

CHAPTER 3

VHA Central Office Reorganization

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VHA Special Programs

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

***NOTE:**

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

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

Figure 3.1

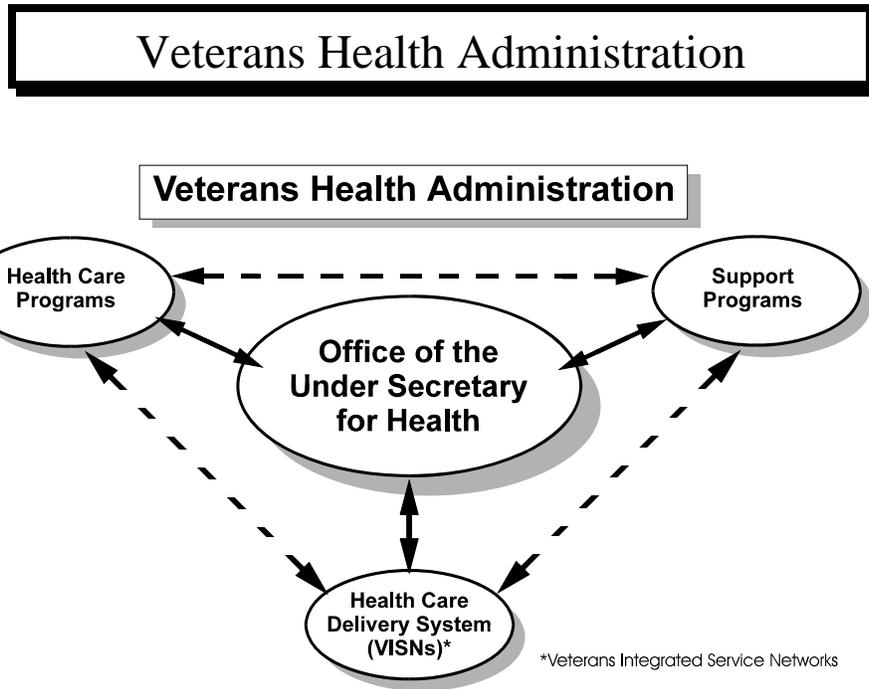


Figure 3.2

Veterans Health Administration:
Office of the Under Secretary for Health

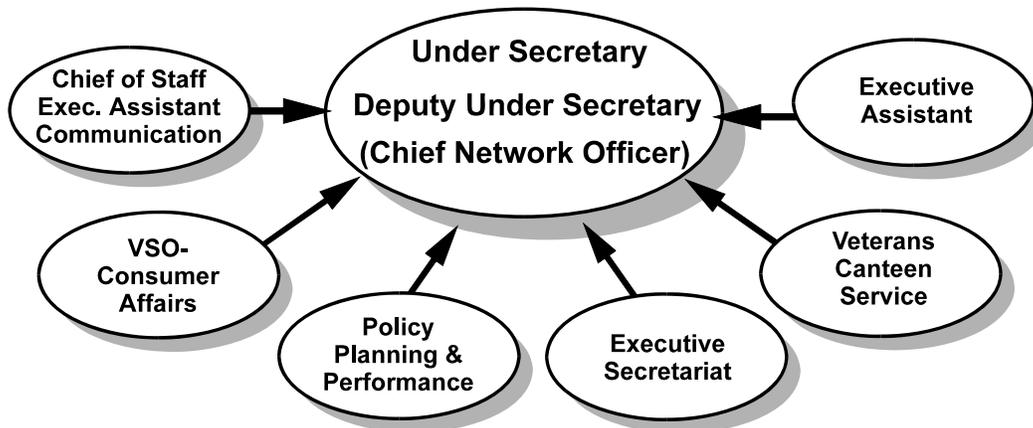


Figure 3.3

Veterans Health Administration:
Veterans Integrated Service Networks

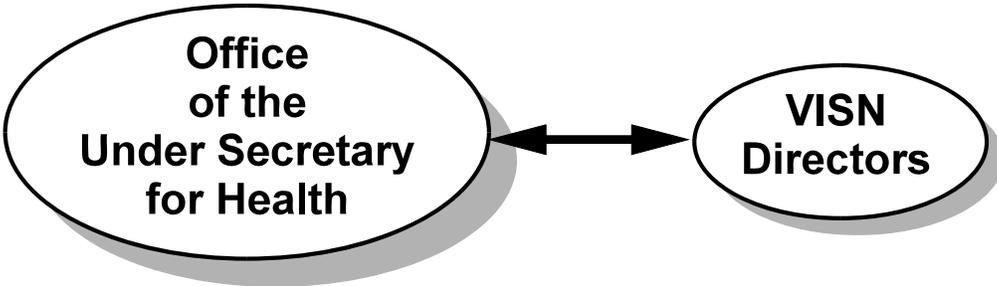


Figure 3.4

Veterans Health Administration:
Health Care Programs

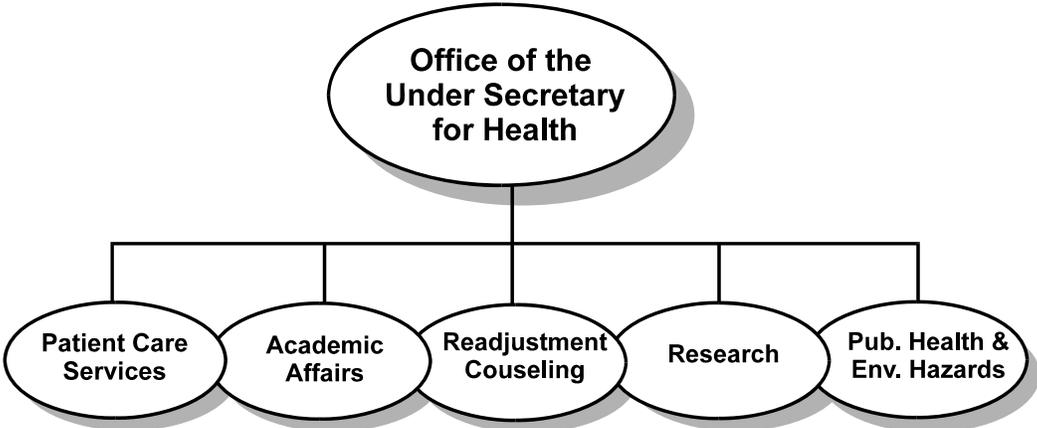


Figure 3.5

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

