



## Three Paths of Implementation: Network-Level Service Lines, 1997-1999

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The Management Decision and Research Center (MDRC) recently completed the third year of its examination of VHA facility and network clinical service lines (see pages 4-5). In this article we report on the development of VISN-level service lines since 1997. The MDRC found:

- As of December, 1999, all networks utilize some form of service line-like structure<sup>1</sup>. The greatest number of network-level service lines are in the clinical areas of primary care, mental health and geriatrics/extended care;
- Over the period of study, 1997-1999, many network-level service lines changed their form significantly. This includes the use of a form we had not seen before at the network, the matrix structure;
- Networks can be roughly divided into three groups based on the degree to which they employ service lines. Few networks have given service lines personnel or budgetary authority.

According to VHA definition, service lines are a family of organizational structures and integrating strategies that incorporate management practices for focusing an organization's efforts on its outputs, rather than on its inputs. They integrate multiple inputs produced across sites and disciplines to achieve outputs that are responsive to customers. Outputs are conceptualized into three categories: interventions (such as surgery), diseases (such as heart disease) and populations (such as women's health).

Furthermore, under VHA definition, an organizational unit must have the following characteristics to qualify as a service line: a permanent structure, an appointed manager, a multi-disciplinary nature, and a patient-focused output.<sup>2</sup>

In our study of service lines in VHA, we found differences between service lines that exist at the facility

<sup>1</sup> As is explained later in this article, this tally is based on a theoretical definition of service lines that is more inclusive than the VA definition.

<sup>2</sup> See earlier issues of *Transition Watch* for a more extensive discussion of service line definitions.

level and those that are VISN-wide. One goal of facility-level service lines is to break down barriers among disciplines. Network-level service lines, however, also serve to integrate across facilities. One Network Director discussed how service lines help with cross-facility integration by saying, "There is no way that a few people in one location make an integrated system. There has to be buy-in from the whole system. Service lines allow us to do that."

Networks have created a number of organizations that may resemble service lines because they exist across several sites – a network-wide purchasing department for example. However, since the purchasing department does not integrate many disciplines, it is better termed a "consolidated service" than a service line.

We have identified and studied five integrating structures at the network-level (see Table 1): Integrator, Task Force, Team/Council, Matrix and Division. Two of the structures, Integrator and Task Force, are not considered to be service lines under VHA definition. However, these structures represent important innovations and frequently change into other models, so it is important to identify them and understand how they function. The service line theory suggests that the Matrix and Division models provide greater integration across facilities than do other integrative structures.

### Where Service Lines Are

#### 1999 Clinical Focus of VISN-level Service Lines

Chart 1 shows the distribution of clinical service lines within the 22 VISNs from 1997-1999. In almost all clinical areas, the number of network-level service lines has increased from 1997 to 1999. In 1999, mental health, primary care and geriatrics/extended care each were used by more than half of the VISNs. Twenty-one of the VISNs have a mental health

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service line, seventeen have a primary care service line and sixteen have a geriatrics/ extended care service line.

The scope of services included in primary care service lines varies greatly across networks. Many networks define the service line to include all ambulatory services; VISN 2 has grouped even more services, including medical/surgical specialties and inpatient services, into a service line called “Medical VA Care.” Some individuals have expressed concern about the inclusion of such a wide range of clinical areas in one service line. Others have been concerned about separating primary and speciality care. Exploring the differences between primary care service lines that include only primary care and those with a broader scope will be the focus of future study.

### Matrix Models

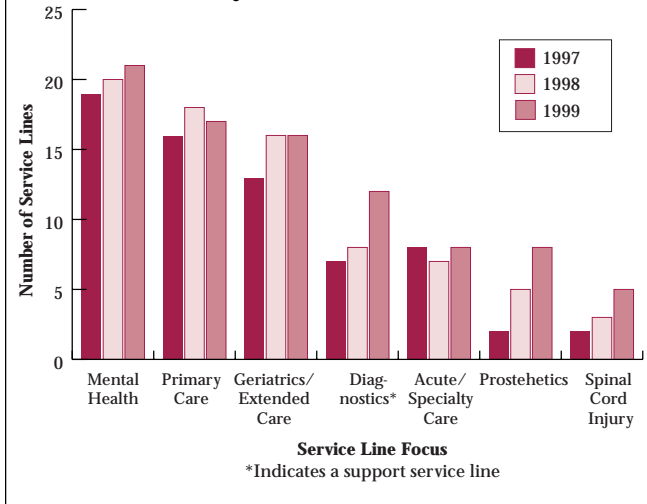
New in 1999 is the emergence of the matrix model at the network level. Matrixed service lines are intended to attain a balance between the traditional facility-based organization and network-based service lines.

Following traditional organization theory, we have looked at two elements when classifying network-level service lines: line authority and budget authority. In a division structure at the network level, both of these features would be under the control of the service line director. That individual would be responsible for administering the service line budget across facilities and for evaluating local service line managers. In a matrix structure, both personnel authority and budget authority are shared between the service line director and the facility director. The two individuals would jointly evaluate care line managers and have responsibility for budgetary resources. However, the few examples we have seen thus far in VA have taken a different approach. Budget and line authority have been separated rather than splitting each one equally between two different individuals. In this structure, the VISN service line director controls the budget, while facility leadership retains line authority over personnel. This approach is intended to achieve the same objectives as a traditional matrix structure, i.e., balancing the influence of the service line and facility. All of the service lines in VISN 10 are of the matrix nature, VISN 1 uses one matrix clinical service line and VISN 13 projects a matrix form for its service lines.

**Table 1. Definitions of VISN-level Integrating Structures**

<i>Integrator</i>	Service Line Integrators are managers who have responsibility but neither personnel nor budget authority for service lines. They generally focus on planning and clinical process improvements. Lacking formal authority, they must rely upon interpersonal skills to attain cooperation from personnel in different disciplines and facilities.
<i>Task Force</i>	Task Forces are groups of individuals from facilities across the network charged with planning, recommending improvements, and/or sharing information in a clinical area. Task Forces have a limited duration and disband when their work is done. Individual facilities within the network do not necessarily have to be organized into service lines in this model.
<i>Team/Council</i>	An on-going team or council is established to exchange information and/or develop policy for particular service lines. Two variations of this structure have been observed. In the first variation, facility representatives participate on the network-level team, but they do not represent facility-level service lines. In the second variation, all facilities are reorganized into service lines and the members of the team/council are facility-level service line managers (SLMs). SLMs generally report to their facility director (FD), and budget authority still resides at the facility.
<i>Matrix</i>	This hybrid balances facility perspectives and influence with those of network-level service lines. FDs and service line directors (SLDs) share line authority over the SLM, and work together to develop the budget for the service line. Alternatively, budget control could lie at the network level, while line authority remains at the facility. This is a difficult structure to maintain, and this model can easily shift to either a Team/Council or Division structure.
<i>Division</i>	Divisions are permanent interdisciplinary, inter-facility organizational arrangements. A SLD has line authority over facility SLMs. Budget authority for the service line usually lies with the SLD rather than remaining at the facility level.

**Chart 1. 1997-1999, Number of Service Lines by Area of Focus**



Some individuals that we interviewed expressed the opinion that this is a way to solve the problem of geographically spread networks. Rather than try to evaluate service line managers over such distances, they believed that it is best to perform evaluations locally.

**1999 Structure**

Chart 2 shows how network-level service lines in primary care, mental health and geriatrics/extended care are organized across the variety of service line structures. In these clinical areas, task forces are the most widely used structure, as is the case for network-level service lines as a whole. Of the 21 VISNs having a mental health service line, 13 organized it as a task force. Two VISNs have a mental health division structure, five use a team and one employs a matrix (see right). In primary care, ten VISNs have a task force, three a team, two a matrix and one a division. In geriatrics/extended care, ten VISNs use a geriatrics/extended care task force, three a team, one a matrix and two a division.

When looking at the overall pattern of service line use, networks maybe classified into three groups. One group uses primarily matrix or division structures; the second group relies mainly upon service line teams; and the third group uses task forces almost exclusively.

- A group of networks either already use **matrix** or **division-level** service lines or are in the process of implementing them. For these networks, service

lines are central to the network’s strategy of achieving network-wide integration. Networks 2, 5 and 10 have matrix or division models in place, while VISNs 1 and 13 anticipate their extensive use in the near future.

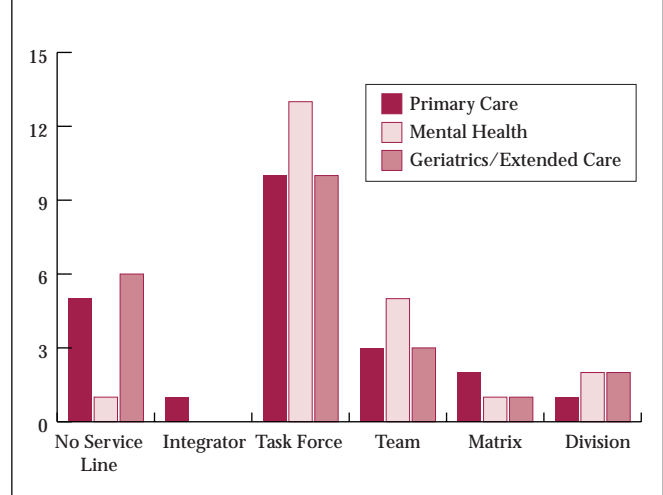
- A group of networks have a number of service line **teams** in place, but have chosen not to employ any matrix or division structures. VISNs 6, 7 and 16 fall into this category.
- A group of networks have **task forces** that operate in a variety of clinical areas. These networks may use task forces as a way of sharing information across the VISN, but rely upon other methods to achieve network integration. This group may be further broken down into two subsets. The first subset, while relying largely on task forces, has one or two division structures in place in focused clinical areas such as prosthetics or spinal cord injury. VISNs 3, 9 and 22 all operate one or two service line divisions while still predominantly using task forces. Networks in the second subset use only task forces.

**Where Service Lines Were**

With three years of data to examine, we have been able to track VISN-level service lines over time. Chart 3 shows changes in the 97 clinical service lines that networks have used from 1997 – 1999. These 97 service lines are the sum of the number of clinical service lines across all networks.

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**Chart 2. 1999 Network-Level Service Line Structure**



## VISN Service Line Implementation as of October 1999

VISN#	SL name	Structure				Budget Authority			
		1997	1998	1999	Projected	1997	1998	1999	Projected
1	Mental Health	Task Force	Task Force	Team	Division	No	No	No	Yes
	Extended Care	Task Force	Task Force	Task Force	Division	No	No	No	Yes
	Ambulatory Care	Team	Team	Matrix	Division	No	No	Yes	Yes
	Laboratory*		Team	Matrix	Division		No	Yes	Yes
	Acute & Subspecialty Pharmacy*	Task Force		Task Force	Division	No		No	Yes
	SCI			Team	Undecided			No	Undecided
			Team	Division			No	Yes	
2	Behavioral VA Care	Task Force	Division	Division	Division	No	Yes	Yes	Yes
	Geriatrics/ Extended Care	Task Force	Division	Division	Division	No	Yes	Yes	Yes
	Medical VA Care	Task Force	Division	Division	Division	No	Yes	Yes	Yes
	Diagnostics/ Therapeutics*	Task Force	Division	Division	Division	No	Yes	Yes	Yes
3	Mental Health	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Geriatric/Extended Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	SCI	Team	Division	Division	Division	No	Yes	Yes	Yes
	Prosthetics	Division	Division	Division	Division	Yes	Yes	Yes	Yes
	Operative/ Invasive Procedures	Task Force				No			
	Diagnostic/ Therapeutics*	Task Force				No			
	Support Services*	Task Force				No			
4	Primary Care Paradigm Group	Task Force	Task Force	Task Force	Undecided	No	No	No	No
	Long-Term Care Paradigm Group	Task Force	Task Force	Task Force	Undecided	No	No	No	No
	Acute Care Paradigm Group	Task Force	Task Force	Task Force	Undecided	No	No	No	No
	Clinical Support Services Paradigm Group*	Task Force	Task Force	Task Force	Undecided	No	No	No	No
	Behavioral Health Paradigm Group	Task Force	Task Force	Task Force	Undecided	No	No	No	No
5	Mental Health	Task Force	Reorganize Facilities	Division	Division	No	No	Yes	Yes
	Geriatrics/ Extended Care	Task Force	Reorganize Facilities	Division	Division	No	No	Yes	Yes
	Women's Health	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Pathology and Laboratory*		Reorganize Facilities	Division	Division		No	Yes	Yes
	Prosthetics			Division	Division			Yes	Yes
	Primary Care			Task Force	Task Force			No	No
6	Mental Health	Task Force	Team	Team	Team	No	No	No	No
	Primary Care	Task Force	Team	Team	Team	No	No	No	No
	SCI	Task Force	Team	Team	Team	No	No	No	No
	Extended Care		Task Force	Team	Team		No	No	No
	Acute Care		Task Force	Task Force	Undecided		No	No	No
	Clinical Support*			Task Force	Undecided			No	No
7	Mental Health	Team	Reorganize Facilities	Team	Undecided	No	No	No	Undecided
	Primary Care	Team	Reorganize Facilities	Team	Undecided	No	No	No	Undecided
	Extended Care	Task Force	Reorganize Facilities	Team	Undecided	No	No	No	Undecided
	Clinical Support*	Task Force	Reorganize Facilities			No	No		
	Acute Care			Team	Undecided			No	Undecided
8	Mental Health	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Extended Care/ Geriatrics	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Home Care			Reorganize Facilities	Division			No	Yes
9	Mental Health	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided
	Prosthetics		Team	Division	Division		No	Yes	Yes
	Pharmacy*			Integrator	Undecided			No	Undecided
Primary Care & Ambulatory Care	Task Force	Task Force	Integrator	Undecided	No	No	No	Undecided	
10	Mental Health	Task Force	Team	Matrix	Matrix	No	Yes	Yes	Yes
	Primary Care	Task Force	Reorganize Facilities	Matrix	Matrix	No	No	Yes	Yes
	Extended Care	Task Force	Team	Matrix	Matrix	No	No	Yes	Yes
	Medical/ Surgical	Task Force	Reorganize Facilities	Matrix	Matrix	No	No	Yes	Yes
	Rehabilitation	Task Force	Team	Matrix	Matrix	No	No	Yes	Yes
	Clinical Support Services*	Task Force	Team	Matrix	Matrix	No	Yes	Yes	Yes
11	Mental Health	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided
	Extended Care	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided

\* indicates a support service line or consolidated service.

## VISN Service Line Implementation as of October 1999

VISN#	SL name	Structure				Budget Authority			
		1997	1998	1999	Projected	1997	1998	1999	Projected
12	Cardiac Surgery	Task Force				No			
	Mental Health	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided
	Path. & Lab Med.*	Task Force	Task Force	Division	Division	No	No	Yes	Yes
	Imaging*	Task Force	Task Force	Task Force	Division	No	No	No	Yes
	Prosthetics	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care		Task Force	Task Force	Task Force		No	No	No
13	Mental Health	Task Force	Reorganize Facilities	Team	Matrix	No	No	No	Yes
	Primary Care	Task Force	Reorganize Facilities	Team	Matrix	No	No	No	Yes
	LT/ Extended Care	Task Force	Reorganize Facilities	Team	Matrix	No	No	No	Yes
	Specialty Care	Task Force	Reorganize Facilities	Team	Matrix	No	No	No	Yes
14	Mental Health	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided
	Primary Care	Task Force	Task Force	Task Force	Undecided	No	No	No	Undecided
	Acute Specialty		Task Force				No		
	Long Term Care		Task Force	Task Force	Undecided		No	No	Undecided
	Radiology*			Task Force	Undecided			No	Undecided
	Pharmacy*			Task Force	Undecided			No	Undecided
Laboratory*			Task Force	Undecided			No	Undecided	
15	Mental Health	Team	Integrator	Task Force	Task Force	No	No	No	No
	Primary Care	Team	Integrator	Task Force	Task Force	No	No	No	No
	Specialty Care	Task Force		Task Force	Undecided	No		No	Undecided
	Clinical Support*	Task Force				No			
16	Mental Health	Team	Team	Team	Team	No	No	No	Yes
	Primary Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Extended Care	Task Force	Task Force			No	No		
	Tertiary Care	Task Force	Task Force			No	No		
	Diagnostic Product Line*			Team	Team			No	Yes
	Prosthetics			Team	Team			No	Yes
17	Hepatitis C		Task Force	Task Force	Task Force		No	No	No
	Severely Mentally Ill		Task Force	Task Force	Task Force		No	No	No
	Cardiac Catheterization		Task Force	Task Force	Task Force		No	No	No
18	Mental Health		Task Force	Task Force	Task Force		No	No	No
	Care Management		Task Force	Task Force	Task Force		No	No	No
	Geriatrics/ Extended Care		Task Force	Task Force	Task Force		No	No	No
	Rehabilitation/ Prosthetics		Task Force	Task Force	Task Force		No	No	No
	Diagnostics*		Task Force	Task Force	Task Force		No	No	No
19	Mental Health	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Dental Health		Task Force	Task Force	Division		No	No	Yes
	Home Care		Task Force	Task Force	Task Force		No	No	No
20	Mental Health	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	LT Care	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Same Day Surgery	Task Force	Task Force	Task Force	Task Force	No	No	No	No
	Medical Specialties	Task Force	Task Force	Task Force	Task Force	No	No	No	No
21	Mental Health	Team	Task Force	Task Force	Task Force	No	No	No	No
	Primary Care	Task Force	Task Force			No	No		
	Extended Care	Team	Task Force	Task Force	Task Force	No	No	No	No
	Orthopedics	Task Force				No			
	Cardiac Care	Task Force				No			
	Urology	Task Force				No			
	Lab*			Task Force	Task Force			No	No
22	Cancer		Task Force	Task Force	Task Force		No	No	No
	Women's health		Task Force	Task Force	Task Force		No	No	No
	Homelessness		Task Force	Task Force	Task Force		No	No	No
	Prosthetics		Task Force	Division	Division		Yes	Yes	Yes
	SCI		Task Force	Task Force	Task Force		No	No	No
	Laboratory*			Task Force	Task Force			No	No
	Radiology*			Task Force	Task Force			No	No
	Mental Health			Task Force	Task Force			No	No

## Network-Level Service Lines, 1997-1999

Continued from page 3

In some networks, service lines moved to a less integrative structure. In Network 21, teams in Mental Health and Extended Care in 1997 became task forces in 1998. In four networks, VISN-level task forces disbanded. Individuals within the networks gave different reasons for why the task forces disbanded. In one network, the Network Director cited the lack of line or budget control as the reason the task forces were not successful at achieving integration. In another network, a change in leadership was partially responsible. The current Network Director stated, “Most of the network service lines are non-existent; they were created by the previous Chief Medical Officer/Network Director... they really weren’t accomplishing anything; there was no effort to try to reinvigorate them. We were cutting our losses.”

In more cases, however, the service line structure moved to a more integrative model over time. In Network 2, network-level task forces in 1997 became divisions in 1998. Network 10, in a more gradual change process, employed task forces in 1997, teams in 1998 and the matrix model in 1999. In these locations, over time the networks became more comfortable with service lines and developed a more integrated structure.

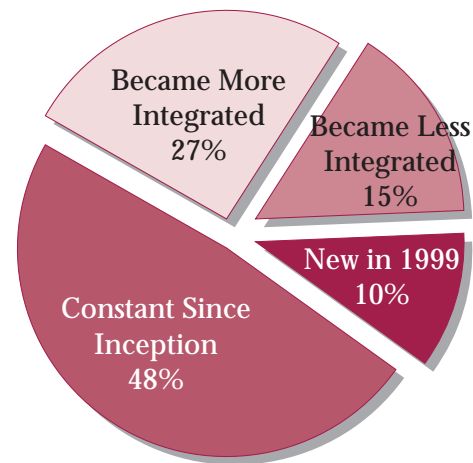
### *Where Service Lines Are Going*

In general, networks have implemented less-integrative forms of service lines than have facilities. This may be in part to unique issues facing networks, such as the geographic distance between facilities. It is also possible that networks have not been in existence long enough to form highly evolved service line structures.

Some networks anticipate moving to a more integrated service line structure in the future. For example, five networks expect to give budget control to service lines that currently do not have this authority.

We will continue to track these changes in service line structure, and will examine the forces that may cause networks to change their service line strategy. Following movements of networks among the three groups we identified earlier will be one manner in which we hope to accomplish this.

**Chart 3. Change Process Among Network-Level Clinical Service Lines, 1997-1999**



In total, about one-quarter of networks have adopted service lines as a means by which to achieve their integration strategy. Other networks have chosen not to, or are still evaluating whether service lines are an appropriate management tool for them. We hope to inform these decisions by continuing to research service lines and by disseminating information on the relationship between service line structure and outcome measures. ■



# System Identification: A Key to Cultural Integration

Carol VanDeusen Lukas, EdD

In our work on the integration of VA medical centers, we have found that cultural integration is among the most difficult aspects of system integration — one that all systems report is still in progress. The culture of an organization includes the shared norms, values, beliefs and assumptions that guide an organization and provide the frame of reference through which employees view the organization. We are interested in cultural integration as a signal that the staff in previously separate hospitals are really working together as part of a larger system. As such, it is both a measure of the extent of integration and an intermediate measure of the impact of integration.

During our visits to integrating systems, people talked extensively about cultural differences. In most cases, staff could characterize those differences well. Often they talked about having one small facility with a stable workforce that considered itself family and where staff members were used to doing things informally, and one large, complex facility, usually urban, usually with a strong affiliation, where staff turnover was higher and operations more bureaucratic. Staff at both campuses could articulate these profiles consistently, in relation to

both themselves and the other campus. And they could articulate the mistrust, miscommunication and missteps resulting from these differences.

In other cases, though, staff could not articulate differences in culture, and in fact based on MDRC observations and organizational survey measures, the facility cultures appeared to be similar. But staff at each campus still mistrusted each other and found it difficult to work together.

It appears, then, that the important barrier to staff working together across the system is not differences in organizational culture, but strong identification with one campus and local colleagues, and distrust of staff at the other campuses. Conversely, what seems key in creating an integrated system is having people who trust each other and work together productively across campuses — and who think of themselves as employees of the larger integrated health care system rather than just their former facility. Thus, it seems that system identification provides a good proxy for cultural integration.

To measure system identification in the second phase of our facility integration study, we asked managers in 19 VA integrating systems to report the proportion of their staff who identified with the system versus their campus. The question was included in an integration supplement to the national quality improvement survey conducted annually by the MDRC. The 19 systems were those approved for integration between January 1995 and December 1997. Managers rated system identification on a five-point scale from high identification (All of my staff think of themselves primarily as employees of the health care system....) to low identification (All of my staff think of themselves primarily as employees of their respective campuses....).

Across all 19 systems, the average score was 2.70, slightly below the midpoint of the range where half the staff identifies primarily with the system and half with the campus. Around this average, there was considerable variation, with individual system averages ranging from 1.80 to 3.75. To try to explain why some managers judged their staffs' identification with the system higher than others, we identified system characteristics that we expected to be related to higher system identification. To look systematically at the relationship

*Transition Watch* is a quarterly publication of the Office of Research and Development's Health Service Research and Development Service that highlights important information and learnings from the organizational change processes underway within the Veterans Health Administration. Special focus will be given particularly to findings from three organizational studies: the Service Line Implementation Study, the Facility Integration Study and the National Quality Improvement Study. The goal of *Transition Watch* is to provide timely and supportive feedback to VHA management throughout the change processes being studied as well as to draw on the change literature to assist managers in their decision making. For more information or to provide us with your questions or suggestions, please contact:

GERALDINE MCGLYNN, EDITOR

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## System Identification: A Key to Cultural Integration

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between each of these characteristics and the extent of system identification — and to determine the relative importance of the characteristics — we conducted standard regression analyses. The model that explains the most variation indicates that managers in integrated systems are more likely to report high system identification among their staff when:

- The system is an older integrated system — it was approved for integration in 1996 or earlier;
- The system has a strong headquarters — where most or all top management and service chiefs are based together at one campus, as distinguished from systems where chiefs are divided across campuses;
- The policies in the manager's service are the same across campuses.

Clearly, system identification is higher where the integrated system is more mature, both in terms of age and extent of integration. This pattern is not surprising. Generally older systems are more likely to be organizationally and operationally integrated than newer systems. But the passage of time by itself does not guarantee greater organizational and operational integration and therefore probably does not ensure system identification. If two or more medical centers are joined administratively but continue to operate essentially independent, with little change in staff work, there is little reason for staff to change their allegiance to identify with the larger system. However, if the organization builds bridges across campuses, for example by setting common policies across the system, the larger system has a reality that affects staff members' daily work and they are more likely to identify with it. Often the process of working to create joint processes

itself facilitates system identification. As we have noted in earlier *Transition Watch* articles, many systems report that the process of preparing a single set of policies for their Joint Commission surveys bonds the staff across campuses.

The relation between strong headquarters and system identification is at first glance more surprising. Systems with strong headquarters are often dominant-partner systems with substantial differences in their size and complexity before integration. Those differences are usually associated with very different organizational cultures, and one might expect the cultural differences to pose barriers to system identification. One might also expect that having most or all top managers and chiefs based at one location would be viewed negatively by staff at the non-headquarters campuses. They might feel that their facility had been taken over and diminished, and this would lead to a stronger loyalty and solidarity with their campus. One explanation for this apparently contradictory pattern is methodological. By surveying system managers, we may have gotten a biased perspective when most managers are based at one campus: if those managers do not interact frequently with staff at the other campus, they may understate those staff members' negative feelings and overestimate their system identification. The pattern is so strong here and in other analyses in our study, however, that it seems unlikely that managers' bias would be so consistent and prevalent as to account for the full effect. An alternative explanation is that, in fact, a different dynamic holds than the one we expected, at least in some systems. It appears that systems with central headquarters also tend to move fairly decisively to integrate the system. From our earlier interviews with staff in integrating systems, we know that staff are most anxious about uncertainty. By moving decisively, central headquarters systems reduce anxiety. Divided headquarters may reflect a lack of decisiveness, or less cohesiveness — and therefore less system identification. ■