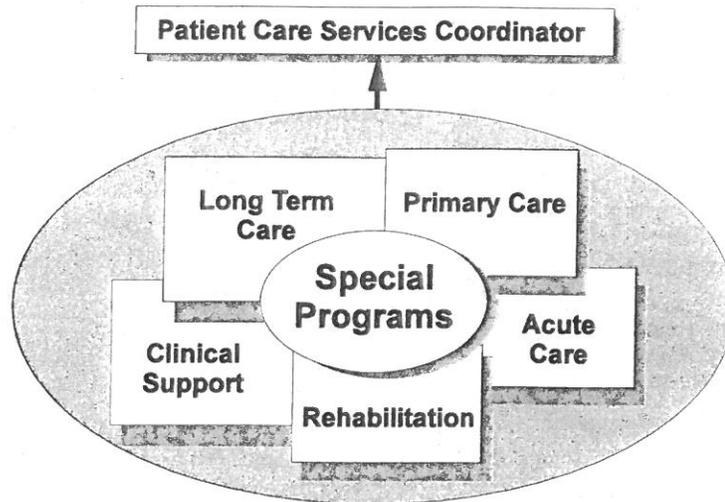
Office of Administrative Programs



This office houses VHA's administrative support programs and systems, and serves as principal advisor to the Office of the Under Secretary on administrative matters and a number of policy and operational issues external to VHA. Program functions assigned to this office include all of those formerly assigned to the Associate CMD for Administration, with the exception of the Medical Information Resources Management Office (MIRMO) which will become part of the new Office of the Chief Information Officer. In addition, two new activities will become part of the office: a new headquarters administration function for overall administrative support of the internal operation of VHA headquarters, and liaison with the Office of Acquisition and Materiel Management. Also, the Engineering Management and Field Support Office (EMFSO) will be reassigned from Operations and will be integrated with the Environmental Management Service to create a consolidated facilities management function.

Health Care Programs

Office of Patient Care Services



This office houses VHA's clinically-related headquarters programs that serve to support the actual delivery of patient care services in the field. It integrates professional knowledge and practice skills into policy, planning, and systemwide development of patient care guidelines, critical pathways, and practice parameters. This includes providing leadership for those programs designated as "special programs" by the Under Secretary. Working with the Office of Policy, Planning and Performance, network and field representatives and appropriate external stakeholders, the office will develop evaluation mechanisms and outcome measurements for these programs. Interdisciplinary clinical leadership will be available to the Office of the Under Secretary and the field for consultation and to provide clinical coordination and integration with research, education and emergency medical preparedness activities. The office will also provide national leadership on professional issues for the medical, technical and allied health disciplines and serve as liaison to various professional organizations. These functions include the

offices

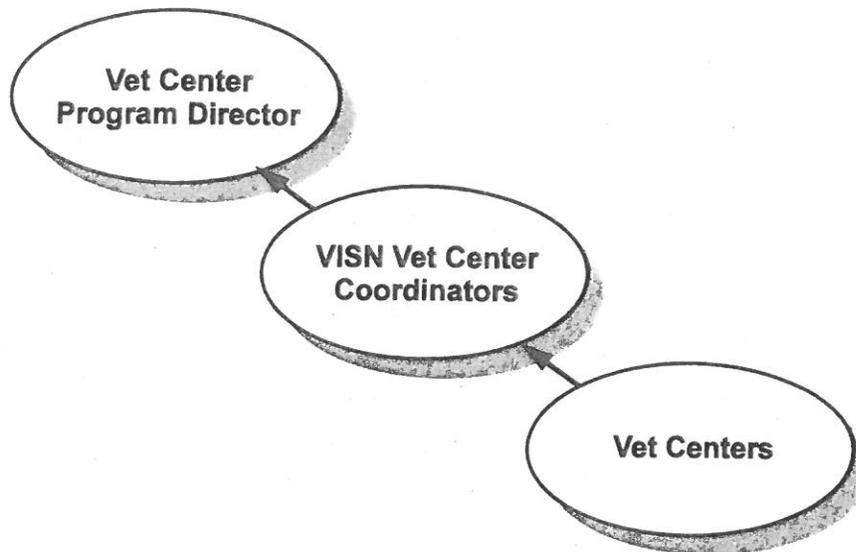
formerly reporting to the ADCMD for Clinical Programs, with the exception of Readjustment Counseling Service and the Office of Public Health and Environmental Hazards, which now report separately to the Office of the Under Secretary. Rehabilitation Research and Development Service will move to the research organization. The Professional Affairs Staff, formerly reporting to the Deputy Under Secretary, will be assigned to this office. The traditional “stovepipe” structure organized around discrete professions and disciplines will be replaced with a structure that will be organized around substantive clinical functions and product lines. Examples of such activities or product lines are primary care, acute inpatient care, rehabilitation and long term care.

Office of Public Health and Environmental Hazards



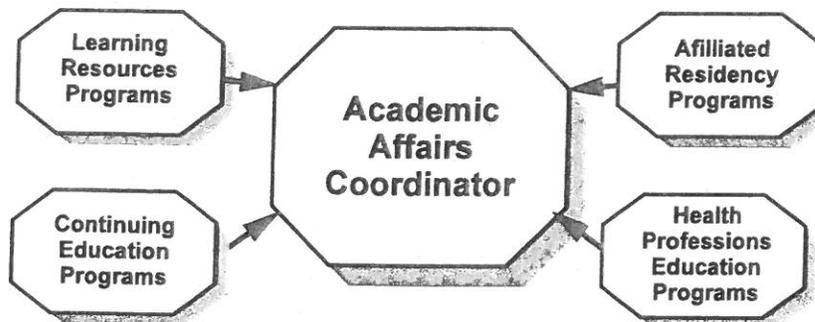
This office houses VHA's public health and environmental hazards programs and serves as principal advisor to the Office of the Under Secretary on public health issues and environmental hazards, including exposure to phenoxy herbicides (e.g., Agent Orange), ionizing radiation and Persian Gulf health issues, as well as the AIDS/HIV program, the women veterans program and the smoking program.

Office of Readjustment Counseling Services



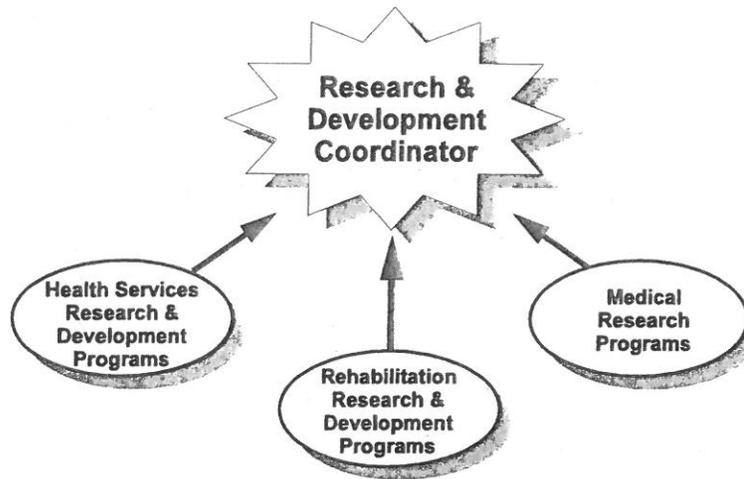
This office is responsible for supervising the management of the readjustment counseling operations carried out in over 200 field-based Vet Centers. The office establishes policies for services, training and quality control for all program activities. The readjustment counseling field structure will be modified from the present seven regional manager offices for the purpose of better integration of readjustment counseling activities into the total health care delivery mission of the network, although it will maintain its present separate reporting line and funding stream.

Office of Academic Affairs



This office houses VHA's academic activities and serves as the principal advisor to the Office of the Under Secretary on academic matters. It is responsible for management of a variety of programs that support training, recruiting, and retraining health care professionals and administrative personnel to meet the needs of the VA health care system and contribute to the nation's health manpower pool. It develops, monitors, and supports graduate education and training programs and serves as the Under Secretary's primary liaison with the academic community. It continues its present mission and structure pending evaluation and decision on the recommendations in the "Report of the VHA Education and Training Review Task Force," which was presented to the Under Secretary on January 30, 1995.

Office of Research and Development



This office houses VHA's research and development activities and serves as principal advisor to the Office of the Under Secretary on research matters. It is responsible for formulating policies and procedures for biomedical and health services research. The responsibility for rehabilitation research and development, formerly located in the Office of Clinical Programs, will be added to this office. Health Services Research and Development continues responsibility for VHA's technology assessment function. The office is also responsible for management of a scientific peer review system to evaluate research applications for funding, determination of research funding and FTE levels for the field, and development of the annual medical and prosthetic research budget request.

Additional Information on
Selected VHA Performance
Measurement Programs

Additional Information on Selected VHA Performance Measurement Programs

A. Quality Improvement Checklist (QUIC). The QUIC is an automated examination of local databases for key parameters of care resulting in a national roll-up and a report back to the facility showing comparison of local results to national VA results. Its rapid turn-around of comparative data (less than 30 days) makes it appealing, and the validity of the information, as well as its clinical applicability, have led to several important improvements in health care delivery within VA. The QUIC data collections have occurred every six months since November 1991. Examples of QUIC questions are shown in **Table 4.4**, (page 70).

B. External Peer Review Program (EPRP). The EPRP completed its second full year of data collection in January 1995. This program uses an outside contractor (currently the Peer Review Organization for the state of West Virginia) to measure the quality of care processes and outcomes in VA patients. The mechanism compares VA care to an external set of criteria drawn from a clinical guideline written by non-VA physicians in active practice -- thus constituting a putative community standard. Medical diagnoses and surgical procedures judged to be high volume, high risk or problem prone were initially examined. Results are returned to individual medical centers with comparisons to national averages. Overall, VA's quality of care has met or exceeded the community standard in more than 97% of cases (total cases reviewed since the program began is about 100,000). Examples of the information available through the EPRP are shown in **Table 4.5**, (page 70).

C. Surgical Quality Improvement Program. The Surgical Quality Improvement Program is a landmark undertaking begun in early 1992. Over a two-year period more than 88,000 surgical cases were prospectively entered into a database with collection of explicit information on risk factors. The database has been used to construct a risk-modeling

mechanism that will allow VA (and other users) to perform risk-adjusted surgical outcome measurement. The cardiac surgical review committee in VHA has used this technique for adjusting cardiac surgery data for over seven years and has produced a more than 24% improvement in mortality rate nationwide during that time. Sometime in 1996, surgical risk-adjusted mortality and morbidity data will come available for use in the assessment of both cohort-specific and "product line" activity.

D. National Customer Feedback Center. In 1993, VHA established the National Customer Feedback Center and began updating and revising the Patient Satisfaction Survey instrument used in VA since 1972. VA developed a partnership relation with the Picker-Commonwealth Foundation of Boston, Massachusetts, and patient focus groups were held to determine what patient priorities were. New survey instruments were developed and tested and in September 1994, a national mailout survey was sent to 68,000 recently discharged veteran patients. Over 68% of the surveys were returned and have been analyzed. The results were initially presented to the facility directors at the Senior Management Conference in January 1995. Plans are underway to complete a survey of outpatients and extended care patients in 1995. Data from these surveys indicate some areas where VA can improve its dealings with patients; several follow-up programs and initial responses to the findings are already underway. The patient feedback survey instrument contains more than 40 questions, including some which allow patients to report their health status so that the results can be adjusted for patient condition. The satisfaction questions deal directly with issues the focus groups identified as important and ask for patient feedback about what happened (the patient serving as a reporter). There are a few global questions about how the patient views the care (the patient as a rater). Focus groups identified specific areas of concern such as relief of pain, emotional support, adhering to patient preferences, communication with members of the treating team, etc. The scores in these areas, rather than specific questions, will be used to determine whether a concern about patient satisfaction should be included on a

performance contract. Examples of some of the areas of patient concern are shown in **Table 4.1** (page 68).

References

References

Copies of the following VHA specific analyses, reports, plans and articles were used as reference materials during the formation of this report:

1. Analysis of the Organizational Structure and Management of the VA's Health Delivery System, prepared by Northwestern University and VA Health Services Research and Development for the Commission on the Future Structure of Veterans Health Care. May 1991.
2. Report of the Commission on the Future Structure of Veterans Health Care ("Mission Commission"). November 1991.
3. VA Steering Committee Report on Recommendations of the Commission on the Future of Veterans Healthcare. March 1992.
4. "Post-Installation Evaluation Survey Report" Ñ Report of VHA Management Support Office on Success of the 1990 Field Organization. August 1992.
5. Approaches to Decentralization, VHA Management Decision and Research Center Rapid Response Project #MMR92-3. October 23, 1992.
6. Proposed Management Improvements, Draft Report by the RPM Field Oversight Committee, January 1994.

7. A Managed Care Strategy for VHA, Department of Veterans Affairs, Draft Report. October 13, 1993.
8. "Analysis and Recommendations for Reorganization of Veterans Health Administration, Management Decision and Research Center," Management Decision and Research Center, MRR93-17. October, 1993.
9. Issues facing VA Healthcare in 1995: Results of a Three Stage Delphi Process, Survey Results from the Fiscal Year 1994 Senior Management Conference. February 17, 1994.
10. VA's National Health Plan: Meeting the Challenge of National Health Care Reform. April 28, 1994.
11. Report of the Task Force for Further Development of the VSA Concept. November 10, 1993.
12. Report of the Task Force on the Reorganization of VHA Central Office ("Thibault Report"). September 1994.
13. Report of the Task Group on Veterans Health Administration Field Reorganization ("Deters Report"). November 1994.