



# A Greater Boston VA Healthcare System





Integrating Two Adjacent Divisions of VA New England Healthcare System



December 2011

# **Executive Summary**

VA New England Healthcare System has proposed an integration of its two adjacent divisions serving the Greater Boston area: VA Boston HCS and Bedford VAMC. These Medical Centers serve the same geographical area and Bedford is dependent on Boston for many clinical services. Over 40% of Bedford's patients use Boston annually. Having two systems with separate electronic medical records, appointment systems, medical staffs, transportation systems, and organizational infrastructures has created barriers to coordination of care, access, operational efficiencies, and regional planning.

The proposal is to integrate the two divisions into one unified VA healthcare system serving the Greater Boston area. It would have one leadership team, one medical record, and one medical staff. All four campuses—Bedford, Brockton, Jamaica Plain, and West Roxbury—would continue to operate and patients would continue to obtain care from the sites and providers they currently utilize. All community-based outpatient clinics would continue to operate. The integration would occur with no loss of jobs and with no diminishment of services for patients served in the Bedford VAMC catchment area. The proposal is about how VHA organizes and manages care in Greater Boston, not about changes to clinical services, and is intended to unify the organization, management, and direction of the care of Veterans in the Greater Boston area. Moreover, the goal is to improve care for Veterans by:

- enhancing information flow for patient safety, coordination of care, and provider convenience by having a single medical record and appointment systems;
- making coordinated care available at all sites around Boston;
- obtaining operational efficiencies by reducing duplication of processes and programs; and
- achieving better regional planning.

Over 70 other VAMCs have participated in integrations over the past two decades. Analysis of those experiences demonstrates cost savings, better coordination of care, and improved access. Bedford remains the only stand-alone, metropolitan, low complexity VA hospital in the country. Integrations are also common in private healthcare, recently have been increasing in frequency, and have been shown to result in consistent cost savings, averaging 7 percent.

Challenges of the integration include the need for resources to achieve the change, electronic medical record conversion, maintaining employee morale, and ensuring availability of leadership. Mitigation strategies for each have been developed for the current proposal. A comprehensive two-way communication campaign has been executed, with the large majority of input received from Veterans and staff expressing support for the integration. A recommendation regarding the proposal will be finalized soon for submission to VA leadership in Washington.

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#### Introduction

VA New England Healthcare System/Veterans Integrated Service Network 1 (VISN 1) has proposed combining its two divisions in the Greater Boston area—VA Boston Healthcare System (HCS) and the Edith Nourse Rogers Memorial VA Hospital (Bedford VAMC)—into a single integrated system.

This White paper provides information pertaining to this proposed integration, including an analysis of the proposal, along with general information on both facilities. This document includes data pertaining to available clinical services, Veteran population served, workload, benefits of integrating VA Boston HCS and Bedford VAMC, and a review of previous research related to hospital integrations, both within and outside of Veterans Health Administration. It identifies potential challenges should the integration proceed as well as mitigation strategies. Finally, it reviews communication activities with stakeholders and input received to date.



#### I. Current VHA Services in Greater Boston

#### **Veterans Health Administration**

The Veterans Health Administration (VHA), a part of the United States Department of Veterans Affairs (VA), serves United States Veterans through the largest integrated healthcare system in the nation. The VHA system consists of 152 Medical Centers and nearly 800 community-based outpatient clinics (CBOCs), along with community living centers (nursing homes), and domiciliary residential rehabilitation treatment programs. Together, these healthcare facilities—with the more than 53,000 independent licensed healthcare practitioners who work within them —provide comprehensive care to 6 million Veterans each year. VHA operates its medical facilities through a system of 21 integrated regional networks, known as Veterans Integrated Service Networks (VISNs). Traditionally, VHA was organized around a hospital-based model. Over the past 20 years, it has shifted to the creation of population-based regional healthcare systems that provide a full range of services to a population of Veterans in a coordinated fashion. It has expanded outpatient activities and opened multiple CBOCs with the goal of improving access to Veterans across urban and rural environments.

# **VA New England Healthcare System**

VA New England Healthcare System, VISN 1, is the VHA regional network for New England. This network provides healthcare for Veterans through 8 Joint Commission-accredited Medical Centers in the 6 New England states—Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. These Medical Centers also include more than 40 CBOCs, 6 community living centers (nursing homes), and 5 domiciliaries. The locations of these VA New England Healthcare System facilities appear in Figure 1, below.

<sup>3</sup> VA Benefits & Health Care Utilization, U.S. Dept. Veterans Affairs (updated Aug. 8, 2011), available at http://www.va.gov/Vetdata/docs/Quickfacts/Summer2011.pdf (last accessed Nov. 8, 2011).

<sup>&</sup>lt;sup>1</sup> About VHA, U.S. Dept. Veterans Affairs, available at http://www.va.gov/health/aboutVHA.asp (last accessed Nov. 8, 2011).

² Id.



Figure 1: Map of the VA New England Healthcare System

As the tenth largest metropolitan area in the United States, Greater Boston (an area that includes Boston, Massachusetts, and surrounding areas) is home to more than 4.5 million people. Of VA New England Healthcare System's 8 Medical Centers, 2 are in Greater Boston: the Bedford VA Medical Center (Bedford VAMC) and the VA Boston Healthcare System (VA Boston HCS).

#### **Bedford VAMC and VA Boston HCS: An Overview**

#### **Bedford VAMC**

Bedford VAMC—also named the Edith Nourse Rogers Memorial Veterans Hospital in honor of former Congresswoman Edith Nourse Rogers, co-author of the G.I. Bill—was one of the first hospitals established in the country to care for Veterans. Construction of the first 10 buildings occurred in 1925. Bedford VAMC admitted its first patient on July 17, 1928.

The Bedford VAMC has grown significantly. The main campus now includes more than 58 buildings, located on 183 acres in the Town of Bedford, Massachusetts. Bedford lies approximately 22 miles northwest of downtown Boston. The Bedford VAMC also includes three CBOCs; these are located in Gloucester, Haverhill, and Lynn, respectively.

Bedford VAMC has special focuses in Mental Health as well as Geriatrics and Extended Care. Bedford VAMC has a variety of clinical programs, including primary care,

<sup>&</sup>lt;sup>4</sup> U.S. Census Bureau, Population Division. *Table 5. Estimates of Population Change for Metropolitan Statistical Areas and Rankings: July 1, 2008 to July 1, 2009* (CBSA-EST2009-05) (Release Date: Mar. 2010).



dental care, mental health, a broad spectrum of treatment services for substance use disorders, and one of the largest vocational rehabilitation programs throughout VHA. Bedford VAMC provides neither acute inpatient medical or surgical services, nor outpatient services requiring moderate sedation. Bedford VAMC's specialized programs include the Veterans Community Care Center (VCCC), a Vietnam Veterans Outreach Center, and transitional housing for homeless Veterans.

Bedford VAMC is a teaching hospital, with education and research programs as well as two medical school affiliations. Research and education programs include medical student teaching; resident training in psychiatry, geriatric medicine, optometry, preventative medicine, and dentistry; the Health Services Research and Development Service (HSR&D); a Geriatrics Research Education and Clinical Center (GRECC); and a Mental Illness Research, Education & Clinical Center (MIRECC). A large number of education programs exist in the allied/associated health professions, including psychology and nursing.

A four-member executive team, known as a Quadrad, leads Bedford VAMC. This team includes a Medical Center Director, an Associate Director, a Chief of Staff, and a Nurse Executive/Associate Director for Patient Services. A diagram of the current organizational structure at Bedford VAMC appears below (Figure 2).

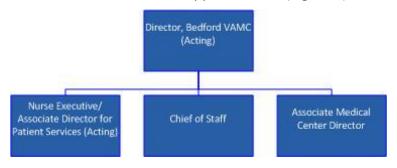


Figure 2: Leadership Structure, Bedford VAMC

#### **VA Boston Healthcare System**

VA Boston Healthcare System (HCS) is the product of a series of integrations involving 4 formerly independent Medical Centers (Brockton, West Roxbury, Jamaica Plain, and the Boston Outpatient Clinic (Causeway)). These campuses have constituted an integrated system, VA Boston HCS, since April 2000.<sup>5</sup>

VA Boston HCS includes 3 main campus divisions. Each of these is located within 40 miles of Boston. These campus divisions include Jamaica Plain, located in the heart of Boston's Longwood Medical Community; West Roxbury, located approximately 10 miles

<sup>&</sup>lt;sup>5</sup> Carol VanDeusen Lukas & Lois Camberg, *Integration of Affiliated VA Medical Centers: Preliminary Report*, Management Decision and Research Center, Health Services Research & Development Services, U.S. Dept. Veterans Affairs (Nov. 2000), *available at* http://www.colmr.research.va.gov/publications/reports/affiliated-integration-1.pdf.

west of downtown Boston; and Brockton, located 20 miles south of Boston, in the City of Brockton. VA Boston HCS also includes 5 CBOCs: Dorchester, Framingham, Lowell, Quincy, and Causeway Street (Boston).

VA Boston HCS has received Centers of Excellence Awards for the following five programs: Cardiac Surgery, PTSD, Women's Health, Seriously Mentally III, and Substance Abuse. As a teaching facility, VA Boston HCS provides a full range of services, with state-of-the-art technology as well as education and research, offering specialized training to over 1,200 residents and fellows, 250 medical students, 670 nursing students, and 500 students in psychology, optometry, pharmacy, and other allied health professions. VA Boston HCS has affiliations with 7 other major medical facilities in the Greater Boston area, and is a member of the Conference of Boston Teaching Hospitals.

The leadership team at VA Boston HCS's includes a Director, a Deputy Director, 2 Assistant Directors, a Chief of Staff, and an Associate Director for Nursing/Patient Services. While the West Roxbury campus serves as the base for most of this executive leadership team, the Assistant Medical Center Directors work out of the other campus divisions. One works from the Brockton Division, the other works from Jamaica Plain. A diagram of VA Boston HCS's current organizational structure appears below (Figure 3).

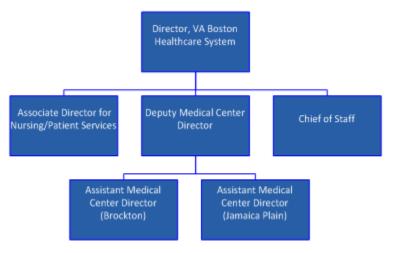


Figure 3: Leadership Structure, VA Boston HCS

Each of VA Boston HCS's 3 divisions plays an important role in the system. Descriptions of the campus divisions follow.

# West Roxbury Campus

The West Roxbury Campus serves as the tertiary inpatient Medical Center for VA Boston HCS and other VAMCs in the VISN. This facility offers cardiac catheterization, a medical intensive care unit (MICU), coronary care unit (CCU), surgical intensive care unit (SICU), progressive care unit (PCU), and an open-heart surgery program. The West Roxbury Campus also has a nationally recognized acute spinal cord injury program. This division is also one of few VHA facilities with a Commission on Accreditation of



Rehabilitation Facilities (CARF) accredited acute rehabilitation program.<sup>6</sup> This campus supports an interventional cardiology program with electrophysiology. In addition, West Roxbury serves as the regional referral center for intensive inpatient surgery and provides complex and high-risk surgeries, such as vascular surgery, specialized general and cancer-related surgery, orthopedics, hand and joint replacement surgery, plastic surgery, urology, and neurosurgery. West Roxbury maintains a 24-hour emergency department and has a new magnetic resonance imaging (MRI) suite.

#### **Brockton Campus**

The Brockton Campus offers Veterans a wide range of healthcare services, including short-term rehabilitation and medical care, palliative and hospice care, long-term care, a chronic spinal cord injury (SCI) unit, mental health services, comprehensive primary care, and a domiciliary for Homeless Veterans. Also available at the Brockton Campus is an inpatient psychiatric unit for women and a residential rehabilitative unit for women affected by PTSD and substance abuse. These units, in conjunction with the outpatient Women's Health Center, offer female Veterans a complete spectrum of healthcare services. Both the Homeless Veterans program and the Women's Program are regional referral centers for Veterans throughout New England. The SCI unit offers specialized programs and respite care for Veterans with spinal cord injuries and disabilities. The Community Living Center (Extended Care) provides rehabilitation and restorative care for medical and postoperative patients from the West Roxbury inpatient units and other facilities, serving as a venue for transitioning patients from acute inpatient care to home. The Brockton Campus offers extensive inpatient and outpatient mental health services, including chronic and acute inpatient psychiatric programs and programs in substance abuse.

# Jamaica Plain Campus

The Jamaica Plain Campus offers ambulatory care and primary care services. The state-of-the-art ambulatory care center serves as a hub for outpatient care. Specialized services include audiology, ambulatory day surgery, MRI, computerized axial tomography (CAT), positron emission tomography (PET) scans, and specialized aphasia treatment. This division also offers an eye center, providing argon laser therapy to treat retino-vascular diseases, argon/yttrium-aluminum-garnet (YAG) laser treatment of eye diseases, and vitrectomy surgery. In addition, Jamaica Plain offers argon/YAG laser treatment of cancer. Medical and mental health services located at the Jamaica Plain Division also include substance abuse, neuropsychology, and the only radiation oncology program in VISN 1. This campus is also home to the Behavioral Science and Women's Health Sciences Divisions of the National Center for Post Traumatic Stress Disorder.

<sup>&</sup>lt;sup>6</sup> A therapeutic swimming pool, located in the hospital, supports the West Roxbury acute rehabilitation program.

# **Comparative Details Regarding Bedford VAMC and VA Boston HCS**

Details of the 2 VAMCs in Greater Boston, including mission, budget, staffing levels, workload, campus characteristics, accreditations, component clinics, academic affiliations, and research programs, appear below (Table 1).

Detail	Bedford VAMC	VA Boston HCS
Campuses	1	3
Address(es)	200 Springs Road, Bedford, MA 01730	West Roxbury Division: 1400 VFW Parkway West Roxbury, MA 02132 Jamaica Plain Division: 150 S. Huntington Avenue Boston, MA 02130 Brockton Division: 940 Belmont Street Brockton, MA 02301
Mission	The mission of the Bedford VAMC is to honor America's Veterans by providing exceptional healthcare that improves their health and well-being.	The mission of the VA Boston HCS is to honor America's Veterans by providing exceptional healthcare that improves their health and well-being.
Complexity <sup>7</sup>	3	1a
Station Number	518	523
Total Yearly Expenditures <sup>8</sup>	\$ 213,086,688.55	\$ 741,528,206.78
Total Full Time Employee Equivalents (FTEE) <sup>9</sup>	1,302.95	4,040.28
GME Medical Residents Positions for Academic Year 2012	13.5	148.5
Total Unique Patients <sup>10, 11</sup>	19,242	66,116

<sup>.</sup> 

VHA's facility complexity (grouping) model allows grouping of facilities for various peer grouping purposes, such as operational reporting, performance measurement, and research studies. Complexity levels, determined based on a set of standardized criteria, range from 1a (the most complex) to 3 (the least complex). Source: VHA Office of Productivity, Efficiency, and Staffing (OPES), Facility Complexity Levels (accessible via the VA Intranet).

<sup>&</sup>lt;sup>8</sup> Source: VSSC FMS 830 Report (Fiscal Year to Date—September 2011, All VA Cost Centers, Personal Services & All Other) (pulled Oct. 24, 2011).

³ Id.

<sup>&</sup>lt;sup>10</sup> Total Unique Patients includes pharmacy-only. Source: VSSC Unique Patients Single Reporting Level Display (Fiscal Year 2011, through September 2011) (pulled Oct. 24, 2011).



Detail	Bedford VAMC	VA Boston HCS
Total Outpatient Visits <sup>12</sup>	215,086	735,730
Total Operating Beds <sup>13</sup>	461	659
Hospital Beds <sup>14</sup>	65	349
Nursing Home Beds <sup>15</sup>	304	160
Domiciliary Beds <sup>16</sup>	50	112
Psychiatric	42	38
Residential		
Rehabilitation		
Treatment Program		
Beds <sup>17</sup>		
Buildings <sup>18</sup>	65	62 (Jamaica Plain: 12; West
40		Roxbury: 16; Brockton: 34)
Historic Buildings <sup>19</sup>	45	2
Gross Square	1,179,298	2,576,828 (Jamaica Plain: 957,291;
Footage <sup>20</sup>		West Roxbury: 551,306;
		Brockton: 1,068,231)
Campus Acreage <sup>21</sup>	183.7	193.4 (Jamaica Plain: 17.7; West
		Roxbury: 30.0; Brockton: 145.7)
Joint Commission	Yes. Date of last survey:	Yes. Date of last survey:
Accreditation	05/22/2009	02/27/2009
Commission on	Yes	Yes
Accreditation of		
Rehabilitation		
Facilities		
Accreditation		

 $^{11}$  Further information on Unique Patients, including historical details, appears in Appendix 4 .

Source: VSSC Outpatient Visits and Uniques Report (FY2011 Cumulative Visits through September 2011) (pulled Oct. 24, 2011).

Source: VSSC Beds Using PTF Report (Operating Beds: Facility Totals, Workload by Bed Section, Fiscal Time Period—FY11, Beds Data Through 09/30/2011) (pulled Oct. 24, 2011).

<sup>&</sup>lt;sup>14</sup> Source: VSSC Beds Using PTF Report (Operating Beds: Hospital, Workload by Bed Section, Fiscal Time Period—FY11, Beds Data Through 09/30/2011) (pulled Oct. 24, 2011).

<sup>&</sup>lt;sup>15</sup> Source: VSSC Beds Using PTF Report (Operating Beds: Nursing, Workload by Bed Section, Fiscal Time Period—FY11, Beds Data Through 09/30/2011) (pulled Oct. 24, 2011).

<sup>&</sup>lt;sup>16</sup> Source: VSSC Beds Using PTF Report (Operating Beds: Domiciliary, Workload by Bed Section, Fiscal Time Period—FY11, Beds Data Through 09/30/2011) (pulled Oct. 24, 2011).

<sup>&</sup>lt;sup>17</sup> Source: VSSC Beds Using PTF Report (Operating Beds: PRRTP, Workload by Bed Section, Fiscal Time Period—FY11, Beds Data Through 09/30/2011) (pulled Oct. 24, 2011).

<sup>&</sup>lt;sup>18</sup> Source: VA Capital Asset Inventory (Version 1.2.2) Station Summary (pulled Oct. 25, 2011).

<sup>&</sup>lt;sup>19</sup> *Id.* 

<sup>&</sup>lt;sup>20</sup> *Id*.

<sup>&</sup>lt;sup>21</sup> *Id*.

Detail	Bedford VAMC	VA Boston HCS	
Community-Based	3: Gloucester, Haverhill, Lynn	5: Dorchester, Framingham,	
<b>Outpatient Clinics</b>		Lowell, Quincy, Causeway Street	
		(Boston)	
Union Partners	NAGE, Local R1-32/32a	NAGE, Local R1-25	
	NAGE, Local R1-132	NAGE, Local R1-86	
		NAGE, R1-187	
		AFGE, Local 2143	
		AFGE, Local 221	
Medical School	Boston University School of	Boston University School of	
Academic	Medicine	Medicine	
Affiliations	University of Massachusetts	Harvard Medical School	
	Medical School	Tufts University School of	
		Medicine	
		University of Massachusetts	
		Medical School	
Research Program	Bedford VAMC includes the	VA Boston HCS has one of the	
Description	Bedford Geriatric Research	largest and most active research	
	Education Clinical Center	programs in VA nationwide.	
	(GRECC), a division of the New	Researchers on each of the 3	
	England GRECC, and the Bedford	· ·	
	Division of the New England	provide state-of-the-art medical	
	Mental Health Illness Research	techniques and treatments for	
	Education and Clinical Center	Veterans.	
	(MIRECC).	Total funded projects: 556	
	Total funded projects: 63	Active Principal Investigators: 245	
	Active Principal Investigators: 56		
Research	\$8,030,078	\$56,141,698	
Expenditures (FY2010)			
VHA Indirect Support	\$5,026,841	\$18,657,925	
for Research	' ' ' ' '	, , , , -	
(Research VERA)			

Table 1: Bedford VAMC and VA Boston HCS Details

# **Geographic Areas Served**

Bedford VAMC and the 3 VA Boston HCS campuses share a healthcare delivery area, with the geographical areas served appearing below (Figure 4). This map contains lines marking areas within a 60-minute drive from the Bedford VAMC (dark blue) and the West Roxbury Division of the VA Boston HCS (light blue). It is noteworthy that the area north of Boston outside the light blue line (i.e., 60 minutes from West Roxbury) is served by the Manchester NH VAMC. The area south of Boston outside the dark blue line (i.e., more than 60 minutes from Bedford) is served by the Providence RI VAMC. Thus, the 2 Medical Centers serve the same geographical area and the same population of patients.



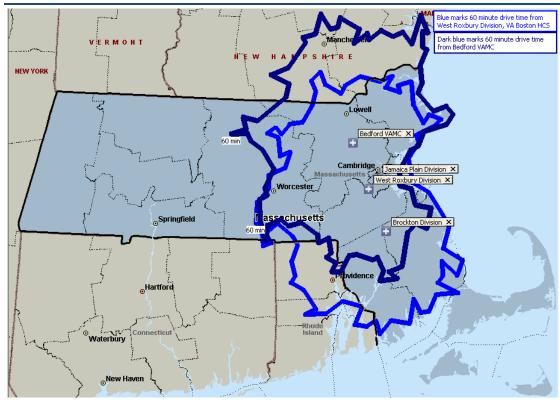


Figure 4: Map of 60 Minute Drive Times and Geographic Overlap

Figures 5 and 6, both below, provide details on the distances—in miles and minutes—between each of the 4 Greater Boston VHA campuses. It is noteworthy that Bedford is almost the same distance from the West Roxbury and Jamaica Campuses as Brockton.

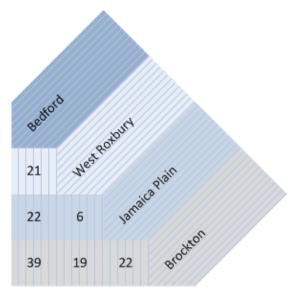
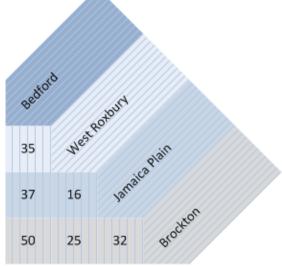


Figure 5: Inter-Campus Distance (Miles)



**Figure 6: Inter-Campus Drive Time (Minutes)** 

Four CBOCs are located north of Boston. Lowell is part of the VA Boston HCS and is located only 10 miles from the Bedford Campus, but 33 miles from Jamaica Plain and 32 miles from West Roxbury. The Lynn, Gloucester, and Haverhill CBOCs are part of the Bedford VAMC system. However, Lynn is located 16 miles from the Jamaica Plain campus, but 22 miles from Bedford. Gloucester is 38 miles from Bedford and 39 miles from Jamaica Plain. Thus, the assignment of CBOCs does not follow logical geographical assignment with regard to travel distance.



# **Clinical Services**

Table 2 presents a listing of clinical services offered by Bedford VAMC and VA Boston HCS.

Clinical Service	Bedford	Boston		
Medicine (Specialty & Acute Care)				
Allergy & Immunology	No	Yes		
Cardiacelectrophysiology	No	Yes		
Cardiology	Limited	Yes		
Colonoscopy	No	Yes		
Cystoscopy	No	Yes		
Dental	Yes	Yes		
Dermatology	Limited	Yes		
Dialysis	No	Yes		
Echocardiography	Yes	Yes		
Electroencephalography (EEG)	No	Yes		
Electromyography	No	Yes		
Emergency Department	No	Yes		
Endocrinology	No	Yes		
Esophagogastroduodenoscopy	No	Yes		
Exercise Tolerance Test (ETT)	Limited	Yes		
Gastroenterology	Limited	Yes		
Gynecology	No	Yes		
Hematology/ Oncology	No	Yes		
Holter monitor	Yes	Yes		
Infectious diseases	Yes	Yes		
Inpatient medicine (including				
Intensive Care Unit (ICU))	No	Yes		
Neurology	Yes	Yes		
Pulmonary Function Test	Yes	Yes		
Pulmonology	Limited	Yes		
Renal	No	Yes		
Rheumatology	Yes	Yes		
Sleep Study Lab	No	Yes		
Urgent care dept	Yes	Yes		
Primary Care				
Primary Care	Yes	Yes		
Primary Care Women's Health	Yes	Yes		
Geriatrics & Extended Care				
Alzheimer's Unit	Yes	No		
Community Living Center (CLC)	Yes	Yes		

Clinical Service	Bedford	Boston
Hospital-Based Home Care	Yes	Yes
Palliative Care	Yes	Yes
Military Sexual Trauma	Yes	Yes
Outpatient Mental Health		
(Specialty Programs)	Yes	Yes
Post Traumatic Stress Disorder		
(PTSD) Treatment	Yes	Yes
Psychiatric Residential		
Rehabilitation Treatment		
Program (PRRTP)	Yes	Yes
Smoking Cessation	Yes	Yes
Substance Abuse Treatment	Yes	Yes
Surgery		
Bariatric Surgery	No	Yes
Cardiothoracic Surgery	No	Yes
Ear, Nose & Throat	No	Yes
General Surgery	Limited	Yes
Inpatient Surgery (including		
Intensive Care Unit (ICU))	No	Yes
Lithotripsy	No	Yes
Major Orthopedic Procedures	No	Yes
Neurosurgery	No	Yes
Ophthalmology	No	Yes
Optometry	Yes	Yes
Orthopedics	Limited	Yes
Outpatient Surgery	No	Yes
Pain Management	No	Yes
Podiatry	Limited	Yes
Urology	Limited	Yes



Clinical Service	Bedford	Boston
Clinical Laboratory & Pathology		
Autopsy	No	Yes
Basic Laboratory Tests	Yes	Yes
Referral Laboratory	No	Yes
Imaging, Radiology & Nuclear Medio	cine	
Cardiac Catherization &		
Interventional Cardiology	No	Yes
Computerized Axial Tomography		
(CT)	No	Yes
Magnetic Resonance Imaging		
(MRI)	No	Yes
Mammography	No	Yes
Nuclear Medicine	No	Yes
Plain Film X-Rays	Yes	Yes
Ultrasound	No	Yes
Sensory & Physical Rehabilitation; Տբ	pinal Cord Injury & D	isorders
Audiology	No	Yes
Category II Polytrauma Center	No	Yes
Occupational Therapy	Yes	Yes
Physical Therapy	Yes	Yes
Speech Therapy	Yes	Yes
Spinal Cord Injury Center	No	Yes

**Table 2: Clinical Services Inventory** 

VA Boston HCS serves as a tertiary care referral center for much of New England. Thus, it offers several highly specialized, technology-intensive and high cost services that are not offered at several of the other VISN 1 VAMCs. However, the table above identifies a large number of services commonly available within a healthcare system that are provided to Bedford patients by VA Boston HCS. These include inpatient medical and surgical care, most outpatient medical and surgical specialty consultations, and imaging services above basic plain film x-rays. Boston and Bedford also share many joint programs. For example, the Boston Radiology Service reads all x-rays taken at Bedford, and the Laboratory and Pathology Service runs the laboratory at Bedford. Furthermore, both Medical Centers participate in several regional programs run at the VISN level, including clinical and biomedical engineering, human resource programs for classification, retirement and workman's compensation, business office functions, library, interior design, and clinical informatics. Bedford VAMC and VA Boston HCS also share medical school affiliations. The two major affiliates of Bedford, Boston University and University of Massachusetts Medical School, are affiliated with VA Boston HCS, which also has major academic affiliations with Harvard Medical School and Tufts Medical School. The two Medical Centers also have a combined Geriatric Research, Education, and Clinical Center (GRECC).

#### **Overlap of Patient Populations Served**

With their shared healthcare delivery area, Bedford VAMC and VA Boston HCS treat many of the same patients. In Fiscal Year 2011 (FY 11), Bedford saw 18,893 unique patients. Of these 7,817 (41%) were also seen by Boston in FY 11. The percentage of overlap has increased over time.

A diagram depicting this overlapping patient population appears below (Figure 7).



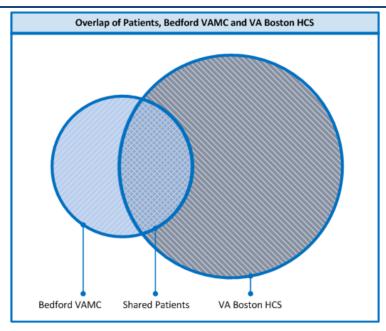


Figure 7: Overlap of Patients

	This Facility Count	Shared Greater Boston Count	Shared Greater Boston percent
Bedford <sup>22</sup>	18,893	7,817	41

#### **Medical Record Systems and Appointment Scheduling Systems**

In VHA, each Medical Center maintains its own Electronic Medical Record (EMR) system, known as the Computerized Patient Record System (CPRS). As a result, Boston and Bedford maintain independent CPRS systems.

While each VAMC has a separate record system, medical records at one facility are available to and can be viewed electronically at all other VHA locations through a secure website known as VistAWeb. Although available for passive viewing, medical records are not integrated across Medical Centers. Orders entered into one system, for instance, are not active in the systems of the other VAMCs, and electronic alerts and reminders function only within a single system. Progress notes, discharge summaries, laboratory and imaging reports, medication lists—the full range of medical information for a given patient—are not immediately available outside its source medical record. For example, when a provider reviews the medication list at Bedford, medications ordered by Boston providers are not listed in the medical record. Lab work done by Boston does not appear in the laboratory reports. Updates to one EMR system do not

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<sup>&</sup>lt;sup>22</sup> Source: VHA Support Service Center Patient Comparison Counts Report (pulled Nov. 01, 2011).

automatically update the other VHA systems. Thus, staff providing care at Boston and Bedford are utilizing different medical record systems even when caring for the same patient.

Because they are separate Medical Centers, Bedford VAMC and VA Boston HCS also have separate patient scheduling systems. The separate scheduling systems do not provide information to one Medical Center about existing appointments at the other. Given the frequency with which Veterans receive care at both systems, scheduling conflicts frequently occur and are a source of considerable Veteran dissatisfaction.

#### **Medical Staffs**

As separate Joint Commission-accredited healthcare organizations, VA Boston HCS and Bedford VAMC maintain independent medical staffs. Membership to a hospital's medical staff provides a medical staff member privileges at that healthcare system. Members of the medical staff can, among other things, admit patients, order tests, and prescribe medicine for that hospital (and any other components of the hospital, such as outpatient clinics). As VA Boston HCS and Bedford VAMC have separate medical staffs, medical providers at Bedford cannot perform these functions within the Boston system (and vice-versa). This leads to increased time and/or travel needs for patients. For example, if a specialist at the Lowell CBOC, which is part of the VA Boston HCS, orders blood work for a patient, that patient has to travel to one of the other Boston facilities—not Bedford—to have this blood work done, even though these facilities are much farther away from Lowell.

#### **Patient Transportation Systems**

Given the fact that many services in each VA healthcare system are located only at specific sites, each VAMC maintains a transportation system for Veterans. These systems are a combination of volunteer-based transportation, largely supported by the Disabled American Veterans (DAV), together with transportation supported directly by VHA. The patient transportation systems at Bedford VAMC and VA Boston HCS are separate. Each focuses on transporting patients between their own affiliated sites, although Bedford offers travel to the Boston locations that provide a number of specialized services, principally Jamaica Plain. These two systems are not designed around actual patient usage patterns for the entire Greater Boston area. separation creates a number of difficulties for patients. For example, Bedford provides several specialty services but there is no shuttle from the Lowell clinic, only ten miles away, because Lowell is part of the Boston system. Instead, Lowell patients are offered services in downtown Boston, at Jamaica Plain, and must take the longer trip to that site if they depend upon VA transportation. Similarly, patients from outlying clinics at Haverhill, Gloucester, and Lynn must take shuttles to Bedford and then transfer to shuttles to Boston in order to get care at Boston sites, often making a single appointment an all-day undertaking.



#### **Shared Governance**

As elements of the national VHA system, both Bedford VAMC and VA Boston HCS operate using a very large number of shared, standard policies and procedures. Human resource, fiscal, health information, business office, and clinical regulations and processes are set by Federal, VA, and VHA policies and directives. Furthermore, as adjacent divisions of VISN 1, the two are not independent entities, but rather divisions of a larger organization. Both Medical Center Directors report to the VISN 1 Network Director and their annual performance plan is based on the same national standards. VISN 1 is managed through a series of VISN committees, led by the Executive Leadership Board and eight key leadership committees. The Medical Center Directors of both Medical Centers serve on the Executive Leadership Board and both chair one of the key VISN committees. Other leaders and key personnel from both Medical Centers serve jointly on the other VISN committees. These committees set policies and procedures for the regional network. Furthermore, VISN 1 maintains a standardized and uniform organizational chart across all its eight Medical Centers such that the organization of the two Medical Centers closely mirror each other. VISN 1 also has an active program of inter-facility service line activities. Thus, service chiefs and other leadership from the two Medical Centers have many joint activities and work together to share best practices, visiting each other and other Medical Centers in the network, and developing policies and procedures that are implemented across all eight Medical Centers in VISN 1.

# II. The Proposal for Integration

VISN 1 proposes to integrate VA Boston HCS and Bedford VAMC into one unified system, serving the Greater Boston area. Under VHA governance, it would have a single 'station number,' indicating that it is operating as a single healthcare system. The integrated healthcare system would operate under one leadership team. It would have a single set of clinical and administrative services, a single medical staff, a single set of policies and procedures, and a single committee framework. It would have a single budget. Under the proposal, all four campuses (Bedford, Brockton, Jamaica Plain, and West Roxbury) would continue to operate. All of the facilities would remain open, and no current inpatients would be moved to a different facility. All CBOCs would remain open without a change in services. The proposal, in essence, addresses how VHA services in Boston are organized and administered—it is not about changes to the clinical services currently available at the various campuses. The goal is to create an integrated healthcare delivery system that provides highly coordinated care, improves access to the full range of VHA services, gains operational efficiencies, and improves regional planning.

# **Leadership Team**

Under the proposal, the two systems would join with one leadership team at the helm. The integrated system would be managed by a single Medical Center Director working alongside a Deputy Medical Center Director (based at the West Roxbury campus); three Assistant Directors (located at the Bedford, Jamaica Plain, and Brockton campuses); a Chief of Staff; and an Associate Director for Nursing/Patient Care Services (Nurse Executive). The leadership team would spend significant time at each of the campuses on a regular basis.

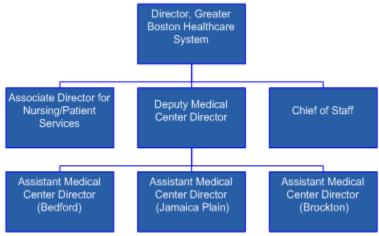


Figure 8: Potential Post-Integration Leadership Structure



Bedford VAMC currently has an acting Medical Center Director and an acting Associate Director for Nursing/Patient Care Services. Should the proposal move forward, both of these positions would remain unfilled until the facilities are integrated. The Medical Center Director position for Bedford would then be discontinued, as the Director for the integrated system would assume these responsibilities. responsibilities of the Associate Director for Nursing/Patient Care Services would be assumed by Boston senior nursing leadership. The Associate Director for Nursing/Patient Care Services of the integrated system would oversee the Deputy Associate Director for Nursing/Patient Care Services and Associate Chief Nurses based at Bedford, Brockton, West Roxbury, and specific services. The Bedford Associate Director would continue as the Assistant Director of the integrated system based at the Bedford campus, a position that would have the same grade as the current Bedford Associate Director position. The Bedford Chief of Staff would continue as a senior member of the medical leadership of the integrated system, with no loss of pay or academic rank.

# **Employees**

Under the proposal, all current employees of VA Boston HCS and Bedford VAMC would remain in place and join to form one workforce. There would be one medical staff managing the care for Veterans in the Greater Boston area.

Staff layoffs are not part of this proposal. No request for a Reduction in Force (RIF) authority is planned. Current staff would not lose their employment as there is no planned downsizing from the proposed integration. Furthermore, the human resource impact of actions such as a change of alignment are fully addressed by current Federal, VA, and VHA laws, rules and regulations. As the clinical services would not change and care would continue at all current sites, the job of the vast majority of employees would remain unchanged. Involved service chiefs and human resources staff would develop a plan for any situations where the scope of an employee's current job or his or her title changes. Certain procedures exist under the Title 5 classification system and through the Title 38/Hybrid Title 38 boarding process that address situations in which an integration would result in an individual's position changing in scope, complexity, or responsibility. Employees with positions where the grade could be impacted due to the reclassification of their position would receive retained grade and pay. Therefore, no employees would lose their current grade or pay.

As in any change in working conditions for VA employees, VISN 1 would meet its National Bargaining Responsibilities. Almost all employees would continue to work at their current duty stations, with minimal travel between campuses, as required for the coordination of service functions. Currently all VA facilities in VISN 1, including VA Boston HCS and Bedford VAMC, provide care at multiple sites. It is current practice at all VA facilities, following appropriate policies, practices and procedures, to have staff work at sites other than their usual duty station if this is required to maintain safe patient care. This would be no different should the proposal move forward. The VISN

included its Labor Partners into the discussion of this proposal for their pre-decisional input. If a decision is made to integrate the two facilities, the National Labor Union Representatives would be notified—including the National Association of Government Employees (NAGE) and the American Federation of Government Employees (AFGE), as well as the VA Labor Relations Office—to meet any bargaining responsibilities.

#### **Service Chiefs**

As noted above, under this proposal, care would continue at all current sites and the jobs of the vast majority of employees would remain unchanged. The proposal, however, does include merging the individual services as the two Medical Centers integrate. Thus, in addition to the leadership Quadrad, individual service chiefs would be impacted. For chiefs of the clinical services who are employed under Title 38 (which governs employees with clinical training, such as physicians and nurses), the service chief of the larger service would continue as service chief in the integrated system. In all cases, these would be the VA Boston HCS service chiefs. For services where the service chiefs are employed under Title 5 (which governs non-clinical civil service employees), regulations provide for the chief at the higher grade to be appointed non-competitively. Under the proposal, if both chiefs are the same grade, the position would be opened for competition and both could apply. The current organizational charts of both Boston and Bedford have been reviewed. Only two services, police and voluntary services, have chiefs of the same grade. In these two instances, the position of the combined service would be opened for competitive selection. In the remaining services, the Boston chiefs are higher grade and would continue as chief of the combined service.

#### **Medical Records**

As noted earlier, VA Boston HCS and Bedford VAMC maintain separate medical record systems. Under the proposal, the integrated healthcare system would move to operating with a single electronic medical record. All the healthcare providers, programs, and sites in the Greater Boston area would use a single EMR. The VA Office of Information Technology (OIT) no longer supports complete mergers of separate electronic medical record systems. Therefore, the integrated system would continue to use the Boston CPRS system, as this system currently covers the large majority of patients. As much information as possible from the Bedford system would be migrated electronically to the Boston CPRS. Information considered critical or of high importance to patient care that could not be transferred electronically would be re-entered into the Boston CPRS system manually. All patient information, including the information not migrated or re-entered to the Boston CPRS, could still be viewed from the old medical records at any time via the VistAWeb website. The site is immediately accessible from the Boston EMR. All new documentation would be entered to the new System's records.



# **Budget**

A single budget for an integrated system would be formed by combining the two separate budgets for Bedford and Boston. Funding for Medical Centers is driven by patient workload as well as educational and research programs. As these factors for an integrated system would simply be the sum of current activities at Bedford and Boston, there would be no cuts in funding for the VHA programs in Greater Boston as a result of the proposed integration. Appropriate supplemental funding would be provided to cover the costs of planning and implementing the integration.

# Alignment of Proposal with VISN Strategic Plan

Integrating Bedford VAMC and VA Boston HCS is in accordance with the strategic plan for VA New England Healthcare System. The VISN 1 2012-2016 Strategic Plan includes five goals: (I) Excellence in Population Health; (II) Excellence in Patient Experience; (III) Excellence in Financial Stewardship; (IV) Excellence in Workforce; and (V) Excellence in Service to Our Communities. As noted above, integrating Bedford VAMC into VA Boston HCS would result in improved access, enhanced coordination of care, and operational efficiencies. Accordingly, while the proposed plan supports each of the VISN's five strategic goals, it most directly serves to provide Excellence in Patient Experience and Excellence in Financial Stewardship. For FY 12, VISN 1 set five strategic objectives in support of the VISN's strategic goals: (1) Build a Culture of Improvement; (2) Increase Accessibility of VA Services; (3) Improve Efficiency of the Organization; (4) Increase Patient Base; and (5) Enhance Academic Relationships. While the proposed integration aligns with each of these objectives, creating a Greater Boston VA Healthcare System would most directly support objectives 2 and 3.

The proposed integration would result in two VA healthcare systems, providing services across Massachusetts.<sup>23</sup> The geographic areas covered by these systems (VA Central Western Massachusetts HCS and the proposed VA Greater Boston HCS), appears below (Figure 9).

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<sup>&</sup>lt;sup>23</sup> Additionally, patients from a small part of the Commonwealth of Massachusetts would continue to receive services from the Providence VAMC.

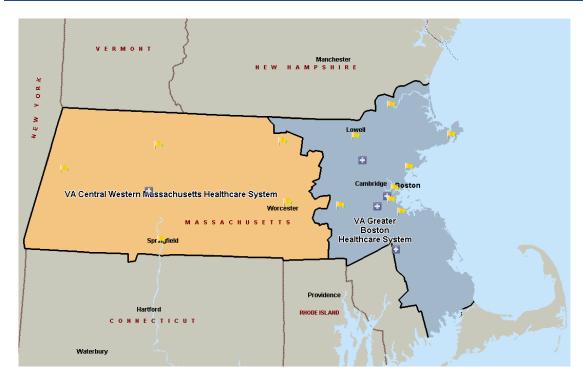


Figure 9: Map of Post-Integration Massachusetts VA Healthcare Systems

In 2000, VHA undertook a comprehensive long-range assessment of its capital assets, entitled CARES (Capital Assets Realignment for Enhanced Services). Several proposals were developed for the Greater Boston area. In considering the proposals, the Veterans of Massachusetts and their Congressional representatives were unified about the importance of continuation of services at the Bedford campus and were strongly opposed to any proposal that recommended its closure. In 2008, James Nicholson, the former Department of Veterans Affairs Secretary, signed off on a final decision on the CARES follow-up study for the Boston area whereby VHA was to continue to operate all four campuses in Greater Boston. As this current proposal recommends developing an integrated system in which the Bedford campus continues to have a fundamental role in providing patient care, the proposal is fully consistent with the CARES decision and completely supportive of the positions advocated for by the Veterans of Massachusetts and their Congressional representatives.

#### **Timeline**

Should this proposal move forward, VISN 1 anticipates that the integration would take effect, at the earliest, at the beginning of FY 13 (October 1, 2012). A proposal to integrate leads to a process of further review at VA Central Office. A decision to integrate the facilities cannot be made by the VISN—it is a decision made by the Secretary of Veterans Affairs. If the Secretary approves the proposal, the VISN would form a steering committee and several work groups to facilitate the integration implementation, which would take place in a phased approach led by a dedicated



project manager. These work groups would include broad representation by involved stakeholders, including employees, union partners, Veterans, and Veteran Service Organizations.

# **III. Benefits of Integration**

Integrating VA Boston HCS and Bedford VAMC would result in a variety of benefits for the Veterans of Greater Boston. These benefits can be categorized into four main areas:

- Better coordination of care
- Improved access to services at all sites of care in Greater Boston
- Operational efficiencies
- Enhanced regional planning

Several specific benefits are identified and discussed below. Each of the topics discussed below may impact several of the main benefits listed above.

# **Integrated Electronic Medical Record**

VHA's highly regarded EMR system,<sup>24</sup> known as CPRS, allows staff instant access to patient records from the same Medical Center. These records include the full range of medical information, including progress notes, laboratory and imaging results, consults, orders, discharge summaries, and appointments. In VHA, all medical orders are entered electronically into CPRS. Furthermore, CPRS performs multiple automated functions to check for safety concerns, alert providers of important findings and events and remind them of needed interventions.

"I have been assisting my father with his healthcare needs over the past three years at the VA facilities. He has had countless tests and two major surgeries. It would be *tremendously* helpful to have all records centralized. We spend hours trying to get all information to each facility and coordinating appointments. It was particularly difficult to get medication correctly administered for his eyes when he was an inpatient at W Roxbury for hip surgery. Please unify the system for the benefit of all. I can't imagine what it is like for those patients who do not have outside advocates helping them through the maze."

-Patient family member

capabilities cannot fail to be impressed.").

<sup>&</sup>lt;sup>24</sup> See, e.g., Adam Oliver, The Veterans Health Administration: An American Success Story?, The Milbank Quarterly, Vol. 85(1) (2007) ("Anyone who has been exposed to a demonstration of [the VHA's EMR's]



In VHA, each Medical Center has its own EMR system. Bedford VAMC and VA Boston HCS, as separate Medical Centers, have separate EMR systems. Staff at Bedford VAMC have the ability to view records from the Boston EMR system (and vice versa), but need to perform additional steps to do so (through VistAWeb). In addition, the system will not run clinical reminders, show tests ordered, or provide other details if the patient is from another system. The coordination of patient care suffers because the

"Unfortunately, having to work across two medical record systems has been an impediment for specialists. Labs, clinic notes, and imaging studies from VA Boston HCS are more difficult to find in Bedford VAMC's system than when the patients are seen at VA Boston HCS."

-Boston Clinician

VHA healthcare facilities in the Greater Boston area do not share a single, integrated EMR system. Given the high frequency with which patients are receiving care in both systems, it is a major source of dissatisfaction and concern to providers, patients, and families.

The integration of the separate EMR systems constitutes a major component of the proposed Bedford VAMC and VA Boston HCS integration. Integration into a single EMR system would remove barriers to patient care by improving the flow of information. More specifically, integrating the EMR system would make the clinical information contained within each system—such as medication lists, doctors' notes, and laboratory and x ray test

results—immediately available in an integrated fashion to healthcare providers across the four campuses and associated CBOCs in the Greater Boston region. This would improve the coordination of patient care, improve safety for individual patients, and prevent duplication of care, all of which would result in higher quality patient care for the Veterans of Greater Boston.

# **Single Patient Scheduling System**

Bedford VAMC and VA Boston HCS have separate patient scheduling and appointment systems. Staff making appointments at one Medical Center do not have access to the list of appointments at the other Medical Center. As noted previously, many Veterans receive care at both of the Boston area VA Medical Centers. When patients from one of the systems need to receive care from the other system, not having a single system for patient appointment scheduling across the region causes

"Speaking as a patient, I can't count the number of times with appointments for the same day, one at Bedford, the other at Causeway Street, or one at Bedford and the other at Jamaica Plain."

-VSO Representative

problems, and may serve as a barrier to proper coordination of care. For example, schedulers at Bedford may inadvertently set an appointment for a patient at the Lynn CBOC at the same time the patient already has an appointment set at Boston's Jamaica Plain campus. The patient, of course,

cannot be at both places at once. This double scheduling creates rework and may result in frustration for both the VHA staff member and the patient. It also contributes to missed appointments and additional travel for patients.

"This is an absolutely wonderful idea. Veterans often ask me to check what date/time their appointment is at JP, etc., and it is time consuming to always open up VistAWeb to find out new lab work, appointment times, discharge notes, etc. Having one connected unit would be more efficient and allow us to better serve our Veterans."

-Bedford Staff Member

Integrating VA Boston HCS and Bedford VAMC would result in the combination of the two patient appointment-scheduling systems. With a combined scheduling system, staff at the Greater Boston VHA healthcare facilities could more easily—and more effectively—coordinate patient care. VHA staff members would have ready access to appointments at all of the VHA facilities in the area. This access would allow the staff member to set an appointment that best fits the patient's needs (and does not require the patient to be in multiple places at once).

# **Unified Transportation System**

VA Boston HCS and Bedford VAMC have separate transportation systems. Like the EMR and patient scheduling systems, challenges arise from having separate transportation systems for the four VHA hospitals in Greater Boston. The challenges caused by the separate transportation systems join with the other problems caused by having multiple systems in the same area, such as those resulting from the separate patient scheduling systems, to form barriers to the optimal coordination of patient care.

"It's a great idea. I am also hoping this will improve transportation from Lowell to Bedford for patients living in Lowell. We have many and there is no direct shuttle from Lowell CBOC to Bedford."

-Bedford Staff Member

Integration of Bedford VAMC and VA Boston HCS would involve consolidating their transportation departments so that they are centrally managed, with a Fleet Manager overseeing the integrated transportation system. This transportation system integration would provide enhanced transportation services for Boston area Veterans, resulting in improved access to VA facilities. Combining the transportation services would result in the efficiencies generated

by the pooling of staff and other resources. This pooling would support greater flexibility for the transportation department to respond to requests for changes to the transportation system, such as requests for additional shuttle stops. The transportation department currently experiences communication problems. These communication difficulties have resulted from the lack of a unified transportation system for all Greater Boston VHA facilities. Integrating VA Boston HCS and Bedford VAMC would address



these challenges. By combining into a single department, integration would also support increased cooperation and coordination with regional transportation authorities. Reduced service requirements from these regional transportation authorities could potentially result from this increased cooperation and improved coordination.

# **Single Medical Staff**

VA Boston HCS and Bedford VAMC have separate medical staffs. As much of the Greater Boston Veteran patient population uses both VAMCs, not having a unified medical staff causes problems by limiting patients' access to some VHA services. The separation of medical staffs may also result in increased patient time and/or travel requirements. For example, if a specialist at a VA Boston HCS facility orders blood work for a patient, the patient would need to have the blood work performed at a Boston

facility, even if the patient lives closer and would

prefer to use the Bedford facility.

Integrating VA Boston HCS and Bedford VAMC would improve access, especially to specialty care, enabling all Greater Boston VHA patients access to high quality VHA programs and removing limitations caused by separate medical staffs. By integrating into a single medical staff, specialists from VA Boston HCS could add clinics at Bedford, affording Bedford patients increased access to Boston specialists closer to where they live.

"I wish Bedford would be integrated with the Boston system. I use the Lowell clinic, but if I need to see a specialist I have to go to Boston, an all day affair for me, plus pay for trains and subways. I could drive to Bedford in 20 minutes."

-Patient from Lowell

# **Improved Access to Care at All Sites**

"I'd like to get my eye care to Bedford, but I'm not leaving my primary care doc at JP because he is excellent and it's too hard to try and use both hospitals."

-Woman Veteran who lives near Bedford The current approach to VHA healthcare delivery in Greater Boston—with two systems and two medical staffs—results in access challenges for patients. With each site affiliated with only one of the two systems and with separate medical staffs, patients and providers often find it difficult to access services based at locations in the other system. VHA does have the ability to set up "interfacility consults," which allow providers in one system to order consults at another Medical

Center. In fact, Bedford patients receive specialty care at Boston through this mechanism. With so many patients utilizing both systems, however, there are many occurrences where the existence of separate systems creates barriers. Providers at Boston may see patients who live close to Bedford or one of its CBOCs, but are unable to place orders for blood work, x-rays, or consults for care at those locations. When a Boston provider orders blood work, patients must travel to Boston to have it drawn, as

they cannot do so at a Bedford site, even if it is closer to their home. Medications ordered by Boston providers cannot be dispensed at Bedford and vice-versa.

Integrating Bedford VAMC and VA Boston HCS would increase access to care by making all VHA services in Greater Boston readily available to all Greater Boston Veterans.

"It is always frustrating to draw blood and have to drive all the way to JP. I have one Veteran who is on Coumadin and lives 5 minutes from the Lynn CBOC. One time, I was unable to draw his blood so I send him to the CBOC in Lynn. When the specimen got to Bedford, no one there knew what to do with it because he was a JP patient. The present system is very inefficient for those of us on the border or the two VAs."

-Home Care Nurse for Boston VA

# **Operational Efficiencies**

The primary driver for this proposal is to improve the care delivered to Veterans; however, an integration would also provide the opportunity for many operational efficiencies. While some mergers, both within and outside the healthcare industry, aim

"I can't believe this wasn't done a very long time ago. Better for us patients and I would think, more efficient and economical."

-Veteran

to achieve major efficiencies by closing key units, such steps are not part of this proposal. Nevertheless, there are many less radical changes that would take place that cumulatively would add up to meaningful efficiencies. Given rising federal budget deficits and the need to

reign in the costs of healthcare in United States, any opportunity to improve efficiency while simultaneously improving quality should be vigorously pursued.

There are many examples of these small but meaningful efficiencies. Having a single leadership team and streamlined management is one. Another is governance. Each VA Medical Center maintains its own set of policies, which at Bedford number over 400.

Each Medical Center has a separate committee structure. Maintaining policies and committees requires considerable staff time. Integrating VA Boston HCS and Bedford VAMC would eliminate the need to maintain duplicative sets of policies and committees. As separate VAMCs, VA Boston HCS and Bedford VAMC participate in several inspection, accreditation, and oversight programs independently of one another. These reviews require considerable commitments of time and staff.<sup>25</sup> Some of these inspections also involve

"A single database would make laboratory operations in Bedford and BHS more efficient and safer for patients by reducing cumbersome shipping manifests, double log in of samples and relabeling of patient specimens."

-Laboratory Staff Member

<sup>&</sup>lt;sup>25</sup> See, e.g., Don A. Rockwell, et al., *The Cost of Accreditation: One Hospital's Experience*, 44(2) Hosp. Community Psychiatry 151-55 (Feb. 1993) ("Documented and estimated costs" required by a 1989 Joint



significant costs.<sup>26</sup> Inspections currently required at both VA Boston HCS and Bedford VAMC are listed below (Table 3).

#### **Inspections, Accreditations & Other Reviews**

The Joint Commission - Hospital

The Joint Commission - Behavioral Health Care

The Joint Commission - Long Term Care

The Joint Commission - Home Care

Commission on Accreditation of Rehabilitation Facilities (CARF)

System-Wide Ongoing Assessment and Review Strategy (SOARS)

Office of the Inspector General (OIG) Compliance Assessment Program (CAP)

Long Term Care Institute (LTCI)

Community Based Outpatient Clinics (CBOCs) Office of the Inspector General (OIG)

Security - VA Police Inspection

**Nuclear Radiation Commission** 

College of American Pathologists (CAP) Laboratory Accreditation

Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC)

Association for the Accreditation of Human Research Protection Programs (AAHARP)

**Environmental Protection Agency** 

Department of Veterans Affairs Central Office Human Resources

Paralyzed Veterans of America (PVA)

Table 3: List of Inspections, Accreditations, and Other Reviews

Integration would eliminate double reviews and accreditation inspections, thereby freeing up human capital and financial resources. In many areas, VA and VHA national programs mandate that each individual Medical Center hire or identify individuals. By integrating into a single Medical Center, duplication of such positions may be eliminated where appropriate. While each of these examples by themselves would not produce significant savings, these opportunities could add up and improve operational efficiencies.

"I think this is a terrific idea! Many researchers do research at the Boston VA as well and this will prevent having to go through two IRBs [Institutional Review Boards]."

-Bedford Staff

Commission accreditation survey process "totaled \$326,784, which represented about 1 percent of the hospital's operating budget for 1989.").

Accreditation by the Joint Commission requires an annual fee in the range of over two thousand dollars to almost forty thousand dollars. The Joint Commission bases these "on the size and the service complexity of individual hospitals." The Joint Commission, *Facts About Hospital Accreditation*, *available at* http://www.jointcommission.org/assets/1/18/Hospital\_Accreditation\_1\_31\_11.pdf (last visited Nov. 3, 2011).

Another source of immediate and substantial fiscal savings would be a reduction in purchased care. While VHA provides most care through its own system, it does purchase some care from outside healthcare providers under a limited set of specific circumstances. This care—known as purchased care, non-VA care, or fee care—exists to provide medical care to eligible Veterans when such care is not available through VHA facilities. In the past several years, purchased care expenditures have risen significantly across VHA. These expenditures reduce resources available to provide care directly by the VHA system. VA Boston HCS and Bedford VAMC fit this general trend; however, the rate of fee care cost increases at Bedford VAMC far exceeds that of VA Boston HCS—at Bedford, such costs increased 88% over the past 5 years, nearly 4 times the rate at Boston (23%). A major source of this increase has been the purchase of outpatient specialty services, such as endoscopy, which rose from \$576,359 in FY 08 to \$2,975,659 in FY 10. Virtually all these services are available within the VA Boston HCS. With an integrated system, leadership would have incentives to bring these services within the VHA system, yielding substantial savings.

Section IV of this White Paper analyzes prior VA and non-VA healthcare integrations. The most consistent finding of the analysis is that integrations do yield operational efficiencies. An analysis of 122 private integrations showed average price reductions of 7%, supporting the hypothesis that meaningful operational efficiencies would result if the proposed integration moves forward.

## **Improved Regional Planning**

A strength of the VA system is strategic planning to coordinate services and ensure access to care across geographical areas. Integration of Bedford VAMC and VA Boston HCS would result in improved regional planning by better aligning all four of the Greater Boston VHA hospital campuses. Clinical service location determinations would better consider the needs of the combined Greater Boston region, instead of only Bedford VAMC and VA Boston HCS. High cost, high technology resources would be better utilized. Unnecessary duplication of programs or equipment could be more readily addressed. Programs that represent special strengths of each campus would be more accessible to providers, patients and families. Shown below is input received from one service chief at Boston providing an excellent example of the type of improved coordination that could occur with an integrated system. With two different Medical Centers and two different leadership teams (each responsible only for the performance of its own units), two budgets and two different strategic plans, it is difficult to achieve the coordination of care for the innumerable different VHA programs. Such coordination would occur much more readily with a single integrated system that has the unified overall responsibility for the care of the Veteran population of the Greater Boston area.



"We have an approved plan for a new outpatient endoscopy center at the Jamaica Plan campus, which will provide an approx. 50% increased procedural capacity by using cutting-edge technology and highly ergonomic layout. Full integration of VA Boston and Bedford VAMC would allow us to restructure subspecialty care and provide mutual and significant benefits to both parties. An integrated system is estimated to increase our current GI procedural demand by 40%, which would be matched by the new endoscopy center's capacity. This could eliminate the need for outsourcing GI procedures from Bedford VAMC, a current and costly necessity. In exchange, concomitant staff and faculty expansion within the new GI section proportionate to this new demand could provide greater flexibility in scheduling GI subspecialty care across 4 hospital facilities and would further improve our ability to provide state-of-the-art tertiary care in GI and hepatology. We are excited and eager to participate in forthcoming discussions about your proposal and share your expectations on the positive changes it may bring about."

-Chief of Gastroenterology (GI) at Boston

## IV. Prior Integrations in VHA

As part of its effort to analyze this proposed integration, VA New England Healthcare System has gained valuable insights by examining the experience of prior integrations throughout VHA. There have been extensive integrations across the nation over the past twenty years and this experience has undergone formal evaluation. Furthermore, these experiences provide lessons learned to assist in a more successful implementation should the decision be made to move forward with the proposal.

#### **VHA Experience with Integrations**

As listed in Appendix II, 71 different VA Medical Centers have participated in integrations, including just under 60 in the past 2 decades. These integrations were part of a VHA strategy aimed at providing more accessible, reliable, and consistently high quality healthcare to America's Veterans.<sup>27</sup> VHA chose to refer to these strategic alignments as integrations because the facilities involved were serving well-defined, shared populations.<sup>28</sup> In comparison to many private hospital integrations, VA integrations have been largely successful. *None of the VHA integrations have been reversed and not a single CBOC has been closed as part of an integration effort.* Factors favoring the success of VA integrations include an established regional and central office structure, similar patient groups (Veterans), similar culture, similar policies across the system, a physician staff model with lack of private practice group economic interests, a focus on population health, and a mature quality management system.

Indeed, integrations have been so much the norm that almost all cities across the country are now served by a single VA healthcare system, many having multiple campuses. Out of all the major cities in the United States, only two—New York with a population of 8,175,133, and Chicago, with a population of 2,695,598—continue to be served by more than one VA healthcare system. The two healthcare systems in each of those areas are large, comprehensive, VA Medical Centers providing a wide range of complex inpatient care. All other major cities, including Los Angeles (the second largest city in the country with a population of 3,792,621), are served by a single VA healthcare system. The fact that Boston, the 22nd largest city in the United States, with a population of 617,594, continues to have two separate VA Medical Centers, makes it an unusual outlier. What makes it even more notable is the fact that Bedford is a low complexity VA Medical Center providing only mental health and long-term care inpatient services without inpatient medicine or surgery. Nowhere else in the country is there a separate VA Medical Center in a major metropolitan area with such a limited set of services such as at Bedford.

<sup>28</sup> Id.

Kenneth W. Kizer, *A Guidebook for VHA Medical Facility Integration*, U.S. Dept. Veterans Affairs (Apr. 1998), *available at* http://www.va.gov/healthpolicyplanning/facintg.pdf.



Following the influx of facility integrations in the mid-1990s, Dr. Kenneth Kizer, then-Under Secretary for Health for VHA, ordered a systematic assessment and evaluation of 23 VHA medical facility integrations by the Management Decision and Research Center (MDRC) of the VHA's Health Services Research and Development Service. This study focused on the structure of the integrating systems and the effects of integration on system performance. It based its analyses on data from three sources: a survey of integrated system directors; a survey of managers in 19 integrated systems; and administrative data for integrated systems and selected comparison facilities. Among the key conclusions, it found the following:

- Integrated systems significantly improved their staffing efficiency after integration and improved it more than comparison groups. Other measures of efficiency and redirection of resources to clinical care, while not showing significant differences, also showed improvement. All cost-related measures of efficiency and redirected resources were significantly weaker in integrating facilities than comparison hospital before integration, despite having comparisons drawn from the same Medical Cost Group. After integration, however, the differences were fewer and smaller. Integration may have been a key element in enabling the facilities to bring their staffing and cost performance closer in line with more efficient Medical Centers. Without integration, their performance might instead have declined.
- Both integrated and comparison systems significantly reduced their access problems after integration. Although integrated systems did not outperform comparison groups, the finding of fewer access problems reported in the Customer Satisfaction Survey after integration was positive. An early concern in many integrating systems was that Veterans might feel that integration reduced their access by consolidating to one campus services that had previously been provided at all. These concerns did not show up here.
- Integrated systems matched or exceeded comparison groups on primary care enrollment and patient satisfaction with continuity both before and after integration. On these measures, comparison groups showed significantly greater improvements after the integration date, but those improvements simply brought them into line with the integrating systems, which had better pre-integration performance.

In Table 9, below, the MDRC Analysis of Facility Integration highlights the extent to which the integrated systems on average changed after integration approval, referred to in the fourth column as the "Pre-post Integration Differences." This column shows that the integrated systems were, on average, more efficient after integration than

<sup>&</sup>lt;sup>29</sup> Carol VanDeusen Lukas & Kamal Desai, *Analysis of Facility Integration: Second Report*, Management Decision and Research Center, Health Services Research & Dev. Services, U.S. Dept. Veterans Affairs, (Dec. 1999), *available at* http://www.colmr.research.va.gov/publications/reports/facility\_int\_2nd\_rpt.pdf.

before, as reflected in the following components: the drop in the cost per unit of adjusted workload by \$138 and lower direct and indirect costs per workload reduced by \$93 and \$45, respectively. The findings also show that integrated systems improved access for Veterans, as seen in the statistically significant drop in access problems by .09 and the rate of problems reported on the Customer Service Survey (CCS) coordination scale falling by a significant margin of .03.

Looking specifically at the drop in full time equivalent employees (FTEE) per adjusted workload by 12.17, it is important to recognize that this was a statistically significant greater reduction than the pre-post difference for the non-integrated comparison group, for which FTEE per adjusted workload was reduced by 10.20. This improvement is particularly noteworthy because this change occurred at a time in which clinical FTEE experienced a slight reduction and the number of unique patients increased in excess of 10%.



Effects of Facility Integration: Systems Integration Before FY 98			
Variable	Pre- Integration	Post- Integration	Pre-post Integration Differences
Cost Savings/System Efficiency			
Total cost/workload	4,495.00	4,357.00	-138.00
FTEE/1000 unit workload	69.21	57.04	-12.17***
Redirection of Resources to			
Clinical FTEE/total FTEE	0.38	0.37	-0.01
Direct costs/total costs	0.70	0.70	0.00
Direct costs/indirect costs	2.36	2.41	0.05
Direct costs/workload	3,141.00	3,048.00	-93.00
Indirect costs/workload	1,354.00	1,309.00	-45.00
Access to Care			
Patient satisfaction (access problems)	0.24	0.15	-0.09***
Number of unique patients	13,642	15,053	1,411
Single Standard of Care			
Percent primary care enrollment	73.38	76.91	3.53
Patient satisfaction (coordination problems)	0.35	0.32	-0.03*
Patient satisfaction (continuity problems)	0.27	0.23	-0.04

#### Notes:

Asterisks indicate significant differences between pre-integration and post-integration.

Integration Pre-post Differences: the extent to which the integrated systems on average changed after integration approval in relation to before.

Source: National Veterans Health Administration Databases

**Table 4: Analysis of Facility Integrations** 

<sup>\*\*\*=</sup>p<.01

<sup>\*\*=</sup>p<.05

<sup>\*=</sup>p<.10

This study also found that the perceived impact of integration was rated positively by a large sample of managers working in the integrated system with regard to adequacy of resources to service, quality of services provided by the service, patients' access to care or services from their service, and ability to obtain services or support from other departments. Improvements in access and quality were rated most highly. Morale of staff was noted to be negatively impacted during the period of integration however.

In another report, Under Secretary Kizer summarized the experience with integrations as follows:

From 1995 to 1997, VHA facility integrations produced efficiencies in excess of \$50 million, reduced administrative FTE, expanded clinical staff, and increased primary and specialty care. Integrated facilities improved access and reduced waiting times by opening and enhancing clinics at facilities that historically referred patients to more distant locations (even while facing a particularly difficult budgetary climate). In addition, VHA used resources generated from these efficiencies to open CBOCs, replace much needed medical equipment, and make necessary facility capital improvements.<sup>30</sup>

Thus, overall these findings provide support that the anticipated benefits of an integration of Bedford and Boston, as detailed in the prior section, including improved coordination of care, improved access, and improved operational efficiencies, are reasonable expectations.

# **Experience with Prior Integrations in VISN 1**

Like many other VISNs, VISN 1 has managed multiple successful Medical Center integrations. Integrations have occurred both in the Greater Boston area as well as in Connecticut. VA Connecticut Healthcare System (HCS) was formed by the integration of the Newington VAMC, located just outside of Hartford, and the West Haven VAMC. Prior to the integration, Newington had provided inpatient services, but these were consolidated at the West Haven campus. The integration proceeded smoothly with Newington continuing to provide a wide range of outpatient and residential rehabilitation services, as well as becoming the site for VBA's regional office. Since the integration, VA Connecticut HCS has been able to significantly expand its services, opening 6 CBOCs across the state and bringing VA care closer to home for many Connecticut Veterans.

Twenty years ago, VA services in the Greater Boston area consisted of five independent facilities (Jamaica Plain, West Roxbury, Brockton, Bedford, and Boston Outpatient Clinic), with four hospitals each providing inpatient medical, surgical, and psychiatric care. The first integration was that of the Boston Outpatient Clinic (currently

<sup>&</sup>lt;sup>30</sup> Kizer, *supra* note 27.



the Causeway Clinic) into the Boston Hospital (Jamaica Plain), an integration that proceeded easily due to the fact the Boston Outpatient Clinic was already dependent upon Jamaica Plain VAMC for many services. In the early 1990s, a plan was developed to integrate Bedford VAMC with the Boston VAMC (Jamaica Plain) and the Brockton VAMC with the West Roxbury VAMC. While the integration of Brockton and West Roxbury eventually proceeded, the integration of Bedford and Boston was put on hold as efforts were focused on the merger of the two larger tertiary care centers: West Roxbury and Jamaica Plain. In the late 1990s, Boston VAMC and West Roxbury proceeded with an integration and closure of inpatient services at Jamaica Plain. This gradual integration of four independent Boston area medical facilities led to VA Boston HCS. Through these integrations, coordination of Veteran healthcare improved and facilities became better able to specialize in particular services while maintaining availability of services.

In 2000, under the direction of the VHA Chief Research and Development Officer, teams from the Health Services Research and Development Service visited VA Boston HCS as part of a study on the integration of high academically affiliated VA Medical Centers.<sup>31</sup> The study found that, by the fall of 2001, VA Boston HCS had made good progress toward organizational integration; all inpatient services, except psychiatry, had been consolidated to the West Roxbury campus; and the mission of the campus at Jamaica Plain was changed to emphasize complex ambulatory care.

The observations made of VA Boston HCS were generally consistent with the findings of the national studies, even though the study was done while the integration was still in process. While the study found that objective performance measures showed a mixed picture, the researchers pointed out that these measures were generally better than the national average. Outpatient satisfaction increased significantly from FY 98 to FY 01 in the areas of coordination of care, and overall care management. Inpatient satisfaction for access and coordination, as well as outpatient satisfaction for continuity of care did not show significant improvements, but all remained better than the national average. In line with the conclusions of national studies, researchers found that efficiency improved at the facility over the period of integration. Between FY 98 and FY 01, both Boston's cost per workload and staff per workload declined, cost/patient workload fell by 13.4%, and employees/1000 patient workload fell by 19.3%. 32

The earlier integration of four Boston area systems including three separate campuses resulted in many efficiencies, without the loss of services in the Boston area. Indeed, with the opening of additional CBOCs, there are now more services in Boston than before the integration. VA Boston HCS now provides care to a much larger number of Veterans than the separate systems did before the integrations.

<sup>&</sup>lt;sup>31</sup> VanDeusen Lukas & Camberg, *supra* note 5.

<sup>&</sup>lt;sup>32</sup> Carol VanDeusen Lukas, et al., Integration of Affiliated VA Medical Centers: Second Report, Management Decision and Research Center, Health Services Research & Development Services, U.S. Dept. Veterans Affairs (June 2002), available at http://www.colmr.research.va.gov/publications/reports/affiliated-integration-2.pdf.

A very important lesson learned from both Boston and Connecticut was that, while mission changes occurred, all of the campuses continue to operate as vibrant healthcare facilities with broad clinical programs, high levels of staff, fully occupied buildings, and clear missions. It is clear that integration does not in any way imply that campuses would be closed or that clinical services for Veterans would gradually decline. Indeed, the opposite conclusion can be drawn: integrations place VA services on a sounder organizational footing and have provided opportunities for continued growth of clinical programs in a way that improves coordination of care, accessibility of services, and improved operational efficiency. Integrations have also supported rational regional planning with the improved utilization of VHA assets in a given geographical area, reducing unneeded duplication of administrative and clinical activities.

Finally, it should not be overlooked that many VISN 1 employees have firsthand experience with hospital integrations. Thus, should the proposed integration of Boston and Bedford proceed, it could benefit greatly from the application of the institutional knowledge these employees possess to support a smooth and successful transition.



# **Non-VHA Healthcare Integrations**

#### **Overview**

As part of its effort to analyze this proposed integration, VA New England Healthcare System has also gained valuable insight by examining the experience of integrations in private healthcare settings. There have been extensive healthcare integrations outside of VA suggesting that the potential benefits of integration are inherent in healthcare, and not a phenomenon specific to VHA. Furthermore, there has been considerable analysis of private sector integrations which may inform this decision and provide lessons learned to assist in a more successful implementation should the decision be made to proceed with the proposal.

According to a report published by the Robert Wood Johnson Foundation, during the 1990s, the hospital industry underwent a wave of consolidation that transformed the inpatient hospital marketplace.<sup>33</sup> By the mid-1990s, hospital integration and acquisition activity was 9 times its level at the start of the decade.<sup>34</sup> The number of hospital integrations peaked in 1996 at 152 mergers.<sup>35</sup> Private sector integrations continued throughout the 1990s and 2000s at a slower pace, but once again are trending upward today.<sup>36</sup> In 2010, 77 hospital integrations throughout the country, involving \$12.6 billion, constituted the most integrations in a decade and far exceeded the \$1.7 billion committed to 52 integrations in 2009.<sup>37</sup> As of the second guarter of 2011, the number of hospital mergers was up 78% from the second quarter of 2010.<sup>38</sup>

The Greater Boston area has been an active participant in this integration activity. Well known examples include Partners Healthcare, an umbrella organization for Massachusetts General Hospital, Brigham and Women's Hospital (itself the result of a merger of three previously independent systems), North Shore Medical Center and nine other organizations. Beth Israel Deaconess Medical Center and the Caritas system are

<sup>33</sup> William B. Vogt & Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? The Robert Wood Johnson Foundation, Research Synthesis Report No. 9 (Feb. 2006), available at http://www.rwjf.org/files/research/15231.hospitalconsolidation.report.pdf.

Alison Evans Cuellar & Paul J. Gertler, Trends In Hospital Consolidation: The Formulation Of Local Systems, Health Affairs, Vol. 22(6), at 77-87 (Nov./Dec. 2003), http://content.healthaffairs.org/content/22/6/77.full.pdf+html.

<sup>&</sup>lt;sup>36</sup> Two New Haven Hospitals' Merger Plan Moves Forward, Hartford (CT) Courant (Sep. 28, 2011), available at http://articles.courant.com/2011-09-28/health/hc-hospitals-merge-092920110928 1 hospital-mergers-religious-directives-hospitals-face.

<sup>&</sup>lt;sup>37</sup> Rinker Buck, Wave of Hospital Mergers Will Continue, Hartford (CT) Courant (Mar. 28, 2011), available at http://articles.courant.com/2011-03-28/health/hc-buck-hospital-mergers-032820110328 1 hospital-mergershartford-healthcare-catholic-hospital.

<sup>&</sup>lt;sup>38</sup> Health Care M&A Activity In Second Quarter Points To A Record Year, Irving Levin Associates, Inc. (July 14, 2011), available at http://www.levinassociates.com/pr2011/pr1107mamq2 [hereinafter A Record Year].

other examples. This interest in integrations continues with several integrations in the Greater Boston area recently proposed, such as Saints Medical Center of Lowell and Lowell General Hospital,<sup>39</sup> and Lahey Clinic and Northeast Health System.<sup>40</sup>

Researchers at the Robert Wood Johnson Foundation have pointed to economic theory that suggests that many changes in the competitive environment may cause integration waves. Changes in demand, input prices, financial markets, tax laws, or production technology can all affect the relative benefits of integration. Although often occurring in waves, private sector integrations have been extensive. It appears as though hospitals are once again recognizing that the current healthcare market has produced an environment in which integrations have the potential to yield substantial benefits.

[Recent studies of private sector integrations show that] hospitals continue to digest the new health care reform law and to wrestle with its implications. One conclusion they have drawn is, come what may, there is strength in numbers. Accordingly, they are buying other hospitals and physician medical groups to build up local and regional systems, implement ACOs—Accountable Care Organizations—and share financial risk and reward through a more diversified provider network.<sup>42</sup>

Private sector integrations remain prevalent today because many hospital and health systems view integrations as a viable strategy for long-term growth and a means to increase their market share. For many economically distressed nonprofit hospitals, integrations are seen as a defensive measure, while larger health systems see integrations as an opportunity to add new services and enter new geographic regions, increasing patient access to care. The principle motive for integrations in the private sector continues to be to compensate for lower revenues by creating economies of scale.

Regarding the motivations for such integrations, Quinnipiac University School of Law Professor John Thomas has noted that the recent wave of hospital integrations "is different than an earlier wave," in that "in the past, hospital mergers were mainly a phenomenon of for-profit institutions that sought to streamline hospital operations to

<sup>&</sup>lt;sup>39</sup> Robert Weisman, *Saints Reneges On Deal With Steward*, Boston (MA) Globe (Oct. 7, 2011), *available at* http://articles.boston.com/2011-10-07/business/30254703\_1\_saints-decision-hospital-system-lowell-general-hospital.

<sup>&</sup>lt;sup>40</sup> Karen M. Cheung, *Massachusetts Mergers Push Full Steam Ahead*, FierceHealthcare (Oct. 11, 2011), *available at* http://www.fiercehealthcare.com/story/massachusetts-mergers-push-full-steam-ahead/2011-10-11.

<sup>&</sup>lt;sup>41</sup> Vogt & Town, *supra* note 33.

<sup>&</sup>lt;sup>42</sup> A Record Year, supra note 38.

<sup>&</sup>lt;sup>43</sup> Richard Pizzi, *More Hospital Mergers on Tap in 2011,* Healthcare Finance News (Feb. 22, 2011), available at http://www.healthcarefinancenews.com/news/more-hospital-mergers-tap-2011.

<sup>&</sup>lt;sup>45</sup> Paul A. Volberding, *Mergers And Acquisitions—Who Benefits? Who Loses?*, New England J. of Med. Vol. 334(11), at 722–31 (Mar. 14, 1996).



generate more money." Thomas believes that the more recent wave of nonprofit mergers is "driven by the response of both the government and private insurers to rising healthcare costs, which is to reduce reimbursements for care. The nonprofits are being forced to merge or form partnerships to become more efficient and survive."

Private sector experiences have indicated that small hospitals or hospitals positioned in very competitive markets would realize greater economic efficiencies from integration. Bedford VAMC meets both these criteria. Researchers at the Robert Wood Johnson Foundation concluded that hospital consolidation produces some cost savings and that these cost savings can be significant when hospitals consolidate their services more fully. Furthermore, one study of more than 3,500 United States short-term general hospitals, including 122 horizontal integrations found that the integrations in general provided a financial benefit to consumers, citing average price reductions of approximately 7%.

#### **Lessons Learned**

Private sector hospital integrations have emphasized the importance of addressing the human and cultural sides of integrations as carefully as the financial and structural sides; hospitals must focus on integrating their people and cultures. Ten key principles identified as critical to successful integrations include: (1) comprehensive services across the care continuum; (2) patient focus; (3) geographic coverage and population identification; (4) standardized care delivery through inter-professional teams; (5) performance management; (6) information systems; (7) organizational culture and leadership; (8) physician integration; (9) governance structure; and (10) financial management. Additional suggestions include evaluating structural attractiveness and organizational resistance, rather than cost savings alone when determining the potential benefits of integration. Additional strategies for success include a clearly defined rationale for integration, specific cost and quality improvements, excellent communication, and a focus on the blending of cultures. Other studies caution against

<sup>&</sup>lt;sup>46</sup> Buck, *supra* note 37.

<sup>&</sup>lt;sup>47</sup> Shoou-Yih D. Lee & Jeffrey A. Alexander, *Consequences Of Organizational Change in U.S. Hospitals*, Medical Care Res. & Rev., Vol. 56(3), at 227–76 (Sep. 1999).

<sup>&</sup>lt;sup>48</sup> Vogt & Town, *supra* note 33.

<sup>&</sup>lt;sup>49</sup> Robert A. Connor, et al., *Which Types of Hospital Mergers Save Consumers Money?*, Health Affairs, Vol. 16(6), at 62–74 (Nov./Dec. 1997).

Diane Schmalensee, et al., *Making Mergers More Successful*, Schmalensee Partners, *available at* http://www.schmalensee.com/files/articles\_mergers\_more\_successful.pdf.

<sup>&</sup>lt;sup>51</sup> Esther Suter, et al., *Ten Key Principles for Successful Health Systems Integration*, Healthcare Quarterly Vol. 13(Sp), at 16–23 (2009).

<sup>&</sup>lt;sup>52</sup> Grace Colon, et al., *M&A Malpractice*, The McKinsey Quarterly, at 62-72 (Winter 1999).

Sabrina Rodak, 4 Ways To Ensure A Successful Hospital Merger or Acquisition, Becker's Hospital Rev. (Apr. 20, 2011), available at http://www.beckershospitalreview.com/hospital-transactions-and-valuation-issues/4-ways-to-ensure-a-successful-hospital-merger-or-acquisition.html.

the negative effects of delays in transactions and emphasize the importance of transparency throughout the process.<sup>54</sup>

Due to the incompatibility of organizational cultures and the elimination of jobs and services, private sector integrations have the potential to decrease employee morale and productivity, as well as have a detrimental effect on physician and community relations. Other challenges identified have included difficulties navigating federal and state anti-trust legislation. 56

Reviews of private sector integrations rarely address patient care quality and access to care as primary drivers for integration or key metrics to determine an integration's overall success. To date, there appears to be little research on non-economic benefits of private sector hospital integrations.<sup>57</sup>

#### **Contrasting VHA and Non-VHA Healthcare Integrations**

It is important to recognize that there exist significant variances in the evaluation and determination of a successful model when comparing private sector integrations and integrations within VHA. The most notable variance is the private sector's reliance on cost savings as a key indicator of success.

Researchers at the Robert Wood Johnson Foundation highlight that, in surveys, hospital executives most commonly cite the following reasons for merging: (1) strengthening their financial position; (2) achieving operating efficiencies; and (3) consolidating services.<sup>58</sup>

The primary driver of the proposed VA Greater Boston integration is to improve the quality of care for Veterans and to increase access to such care. This goal stands in contrast to those of the private sector and stays true to the VHA mission of "honoring America's Veterans by providing exceptional health care that improves their health and well-being."

As a result of a range of collaboration and shared services that currently exist, the Boston and Bedford VA Medical Centers have a distinct advantage over private sector hospitals in that they already have many integration components in place and are accustomed to working together to provide the highest standards of patient care. Furthermore, navigating the cumbersome antitrust legislation would not be a necessary component of the proposed integration.

<sup>58</sup> Vogt & Town, *supra* note 33.

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<sup>&</sup>lt;sup>54</sup> Molly Gamble, *Calling It Off: Why Some Hospital Mergers Fail And Others Don't*, Becker's Hospital Rev. (Sep. 23, 2011), *available at* http://www.beckershospitalreview.com/hospital-transactions-and-valuation-issues/calling-it-off-why-some-hospital-mergers-fail-and-others-dont.html.

<sup>&</sup>lt;sup>55</sup> Lee & Alexander, *supra* note 47.

<sup>&</sup>lt;sup>56</sup> Volberding, *supra* note 45.

<sup>&</sup>lt;sup>57</sup> Astrid Brousselle, et al., What Do We Know About Hospital Mergers?: A Selected Annotated Bibliography, Canadian Health Services Research Foundation (Dec. 1999), available at http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/mergerbib\_e.pdf.



Both the Boston and Bedford VA Medical Centers are and would continue to be part of the VA New England Healthcare System, as well as the national VHA system, sharing many of the same policies and procedures. The leadership team would also be drawing from the existing Senior Executive Service pool. In addition, the shared governance structure and the leaders that comprise it would remain at the VISN level, providing the proposed integration with a greater level of leadership and stability than that which exists in most private sector integrations.

#### **Conclusions**

Integrations are common across the American healthcare industry, and are not simply a VHA phenomenon. Private sector integrations continue at an active rate and indeed there appears to be a second wave occurring at the present time. Many of the motivations for integration in the private sector differ from those driving the Bedford and Boston proposal, but private sector experience has also consistently demonstrated significant efficiency and fiscal savings. Furthermore, studies have pointed to cultural differences as a frequent source of difficulties in private sector integrations. Because Bedford and Boston are already part of the same national and regional systems and have many shared programs and interactions already, this proposed integration appears well positioned to avoid many of the most problematic issues encountered in non-VA mergers.

# VI. Potential Challenges Arising from Integration and Their Mitigation

While integration offers important benefits, it also would entail risks and costs. VA New England Healthcare must mitigate several potential challenges to realize the many benefits of integration. The review of prior VA and non-VA integrations, experience with integrations within VISN 1, and feedback from stakeholders on this proposal have all assisted in identifying major challenges. These include:

- Requirement for additional resources for implementation
- Integrating the Electronic Medical Record
- Maintaining Employee Morale
- Patient and Other Stakeholder Misunderstanding
- Risk of Distant Leadership

Perhaps the most important step in mitigating these challenges is to recognize them, accept the fact of their existence, and pro-actively develop comprehensive mitigation plans. Each of these major challenges and the initial plans for their mitigation are reviewed below.

#### **Requirement for Additional Resources for Implementation**

Disruptions are the result of nearly any change. Bedford and Boston are both large and complex organizations. Integration would require action in many areas. The testimony of Dennis H. Smith before Congress on July 24, 1997, on VA integrations communicates this point well:

"There are some important things that have to be done that aren't easy to do. You have to integrate your databases, your computers, your fiscal systems, your telephone equipment. You have to worry about mundane things like name changes and station numbers and organizational charts and informing people that you now have one organization where there used to be two, that there's going to be one report instead of two, and congressional correspondence has to be directed properly—lots of things that don't come to mind immediately when you begin this process."

As described in prior sections, there are advantages to this integration because Bedford and Boston are already part of the same national system and are adjacent divisions of the same regional healthcare system. There are many joint programs, ongoing interactions and shared governance mechanisms already in place. This integration requires neither merger of major clinical programs nor displacement of personnel. Furthermore, as noted earlier, considerable institutional knowledge exists within the organization on how to successfully implement an integration.



Even with these advantages, however, significant effort is needed to ensure successful implementation. VISN 1 would provide investments of staff and funds for the implementation. This staff would include dedicated project managers. VISN 1 already has a full time project manager guiding the realignment of two CBOCs from Boston and Bedford to VA Central Western Massachusetts HCS, a realignment that will encounter many of the same issues as the current proposed integration, albeit on a smaller scale. A careful and thorough project plan would be developed to ensure appropriate sequencing and resourcing. Consultation would be obtained from others within the VA who have recently been involved in similar activities such as the formation of the new healthcare system in Orlando, Florida (formed by integrating units from three different Medical Centers), and the creation of VA Texas Valley Coastal Bend Healthcare System, another new healthcare system formed by a realignment of services previously part of another VA Medical Center. Extensive stakeholder involvement would be sought throughout the process with the formation of many working and advisory groups to include front line staff, union representation, Veteran advisors, community partners, and public officials. It is anticipated that these steps would provide the necessary support to minimize disruptions and guarantee safe, effective patient care throughout a potential transition period.

#### **Integrating the Electronic Medical Record**

Integrating databases and the EMR stands out as a critically important benefit of integration. However, such EMR integration is not an easy undertaking. There is a very large amount of information in each system, and much of this information is directly applicable to patient care. While the goal is to have a single system, a transition could temporarily exacerbate the problem of information availability. The staff at Bedford would experience a period of time where they work off of the Boston EMR, which would contain some, but not all, of the information from the Bedford legacy system. As time passes, this problem would diminish as more and more recent information would be included in the single system. Nevertheless, it would be important to take vigorous steps to mitigate this disruption and support the integration.

In the past, such as at the time of the Jamaica Plain-West Roxbury integration, "database mergers" did occur in which the two databases were completely merged, combining all the information in each. However, this proved to be technically challenging and very resource intensive. As such, the VA Office of Information Technology (OIT) no longer allows such mergers to occur. Instead, they now employ a process known as "CPRS conversion." In this process, certain specific elements of electronic databases are copied from the legacy system into the new accepting systems. These include:

- Clinical Data
  - Patient Demographics
  - **Future Appointments**
  - Future Orders
  - Active Prescriptions
  - Allergies
- Administrative Data
  - Space and Equipment Files
  - o Employee (PAID) data

A national support team from OIT supports this element of the conversion. Such conversions are a regular event in VHA and OIT has teams developed just for this purpose. They also assist in developing employee handbooks to provide front line staff guidance on the process. In addition, several additional steps would be taken by VISN 1 to support the transition. Locally managed transfer of additional information into the Boston CPRS would supplement the information transferred by OIT. Temporary staff would be hired to assist in this process. Use of dual monitors to allow simultaneous viewing of current and legacy information and provision of longer than usual appointments during the initial transition would be other strategies available. VISN 1 is currently undertaking a similar process as the Massachusetts CBOCs in Worcester and Fitchburg are realigning to the new VA Central Western Massachusetts HCS. Lessons learned from this experience would be of great assistance in the implementation of a Boston and Bedford integration.

# **Maintaining Employee Morale**

Maintaining staff morale during the integration process can pose challenges. Experiences from both VA and non-VA integrations have identified this as a critical success factor. Anecdotal reports from the earlier Boston-area VHA integration indicate that morale did temporarily dip. Nevertheless, since 2005, the initiation year of the current format of VA's All Employee Survey, all elements of VA Boston HCS employee satisfaction have risen. 59 In 2010, VA Boston HCS had the eighth highest overall score among hospitals/healthcare systems in the country<sup>60</sup> and was recently named for the second year in a row by the Boston Globe as a best place to work in Boston. 61

<sup>60</sup> All Employee Survey, (2010).

<sup>&</sup>lt;sup>59</sup> The most significant gains under "Job Satisfaction" have been in the Senior Management, Promotion Opportunity, Work Condition, and Praise job factors. Under "Organizational Assessment," the job factors Innovation, Rewards, and Employee Development have seen the most improvement. Under "Culture," the job factors Group and Entrepreneurial improved the most.

Places to Work. 2011, Boston (MA) Globe (Nov. 4, 2011), available http://www.boston.com/jobs/ topwork places/2011/top\_places\_to\_work\_large/.



As already noted, healthcare systems within VHA are components of the same system and share the same culture. VA Boston HCS and Bedford VAMC, both components of VA New England Healthcare System, share even greater commonalities. Nevertheless, integration brings major organizational change that would require a transition period as people get to know each other and resolve differences. Proper preparation can help smooth out any morale "rough spots" that could arise during an integration process. Key to this process is recognition of the role of culture and the need to develop a common culture. The culture of an organization includes the shared norms, ideas, values, beliefs, and assumptions that guide employee behavior. This culture also includes employees' frames of reference regarding the organization. Employees generally learn culture through informal processes. 62 Cultural integration is generally the slowest part of the integration process. 63 Changing organizational structure and formal working arrangements may occur more easily than changing culture because management has greater control over these features. As it is generally beyond direct control by management, culture change takes place more slowly by comparison.<sup>64</sup>

To mitigate this challenge, VISN 1 would implement several steps. An extensive communication plan would keep employees up to date on the potential integration's developments. It has been shown that effective integration planning and implementation processes help improve staff morale following an announcement of integration. It has also been found that "frequent, clear communication to staff about integration is essential" to support cultural change. VISN 1 would directly involve both service chiefs and front line staff extensively in implementation efforts, to help ensure actions fit the needs of individual programs and staff. It would also seek assistance from VHA's National Center for Organizational Development (NCOD) in this effort. NCOD is a valuable VHA national resource offering organizational assessment and consultation including assistance on managing large-scale system change.

# **Patient and Other Stakeholder Misunderstanding**

As in any other major change, incorrect and misleading information often becomes widespread and can lead to undue concern among key stakeholders such as patients and staff. This can impair patient and staff satisfaction, lead to undesirable staff turnover and consume leadership attention and resources.

<sup>&</sup>lt;sup>62</sup> Ralph H. Kilman, et al, *Gaining Control of the Corporate Culture* (San Francisco: Jossey-Bass, 1986).

<sup>&</sup>lt;sup>63</sup> Carol VanDeusen Lukas, et al, *Analysis of Facility Integrations*, Management Decision and Research Center, Health Services Research & Development Services, U.S. Dept. Veterans Affairs (July 1998), *available at* http://www.colmr.research.va.gov/publications/reports/integrt.pdf.

<sup>°4</sup> Id.

<sup>&</sup>lt;sup>65</sup> VanDeusen Lukas & Camberg, *supra* note 5, at 4.8.

<sup>&</sup>lt;sup>66</sup> VanDeusen Lukas, *supra* note 63, at 33.

Study of previous integrations has demonstrated that strong, clear communication is a prerequisite for successful health system integration.<sup>67</sup> Stakeholders should receive frequent communication regarding the integration process.<sup>68</sup> Accordingly, to mitigate this challenge leadership would develop a detailed explicit communication plan. A prime aim would be to communicate the mission and vision of an integrated VHA healthcare system for Greater Boston in a clear, consistent manner.<sup>69</sup>

Furthermore, successful implementation of integration also requires multidirectional communication: *from* those leading the integration *to* the various stakeholders, and vice versa. The communication strategy would provide for robust solicitation of stakeholder feedback—an essential element to proper integration planning—while simultaneously providing necessary information to stakeholders regarding plans for integration.<sup>70</sup> Many of the same strategies used in the initial communication of this proposal, listed in Section VII, would be used.

## **Risk of Distant Leadership**

Bedford currently has its leadership team located on the Bedford campus. Becoming part of a much larger, four campus system would create the risk of distant leadership. This issue was identified through input from Bedford staff and from local government officials in the Bedford area.

Currently, the leadership team at VA Boston HCS faces this issue in managing a three-campus system. Strategies they have adopted include working out of each campus on a regularly scheduled basis, frequent visits by all leadership to each campus, maintaining two-way communication through a variety of forums including town halls, staff meetings, Labor Management Partnership councils, employee newsletters, and website feedback. Representatives from all campuses are active participants and leaders in committee activities and Medical Center initiatives. Just as important, they have recognized the need to have dedicated leadership on site. Therefore, each campus has a dedicated administrator who serves on the top leadership team. The Deputy Director is based at West Roxbury while Brockton and Jamaica Plain each have their own Assistant Director based on those campuses. The current Associate Director at Bedford, who serves at the same grade as the Boston Assistant Directors, would assume this role for Bedford. With this organization, VA Boston HCS has found that it has maintained

<sup>68</sup> VanDeusen Lukas, *supra* note 63, at 33.

<sup>&</sup>lt;sup>67</sup> Suter, *supra* note 51.

<sup>&</sup>lt;sup>69</sup> Suter, *supra* note 51. Additionally, leadership must recognize the importance of and promote learning as a component of the integrated system. *Id.* 

See, e.g., VA Health Care: Lessons Learned From Medical Facility Integrations, U.S. Government Accountability Office (statement of Stephen P. Backhus) (July 24, 1997) ("Moreover, presenting such planning results in a written document that could be shared with stakeholders would further enhance the opportunity for effective communication by allowing VA to obtain stakeholders' views and gain support or 'buy-in' for its proposed integration activities.").



strong relationships with local stakeholders and has successfully coordinated responses to local issues at each campus.

#### VII. Communication Activities

#### **Identified Stakeholders**

VISN 1 identified multiple stakeholders with potential interest in the proposed integration of Bedford VAMC and VA Boston HCS. Recognizing the importance of sustained dialogue with these interested stakeholders, and in an effort to gather their feedback, VISN 1 developed a comprehensive, strategic communication campaign about this proposal, designed with these particular stakeholders in mind. These stakeholders included Veterans and patients; patient family members and other caretakers; employees and volunteers of the two systems; the VISN (including front line workers, management and senior staff); VA Central Office; local, state, and federal elected officials and other civic leaders; the Deans of the various academic affiliates; and Veteran Service Organizations.

#### **Communication Efforts**

Stakeholders were given the opportunity to learn about the proposal using several methods of communication, including conference calls, town hall meetings, e-mails, flyers, a direct mail campaign, internal and external websites, and through stories placed in local newspapers. VISN, Bedford VAMC and VA Boston HCS leadership also participated in meetings with various interested parties upon request. Town hall meetings at Bedford VAMC, VA Boston HCS, and in the towns where the CBOCs are located formed the cornerstone of this campaign. These town hall meetings allowed for two-way communication and included a question and answer component.

Stakeholders were also given the opportunity to provide their feedback and ask questions via written letters, through comment boxes located at Bedford VAMC, or through the internal and external websites. All of the stakeholders who provided comments through the websites and the comment boxes had the option to send their input anonymously. All of feedback received—positive, negative, or neutral—was reposted on the internal and external websites for other stakeholders to view. <sup>71</sup> Details on the proposal including frequently asked questions (FAQs), the presentation used during the town halls, newspaper articles, a letter of support from a local town Veteran agent, and information on additional meetings and other related events, appeared on these websites. <sup>72</sup> This information was updated regularly to reflect new questions received or additional information that became available.

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<sup>&</sup>lt;sup>71</sup> VISN staff reviewed these comments before posting and, when necessary, altered comments to fix spelling errors or to comply with VA website rules and regulations.

The links pointed to http://www.newengland.va.gov/bbia/feedback.asp.



# **Communication by the Network Leadership**

An overview of the communication by the VISN, including time, place, and audience, appears below (Table 5). At many of these events, leadership from Bedford VAMC and VA Boston HCS, along with VISN 1 executive staff, communicated along with the Network Director.

	Communication Regarding the Proposed Integration			
Date	Location	Event	Audience	
December 18, 2009	VACO	Review of Plan to Explore Potential Integration	Deputy Under Secretary for Operations and Management	
Tuesday, May 17, 2011	Congressman Tierney's Peabody District Office	Meeting with Congressman Tierney to Pre-Brief his office on the proposal	Congressman Tierney, Chief of Staff to Congressman	
Wednesday, May 25, 2011 and Thursday, May 26, 2011	Washington, DC	Pre-Briefings with Massachusetts Congressional Members	Congresswoman Tsongas, Congressman McGovern, and staffers from the offices of Senator Kerry, Congressman Tierney, and Congressman Frank	
Tuesday, May 31, 2011 (morning)	Bedford VAMC	Pre-Decisional Briefing and Discussion	Bedford Unions	
Tuesday, May 31, 2011 (morning)	Bedford VAMC	Briefing and Roundtable Discussion	Bedford Service Chiefs	
Tuesday, May 31, 2011	Phone	Call to Discuss Proposal	Massachusetts Department of Veterans Affairs Secretary	
Tuesday, May 31, 2011	Phone	Calls to Discuss Proposal	Deans of Boston University and Harvard University Schools of Medicine	
Tuesday, May 31, 2011 (afternoon)	West Roxbury Campus, VA Boston HCS	Pre-Decisional Briefing and Discussion	Boston Unions	

C	Communication Regarding the Proposed Integration			
Date	Location	Event	Audience	
Tuesday, May 31, 2011 (afternoon)	West Roxbury Campus, VA Boston HCS	Briefing and Roundtable Discussion	Boston Service Chiefs	
Wednesday, June 1, 2011	VA Boston HCS, Bedford VAMC	E-mail about proposal	All Bedford and Boston employees	
Wednesday, June 1, 2011	VA Boston HCS, Bedford VAMC, VA New England Healthcare System	Posting on Intranet	Bedford, Boston and VISN employees	
Wednesday, June 1, 2011	VA Boston HCS, Bedford VAMC, VA New England Healthcare System	Posting on Internet	All stakeholders	
Wednesday, June 1, 2011	VA Boston HCS, Bedford VAMC	Flyer posted in patient care areas	Patients and families	
Wednesday, June 1, 2011	VA Central Office, Washington, DC	VA Office of Congressional and Legislative Affairs issues Congressional Notification	Massachusetts Congressional Delegation	
Wednesday, June 1, 2011 (morning)	Bedford VAMC	Town Hall Presentation and Discussion	Bedford Employees	
Wednesday, June 1, 2011	Phone	Call to Discuss Proposal	Boston Globe reporter	
Wednesday, June 1, 2011 (afternoon)	West Roxbury Campus, VA Boston HCS	Town Hall Presentation and Discussion	Boston Employees	
Thursday, June 2, 2011 (morning)	Bedford VAMC	Town Hall Presentation and Discussion	Bedford Employees	
Thursday, June 2, 2011	Phone	Call to Discuss Proposal	Congressional staffers from the offices of Senator Kerry, Congressman Tierney, Congressman Markey, and Congressman Lynch <sup>73</sup>	

Staff members from the offices of Senator Brown, Congresswoman Tsongas, Congressman Frank, Congressman Keating, and Congressman Capuano were invited, but did not participate in the conference call. Information about the proposal was sent to all of the Congressional offices via e-mail.



(	Communication Rega	rding the Proposed Integration	n
Date	Location	Event	Audience
Thursday, June 2, 2011 (evening)	Bedford VAMC	Town Hall Presentation and Discussion	VSOs
Thursday, June 9, 2011 (afternoon)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Thursday, June 9, 2011	Bedford VAMC	Discussion on Proposal	Lowell Sun reporter
Friday, June 10, 2011 (afternoon)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Tuesday, June 14, 2011	Chelsea Soldiers Home	Presentation and Discussion	Governor's Advisory Council on Veterans Services
Friday, June 17, 2011 (afternoon)	Bedford VAMC	Presentation and Discussion	All Stakeholders
Monday, June 20, 2011	Blog	Blog About Proposal	All VISN Employees
Wednesday, June 29, 2011 (afternoon)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Thursday, June 30, 2011	E-mail	Outreach to staffers to invite them to town halls, update on feedback regarding the proposal	Congressional Staffers Massachusetts Affected Districts
Friday, July 1, 2011	Newsletter	Story included in NE Connections, the VISN employee newsletter	All VISN Employees
Wednesday, July 27, 2011 (morning)	Bedford VAMC	Presentation and Discussion	Service Chiefs
Wednesday, July 27, 2011 (afternoon)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Monday, August 1, 2011	Video conference	Presentation and Discussion	Management Advisory Council
Thursday, August 11, 2011	Bedford VAMC	Discussion	Bedford and Boston Unions
Tuesday, August 23, 2011	E-mail	Outreach to staffers to update on feedback regarding the proposal, check on additional questions	Congressional Staffers Massachusetts Affected Districts

Communication Regarding the Proposed Integration			
Date	Location	Event	Audience
Wednesday, August 31, 2011	Phone	Discussion on Proposal	Jamaica Plain Gazette reporter
Thursday, September 1, 2011	Phone	Conference call with Congressman Tierney to brief his office on the results of the stakeholder feedback	Congressman Tierney, Chief of Staff to Congressman
Thursday, September 15, 2011 (evening)	Reading Senior Center	Town Hall Presentation and Discussion	Congressman Tierney and his Veterans' Council Members
Friday, September 30, 2011	Newsletter	Story included in NE Connections, the VISN employee newsletter	All VISN Employees
Tuesday, October 4, 2011	E-mail	Outreach to staffers to invite them to town halls, update on feedback regarding the proposal	Congressional Staffers Massachusetts Affected Districts
Tuesday, October 4, 2011	E-mail/Mail	Outreach to town Veteran agents to invite them to town halls, update on feedback regarding the proposal	Local City/Town Veteran Agents and Officers
Tuesday, October 4, 2011	E-mail	Request to Massachusetts Department of Veterans Services to distribute flyer to State Representatives and Senators, as well as other State officials	Massachusetts Department of Veterans Services, State Elected Officials
Tuesday, October 11, 2011 (morning)	Shawsheen Technical High School	Town Hall Presentation and Discussion	Northeast Veterans Council (membership consisting of town and city Veteran agents and officers)
Tuesday, October 11, 2011 (evening)	Lowell Memorial Auditorium	Town Hall Presentation and Discussion	Congresswoman Tsongas' staff and Congresswoman Tsongas' Veterans' Council Members
Tuesday, October 11, 2011	Bedford VAMC, Lowell CBOC	Over 22,000 flyers mailed to all patients of Bedford VAMC and the Lowell, Gloucester, Haverhill, and Lynn clinics	Patients and families



Communication Regarding the Proposed Integration			
Date	Location	Event	Audience
Tuesday, October 11, 2011	Bedford VAMC, Lowell CBOC	Over 13,000 flyers posted in patient care areas, placed in prescription bags and appointment reminders	Patients and families
Thursday, October 20, 2011 (evening)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Tuesday, October 25, 2011	Phone	Discussion on Proposal	Lynn Item reporter
Wednesday, October 26, 2011	Phone	Discussion on Proposal	Gloucester Times reporter
Thursday, October 27, 2011 (evening)	AMVETS Post/Franco American Hall Lynn MA	Town Hall Presentation and Discussion	All Stakeholders
Monday, October 31, 2011 (afternoon)	Phone	Toll Free Conference Call Town Hall Presentation and Discussion	All Stakeholders
Tuesday, November 1, 2011 (evening)	Gloucester City Hall - Auditorium	Town Hall Presentation and Discussion	All Stakeholders
Monday, November 7, 2011 (evening)	Veterans Northeast Outreach Center	Town Hall Presentation and Discussion	All Stakeholders
Wednesday, November 9, 2011 (evening)	Lowell Senior Center	Town Hall Presentation and Discussion	All Stakeholders
Monday, November 21, 2011 (evening)	Bedford VAMC	Town Hall Presentation and Discussion	All Stakeholders
Tuesday, November 22, 2011 (evening)	Phone	Toll Free Conference Call Town Hall Presentation and Discussion	All Stakeholders

**Table 5: Communication Regarding the Proposed Integration** 

# **VIII. Summary of Feedback to Date**

Review of the questions posed by various stakeholders during the pre-decisional stakeholder-feedback stage revealed some common themes. Table 6, below, contains the subjects, or themes, of these questions and the frequency with which questions occurred regarding these subjects. This information appears graphically (via pie chart) in Figure 10: Integration Proposal Comments Received.

Integration Proposal Comments Received (by Comment Theme)	
Theme	Number of Comments
Positive/supportive of integration	99
Question/no comment	26
Integration needs to be thoroughly planned/well thought out	11
Neutral/no opinion	10
Negative/against integration	9
Apprehensive	5
This was already decided	4
Total comments received	164

**Table 6: Integration Proposal Comments Received** 

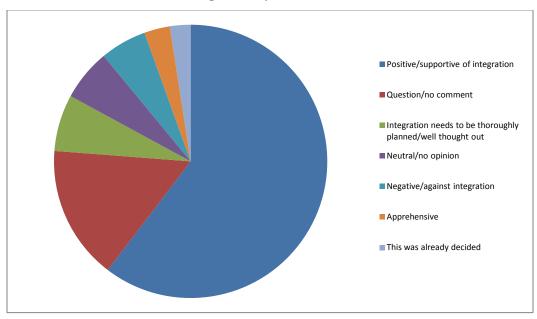


Figure 10: Integration Proposal Comments Received



#### IX. Conclusion and Recommendation

Integrating VA Boston HCS and Bedford VAMC would improve care for Veterans by:

- enhancing information flow for patient safety, coordination of care, and provider convenience through combined medical record and appointment systems;
- making coordinated care available at all sites around Boston;
- generating operational efficiencies by reducing duplication of processes and programs; and
- achieving better regional planning.

Accordingly, VA New England Healthcare System proposes to integrate these two adjacent divisions into a unified VA healthcare system to serve the Veterans of Greater Boston.

VA New England Healthcare System recommends that the Secretary of the Department of Veterans Affairs approve this integration proposal.

# **Appendix 1** Glossary

Administrative Services: Generally those services that support, but are not involved in, direct patient care. Examples: Fiscal Service, Human Resources Management Service (HRMS).

Clinical Support Services: Generally, those services providing support to direct patient care services. Examples: Pharmacy Service, Nutrition and Food Services, Social Work Service, etc.

#### **Community Based Outpatient Clinics:**

VA contracts or operates clinics in locations remote from the Medical Center. To make access to healthcare services easier, VHA utilizes CBOCs across the country. These clinics provide the most common outpatient services, including health and wellness visits, without the hassle of visiting a larger Medical Center. VHA continues to expand the network of CBOCs to include more rural locations, putting access to care closer to home.

Community Living Center: Community Living Centers (CLCs) are skilled nursing facilities, often referred to as nursing homes. Veterans with chronic stable conditions such as dementia, those requiring rehabilitation, or those who need comfort and care at the end of life are served within one of our CLCs.

**Domiciliary**: VHA Domiciliaries provide a variety of care to Veterans who suffer from a wide range of medical, psychiatric, vocational, educational, or social problems and illnesses in a safe, secure homelike environment.

Educational Affiliates: Medical, nursing, pharmacy, social work, etc., schools or programs that have students, residents, and/or trainees at VA Boston HCS and/or Bedford VAMC for educational experience, training, and service.

**Executive Leadership Board**: A VISN operations group made up of the senior management of each facility in the Network.

Fiscal Year (FY): The time period from October 1 each year through September 30 of the next year that marks a budget year. Example: FY 12 is October 1, 2011, through September 30, 2012.

Full Time Employee Equivalent (FTEE):
Counting method for determining the number of part-time and full-time positions working. Example: Two .5 (1/2) time employees equals one FTEE.

Geriatric Research, Education, and Clinical Center (GRECC): A comprehensive program dedicated to all aspects of care provided geriatric Veterans.

**Gross Square Feet (GSF)**: System of measurement for the amount of space found in a building.

Healthcare System: In many areas of the country, several Medical Centers and clinics may work together to offer services to area Veterans as a Healthcare System (HCS) in an effort to provide more efficient care. By sharing services between Medical Centers, Healthcare Systems allow VHA to provide Veterans easier access

to advanced medical care closer to their homes.

**Hospice Services**: Patient care services provided primarily as comfort measures for terminally ill patients.

**Inpatient Medicine or Surgery**: Term used to describe those services provided to patients who are admitted rather than treated on an outpatient basis.

Integrated Facility: Refers to two or more Medical Centers where assets and operations are consolidated to create a single unit under one senior management staff. Integrated facilities can have multiple sites or campuses.

#### Management Advisory Council (MAC):

An advisory group to the Network Director made up of Veterans Service Organization representatives, medical school deans, and selected others.

#### Medical Care Cost Fund (MCCF):

Identifies the program of billing and collecting dollars from insurance companies for services provided for non-service connected care.

**Residents**: Physicians who have graduated from medical school and are in advanced training.

Stakeholder: Individuals with a specific interest in VA plans, activities, or actions being considered. Veterans, employees, etc., served by VA Boston HCS and/or Bedford VAMC are stakeholders in the integration assessment process.

**Third Party Collections**: Refers to the MCCF process of billing "third-parties"/ insurance companies.

Unique Patient: Each individual

Veteran served counts as one "unique patient." Patients who are treated by more than one VAMC during a fiscal year are "shared uniques."

Vet Center: Vet Centers provide readjustment counseling and outreach services to all Veterans who served in any combat zone. Services are also available for family members dealing with military related issues. VHA operates 278 community-based Vet Centers.

#### **Veterans Integrated Services Network:**

The U.S. is divided into 21 Veterans Integrated Service Networks, or VISNs—regional systems of care working together to better meet local healthcare needs and provide greater access to care.



# **Appendix 2** List of Prior VHA Integrations

Facility Name	System Name	VISN #	Int. Period
Brockton	VA Boston HCS	VISN 1	1995 or later
Court Street (Causeway)	VA Boston HCS	VISN 1	1995 or later
Jamaica Plain	VA Boston HCS	VISN 1	1995 or later
West Roxbury	VA Boston HCS	VISN 1	1995 or later
Newington	VA Connecticut HCS	VISN 1	1995 or later
West Haven	VA Connecticut HCS	VISN 1	1995 or later
Batavia	VA Western New York HCS	VISN 2	1995 or later
Buffalo	VA Western New York HCS	VISN 2	1995 or later
Castle Point	VA Hudson Valley HCS	VISN 3	1995 or later
Franklin Delano Roosevelt	VA Hudson Valley HCS	VISN 3	1995 or later
East Orange	VA New Jersey HCS	VISN 3	1995 or later
Lyons	VA New Jersey HCS	VISN 3	1995 or later
Brooklyn	VA New York Harbor HCS	VISN 3	1995 or later
Manhattan	VA New York Harbor HCS	VISN 3	1995 or later
H. John Heinz III	VA Pittsburgh HCS	VISN 4	1995 or later
Highland Drive	VA Pittsburgh HCS	VISN 4	1995 or later
University Drive	VA Pittsburgh HCS	VISN 4	1995 or later
Baltimore	VA Maryland HCS	VISN 5	1995 or later
Fort Howard	VA Maryland HCS	VISN 5	1995 or later
Loch Raven	VA Maryland HCS	VISN 5	1995 or later
Perry Point	VA Maryland HCS	VISN 5	1995 or later
Montgomery	VA Central Alabama Veterans HCS	VISN 7	1995 or later
Tuskegee	VA Central Alabama Veterans HCS	VISN 7	1995 or later
Malcolm Randall	VA N Florida S Georgia HCS	VISN 8	1995 or later
Lake City	VA N Florida S Georgia HCS	VISN 8	1995 or later
Alvin C. York	VA Tennessee Valley HCS	VISN 9	1995 or later
Nashville	VA Tennessee Valley HCS	VISN 9	1995 or later
Cooper	Lexington VAMC	VISN 9	Before 1995
Leestown	Lexington VAMC	VISN 9	Before 1995
Brecksville	Louis Stokes VAMC (Cleveland)	VISN 10	Before 1995
Wade Park	Louis Stokes VAMC (Cleveland)	VISN 10	Before 1995
Ft. Wayne	VA North Indiana HCS	VISN 11	1995 or later
Marion	VA North Indiana HCS	VISN 11	1995 or later
Lakeside	Jesse Brown VAMC	VISN 12	1995 or later
Jesse Brown	Jesse Brown VAMC	VISN 12	1995 or later
Dwight D. Eisenhower	VA East Kansas HCS	VISN 15	1995 or later
Colmery-O'Neil	VA East Kansas HCS	VISN 15	1995 or later

Facility Name	System Name	VISN #	Int. Period
Jefferson Barracks	St. Louis VAMC	VISN 15	Before 1995
John Cochran	St. Louis VAMC	VISN 15	Before 1995
Biloxi	VA Gulf Coast HCS	VISN 16	Before 1995
Gulfport	VA Gulf Coast HCS	VISN 16	Before 1995
Marlin	VA Central Texas HCS	VISN 17	1995 or later
Olin E. Teague	VA Central Texas HCS	VISN 17	1995 or later
Waco	VA Central Texas HCS	VISN 17	1995 or later
Sam Rayburn	VA North Texas HCS	VISN 17	1995 or later
Dallas	VA North Texas HCS	VISN 17	1995 or later
Kerrville	VA South Texas HCS	VISN 17	1995 or later
Audie L. Murphy	VA South Texas HCS	VISN 17	1995 or later
Ft. Harrison	VA Montana HCS	VISN 19	1995 or later
Miles City	VA Montana HCS	VISN 19	1995 or later
Portland	Portland VAMC	VISN 19	Before 1995
Vancouver	Portland VAMC	VISN 19	Before 1995
12th Ave	VA Salt Lake City HCS	VISN 19	Before 1995
Fort Douglas	VA Salt Lake City HCS	VISN 19	Before 1995
American Lake	VA Puget Sound HCS	VISN 20	1995 or later
Seattle	VA Puget Sound HCS	VISN 20	1995 or later
Livermore	VA Palo Alto HCS	VISN 21	1995 or later
Menlo Park	VA Palo Alto HCS	VISN 21	1995 or later
Palo Alto	VA Palo Alto HCS	VISN 21	1995 or later
Bakersfield	VA Greater Los Angeles HCS	VISN 22	1995 or later
Los Angeles	VA Greater Los Angeles HCS	VISN 22	1995 or later
Santa Barbara	VA Greater Los Angeles HCS	VISN 22	1995 or later
Sepulveda	VA Greater Los Angeles HCS	VISN 22	1995 or later
West Los Angeles	VA Greater Los Angeles HCS	VISN 22	1995 or later
Fort Meade	VA Black Hills HCS	VISN 23	1995 or later
Hot Springs	VA Black Hills HCS	VISN 23	1995 or later
Des Moines	VA Central Iowa HCS	VISN 23	1995 or later
Knoxville	VA Central Iowa HCS	VISN 23	1995 or later
Grand Island	VA Nebraska-West Iowa HCS	VISN 23	1995 or later
Lincoln	VA Nebraska-West Iowa HCS	VISN 23	1995 or later
Omaha	VA Nebraska-West Iowa HCS	VISN 23	1995 or later



# **Appendix 3** Table of Feedback Received

	edback: Bedford - Boston Integration
ree	Wednesday, June 01, 2011
1	Great proposal. It is long overdue. I agree that this would promote better continuity of care and seamless access to more comprehensive services and treatments available for Veterans.
2	I think it is a good idea and better system. Will we be getting more money in our pay because we will be operating as one unit.
3	I strongly support the integration of CPRS records.
4	This is a wonderful idea and as a provider I hope that is happens. What a fantastic way to improve care for the Vets!
5	I believe the integration of VA Boston and Bedford VAMC is a very good proposal and its successful implementation would greatly improve VA health care in the region. I would like to comment on how this merger may impact GI subspecialty care.  The Section of Gastroenterology at VA Boston has a faculty with 61/8 physician FTE and 40/8 physician assistant FTE. We have approx. 3,800 specialty outpatient clinic visits/year in Jamaica Plain and Brockton (re-established in 2010) and we perform approx. 4,000 GI procedures/year in our 2 endoscopy suites at Jamaica Plain and West Roxbury. Procedural services are supported by a dedicated endoscopy RN and technician workforce rotating to both locations. Essentially no endoscopy is outsourced from VA Boston (with rare exceptions of weekend emergency advanced procedures). We provide a large variety of highly specialized diagnostic and therapeutic interventions (video capsule endoscopy, double balloon enteroscopy, cryospray and radiofrequency ablation, GI motility assays, etc.) that are available through IFC across VISN1.  As you certainly know, we have an approved plan for a new outpatient endoscopy center at the Jamaica Plain campus, which will provide an approx. 50 percent increased procedural capacity by using cutting-edge technology and a highly ergonomic layout. Construction of this new facility is predicted to begin later this year. We have a well-established relationship with the GI fellowship training programs of Boston University and the Brigham and Women's Hospital, providing us with a cadre of 25 outstanding trainees rotating to our outpatient and inpatient services each year. In the past few years, we have made important strides to meet strict mandates in colorectal cancer prevention and we are getting ready to implement promising new protocols for the treatment of chronic hepatitis C. We pay increasing attention to diagnose the highly prevalent nonalcoholic fatty liver disease and established improved protocols to screen at-risk Veterans for liver cancer, which
	need for outsourcing GI procedures from Bedford VAMC, a current and costly necessity. In exchange, concomitant staff and faculty expansion within the new GI section proportionate to this new demand could provide greater flexibility in scheduling GI subspecialty care across 4 hospital facilities and would further improve our ability to provide state-of-the-art tertiary

Feed	lback: Bedford - Boston Integration
	care in gastroenterology and hepatology.  We are excited and eager to participate in forthcoming discussions about your proposal and share your expectations on the positive changes it may bring about.
6	This is an excellent idea. As an OEF/OIF/OND Case Manager in Bedford, this will make my job coordinating care for Veterans much easier and the process much more seamless for Veterans. I only wish it could be implemented sooner.
7	I was not a VA employee during the last merger. I still hear "horror" stories from staff who went through this. To this day some staff have never gotten over this. Change is difficult but it is often for the better.
	Looking forward I am excited about the potential merger. As a Telehealth nurse I frequently have Pts that have their primary at Bedford but the specialist is at WX. As you noted it is very time consuming getting the information, especially when the vistaweb is down.
	I have found the Staff at Beford wonderful to work with and very interested in the information I need to share with them. It would be so much easier to attach their name to one of my notes instead of having to leave them a phone message or send a second note, with PKI, via outlook.
	From my perspective it would be a win/win situation.
8	This is an absolutely wonderful idea. Veterans often ask me to check what date/time their appt is at JP etc. and it is time consuming to always be opening up VistaWeb to find out new labwork, appt times, discharge notes, etc. Having one connected unit would be more efficient and allow us to better serve our Veterans.
9	The 3 campuses of VA Boston HCS nicely complement each other. What will be Bedford's role in the strategic vision of the Greater Boston VA system? Currently it is a very similar campus to Brockton.
10	This integration effort makes good theoretical sense. The problem is in the details. The current integration is a mess w/ only 3 facilities and CBOCsin Mental Health there is vast duplication of services, too many layers of middle management, morale is poor. Adding yet another site without some major structural changes is a recipe for disaster.
11	Sounds good. What we really need is a single medical record for the entire VISN. Veterans from all over new England come to the Boston System.
12	I think it sounds like a great idea. Clinically one medical record would streamline the process and, in theory, should make referrals between Bedford and Boston much easier. I vote YES!
13	I feel that as a medical center, having 3 sites all serving different and/or overlapping functions is a serious inefficiency. Adding Bedford to VA Boston Healthcare System is only logical given its geographic location. This however would be adding one more site with overlapping services within a close geographic location. I understand the crucial role that CBOCS and CLC's in different locations serve, however to have patients transported tens of miles daily via ambulance between facilities to see various providers is not in any way cost effective long term. Let alone the work time taken up by staff driving between facilities. Integrating our healthcare system further (Bedford included) is what we should be focusing on. Just my thoughts. Thank you for listening.



Fee	dback: Bedford - Boston Integration
14	I think this is a great idea. It would be much more convenient to be able to view Bedford information without having to access remote data. Also Bedford has some services that could benefit Boston patients, such as their gym and recreation programs.
	Thursday, June 02, 2011
15	Given that the email to all Bedford users didn't go out until 3:51pm yesterday, there is a high probability that most staff were not able to make any of the meeting times currently listed. I personally have no objection to the integration of the facilities but would like fair process so that all can have their concerns heard.
16	As a psychology practicum student, I would like to express my hopes that the practicum and internship psychology training programs remain specific to their separate locations, for a few reasons. First, there are too few internships available to psychology students already please do not reduce the number further! Second, and more importantly, having had the opportunity to train at the Bedford VA, and listening to descriptions of my peers who have trained at Jamaica Plain, and Roxbury, it is very clear that each training program provides a very different experience, each of which is important and useful based on the specific interests of the trainees, and which would suffer by being squashed together.
17	Would certainly simplify searching CPRS by having one system.
18	A single database will make laboratory operations in Bedford and BHS more efficient and safer for patients by reducing cumbersome shipping manifests, double log in of samples and relabeling of patient samples.
19	I think this is wonderful, and a long time coming. Good job! A suggestion: Working with Active Duty and transitioning Veterans who have tricare, Bedford currently is not a tricare facility except for mental health. Could this change? Also, an idea where Bedford is so close to Hanscom and the local Community Based Warrior Transition Unit, it may be beneficial to set up a returning Veteran clinic at Bedford, using the RI model, and the Steve Hunt model. It would centralize care and could boost revenue and performance outcomes possibly.
20	This is an excellent idea that will improve patient care and expand research opportunities.
21	Will the Bedford Service Lines continue? I find it very useful & helpful to have monthly contact with other VA employees within my discipline. This support is essential to employee health & satisfaction.
22	Bringing the staff from Boston appears to be a clear statement that this will be the management team once the integration is complete. If this is correct, it might be useful to say so, as I believe the process would be facilitated by reducing as much ambiguity as possible.
23	I think the integration of Bedford into the VABHS is an excellent idea. There are several services that are already merged, such as Biomed/Clinical Engineering, Pathology & Lab. Medicine Service, etc. It is my suggestion, that first merge the most technical services using their technology base as the prime factor - it is easier with these services. Examples, are Dental, Engineering, follow that with SPD with product changes for sterilizing with nonethylene oxide use procedures. EMS with cost savings with standardized purchases of toilet tissue, paper hand towels, and disinfectants for all facilities. Prosthetics is another service excellent for merger cost savings with additional purchases of wheelchairs and combining services for Veterans for prosthesis. The most difficult services for merger will be mental health. All campuses have good programs, so here are personalities involved to determine

Feedback: Bedford - Boston Integration	
	which mental health programs need modifications and which ones need further investments. By starting with the most technical based services - the technology features will ease the merger with least resistance with personalities and staffing. The driving force is technology for better services for the Veterans. If I can be of assistance, please let me know.
24	Would appreciate being provided information on both Veteran and employee satisfaction before and after the mergers of the other facilities in the Boston area and how they compare to the ratings at Bedford. I believe that this information might prove encouraging to both Veterans and staff faced with this upcoming changes. If the numbers are not encouraging, I believe it is important to look at ways that the transition might address this issue.
25	Excellent Idea that is overdue!!! This should reduce waste and unnecessary duplication of administration and mgmt staff. Hopefully, Available resources can be better directed for more staff providing direct care to Veterans. It should reduce Barriers to care for our Veterans. There shold be a greater capacity to share information and order necessary consults that at sites that are geographically close to the Vets home. Let's not talk about it too much, LET's DO IT!
26	This is a great idea. I think the union strengthens the care for the Veterans and our VA system in this area. Plus I feel there will be greater efficiencies which will save money.
27	The only thing that makes transfers to Bedford tolerable is Sandy Turkott when she is off the procedure falls apart. Consolidating them with the Boston Healthcare System would be a much smoother process.
28	What is the plan for services that are merging that currently have different pay scales. For example a service in Bedford at GS-6 making 40k a year and in Boston at GS-7 making 55k a year?
29	I think it is a wonderful idea.
30	Why bother with feedback? This has apparently been in the works for some years. It is not really news and your protestations that no decision has been made are ridiculous.
31	I think this is a great start in providing seamless care for you Veterans. I would like to see a fully integrated VISN that operates from one electronic medical record. I believe the benefits are worth the effort!
32	I thought the presentation was good. I support the merger with Boston, but hope that Bedford can keep its own identity.  Due to the space and parking issues at Bedford, do you feel the tele-work will be utilized more frequently for administrative positions?
33	Great concept and idea to facilitate services to our Veterans and ensure continuum of care throughout the VSIN. They deserve this and much more from Veterans Affairs nationwide.
34	Great idea. I support it.
35	I think it is an awesome idea. As a Vet and an employee I think an integration will help us.



# Feedback: Bedford - Boston Integration 36 I have concerns: I truly hope we will be funded so that we can continue to grow professionally and remain a presentable facility. I do not want to take two steps backward again. We have come along way in 3 years with positive direction. The department heads/chiefs at present will not be able to take over a position due to the fact that the decks have been stacked with grades in BHC system, very convenient. Rank has its privileges, however, I hope it is not at the expense of the personnel in Bedford. Bigger isn't necessarily better. Merging laundry and food services with Brockton has not been a terrific merger. Lots of lost and ruined clothing and bedding etc. doesn't make for a wonderful time. Also we will have no say about the food which at best needs lots of work. Our Food and Delivery Dept. has to constantly keep on top of the food items because they do not meet the desires of our patients. I understand the overall thinking of the merger and why it is thought to be a good idea. However, make sure that it remains an integrated effort and that the staff at Bedford is listened to. On the surface Brockton looks like a lost soul. We have hard working personnel in this facility and we don't deserve to be ignored. Last but certainly not least our PATIENTS DESERVE THE BEST! WE MUST CONTINUE TO MAKE THIS A BETTER FACILITY. **37** I think this is a horrible idea. Communication with leadership is already difficult here at Bedford. Having administrators off site will be a nightmare. What is the plan for integrating research, R&D, and the IRBs at both sites? The IRB at Bedford is already overwhelmed; I can't imagine how bad the backlog of amendments and continuing reviews will be if we combine research at Boston and Bedford. Not to mention the difficulty of having the IRB and R&D off site. I also find it hard to believe that the "higher ups" will not lose their jobs here at Bedford. What will their new role be? The VA is slowly improving its reputation with Veterans. I'm sure the administrative mess that this integration will cause will not only hinder our ability to serve the Veterans, but tarnish the very fragile reputation we have right now. Yes, this is a good for Bedford VA. 38 39 I think the proposal is a positive change especially for a single med chart (would make med reconciliation, clinical reminders, etc much easier). Hopefully more services would be provided at Bedford, since Vets find it difficult and time consuming to go to JP, West Rox or Brockton. Proposal for the anticipated incorporation of Bedford VA: 40 To include: The usage of the states' Veterans Agents in a more sensitive way. All towns in the state have one and are more in tune with the Veteran and his medical needs. They can get the Veteran to use VA clinics because they themselves live in the town and will be able to outreach more and identify and in some cases know personally that Veteran. GREAT IDEA- long time coming, I am on staff at both places, and makes no sense to have 41 two different systems 42 I think this is a wonderful proposal. As a home care nurse for the Boston VA who cares for Veterans on the North Shore, it is always frustrating to draw blood and have to drive all the

way to the lab in JP. I have one Veteran who is on Coumadin and lives 5 minutes from the Lynn CBOC. He needs monthly PT/INR draws which have to be brought into JP. One time I was unable to draw his blood so I sent him into the CBOC in Lynn. When the specimen got to Bedford, no one there knew what to do with it because he was a JP patient. It took a few phone calls to straighten it out. The present system is very inefficient for those of us on the

Feed	back: Bedford - Boston Integration					
	border of the two VA's. I have several Vets who hate having to go into JP but their PCP is there so they cannot go to Lynn though it would be safer and more efficient for them to do so. I hope the change goes through and goes through quickly.					
43	A terrific and overdue idea, which should benefit clinical, education and research programs. The long-term care programs at Bedford (CLC et al.) could eventually provide important settings for resident, fellow and student training in geriatric and palliative care - but implementing this will require considerable planning.					
44	Conceptually it makes perfect sense. Getting it to actually work may be a different story. Sometimes bigger is not better. An example might be the telephone system. Veterans have difficulty getting to where they want to go just within the Bedford system. Imagine when integrated. Another note is that the anxiety level has risen considerably in the Bedford employee circle. I do hope it would make it better for the Veterans. Thanks.					
45	That is a great idea, I support it because we will be able to access patient information easily and we the staff and patient will not be frustrated about dealing with two different system. Great idea VA!! Thanks to those who suggested this idea.					
46	An excellent idea. I fully support the integration proposal. This will increase the efficiency and effectiveness of services to our fellow Veterans.					
	Friday, June 03, 2011					
47	One administrative team, one medical record system and one medical team seems ideal and would improve many of the Bedford system's problems and inadequacies.					
48	I have been at Bedford since 1983 in one capacity or another and have heard that this is going to happen at least 5 and likely more times. What makes it more likely to happen this time and I hear concerns that the needs of Bedford patients and staff to serve them will be put at the bottom of the pile. What assurances do we have that this will not happen?					
	Saturday, June 4, 2011					
49	Feedback: It's about timeI'm an employee and a VeteranI think it's a great idea!!!					
	Sunday, June 5, 2011					
50	As Clinical Director of the VISN Allergy program, I am most supportive of this proposed joint venture incorporating Bedford into the Boston campus. Seeing patients from great distances within VISN1, I most sensitive to the great distances traveled to receive specialty care, and in this case, Allergy. Bringing Bedford on board would support the capacity to offer on-site Allergy immunotherapy, a venture we have not been successful in facilitating as of yet with this campus. Many patients who are referred from Bedford are currently having Allergy immunotherapy at the Boston campus or postponing immunotherapy until services can be provided at Bedford. We will continue to encourage the Bedford campus to consider the offer of Allergy training for Nursing and subsequent provision of Allergy immunotherapy as many of the other VISN 1 VA centers have successfully accomplished with our training. Though the intergration of this campus with the Bedford campus would most certainly promote and support our current efforts to provide this valuable patient care service.					
	Monday, June 6, 2011					



Feed	dback: Bedford - Boston Integration
52	Many Veterans I've had had contact with, already think Bedford is part of the Boston VA. If it is better and safer for the patients we serve, it is worth the energy expended to bring the facilities together administratively.
53	An excellent proposal - this would provide more opportunities for Medical Centers like ours to refer care to a single case management team.
54	VA is about compassion, professionalism, protecting government access (fund, competence, and excellent health care delivering to Veterans as they deserve the best of all due their enormous sacrifices to keep this Greatest Nation on earth (USA) safe and prosperous. However, emerging facilities sound a good idea but that does not to focus on one area if it aims only to save money, by taking staff from one area to bring to another area, it must be purposely for improvement patient waiting time on regular Physician appointment, increasing patient, by reducing disparity, making VA more accessible to patient that live far from Boston, keep VA quality service delivered to its patients all time high, and maintaining also customer satisfaction in both aspects, employees and patients. Cutting staffs or mangers from one Facility to provide for another facility when "Short-staffs are already an issue to solve. I want to encourage this strategy but we need to focus at all time about quality and best care system.
55	IT'S REALLY ABOUT TIME FOR THIS TO HAPPEN THIS IS SOMETHING THAT HAS FRUSTRATED VETERANS FOR AWHILE NOW BEING A VETERAN AND A EMPLOYEE I SAY WHAT ARE YOU WAITING FOR GUYS COME TO BOSTON FROM BEDFORD AND THINK IT'S ALL THE SAME VA ONLY TO FIND OUT THAT IT'S NOT
56	I wish Bedford would be integrated with the Boston VA system, I use the Lowell clinic, but if I need to see a specialist I have to go to Boston, an all day affair for me, plus pay for trains and subways, I could drive to Bedford in 20 minutes.
57	This is an EXCELLENT idea!! Long overdue!! Wrox provides many services for Bedford pts, and the reality of a single, integrated, computerized system for all four campuses (WR, JP, BR, BED)will be welcomed with open arms by all staff, I can assure you! for all (4) campuses (Wr, Jp, Br, and Bed) will be welcomed with open arms by all staff members, I can assure you!!
	Tuesday, June 7, 2011
58	I am supportive of the administrative integration proposal as stated. As a patient of each of the listed facilities (for various health issues/treatments), the integration plan would make my treatment referrals and records access much simpler and more efficient.
59	Q. All four campuses (Bedford, Brockton, Jamaica Plain and West Roxbury) would continue to operate. No facilities would close as a result of this administrative integration. Following earlier integrations, all three campuses within Boston VA Healthcare System continue to operate as vibrant health care facilities with broad clinical programs, high levels of staff, fully occupied buildings and clear, complementary missions. In this proposal Bedford would become a fourth campus of a VA Healthcare System serving the Greater Boston area.  A. I feel that all four campuses should have been integrated a long time ago technical uses only get updated with the new technology., So that when our patients go to Boston for whatever reason the doctors would be able to take care of these patients in a professional manner.

## Feedback: Bedford - Boston Integration

## Q. There would be a single electronic medical record.

A. Again how archaic are we now this should have been done years ago you should be able to view all patients records when they visit your facilities

#### Q. There would be one medical staff.

A. How would that be possible if this facility is still here and the patients have their own doctors here at Bedford, they don't need to be shifted to other facilities what we need is a better functioning system here, as we have the room the only thing that we are lacking is that the services have been taken away. I as a Veteran do not want to be bounced all over the world to see a physician or any other kind of professional person. I feel that you have not quite grasped the concept that we are not here for ourselves, it's not about you, we are here for the Veterans

### Q. There would be one leadership team.

A. One leadership team, that would be hard for anyone person to oversee, we are not talking about people coming in and out each day; this is the Veterans home. Which in my view takes a little more effort? We have a fine facility here in Bedford, with a fantastic staff; we are just a little short of services to treat the patients. You have already cut patient care so much that it looks like these Veterans are in some kind of war camp. It would be really nice to have someone take the patients outside weather permitting, I think that would be better than a tonic. I am sick of hearing there is no staff, that is not a Veterans problem; these people are dying and just would like to see the outside one more time. That should not be a big deal that should be necessity, is this how we are going to treat the Veterans for all that they have done for us.

#### Q. Current staff would not lose their employment nor have a decrease in pay.

A. If there is only one leadership team, then someone will have to go somewhere down the line maybe not now, but I will bet on it that it will happen. Otherwise you will be paying these people to do nothing. We all know that when that person in that position leaves then we don't fill it, the only thing that this tells me is how much work are you putting on the other fellow that is below the one that left. You have just let the service to the Veterans out the door, you are decreasing their service.

#### Q. No current inpatients would be moved to a different facility.

A. I would hope not, people come here for a reason, I know this is not a concern of yours but these families have already taken a hit, some of them cannot drive or get transportation to see their loved ones but just once a week. I would think this would be devastating to the family members that are left to try and keep what little dignity that is left.

## Q. All existing CBOCs would continue to operate.

A. Is that what would be left after you fill Boston, with all the services and good staff from Bedford and the other facilities. Maybe we would operate a little better, if the facility did not have to send out our patient for simple things, just think how much money that would be saved on a daily basis if the facility was fully functional. I know that you have to turn people away on a weekend, what nobody wants to work, again how much money would you save if you actually treated these people instead of letting them go to Lahey or the surrounding hospitals.

I think this is a terrific idea! Many researchers do research at the Boston VA as well and

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Feed	back: Bedford - Boston Integration
	this will prevent having to go through two IRBs. The only concern is that the staffing levels for the IRBs would have to be increased (or at least not decreased) as both Bedford and Boston IRBs are already overwhelmed, making it hard to get approvals in a timely manner.
61	"Bigger" is never better than "smaller" in health care, for Veterans or staff. Bedford needs its own leadership team who intimately knows and supports it's staff and Veterans. No Bedford director? New chiefs, who are in Boston? Associate Directors and Associate chiefs? Doesn't sound appealing to me  The improvements in ease of care for Veterans can be accomplished without Bedford being "under" Boston. I applaud the effort to do so. I accept change as mandated though and will do my best to adapt. I hope it really will be evaluated carefully. Looks like a "done deal" to me.
	Wednesday, June 8, 2011
62	One of the points made during the presentation was that a number of large metropolitan areas had already undergone some form of integration. Is there information available on what they experienced, both on the process and the gains and losses as a result of the integration? It would be helpful in thinking about what to expect and how to be useful if such information were available. It would also be reassuring to know in what ways we have learned from the experience of others and how we are working to avoid the problems they may have encountered.
63	You say that no one will lose their job but you will not be needing TWO service chiefs for every service. How will that be resolved? Will you plan to have an Associate Director here at Bedford?
	Thursday, June 9, 2011
64	One of the points made at the presentation was that a number of large metropolitan areas had already undergone the process of integrating into one system, and, of course, there has already been an integration of most of the facilities in the Boston area. It would be useful to have information on the process of those integrations, the difficulties encountered and addressed and the gains and losses that resulted. Any information on what has been learned from these integrations and how we will strive to address any anticipated problems would be helpful. More information might also assist us in providing useful feedback.
65	If the proposal of the merger is to be like planned I see no reason for not having the Merger of the 4 Campuses.
	Friday, June 10, 2011
66	You will need many more shuttles.
67	Still curious as to how this will make anything easier for the Veterans. They still have to travel back and forth. Why not just upgrade the network applications to make accessing records easier.
68	Other than eliminate a lot of chief positions in this facility, what exactly will change? Politics, politics, politics.
69	Not going to affect our paywill we be getting some of those FTE that Boston seems to have no trouble hiring? Will this eliminate the rampant nepotism at this facility? Will this mean hiring more Veterans, like we are supposed to?

# Feedback: Bedford - Boston Integration Saturday, June 11, 2011 70 I would like to provide feedback regarding your Bedford/ Boston administrative proposal. I would like to know specifically how this merge would improve regional planning? I am assuming that you currently have a planner and public works department to manage the facilities of all three units and sites. With the integration of the Bedford branch, would the current facilities planner need to manage the Bedford branch as well or would the facilities management department in Bedford still have control of managing the facilities? If the integration proposal you are proposing were to succeed, how would you go about integrating both facilities and funds to properly manage the buildings, structures, and resources? Also, how would you develop a plan to continue to supply the same amount of resource of funds to the Bedford branch when you will have comingled the funds with the other branches? With the regard to different properties that you are currently managing, aren't the funds provided for each facility paid to the category they support? If all four facilities have the same category, then the funds may be used more in one unit than another, thus limiting the amount of needed services to all units. I am very interested in hearing more about your proposal and commenting further. Please let me know if you will be presenting anything more in the future. GREAT idea!! Go for it!! 71 Sunday, June 12, 2011 72 Do it. Monday, June 13, 2011 73 This is a great idea. Patients should be excited about this. I imagine that different services would eventually be offered, e.g. optometry, lab, radiology at all the sites. Good work improving what we do! Wednesday, June 15, 2011 74 Integrating the medical records is a great idea, IF it's real integration. If the provider's view of past treatment is limited in the new system, integration could do more harm than good. Thursday, June 16, 2011 75 I very much welcome this news. There have been pervasive elements of old boy/old girl behavior, nontransparency, and selective involvement in problem solving. Nursing has been decimated since the retirement of the CNE. We need a change in culture but that will only occur with a change in leadership at the chief and quadrad level. Saturday, June 18, 2011 It's a great idea. I'm also hoping this will improve transportation from Lowell to Bedford 76 for the patients living in Lowell. We have many, and there is no direct shuttle from Lowell CBOC to Bedford. Monday, June 20, 2011 77 Excellent idea, I am all for this. How fast can we complete this merger. 78



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79	It would be a good idea only if duplication of services and staff are looked at w/the goal of decreasing numbers. At this time the "administration" is "top heavy" and services seem to overlap (ex Brockton and Bedford).		
80	One of the principles of transformative organizations is leadership that is close to the action - including executive leadership. I am worried about distant leadership that is not engaged in the culture at Bedford. And what if the merger costs money instead of saving money - at least in the near term? Leaving leadership positions vacant or "acting" is discouraging at best and demoralizing to be in a "hold" situation.		
	Tuesday, June 21, 2011		
81	Thank you several thoughts come to mind: 1) we have many women who travel here (VA BHS) because they perceive the services (both primary care and mental health) for women to be far superior and more extensive, planners have likely looked at the number of Veterans living in the Bedford catchment area who get services in Boston, 2) many Bedford patients receive tertiary and specialty care in Boston the fact that we have separate medical record systems hampers continuity of care and transitions, 3) we have had primary care patients who need services but they fall in the Bedford catchment area and we find ourselves unable to help them or offer the full "PACT" model of care. Thank you.		
82	Bedford/Boston Integration is critical for continuity of patient care.		
83	I think having the hospital @ Bedford integrate with Boston will enhance the services presently available @ the different sites. One leadership team will be instrumental in streamlining several of the operational processes. This is a great idea.		
84	An obvious necessity, but the last time there was much deal-making over which medical school and which chief would survive. Unfortunately, running two branches of a service is taxing enough for some chiefs, now they may be running four. I believe a big part of this decision is to reduce management salary dollars, but it will also dilute the attention of service chiefs/managers paid toward each division as time becomes more scarce. Delegation of management effort is not a strength of government; instead, I predict poorer, not improved oversight on the day-to-day activity within our services. Coordination will be an issue. Things are still done differently within the same services at WR, JP and BR many years after these mergers.		
85	Bigger is not always better. I've talked to Veterans who have tried calling into the Bedford VA for hours or days with no luck. How will integration address this?  Also, communication is severely lacking within and between departments, how will integration address this?  Bottom line ALL Veterans deserve the best, most efficient care we can give them. Once this is started, periodically let the Veterans speak by offering them a "how are we doinghow can we improve your services " survey online via va website, through MyhealthlyVet, or at clinic visits.  MANAGEMENT must stress COMMUNICATION		
86	Are you only posting the positive comments? Please be honest with the staff at Bedford. You are not going to need TWO service chiefs for every service? How can you say jobs will not be effected by this merger? How can you ensure that the unique needs of Bedford Veterans		

	dback: Bedford - Boston Integration					
	and staff are met? Why aren't you posting comments that question your plan?					
87	IT'S ABOUT TIME, MAYBE PEOPLE CAN GET BETTER JOB NOW.					
07	Monday, June 27, 2011					
88	I think the proposal makes good business sense.					
00	My comments are geared more for the human aspect. When I started, it was just after the merge between Brockton and West Roxbury. I worked at both campuses, and I heard a lot of "Us vs. them" comments and sentiment.  When the integration with Boston was undertaken in 1999, it was even worse, and, I still					
	experience it to this day. "Oh, you're one of THOSE people", and "WE don't do things that way" etc.					
	Unfortunately, it may be too early in the process for me to offer constructive feedback on ways to mitigate the same effect on this proposal, so if it could be kept open for a future topic of discussion among involved management, as well as employees, I guess that's all I can ask.					
	Thank you for your consideration.					
	Tuesday, June 28, 2011					
89	Who will review Nursing proficiencies? Will Bedford keep the same nursing board to do this?					
	Tuesday, July 5, 2011					
90	I welcome the opportunity to work more closely w/Boston VAHCS urology staff.					
91	I am curious if the GRECC inpatient program would remain and if it would continue as a research facility? Would there be changes to staff and programs for the unit?					
	Friday, July 8, 2011					
92	I have been here at Bedford since 1983 and this is the 3rd or 4th time I have heard this proposed. While it sort of makes sense it would make more sense to include Manchester. I also have concerns about transitioning Research from one facility to the next. It is already messy.					
	Monday, August 22, 2011					
93	Great idea, I have been struggling with the two separate centers for over 20 years and I'm so ready for this change.					
	Thursday, August 25, 2011					
94	would the staff have to work at different facilities as needed when needed? or would they stay at their current sites?					
	Wednesday, September 7, 2011					
95	I'm the primary caretaker and advocate of a Veteran who receives services in both Bedford and Boston. I believe this merger would be nothing but positive. The disconnects between the two VA Systems at this time is aggravating to say the least. The Boston VA seems to be so much more involved in all aspects of care for both inpatient and outpatient Veterans. This would allow for a more integrated level of care that Veterans, but disabled and able bodied both need and deserve. It also means less time focused on filling in the gaps to the					



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	two separate systems and more time focused directly on the patient.
	Friday, September 23, 2011
96	As both a Veteran and an employee, I'd like to encourage all to support this long overdue merger. Please proceed with this as quickly as possible. This will result in better care for the Veterans we serve. Thank you!
97	Bad idea. Put the Vets first, not VISN leadership.
	Tuesday, September 27, 2011
98	I have a number of concerns regarding the proposed merger. First, I worry that our Veterans will lose a local voice in addressing their concerns and complaints. They will become much more anonymous. Secondly, I worry that our facility will lose its culture of pt. centeredness and become part of a larger bureaucracy. Thirdly, mergers often result in one party holding more power than the other resulting in struggles for resources and input on decision making. I recall the merger between other hospitals such as B.I. and N.E. Deaconess was not without initial difficulties. There is the potential for staff losses including staff with much institutional experience and wisdom. Please consider all of this and the impact on our Veteran population. I know from the feedback that I get from Veterans that they do not like to go to Jamaica Plain; issues with driving and finding their way to the inner city poses a real challenge. Shuttles do not accommodate everyone's time schedule and constraints. Thank you for your consideration.
	Thursday, September 29, 2011
99	As long as the changes will improve efficiency, then I support this proposal. If this is intended to eliminate the Bedford facility, then this proposal needs to be dropped.
	Tuesday, October 4, 2011
100	I think the merger of Boston and Bedford will help our outpatient population especially with specialty services. My biggest concern is the merging of medical records. Fitchburg and Northampton records still have not merged and will not be until Feb 2012 and it is a much smaller entity than all of Bedford. Discussing this and plan to make the merger of the records would be very helpful.
	Wednesday, October 5, 2011
101	The integration of Bedford with Boston is a win situation for Veterans. It also provides an opportunity for greater management efficiencies and joining with a well established BHCS leadership team. There are many access and resource issues at Bedford that are beyond the scope of current continuing acting staff.
102	Discharge planning and coordination between Boston and Bedford would have a better chance of being implemented with a merger. Case in point Bedford Patient A d/c from BHCS; numerous appts on various days for this poor man not taking into consideration his stamina, transportation, etcThis is a good potential example of a poor use of multiple resources including the patient's

## Feedback: Bedford - Boston Integration Thursday, October 6, 2011 As an over twenty five year employee of the Bedford VA, I'm very alarmed by the 103 prospects of a merger with the Boston Heath Care system. I am primarily a researcher and it is totally unacceptable to close the Bedford animal facility as has been proposed by Dr. Mayo-Smith. Also, while Bedford has many flaws such as the time it takes to hire new employees or to get contracts, adding a layer of bureaucracy that is 20 miles away instead of just down the road would make the processes I have mentioned above even more cumbersome. Investigators I known have complained bitterly above the time it takes to get projects approved by the IRB at the Boston system. In summary I feel that the proposed merger would be a great loss to Bedford researchers who in many cases are the patient health care providers. If they leave Bedford it will be a great loss to patient care, which the network director indicates he wants to improve. This is better for Veterans/patients, and that is what people need to focus on. It has been 104 said that no one will lose their employment or have a cut in pay. We are all very lucky to work for the federal government, because that is something that never happens in the private sector. Mergers always mean a loss of jobs or layoffs. I have been laid off before in the private sector, and I am very thankful to work for a place that is committed to keeping me as a staff member. Since this will lead to better quality for our patients and staff are not taking a hit, this proposal seems like a no brainer. I fully support this endeavor and think everyone should get on board. Thursday, October 13, 2011 I have been assisting my father with his health care needs over the past three years at the 105 VA facilities. He has had countless tests and two major surgeries. It would be TREMENDOUSLY helpful to have all records centralized. We spend hours trying to get all information to each facility and coordinating appointments. It was particularly difficult to get medication correctly administered for his eyes when he was an inpatient at W Roxbury for hip surgery. ' Please unify the system for the benefit of all. I cant imagine what it is like for those patients who do not have outside advocates helping them through the maze. Saturday, October 15, 2011 106 this is a great idea as a Veteran going into Boston no knowing your way around is never easy going to Bedford after 9.30am in the morning is easy late appointments in Boston is traffic hectic so make this proposal happen please thank you good idea the va. has the best computer system going it is grate too have the two joined 107 as one this would improve all our info I can't believe this wasn't done a very long time ago. Better for us patients and, I would 108 think, more efficient and economical. Sunday, October 16, 2011 Sounds like a win-win situation. 109 110 As long as the integration is well-planned and implemented the efficiency to be achieved is a positive thing. I am for it.



Feed	back: Bedford - Boston Integration
111	I have two major concerns with this proposal:  1) Pharmacy Formulary. Some of my prescriptions available through Bedford are not available through Boston. Hopefully the formularies will merge and not be replaced.  2) Fee Basis personnel: Boston is HORRIFIC. They, as a policy, do not answer their phone or email. It takes, on average, over 1.5 years to process a claim. (Even hand-delivering the claims several times did not work.) Bedford is great. They were able to take care of my problem over the phone immediately. Please do not even consider replacing the Bedford staff with the Boston staff.
112	As a former hospital administrator and Veteran who is serviced at both the Jamaica Plain and Bedford facilities, I have found it to be a bit frustrating to be treated under two systems. Though both are excellent facilities I feel it makes sense to combine records for treatment purposes.
113	I am an eighty-one year old Veteran. I live in Peabody and utilize the Gloucester VA facility. Everything has worked out well for seven years and I have no complaints. On the other hand, there is always room for improvement and it seems to me that this proposal is just that. It is my wish, therefore, that I be recorded in total support of the consolidation.
114	I think the merging of medical records, and improved access to specialties at all locations would really be a plus. I would not want to see current staff being laid off. I would also like to see expanded services for all Veterans.
	Monday, October 17, 2011
115	Sounds like a great idea
116	If there are no lost jobs involved and the advantages are as explained in your letter then this should be a plus to patients and health care workers.
117	I've had some experience with Jamaica Plain and this integration could be a problem. One appt system will be difficult. JP never answers their phone!! I've spent hours trying to reach various offices. It will depend who you put in charge of appts.  How will administrative overhead be reduced without reducing staff and personnel? Doesn't seem possible. I've had billing questions and concerns with JP and no one is ever in and they rarely answer their phone.
	The only good thing I could see in this plan is the integration of medical record systems. Now, the staff at Bedford VA can't see anything at JP VA. And vice versa. Which is a real hassle when I want to get copies of data and test results.
118	if it's not broke, don't fix itleave well enough ALONE
119	Such a proposal coming from the VA actually scares me, because it makes too much sense. The VA is not known for doing things that make sense.
120	I think this is a wonderful concept. As a client I have experienced the disjointed communications between Boston area facilities and it has not been a pleasant experience. A coordinated approach will bring the system to where it should be in this age. It cannot help but be a great step forward for both the clients and the providers. I have always been highly satisfied with my care and this proposal, if adopted, should be a bonus for all concerned.
121	I hope this does not effect the Fitchburg Operations

# Feedback: Bedford - Boston Integration Tuesday, October 18, 2011 122 I live in Woburn and see my Doctor, get my eyes tested, get to visit the Brace Clinic to obtain my diabetic footwear, and get my prescriptions filled at Bedford facility. I am very pleased with this arrangement and hope it doesent require my going to Jamaica Plain for any of the above stated visits. I have been to Jamaica Plain for hearing needs and absolutely hate the drive and no place to park when I get there. Please tell me I will be able to continue my appointments at Bedford, and even better, tell me I can get hearing attention at Bedford. 123 Three Veterans attended a monthly meeting and asked that the following feedback be shared: The three Veterans attending the meeting spoke about a range of topics including parking The Veterans broached the topic of the proposed merger between the Boston and Bedford VA. They stated that they have heard about this from different sources. They expressed concern that they did not have the detailed information needed to know whether this would have a negative or positive impact on their care. They expressed hope that this could benefit them in terms of easier access to care. They expressed suspicion that the lack of specific information was a strategy by the VA to keep Veterans from giving informed feedback. They expressed concern that this may be a follow-up strategy to the CARES program, and is designed to subsequently reduce or eliminate services at Bedford and force them to go to Boston or Brockton for services. They expressed that they would not support the merger if it meant reduction of services at Bedford, or that they would have to move their care to Boston or Brockton. Senior leaders, what's in this for you? Promotion? There may be no decreases in pay, but 124 people will lose titles...not that that's important down here in the trenches. How does this help Vets? 125 I am a Veteran first, Employee second. How is this going to help? Do we really need to integrate an entire health care facility to a larger one to iron out a few software issues, ie, more accessibility to medical records? That is a pretty flimsy excuse..yes we are scared and have every reason to be. If we can now access Vets records active duty to integration into the VA, why can't we do it inter-VISN? 126 The re-integration is a progressive idea. There are management efficiencies that are needed. Many grade 4 nurses at Bedford which is unprecedented and leadership is poor. Alsothere needs to be a more transparent and less paternal culture which affiliation with BHCS will provide given the management style is apparently more respectful. Bedford is not a "100 best places to work" facility. The culture is closed and male dominant. 127 I think this is a fantastic idea and far over due. This will help thousands of Veterans conduct medical issues without worry about things such as transportation to connecting facilities; prescription drug medications; conflict with prescription drugs; medical record information; possible quicker appointments in other departments that has the equipments to conduct specific procedures (such as MRI, Mammography, Radiology, Dental and etc). Fantastic plan! Hopefully, in the future, a plan is implemented to bring a similar upscale medical and health care facility and benefits to the city of Lynn. By all means integrate the two systems, anything that will prevent trips to Jamaica Plain is 128



Feedback: Bedford - Boston Integration			
	a positive move. The parking situation at J.P. is an out right disgrace and has been for over 25 years.		
129	The lack of details on how the merger will look in the end is disturbing. I have lived through mergers in the private sector (BI-Deaconess - CareGroup) that were destructive despite everyone's good intentions. In the private sector, mergers are pursued in order to increase market share - which is irrelevant in the VA. I don't see why the supposed benefits cannot be achieved through VISN/Network cooperation - isn't that why there are VISNs? Having administrative functions centralized in Boston will leave Bedford unrepresented and create greater difficulties in resolving issues. When leadership is located on the same campus, the ease of having a face-to-face meeting to reconcile problems is invaluable. Also, leadership will receive a memo written by Bedford researchers that outlines our concerns under a merger, e.g. fewer opportunities to apply for grants that are limited 1/facility. I do not know of one researcher at Bedford that has had a satisfactory experience going through the VABHS IRB. Lastly, as a member of GRECC, I was greatly disturbed to see a response to an oversight committee recommendations that was recently submitted AND rejected by the committee because of the biases in the document. The response was clearly written 75 percent from the Boston campus perspective and distorted facts that I will be communicating/correcting to Ms. Croteau to try to compose a more fair and balanced response. This experience leaves me unconvinced that the Bedford staff will have a "voice" in a merged VABHS.		
130	I think the integration is a good idea from the standpoint of providing better care to our Veterans. I also feel that Bedford administration in Primary Care needs to be evaluated for their effectiveness as leaders and their attitudes towards staff. Nursing is under a great deal of stress with more expected of them every single day. There is no support and most fear retaliation if they speak up. There have been multiple incidents where staff has been threatened or yelled at. This is an unacceptable situation and everyone who has tried to get something done about it has been targeted or ignored. The chain of command has failed as well.		
131	DO supervisors loose their grade and salary? You say they do not but after two years when they do not have the same job description, they get downgraded. IS THAT CORRECT??		
132	As a Vet who gets pcp in bedford and specialty care in Boston group, I am very much in favor of the proposed integration. One big improvement would definitely be sharing of Lab results between physicians in both facilities. I frequently use the shuttle between Bedford and JPVA. I expect that this will be the same or better service after such integration. Thank You for giving us a say in this matter.		
133	Sounds reasonable. re improved access; can providers expect to see patients from other geographic areas, who previously went to other facilities exclusively for episodic visits? will current panels remain basically intact?  Also, this sounds like a huge undertaking for IRM as a unit. Would that staff be expanded? to support us through the transition?		
134	It appears to be progress and more efficient.		

Feed	back: Bedford - Boston Integration
135	Will "all" outpatient care remain at the same facilities (Bedford) or would some of those change to a Greater Boston facility.Parking is sparse at Bedford. BTW is it possible to restrict employee and student workers be restricted to the lot near the golf course. That would relieve the patient only parking more available. It is truly shameful for young healthy students take up nearby parking spaces for older and less healthy Veteran Patients. Likewise for the other facilities.Parking at W.Rox and J.P. is absolutely horrible. Will travel pay still be available in Bedford.
136	This proposal seems to be a great idea. It has my vote
137	Is the 'integration' of VAMC Bedford/ Boston administrative dependent on 'integration' of the medical records? What has been done to ascertain the steps required to 'integrate' the administrative as well as the medical records?
138	What about comment boxes for VA Boston employees who do not have access to outlook?
139	What will happen to the training programs? There are currently separate training programs for interns, post-docs, practicum students, residents, etc. Will these continue to stay separate?
140	I thought this integration already took place, for obvious reasons.
141	1) I'm worried that the centralized leadership structure will mean that it takes even longer to get things done. Bedford's hospital director is asked to sign a host of documents, from cell phone requests to research funding proposals. I can only imagine that a centralized leadership structure will mean that we need to add another 2 weeks to a month to processes that already take too long to complete. Integrating the medical record is a good idea. Eliminating local executive decision-makers is not.
	2) In working in both healthcare systems, I can say that the culture is very different between Boston and Bedford. In my particular service line I find Bedford to be more innovative, Veteran-centered and mutually empowering (for staff and Veterans). By comparison I found Boston to be more hierarchical, stuffy and by-the-book (read, less innovation, more top-down). At Bedford folks in my service line wear open collars. At Boston the majority wear ties. While these differences might sound minimal, I'm concerned that Bedford staff and programs will be expected to assimilate to the dominant Boston way of doing things, if not directly, indirectly via funding decisions, setting of priorities and willingness to accept and support innovative ideas that come from Bedford staff (who have usually gotten the ideas from Veterans).
	3) Finally, until now I have chosen not to be involved in the feedback process re: the integration as it comes off as more of a done deal than a "proposal." When I saw the first intranet image of the new catchment areas it pretty much reinforced the idea that executive leaders have made the decision and are putting out carrots after the fact to pull staff along. While I appreciate the opportunity to provide feedback it does not seem like it will impact the final decision.
142	How will this impact our outpatient clinics?
	Do we have to send staff to Bedford?  N/hat do we do if we do not have evailable personnell (physicians, mid level providers).
	2. What do we do if we do not have available personnell (physicians, mid level providers)



Feed	back: Bedford - Boston Integration
	to staff Bedford?
	Wednesday, October 19, 2011
143	Since, the VABHCS continues growing through integration with other VA facilities and new Veterans due to current war, great percentage of the population we care for becomes in need of long term care among other services. So, my question isdoes the VA have think about having its own Nursing home facility for long term care? probably you are aware that the property accross from JP VA (New England Home for Little Wonderers) is moving out of its current location in the nex couple of years. (I read that in one of the local newspaper few months ago. In my humble opinion that would make a good site for what I mentioned before. Thanks.
144	Great Proposal. It would be great to have teams of specific medical areas i.e.  Dermatology, visit a VA periodicaly to treat patients locally. I have to travel to JP several times a year and cannot collect mileage since the appts are not directly related to my disability.  Shuttle wastes a whole day and Rte 9 is an accident waiting to happen. Please expedite this implementation.
145	I had applied for a position at Bedford ~ 2 yrs ago and was told that Bedford does not use PAs. I was surprised as well as disppointed by these statement. Considering the long, success utilization of PAs in the VA HCS nationwide I was hoping to start my career at Bedford since it is geographically much easier to commute to then JP. I have been at JP and enjoying my experience in providing safe, quality health care to our Vets. Especially, since I am a Vet myself the VA is where I need to practice as a PA. Is there any possibility of getting PAs involved at Bedford as health care providers?
	Thursday, October 20, 2011
146	I think that this proposal is a great idea. I always wondered why they were not intergrated previously.
147	This is a great idea. I would like to see the audio servives in Bedford at least one day a month or week. Thanks for the opportunity for comments
148	I think it is an excellent plan I particularly like the single medical record
149	Sounds like a great (no brainer) go with it
	Friday, October 21, 2011
150	I support the merger of all the locations for my own and convenience of the Vets that use the Lowell VA. It is very inconvenient to have to go in to Boston and spend the better part of the day there for a test that takes less than 5 minutes. A short trip to Bedford, either by bus or private car, would be much more convenient for the Vet.
151	As a VA patient living in Lowell, some of my appointments require me to go to JP and it turns out to be an all day affair for one appointment for I choose to take the shuttle. If I could go to Bedford for the same appointment, say ENT, I could drive there and wouldn't have to spend an entire day.
152	I have used both the Bedford and Boston systems and have never understood why they were not integrated. I think this proposal is excellent and long overdue. Go ahead with it.

Feed	back: Bedford - Boston Integration					
153	I think this makes sense, however will the Lowell Clinic remain open. You talk about lab work at Bedford or Gloucester, Lynn and Haverhill. What about Lowell? They have a great clinic there.					
	Saturday, October 22, 2011					
154	I think merging the two systems would be a great idea because they both really serve the same patients anyway.					
	Sunday, October 23, 2011					
155	to this Vet having used the w.roxbury hos. for my colon cancer 5yrs.past and feeling good i can only say any chance too combine all of the v.a.as one could be the best way to go. god bless the Vets and the v.a.					
156	In the literature regarding the Integration Proposal I see no mention of the integration of the pharmacy services. I am a Bedford patient, if I am prescribe a medication in Jamaica Plain will I be able to pick it up at Bedford? Will I be able to get a refill at Bedford?					
	Tuesday, October 25, 2011					
157	This proposal sounds like a very good one. I am in favor of it.					
	Wednesday, October 26, 2011					
158	My Dad is a Veteran and has all of his medical care provided through the VA. He is 86 years old. We have both read the informational flyer that was recently mailed to him. We are both very much in favor of the proposal. It would be so much easier for him and for our entire family to have these services combined and to have medical records, doctors and clinics available at both sites. Thank you.					
	Sunday, October 30, 2011					
159	I think this is a fantastic idea and is a first step in joining the 21st century of medical care. It should be extended as far as possible, even to private providers. In this case, more is better for the patents, doctors and costs.					
	Monday, October 31, 2011					
160	With all the changes, it would be greatly beneficial to many of the Bedford campus users to have a branch of the audiology lab located there.					
	Wednesday, November 2, 2011					
161	In this transition, if employees (GS/WG) in Boston are rated higher in grade or steps, than employees at Bedford doing the same job, how will that impact employees at the Bedford VA?					
	Sunday, November 6, 2011					
162	sounds like a very good idea. would save a lot of duplication.					
	Monday, November 7, 2011					
163	I am writing you in regard to the proposal of combining the Boston and Bedford merger.  My husband is a victim of dementia and is unable to voice his approval for the merger.  Therefore I am writing this letter on behalf of him.					



# Feedback: Bedford - Boston Integration

This proposal of integrating the Bedford center makes perfect sense. My husband has received medical care at Boston and Bedford and we have been very happy with the care he has received. Please keep your good work going and continue to fight for the merger of the medical centers.

## Friday, November 11, 2011

164

I see this as a win, win for all. I go back to WW2 and in my eighties. I have to go to Jamaica plain for my hearing. It would be just great if I could do that in Bedford. My thanks to you all, My five years in the Navy 44-49 gave me back an education that led from immigrant parents to a great career that provided for a beautiful family and so many happy memories.

# **Appendix 4** Workload Details

Facility <sup>74</sup>	September	September	September	3 Year percent Change -
	(EOY) 2009	(EOY) 2010	(EOY) 2011	September
Bedford, MA	17,992	18,671	18,863	4.8%
(518) Bedford VAMC	16,982	17,776	17,765	4.6%
(518GA) Lynn/North Shore CBOC	1,985	2,099	2,147	8.2%
(518GB) Haverhill CBOC	2,393	2,491	2,604	8.8%
(518GE) Gloucester CBOC	1,332	1,306	1,375	3.2%
(518GG) Fitchburg CBOC <sup>75</sup>	2,001	2,075	1,974	-1.3%
Boston, MA	61,441	63,093	65,453	6.5%
(523) Jamaica Plain Division	43,484	47,069	48,669	11.9%
(523A4) West Roxbury Division	37,412	40,560	42,827	14.5%
(523A5) Brockton Division	15,771	16,157	16,977	7.6%
(523BY) Lowell CBOC	3,493	3,499	3,429	-1.8%
(523BZ) Causeway Clinic	5,059	5,120	4,815	-4.8%
(523GA) Framingham CBOC	1,677	1,672	1,719	2.5%
(523GB) Worcester CBOC <sup>76</sup>	6,567	6,646	6,702	2.1%
(523GC) Quincy CBOC	1,455	1,451	1,441	-1.0%
(523GE) Dorchester CBOC	92	73	n/a	n/a

<sup>&</sup>lt;sup>74</sup> Source: VSSC Trip Pack Report II - FY2011 through September, Total Uniques (Accessed Oct. 25, 2011).

<sup>&</sup>lt;sup>75</sup> The CBOC in Fitchburg, now part of the VA Central Western Massachusetts HCS, was a component of the Bedford VAMC until Oct. 1, 2011.

<sup>&</sup>lt;sup>76</sup> The CBOC in Worcester, now part of the VA Central Western Massachusetts HCS, was a component of the VA Boston HCS until Oct. 1, 2011.