



## Elements of Successful Integration Processes

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Integrating two or more organizations requires extensive efforts on multiple levels. At one level, the newly created system has to work out practical details ranging from major policy decisions about system mission and organizational structure to specific operational details such as telephone systems and transportation schedules between campuses. At another level, the system faces the dynamics of major organizational change, which generally include strong resistance to change and organizational inertia.<sup>1</sup> In the case of facility integration, these dynamics are heightened by the challenges of trying to coordinate, communicate with, and bring together, the organizational cultures of two or three previously independent entities.<sup>2</sup> The dynamics of change are also especially challenging when they involve clinical as well as administrative services,<sup>3</sup> often with accompanying teaching and research functions. Relatively few constraints were imposed by VA headquarters on integrating facilities as they planned and carried out their integrations. Systems could therefore develop a variety of approaches to merging facilities. In previous articles in *Transition Watch*, we have offered examples of integration activities in the 14 systems we are studying. In this article, we focus on success of integration processes and the activities and approaches associated with success.

### Measures of successful integration processes

We defined process success on two dimensions and looked at system performance on each:

- **Duration of Integration Planning and Implementation**

Duration of the integration process is an important indicator of success because the integration period entails considerable uncertainty, disruption and stress on facility staff and patients. Slowing major organizational change frustrates staff, creates unnecessary resistance and sometimes stifles change.<sup>4</sup> A large majority of substantial organizational transformations are accomplished through rapid and discontinuous change across most or all domains of organizational activity rather than through small incremental changes.<sup>5</sup> We therefore assumed that shorter integration processes would be smoother and less disruptive.

We defined the duration of integration for this analysis as the number of months between the approval of integration and the adoption of common policies across campuses. While we recognize that organizations continue to evolve following the integration of policies, this is an objective point to measure and, we believe, represents a major point of accomplishment after which a system begins to settle into its new modes of operation and service delivery.

Among the eight systems that described their integrations as complete last fall, four systems reported that integration took 13 months or less (Palo Alto, Puget Sound, South Texas and Western New York) and four reported that integration took between 18 to 22 months (Central Texas, Connecticut, New Jersey, Pittsburgh), as shown in Table 1. Among the remaining six systems where integration was still in progress, integration had been underway for 15 and 35 months (Black Hills, Central Alabama, Chicago, Maryland, Northern Indiana, Southern California). Several of these in-progress integrations are among those with the longest duration,

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<sup>1</sup> Shortell SM, Gillies RR, Andersen DA, et al. Remaking health care in America: building organized delivery systems. San Francisco: Jossey-Bass, 1996.

<sup>2</sup> Alexander JA, Halpern MT, Lee SD. "The short-term effects of merger on hospital operations." *Health Services Research* 1996; 30(6): 827-847.

<sup>3</sup> Shortell SM, Gillies RR, Andersen DA, et al. Remaking health care in America: building organized delivery systems. San Francisco: Jossey-Bass, 1996.

<sup>4</sup> Kotter JP. *Leading Change*. Boston: Harvard Business School Press, 1996.

<sup>5</sup> Romanelli E, Tushman ML. "Organizational transformation as punctuated equilibrium: an empirical test." *Academy of Management Journal* 1997; 37(5): 1141-1166.

suggesting they are having a complicated integration process.

- **Staff Morale and Satisfaction**

Staff morale is an important indicator of success for many of the same reasons a limited time for integration is desirable: Integration entails significant and potentially disruptive changes in organizational structures and processes, and in staffing patterns and assignments. These changes can have significant negative impacts on staff morale and functioning. Ideally, major organizational changes such as integration would be accomplished with only minimal adverse impacts on morale. More severe impacts are likely to be associated with higher turnover, lowered productivity, and diminished effectiveness of integration planning and implementation processes. We expected morale at all integrating systems to be low at the time the integration was announced—a time of great uncertainty and therefore anxiety—and to rise as uncertainty was resolved with new structures in place and as the system settled into its new configurations and working arrangements.

Our primary measure of staff morale was based on perceptions by system managers about the impact of integration on staff in their departments. In a survey of managers last fall, we asked them to rate the impact of integration on their staff’s morale on a 5-point scale. The scale ranged from ‘1’ (very/mostly negative) to ‘5’ (very/mostly positive), with ‘3’ defined as ‘neither negative nor positive.’

Not surprisingly, systems with completed integrations tended to report higher staff morale than systems with the integration still in progress. Of the eight systems which reported their integrations complete, three (Palo Alto, Puget Sound and South Texas) reported that the integration had a positive impact on morale ( $\geq 3.25$ ), four (Central Texas, Connecticut, New Jersey and Western New York) reported a neutral impact (2.76–3.24) and only one reported a negative impact (Pittsburgh: 2.70), as shown in Table 1. Among the six in-progress systems, two (Maryland and Black Hills) reported neutral impact (2.94–2.97) and four (Central Alabama, Chicago, Northern Indiana and

**Table 1. Factors Affecting Integration Process Success**

System	Process Success Measures		Factors Affecting Success	
	Approval to Standard Policies and Procedures*	Impact of Integration on Staff Morale	Approval to Appointment of System Director *	Planning Model**
Black Hills	23	2.97	3	SL
Central Alabama	18+	1.98	4	TD
Central Texas	20	2.98	2	TD
Chicago	23+	2.61	0	BU
Connecticut	21	2.93	0	SL
Maryland	27+	2.94	8	SL
New Jersey	18	2.88	0	TD
Northern Indiana	35	2.67	7	BU
Palo Alto	0	3.46	-7	SL
Pittsburgh	22+	2.70	5	SL
Puget Sound	12	3.25	0	SL
South Texas	12	4.10	0	SL
Southern California	17+	2.73	6	SL
Western New York	13	3.07	0	BU

Note: \* Time in months for formal appointment of system director

\*\* Terms defined in Table 2

Southern California) reported negative impact (1.98–2.73).

### Why are some systems more successful?

When we looked for aspects of the integration processes that were related to these success dimensions, we identified two factors:

- **Speed of Appointment of a System Director**

The amount of time required to appoint a permanent system director varied from seven months *before* the formal integration approval date to eight months following the approval date, as shown in Table 1. Seven out of 14 integrations appointed the new system director rapidly (on or before the integration approval date). Early appointment was facilitated in four of seven cases by the resignation or reassignment of one of the prior facility directors (Palo Alto, Western New York, Chicago and Connecticut). In the three remaining rapid appointment systems (South Texas, Puget Sound, and New Jersey), the director’s appointment occurred concurrently with integration approval and in the context of active opposition to the integration by the director of the smaller facility.

Systems in which the system director was appointed quickly were more likely to have a shorter integration

process and staff with more positive views about integration. For rapid-appointment systems, the average length of the integration process was 14 months compared with 23 months for the remaining sites. Either the longer appointment process is a marker for a facility with more complex integration challenges or the delayed appointment has a domino effect to slow other activities and thus delay the overall integration process.

For rapid appointment systems, integration had a more positive impact on staff morale (mean score = 3.19) than in systems with slower appointments (2.71). This relationship supports the perspective that prompt action in organizational change is reassuring to staff, and is consistent with the relationship between the director’s appointment and the duration of integration.

- **Models of planning involvement**

In most systems we studied, staff at all levels of the organization were involved in some aspect of planning and implementing the integration. Across systems, the process was inclusive in the implementation phases. Systems differed, however, in the roles of top and middle management in the early planning phases of integration. Based on our site interviews and document analysis, integrating systems tended to fall under one of three models, as shown in Table 1. The fit between any one integrated system and the model we assigned it to was imperfect, but the models captured core features of a continuum that shaped the process of integration, as shown in Table 2.

Systems using the *shared leadership* model, which balances participation with leadership and prompt action in appointing service chiefs, were most likely to report a positive impact of integration on staff morale. (mean = 3.14) Mean staff morale scores at sites following *top down* and *bottom up* integration processes were both somewhat negative (2.61 and 2.78). Finding low

morale under the top down model is not surprising, but low morale associated with the bottom up model is.

Two factors explain the comparatively low morale in systems using the bottom up model. Both are associated with what staff reported as considerable discomfort with uncertainty and lack of direction in the planning process. Virtually all management of change theories emphasize the importance of broad staff involvement in the change. But most people are apprehensive of change. They do not like uncertainty, are worried about losing jobs, losing status, and changing routines. In the systems we visited, staff complained about delays and uncertainty in establishing the structure for the integrated system – they wanted to know who they were going to work for and felt that the absence of key managers, especially when lasting for several months or more, paralyzed the organization

In addition, the staff we talked with were unhappy about putting effort in planning processes and workgroups that did not go anywhere. It was common for staff to report that considerable work group time was spent developing recommendations that later were not used or had to be fundamentally revised after they were found to be inconsistent with top management’s vision of integration. In cases where service chiefs for the new system had not yet been appointed by the time work groups were convened, work group members reported that their meetings were controversial, unproductive, and marked by unclear lines of authority and intense competition rather than cooperation among staff of different facilities.

The planning models are also related to the duration of integration. Systems using the shared leadership model and the top down models move more quickly through the integration process (18.6 and 19 months) than systems using the bottom up model (23.7 months).

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**Table 2. Leadership and staff involvement in early integration planning**

<i>Top down (TD)</i>	Top management plays the dominant role in formulating, refining and making final strategic decisions regarding the structure of the new system at both the system and service levels; middle managers are appointed after the structure is set and are responsible primarily for working out operational details for their integrated service.
<i>Shared leadership (SL)</i>	Top management takes leadership but middle managers for the new systems are appointed quickly—either in permanent or interim positions—and are involved early in the planning of the service structures and staff mix.
<i>Bottom up (BU)</i>	Middle management and line staff participate in designing the new system at the beginning of the planning process—sometimes without clear leadership from the top.

# Where do we stand? Comparing system-level service lines in the private sector and in VHA

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Recently, our service line project team had the opportunity to speak with 15 senior managers in private sector integrated delivery systems about their experiences with system-level service lines. In analyzing their experiences, we were struck by both some of the similarities and some of the differences between what they have experienced and what we have heard within VHA regarding VISN-level service lines. We thought you might also find the comparison interesting.

Nearly all private sector service lines are clinical, while in VA both clinical and non-clinical service lines have been implemented. In this article, we focus on clinical service lines.

## Revisiting service line definitions

Due to the continuing conversation about what exactly service lines mean, we begin with our current understanding of the term. Service lines may be defined as a family of organizational arrangements based on an organization's outputs rather than its inputs (which form the basis of traditional organization designs). Their outputs can be conceptualized in terms of:

- *Interventions:* such as surgery, radiation therapy, or organ transplantation;
- *Diseases:* disease-related groupings, such as comprehensive care for cancer or heart disease; or
- *Populations:* care to and/or maintaining health of identifiable segments of the population (e.g., geriatrics, pediatrics).

All of these bases for service lines can be readily found in practice. Key defining characteristics of clinical service lines are that they:

- are multidisciplinary;
- have a clinical care mission;
- provide a mechanism for integrating personnel and services across disciplines; and
- provide for coordination across multiple settings of care in integrated delivery systems.

Although not consistent with the service line definition, some organizations also conceptualize

service lines in terms of location of service<sup>1</sup> (acute care, ambulatory care) or consolidations or central management of clinical or administrative support services among multiple sites (e.g., clinical laboratories, pharmacy services).

## Private sector system-level service line experiences

Twelve of the fifteen private sector organizations we talked with reported having service lines, and one indicated they were planning them. Service lines described in the interviews varied considerably in scope. Broadly constituted service lines included mental health and long-term care, while more narrowly focused service lines included specific procedures such as heart valve surgery and bowel procedures and conditions such as pneumonia and kidney disease. The most frequently mentioned service lines were:

Private Sector Service Lines	Frequency Mentioned
Cardiology/Cardiac services/Heart center	11
Oncology/Cancer center	10
Women's health/Women and infants	9
Orthopedics/Musculoskeletal	8
Mental health	7
Long term care	5
Neurology/Neurosciences	5
Home health care	4
Pediatrics	3
Gastrointestinal	3

The three most common types of service lines are the same as those reported by Bowers (1990)<sup>2</sup> as the most

<sup>1</sup> This conceptualization and distinction among interventions, disease management and locations is based on discussions with Gerald Bryant of Baylor Health Care System.

<sup>2</sup> Bowers MR. Product line management in hospitals: an exploratory study of managing change. *Hospital and health services administration*, 1990; 35(3): 365-375.

frequently occurring. They represent areas that often provide potential for profitability, and are relatively discrete from other services (as contrasted to general medicine, for example). Gaining market recognition in one of these areas reflects positively on the overall image of the system. For example, one interviewee noted, “We want people to say ‘that is where I go to get my heart fixed.’”

### *Comments on Impacts of Service Lines*

*Most interviewees believed that service lines had positive effects. These comments included:*

- “Managers are more focused and informed with regard to planning and decision making.”
- “There is better technical knowledge and focus than before.”
- “There is reduced friction among facilities with regard to hiring and salary. It also improves the experiences of people to prepare them better to move up to the next job.”
- “There is a greater accountability as a result of service lines. It is an important shift from traditional management toward clinicians and patients.”
- “Service lines are useful to diffuse competition among facilities. They foster more system-wide analysis.”
- “We have greater coordination across inpatient and outpatient. There is improvement in care delivery and cost. The combination of medical and surgical was successful.”
- “Service lines work well when there is a pre-existing center of excellence among hospitals in the system.”
- “Clinicians appreciate the greater focus on their particular area.”

### *Negative comments included:*

- “It hasn’t really affected decision making. There are lots of politics to manage. It’s still in the early stages.”
- “There is nothing magic about service lines, just a different set of silos. You need to identify critical success factors to give service lines more legitimacy.”
- “It has made things more complicated, and created some blockages and back-logs. It’s hard work getting people on the same page. The jury is still out.”
- “It works well for some service lines but not for others. Cardiology and Behavioral Health work well, in part, because of market pressures. Oncology is still a problem.”
- “Collaboration has been difficult.”
- “We have a long way to go. We are wrestling with how to give service line managers enough authority.”

- “It’s like trying to get the Yankees and the Red Sox to play on the same team.”

In reviewing the interview data we note that several organizations say a benefit of services lines is reduced competition and less friction among facilities. Yet, “politics” and “competition” among facilities are cited as key barriers in implementing service lines. To some degree, market forces and historical factors explain the variation in the type of service line implementation among organizations. For example, in some systems specialty hospitals formed the core of a service line, and other aspects were built around this core. The preeminent position of the specialty hospital was so established that the clinical and management expertise in the particular specialty could be built upon and resistance from other parts of the system was minimal. This contrasts with systems where several member hospitals competed in the same market, and the efforts in forging a system-wide effort have not been successful.

Market characteristics also explained differences among systems. Some interviewees remarked that high levels of competition had not yet reached their parts of the country. Until the competition and pressures from payers increased, they felt they did not need to move quickly to implement service lines or develop them more fully. They could continue to operate their systems as a set of relatively autonomous facilities. At most they sought to share innovations and best practices across sites, but not to actively manage integrated clinical delivery across sites.

*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. *Transition Watch* is available on the web at [www.va.gov/resdev/prt](http://www.va.gov/resdev/prt) and on our Fax service by calling (617) 278-4492 and following voice prompts. For more information or to provide us with your questions or suggestions, please contact:

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The focus of the service line was also associated with differences in organization. In several systems, home health care, operating relatively independently of acute care facilities, could be organized as a “service line” with little disruption or resistance from other parts of the system. They also competed in a different part of the market and faced different reimbursement issues than the acute care hospitals. (We do question, however, whether such entities are actually service lines in that they do not integrate across facilities). Those systems citing “marketing” as a primary reason for implementing service lines had fewer but more focused service lines.

Although we noted that history, geography, and market factors accounted for differences in service lines and their perceived effectiveness, we also observed systematic variation related to the form of service line organization implemented. Three systems utilized individual service line managers, one used task forces, four used teams, and three had altered reporting relationships to implement divisional structures.

Systems focusing on marketing only used weaker service line structures than systems where marketing was not a primary goal. By “weaker” structures we mean the appointment of service line task forces or managers without formal authority, but with responsibility for planning and coordinating.<sup>3</sup> In most cases where the organization sought to address the coordination of care, or cost reductions and/or reengineering delivery of care, they were not successful unless they organized with either a service line team or service line divisional form. Our observation, consistent with the literature, is that greater coordination requirements are addressed with “stronger” organizational approaches.

Information systems were also cited as an important factor in managing service lines. One large multi-state organization, for example, attributed its rigorous, clinically focused outcomes reporting system as the backbone of its service lines. This system is used for:

- outcomes measurement;
- providing feedback to hospitals; and
- sharing information on best practices as related to outcomes.

In contrast, a small system noted that the lack of development of its information system was an impediment to service line implementation.

<sup>3</sup> These service line arrangements are discussed in the Fall 1997 issue of *Transition Watch*.

## VHA network-level service line experiences

As reported in an earlier issue of *Transition Watch*, most VISNs are also implementing some form of network-level service lines. However, the clinical areas most frequently chosen for this form of organization look very different from those selected in the private sector:

VHA Network-Level Service Lines	Frequency Mentioned
Mental health/Behavioral health	18
Primary care	15
Extended care/Geriatrics/Long-term care	13
Medical/Surgical (individually or together)	6
SCI	2
Prosthetics	2

Besides the different areas selected for service lines, the form of organization selected also seems to differ quite a bit between VHA and private sector integrated delivery systems. In contrast to the private sector, where we observed a balanced number of individual service line managers, teams, and divisional structures, the majority of VISNs are currently using task forces, a relatively weak mechanism for integration. Six VISNs are using teams for at least one service line, while only one had implemented a service line division structure, as of the end of 1997.

## VHA versus private sector service lines: What makes for the differences?

*Content Areas for Service Lines:* A cursory examination of the two charts above reveals very different patterns in the frequency of content areas for service lines. Within VHA, there appear to be several different forces driving the selection of service line areas. One such force may be areas of clinical focus that have been identified as priorities for program development by Headquarters (e.g., primary care and mental health services). Another such force may be the momentum generated in areas in which there is already cross-disciplinary synergy and coordination, such as mental health. A third force accounting for the pattern observed in VHA may be the necessity for cost efficiencies in certain areas, such as in extended care.

In contrast, the private sector system-level service line choices tend to be determined by which areas are most competitive and profitable in terms of the local markets. For example, cardiac services are often

perceived as a potentially profitable arena and hence perceived as fruitful areas for service line activity. Pressures from managed care insurers who are looking to buy services on the basis of disease groups (e.g. capitated cardiac care) contribute to this dynamic. Another factor driving such choices is often the existence of a center of excellence for cardiac care at one member hospital, around which a service line can be developed.

**Type of Service Line form:** The possibility of having system-level service lines is fairly new in VHA, since VISNs were only implemented in 1996. Thus, while it may appear that VHA networks have opted for relatively less strong integrating mechanisms, it is possible that many of the task forces are actually precursors to stronger forms of integration. Another force working against the adoption of stronger forms of service line within VHA is that VISNs often reported the same kinds of turf battles cited in the private sector, but without the market-driven imperative to push integration faster and farther. The VHA networks also have several public constituencies as stakeholders, which may work against the development of network-level service lines due to the perception that they threaten the existence of services at individual local facilities. The private sector networks have not had any “organized public” in this sense, and thus can create service lines without regard to such pressures. Similar to the VHA, however, is competition among facilities within a network.

**Reasons for implementing Service Lines:** While in the private sector there were distinct clusters of reasons for implementing service lines at the system level (ranging from marketing to improving operational efficiency) the reasons for implementation in VHA’s VISNs were less clear. In many cases, it appeared to be part of a larger strategy for developing VISN-level thinking and planning. In other instances it appeared to be a vehicle for seeking operational efficiencies and improvements, and for developing uniformity in the delivery of care across facilities. The most notable difference was that within VHA, marketing was rarely cited as a consideration; indeed, many interviewees felt that service lines should be transparent to patients, if possible.

## Concluding thoughts

There are several important conclusions we found from this brief comparison of public and private service line structures:

1. There are clear differences in the purpose for which service lines are implemented. In general, we observed that where service lines were being used for purposes of planning and marketing only, weaker organizational forms were used;
2. The VHA should not just copy the private sector’s experience in the organization and use of clinical service lines. Clearly, there are very different sets of environmental factors at work. Analyzing their successes and failures can inform VHA organization choices;
3. However, we are struck by the success of the systems that used nurses and physicians to facilitate sharing of information and implementation of best practices across facilities. These systems accomplished this without formal authority, but rather with the assistance of well-developed information systems. Other systems reported success from reorganizing to give service line managers formal authority.

There is still much to learn about both private sector and VHA service lines as it unfolds. We will continue to monitor both of these types of service line implementations and report our observations. ■

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The uncertainty and lack of direction associated with the bottom up model appear to delay the integration process.

## Conclusions/Lessons.

These findings suggest that effective integration planning processes balance strong leadership with early involvement of system middle-management and staff involvement within clear boundaries. To achieve that balance:

- *Integrating systems should appoint the system director and service chiefs quickly after the integration announcement – with interim service chiefs appointed and given clear authority if the appointment of permanent chiefs will be delayed because of recruitment or system redesign.*
- *Integration planning workgroups need clear direction and leadership, both in terms of charges to the workgroup and management of workgroup activities; the workgroup products should be reviewed by system leadership and/or the integration governing board against clear criteria and should be implemented if they meet the criteria. ■*

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