

university partners<sup>60</sup>. VHA physician faculty members have joint appointments at the university and at VHA, participating in patient care at VHA facilities, supervising students and residents, and conducting research. VHA would have difficulty delivering high quality patient care without the physician staff and residents that are available through these affiliations. Moreover, residents provide much of the direct medical care, including “24/7” coverage of inpatient services, in those VA medical centers with housestaff. From an historical perspective, VHA’s affiliations with the nation’s medical schools dates from the drafting of Memorandum No. 2, initiated by General Omar Bradley in 1946.

#### CARES and Academic Affiliations

In general, the CARES Market Plan narratives indicate a preference for maintaining facility-based research programs and academic affiliations, citing the loss of affiliations as one potentially negative impact of contracting and/or inpatient and outpatient service reductions. Only one VISN cited the potential for new affiliations and research through contracting with community facilities.

In the past few years, a number of consolidations of affiliated VA medical centers have occurred with somewhat mixed results. In 2002, the follow-up report of a study of three integrations was published.<sup>61</sup> The “lessons learned” from the study of three VA systems with strong academic affiliations—*i.e.*, VA Chicago Health Care System, VA New York Harbor Healthcare System, and VA Boston Healthcare System—may be summarized as follows (from Section 5.2, “Looking Forward,” of the reference cited):

- Staff should be prepared for a lengthy change and adjustment period that will result from the major organizational change involved in consolidations or integrations.
- Major reorganizations need to be carefully staged and synchronized in order to assure that infrastructure and physical space needs are prepared for the restructuring of clinical services.
- Although medical center integration is generally undertaken with an expectation of saving money, an initial need for capital investment is required.

Buildings must be adapted to new (consolidated) uses, often having increased capacity from their prior status. The savings are to be realized from long-term operational efficiencies.

- Moreover, while the division of inpatient and outpatient care may make conceptual sense, a number of logistic problems are created and encountered—especially when the same staff must work at two divisions of a facility. Studies of patient flow patterns, of staff working relationships, and of transportation issues need to be dealt with in advance as part of the planning efforts.

- Shared leadership of education programs is difficult in practice. Recruitment of faculty (attending physicians) and especially of service line and/or section chiefs often becomes problematic.

- Early and on-going involvement of all affiliates is key in assuring a coordinated planning process. Similar academic standing of the involved affiliates may facilitate collaboration, and unequal standing tends to hinder productive interaction.

- VA’s critical missions in research and education should be acknowledged and support of those missions seen as an explicit goal of any integration.

The above-cited study by Dr. Van Deusen Lukas *et al.* also pointed out that, with respect to the integration process,<sup>62</sup>

- All three systems studied reported some success in passing JCAHO review and in achieving operating efficiencies.

- Different approaches to clinical integration were noted in each of the examples. [The authors characterized these as “wait and see” (Chicago), “targeted opportunities” (New York Harbor), and “full consolidation” (Boston).

- Not surprisingly, Boston achieved the most progress, but also faced the greatest challenges in terms of transition issues, timing of moves and restructuring space needs, organizational issues, and external impacts (especially budgetary challenges and lack of initial funding for renovation construction projects).

The authors also noted that, from the standpoint of the academic missions involved, education was more affected than research during facility integrations. The impact on education was largely because of the service-based organization of clinical teaching, which, in the integrated facilities, required some division and/or sharing not only of teaching responsibilities but also of administration (*e.g.*, which affiliate

recruits and hires the service chief, how residents are supervised and evaluated in a dual affiliation situation, and how faculty are appointed).

#### Summary and Conclusions

VA’s missions in health professions’ education and medical research continue to be strongly supported by the CARES process. Opportunities for enhancement of research space have been identified. With respect to education, research done by the HSR&D Management Decision and Research Center points out that tertiary facility consolidations and integrations may be successfully accomplished. However, the process is a complicated and difficult undertaking. Integration is subject to a number of key factors that require the on-going participation of the academic affiliates in the transition to an integrated facility management. Facility consolidations require an initial, up front capital investment to reconfigure space in order to achieve long-term operational efficiencies. The most successful examples are those in which the involved academic affiliates are active participants in the planning for the new organizational structures.

Please refer to Chapter 9, Proximity and Campus Realignments, for information on the proposed resolution of Proximity Planning Initiatives that may involve consolidation of services. As VA moves forward with the implementation process, recognition and continued attention to its academic mission (research and education) and partners (academic affiliates) will ensure a smoother transition in the proposed consolidations and the maintenance of high quality care to veterans.

#### Chapter 16: Staffing and Community Impact

##### *Anticipating Impact Was Integral to Process*

A salient feature of CARES was the ability to recognize and manage interrelated consequences of various planning solutions.

Consider, as an example, the dynamics for an Access Planning Initiative. When an access “gap” was discerned, other issues immediately came into play, including “Partnering with DoD” (to examine potential sharing of military ambulatory care services), “Ensuring Inpatient Capacity” (to evaluate referral patterns for any outpatient service solution), and “Quality” (which ultimately reviewed any arrangement to provide care.)

This capability is prominently applied in anticipating the impact of

<sup>60</sup> Office of Academic Affairs Web Site, Veterans Health Administration, Department of Veterans Affairs [<http://www.va.gov/oaa/default.asp>]

<sup>61</sup> Lukas C VD, Camberg L, Taneja LC, Integration of Affiliated VA Medical Centers: Second Report (June 2002; HSR&D Management Decision and Research Center, Boston). [<http://www.va.gov/resdev/prt/affiliated-integration-2.doc>]

<sup>62</sup> Lukas, *et al.*, Op. cit. “Highlights.”