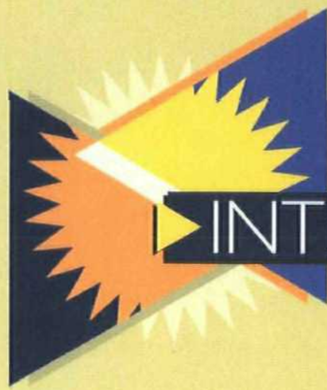

INTEGRATING CULTURES

A tool for mission leaders and others in collaborating organizations

Today's marketplace pressures are increasingly driving healthcare-related organizations—systems, hospitals, insurers, physician groups, long-term care facilities, and clinics—into collaborative ventures. According to the 1997-98 Catholic Health Association strategic information surveys, three-quarters of CHA's member systems and half of CHA's member hospitals have collaborated in some way with an organizational partner. Linkages with related services can provide synergies for healthcare organizations and bring otherwise unavailable services to populations in need. Collaborations with physicians are essential for successful healthcare delivery under any payment mechanism.

Such collaborations are expensive, with high opportunity costs and even higher costs of failure. They are time-consuming, distracting, and often anxiety producing for those board members, senior executives, and physicians involved directly in the negotiations. They are often equally stressful for the employees who carry on the day-to-day clinical and administrative operations and whose jobs may be threatened.[1]

Whether through a full merger of assets or a joint operating agreement that integrates only revenues and expenses, the linkage of two or more organizations is also the linkage of two or more unique organizational cultures. Experience has demonstrated the need for both collaborators to recognize the differences in their organizational cultures and then to make explicit efforts to develop a shared sense of purpose.[2] In CHA's recent study of Catholic healthcare organizations collaborating with other-than-Catholic organizations, most of the leaders interviewed reported that they had underestimated the importance of understanding cultural similarities and differences.

Collaborating organizations may strive to sustain their distinct, individual organizational cultures while showing respect, even reverence, for the cultures of their partners. Conversely, the desired outcome of a collaborative venture may be the integration of two organizational cultures into one, drawing the best aspects of both into a new reality. For collaborating organizations, culture integration is a continuum.

One interviewee in CHA's study of Catholic and other-than-Catholic collaborations, an executive from Denver-based Centura Health, noted that creating a culture that is a generic gray is dangerous. He prefers to think of Centura's faith-based partnership in terms of a "mosaic" of different colors. Centura's Catholic and Adventist sponsors are not trying to accomplish a "Cathventist" culture, he said.

This resource is intended to assist people in Catholic healthcare organizations who are charged with bringing about culture integration. Often, this challenge is assigned—in small or large part—to the organizations' mission leaders.

Integrating Cultures is based on the experiences of the authors—system mission leaders and a hospital chief operating officer—in culture integration. They have observed and participated in a wide range of collaborations, ranging from joint ventures to the acquisitions of non-Catholic entities by Catholic systems. They offer the lessons they have learned about how organizational cultures are assessed, merged, and re-created as guidance, recognizing that each collaboration is unique and requires creativity and leadership from the persons involved.

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WHAT IS ORGANIZATIONAL CULTURE?

Simply, organizational culture can be defined as values that influence behavior. These values, when they are shared by the people in the organization, persist over time even when the membership of the group changes. Organizational culture is often expressed as "the way we do things around here."

The organizational—or "corporate"—culture differentiates the organization from other organizations and provides a sense of identity to its members: employees, physicians, trustees, volunteers, donors, and others. Culture facilitates commitment from such people and provides the "glue" that holds them together in a social system.

Culture is not the same as an organization's strategy. Strategy is simply a plan to achieve a desired outcome. The practices called for in a particular strategy may or may not be compatible with the organizational culture. When they are not, success in implementing the strategy is usually difficult to achieve.

WHAT SHAPES CULTURE?

The culture of an organization is shaped by, and communicated among, its members by way of assumptions, stories, rites, symbols, rules, and other similar means. A variety of factors contribute to

This resource, Integrating Cultures, *is a direct response to numerous requests received last fall from mission leaders in CHA-member organizations struggling with the cultural realities of strategic alliances. This tool presents the learnings of five authors who shared their significant experience of collaborative activities in ministry organizations, ranging from joint operating agreements to full mergers of assets and expenses.*

This resource specifically addresses the challenges facing organizations in the first 18 to 24 months following the finalization of a collaboration. Strategies are presented here for bringing together previously distinct communities of people into positive, healthy new cultures that reflect the visions and purposes of the collaborative activities. Future articles will recommend culture integration strategies appropriate at other points along the collaboration timeline: the period of initial investigation, the stage of due diligence, and the ongoing life of collaborating entities two years and more after signing the final papers.

Integrating Cultures *and a resource from CHA on collaboration with other-than-Catholic organizations (set for publication later this spring) were developed in response to members' requests for the accurate information they need as they proceed with integration strategies in today's healthcare environment. These resources are examples of the powerful knowledge transfer and wisdom sharing that is possible when ministry leaders work with and for one another to make Christ's healing presence more evident in our world.*

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organizational culture. They include corporate policies; compensation and benefits packages; tangible artifacts such as mission statements, religious symbols, and portraits of founders/foundresses; explicit training such as occurs in new employee orientation programs; and the spoken and unspoken expectations concerning employees' interactions with each other and with the persons they serve.

Perhaps the most important factor in shaping culture is the style and behavior of the senior leaders. Leaders affect culture through role modeling, coaching, and teaching; through recruitment, selection, promotion, and communication efforts; in the ways they react to critical incidents and organizational crises; and through the allocation of rewards and status. The leaders of the organization can create a sense of urgency for the new culture.

In efforts to integrate two cultures into a new one, leaders have both principal responsibilities and principal impact.

SUCCESS IN INTEGRATING CULTURES

Successfully integrating two distinct cultures is the result of careful, consistent, and persistent efforts to help all people in the new combined organization survive change together.

In *Managing at the Speed of Change,* Daryl Conner describes four distinct roles critical to the change process. First are the *sponsors* of change,* the individuals or groups who have the power to sanction or legitimize the change. These might be board members, CEOs, and/or system leaders. Second, there are the *agents of change,* the individuals or groups who are responsible for actually making the change happen. These might include CEOs, other senior leaders, corporate counsel, and outside consultants. *Targets of change* are the people who must actually change: employees, physicians, even patients, families, clients, and residents. Finally, there are *advocates of change,* the persons or groups who want to achieve the change but lack the power to sanction it. Advocates may be found among employees and physicians, but might also include employers, payers, community planners, and others. Conner writes:

> *At different times and in the face of different challenges, you may play the role of sponsor, agent, target, and/or advocate. Many change projects require you to wear more than one hat.*

* Conner's use of "sponsors" is distinguished from the traditional Catholic healthcare understanding of the term. Sponsors of Catholic healthcare organizations—traditionally institutes of women and men religious and dioceses—may or may not fill the role of Conner's "sponsors of change."

It is not unusual for people to say, "I'm an agent for my boss, but the sponsor to my people." The issue is not whether you are a sponsor or whether you are an agent, but in which type of situation you will be a sponsor and under what circumstances you will be an agent.[3]

Understanding these roles and the relationships between them in effecting the integration of two previously distinct cultures can facilitate necessary communication and greatly contribute to the success of integration efforts.

Also key among factors contributing to success in collaboration is an absolute clarity on mission and core values. Important first steps in the process of collaboration are conducting mission-related activities aimed at developing a long-range, value-centered vision and enlisting the commitment to culture change from persons at all levels in the organization.[4]

In linking with other organizations, Catholic healthcare organizations must pay constant attention to the requirements of their identity in the ministry of the Catholic Church. Catholic identity requires its organizations' leaders to hold as non-negotiable some behaviors, policies, and symbols in the development of an emerging culture. These requirements of Catholic identity may deter some potential collaborators from forging linkages with Catholic healthcare organizations.

There may also be other nonnegotiable issues, unrelated to Catholic identity. It is imperative that these issues be identified and communicated clearly to everyone in the new organization to avoid unreal expectations, distrust, and conflict. During the negotiation process and the time immediately following the closing on a collaboration, change will happen rapidly. If absolute requirements are known by all people affected, however, new processes and behaviors can be created and adopted with more confidence.

The need for communication flow throughout the organization is critical, and yet often overlooked. Experience of success in culture integration shows that leaders must communicate with constituencies in the organization far more than they are initially inclined to do. Communications should be ongoing and repetitive, consistent in message, and employ every available medium for delivery. Communications should address such mission and vision questions as, Where are we going? and How will this collaboration help further our ministry and achieve market success? When leaders are not free to explain all the collaboration's details, they should communicate the reasons clearly.[5]

As the organization passes through the stages of collaboration and culture integration, leaders and others must continually look forward and backward. This resource describes four phases of the collaboration/culture integration process. In each phase, planning must be occurring for the next phase at the same time the current phase is being implemented.

These activities should be continually evaluated for effectiveness. Evaluation can be accomplished through a variety of strategies: employee focus groups, surveys and other assessment tools, consultant analysis, and board retreat discussions. Behavioral evidence of effectiveness in culture integration can be observed also. Related groups within the partnering organizations begin planning collaboratively; individuals use positive language about the collaboration and (in the case of a merged identity) identify themselves with the organization's new name; and, in discussion, references to the "old" organizations or to "them and us" dwindle and/or disappear altogether.

ABOUT THIS RESOURCE

The authors of this resource understand that the process of culture integration begins long before the papers completing a collaborative venture are signed. They describe the process of collaboration and culture integration in four phases:

- **Phase One: Preliminary Exploration**
- **Phase Two: Due Diligence**
- **Phase Three: Initial Integration**
- **Phase Four: Ongoing Integration**

John Thomas, corporate counsel for the St. Louis–based Unity Health System, likens the phases of collaboration to love and marriage. In the first phase, two people become aware of each other and court. Then comes engagement, the "due diligence" phase of the relationship. Marriage commits the two

to a life together, and the "honeymoon" phase follows. In the early years following marriage—and especially when children are born—the two discover they have created a whole new family unit.

Effective integration of organizational cultures in Phases Three and Four depends greatly on the actions taken in Phases One and Two. In the section that follows, "Four Phases of Collaboration," we briefly describe the phases, including the aim of each phase, the people involved and the key questions facing them, the phase's activities, and the necessary planning that should occur for the next phase.

After presenting a "big picture" view of the process of collaboration and culture integration, we put special emphasis on the activities of Phase Three: Initial Integration. The concluding section explores a number of strategies. The authors hope that people responsible for culture integration activities will find this section useful as a practical guide. Several sample processes and tools are included as appendixes.

DOING THE WORK OF CULTURE INTEGRATION

Various kinds of expertise are needed throughout the phases of collaboration. During Phase One: Preliminary Exploration, a *Collaboration Coordinating Group* typically includes the local and/or corporate CEOs, chief financial officers, and those responsible for business development. The group communicates frequently with the organization's board and religious sponsors and notifies the local bishop of the possibility of collaboration. The coordinating group is charged with determining the benefits of collaboration for the organizations and the community, with exploring potential compatibility, and with deciding whether to move forward, pursuing approval from the board and sponsors.

Moving into Phase Two, the Collaboration Coordinating Group expands to include a coordinator of merger/due diligence, other senior executives, sponsor and board representatives, corporate counsel and perhaps consultant legal counsel. The tasks of the group in this phase include overall due diligence: negotiating a letter of intent or memorandum of understanding, evaluating similarities and differences in mission, reviewing pertinent regulations, consulting the local bishop on Catholic identity and ethics, negotiating the final agreement, writing bylaws, and maintaining communications.

As the new organization moves into Phase Three: Initial Integration, a *Transition Team* is activated. The Transition Team includes the organization's CEO or the CEO's delegate, the mission leader, directors of human resources and organizational development, and appropriate management representatives. The team is responsible for designing a transition plan, overseeing implementation, and evaluating the effectiveness of activities.

In Phase Four, the Transition Team is enlarged as additional committees are activated. In this phase, the transition activities are expanding into true integrative activities. Based on ongoing evaluation, the team redesigns the transition plan and reconfigures committee structures.

Eventually, as the new culture emerges, the Transition Team is disbanded and ongoing responsibilities pass to the organization's leadership.

A FINAL NOTE

Every organization is unique, and, therefore, every collaboration of two or more organizations is unique as well. The challenges of forging a new merged culture that preserves the best characteristics of previously individual cultures cannot be described generically. In other words, this resource does not present a template for success—"one size doesn't fit all."

There are, however, some tips that, if applied, can promote effectiveness in culture integration efforts:

- Decisions must always be made by persons at the appropriate level based on the nature of the transaction.
- The roles and functions of the Collaboration Coordinating Group and Transition Team should be documented in the collaboration agreements.
- As collaboration moves forward, the Coordinating Group and Transition Team disband and their responsibilities are transferred to the organization's leaders.
- The culture integration plan should be evaluated at least every six months.

FOUR PHASES OF COLLABORATION: THE BIG PICTURE VIEW

	PHASE ONE: PRELIMINARY EXPLORATION	PHASE TWO: DUE DILIGENCE
AIM	To explore compatibility of, and mutual advantage for, the organization, partner, community served, and the Catholic health ministry as a whole.	To research and collect sufficient detailed information to make the decision to acquire a partner, to merge, to affiliate, etc.
TIMELINE	From the initial consideration to the signing of a letter of intent.	From signing of the letter of intent to closing of the transaction.
PEOPLE	CEOs, sponsors, and others with initiating authority are principally involved. These principals keep board chairperson, senior leaders, and sponsors informed; make initial contact with local bishop(s).	Due diligence task forces are made up of representatives from administration, human resources, mission, legal, ethics, public relations, local diocese(s), and medical staff officers. The task forces communicate with local bishop(s), sponsors, medical staff, and strategically selected community leaders.

ACTIVITIES	• Begin initial conversation and data gathering.
	• Establish compelling reasons or case for moving to Phase Two.
	  • Common vision, values
	  • Clear market rationale
		• Specifically assess finances, market position, governance, and culture, and determine compatibility through due diligence.
		• Identify potential impediments to the collaboration.
		• Research and prepare necessary documents for regulatory review (federal, state, local, certificate of need, attorneys general, etc.).
		• Develop legal documents including bylaws.
		• Develop transition (culture integration) plan based on findings of due diligence process.
		• Develop communications plan for internal and external audiences.
		• Obtain approval from bishop(s)/Church.
		• Approve final agreement (including transition plan and timeline).

QUESTIONS	1. Why do we want to do this? 2. What is the potential benefit to the community? 3. Does the collaboration enhance our organization's ability to deliver services? 4. What will be the effect on Catholic healthcare in the community? 5. What will happen to our organization's Catholic identity if we proceed? What will happen if we don't proceed? 6. What are our nonnegotiables? 7. Are the organizations compatible? In what ways? 8. What can we do better together than alone? 9. What will be the outcomes in terms of cost savings? care of persons served? community advocacy? 10. Who are the stakeholders? How can we involve them? How do we involve the local bishop(s)? 11. How will we evaluate our work in this phase?	1. What are the nonnegotiables? 2. What are the benefits to each organization? 3. How are mission issues included in the due diligence process (along with financial, legal, and canonical issues)? 4. How do we involve the local bishop(s)? 5. What are the barriers to and enablers of the collaboration, e.g., ethical barriers? 6. What are the "skeletons in the closet"? 7. How do we decide to continue or stop? 8. What are the elements of the transition (culture integration) plan and timeline? How will they be written into the agreement? 9. Has the Transition Team been identified? 10. What communications do we need for key stakeholders? 11. What is needed for the public relations plan? 12. How will we evaluate our work in this phase?
PLANNING	• Create Collaboration Coordinating Group. • Develop initial communication plan to keep appropriate individuals apprised through the negotiations.	• Identify and form the Transition Team. The transition plan and timeline must be defined in the letter of agreement. • Plan (and conduct as appropriate) educational programs about the collaboration acknowledging the effects of change.

PHASE THREE: INITIAL INTEGRATION

To bring together the best of both existing organizational cultures in a new reality.

The first 18 months following closing of the transaction.

Due diligence task forces are joined by the Transition Team. These teams inform boards of directors, managers, employees, medical staff, volunteers, local church leaders, educators, community planners, and community at large.

- Conduct baseline organizational climate survey.
- Initiate orientation for board, senior and middle management, physicians, and staff.
- Celebrate/ritualize collaboration, with sensitivity to concerns of all audiences.
- Implement transition plan for managing change.
- Plan and implement process for developing shared or compatible mission/vision (may include new mission statement).
- Enlist pastoral/spiritual care, human resources, social services to assist persons through transition. (Address employee concerns about job security.)
- Develop consolidated strategic plan.
- Begin consolidation of nonclinical operations.
- Change symbols and signage.
- Continue revising, implementing communications plan.

1. What strategies do we need to develop for dealing with change?
2. Is the purpose of the collaboration clear? Is the vision of a new organization clear?
3. What has been done to assess the existing culture(s)?
4. Is the transition plan being implemented and evaluated?
5. What is the process for integrating/merging the nonclinical service areas?
6. Is planning underway for ongoing integration?
7. How will we evaluate our work in this phase?

- *Plan for evolution of Transition Team and transfer of responsibility to leadership.*
- Plan ongoing mission integration activities.
- Identify evaluation techniques for assessing Phase Three activities.

PHASE FOUR: ONGOING INTEGRATION

To assess, plan, and implement continuing integration activities.

One to three years following the closing of the transaction.

Internal organizational committees (new and existing structures) continue implementing the culture integration plan, including communication to all the audiences named in Phase Three.

- Transition Team transfers responsibility to leadership, others as appropriate to continue implementation of culture integration plan.
- Continue communications.
- Celebrate/ritualize to create new traditions, preserve the best of previous traditions.
- Develop and implement ongoing mission integration plan. (Evaluate semiannually.)
- Implement consolidated strategic plan.
- Evaluate consolidation of departments; continue consolidation based on early experience.
- Consolidate relationships with external groups such as vendors.
- Consolidate human resources, quality systems.
- Consolidate data (including patient/client/ resident, physician, and employee satisfaction).
- Repeat climate survey three years after closing.

1. Have the goals and objectives of the transition plan been achieved?
2. What is being done to "hold the gain"?
3. What "people issues" still need to be addressed?
4. What ongoing development of staff is necessary?
5. Have the responsibilities of the Transition Team been transferred to existing or new leadership?
6. Has alignment of human resources systems (hiring, compensation, incentives, orientation, leadership development, performance evaluation) been accomplished? Have quality, communications systems been aligned?
7. How will we evaluate our work in this phase?

- *Plan for ongoing evaluation of culture integration activities.*

INITIAL INTEGRATION

This section presents strategies and tactics for achieving the following four outcomes during Phase Three of collaboration, which takes place during the first 18 months after the transaction is closed:

- New relationships are formed.
- Common understanding of shared mission, vision, and values, as well as Catholic identity emerges.
- Resources for dealing with change are well used and appreciated.
- The integration process is recognized as a positive experience by the newly related organizations.

This section of the resource is intended to be a practical guide for those in the organization(s) who are responsible for culture integration activities.

NEW RELATIONSHIPS ARE FORMED.

In this phase of the collaboration, relationships are developing—among people, departments, and organizations—that will benefit the newly combined entity. All the people involved have a common understanding of how the collaborating organizations are related in the new entity. As people from the collaborating organizations learn about each other's traditions, history, culture, and personnel, the emerging culture is created and strengthened.

Rosabeth Moss Kanter, author and Harvard Business School professor, says that "successful relationships manage the partnership, not just the deal." Partnering organizations can build relationships by empowering key managers with the authority to change existing rules to make a joint venture work, by creating an infrastructure for learning through strategies such as appointing cross-functional teams, and by developing shared ways of operating so they can work together smoothly.[6]

Rituals can provide people opportunities to celebrate the new relationships that are developing and the successes of the collaboration. Also, they provide space and time for people to grieve the losses that are a natural part of change: loss of the previous identity, loss of personal relationships, loss of valued roles and status, for example.

Strategy: *Rituals and celebrations honor the transition and allow people within the organizations to find the changes occurring meaningful.*

Healing rituals often include opportunities for people to give "testimonials," to tell stories of their successes and their losses, to share their "prouds" and "sorrys." In one merged organization, the Native American tradition of the "dream catcher" was employed in a ritual to call forth people's hopes and dreams for the new entity. In another organization, the ritual was centered on a tree image (displayed on a large poster). During the ritual, participants were given green-colored, self-adhesive notes and asked to write on them the names of things, people, and events associated with the organization that made them proud. These notes were collected and attached to the tree poster, creating a vibrant image for the new organization.

Rituals can be creative and specific to the needs of the organization's people. Typically, those gathered for the ritual are seated in a circle. Some rituals incorporate flowers of different colors to symbolize the gifts of the past and present and the promises of the future. A continuous ribbon or cord, woven through the hands of the participants seated in a circle, can symbolize the new, unified community and a "safe space" into which participants can speak their hopes and fears about the future. Uniting the flames of many candles in one flame can symbolize the coming together of organizations, departments, and people. Oil or lotion is used in anointing rituals to "commission" healthcare workers to carry on the mission of the health ministry.[7]

Organizations have created "heritage places" within the facilities, attractive displays of photos, and artifacts, for example, that honor the organizations' foundations. Other tactics that have been used by collaborating organizations are:

- Ritual blessing of caregivers' hands
- Leadership retreats
- Candlelight gathering and blessing at time of official transfer of powers
- Grieving prayer services following consolidation

Some leaders may fear that grieving rituals will generate debilitating sadness or harmful anger among employees. When they are conducted in an atmosphere of sacredness and respect, however, such rituals can be healing and trust-building opportunities.

Opportunities for socializing before or after existing gatherings (such as management team meetings) can be relaxed and time limited and should not appear forced. Relationships and trust cannot be mandated.

Strategy: *Bringing together the management teams of the collaborating organizations in social and business settings allows people to meet each other and build trust.*

Reciprocal tours of facilities and "mini" leadership retreats are other contexts for social exchange among managers. Similar social opportunities can be provided for key audiences, such as volunteers and auxiliary members.

COMMON UNDERSTANDING OF SHARED MISSION, VISION, AND VALUES, AS WELL AS CATHOLIC IDENTITY EMERGES.

In this phase of collaboration, people in the newly related organizations begin to understand their roles in living out the mission of the new entity and their relationship to the mission of the Catholic health ministry.

As two or more organizations come together in a new entity, a new mission statement (and new vision statement and core values) will be articulated to direct the organization into the future. For the collaborating Catholic healthcare organization, any process of articulating mission, vision, and values must affirm and uphold the values revealed through the life of Christ told in the Gospels. Respect for the dignity of every human person, a determination to contribute to the common good and justly steward the gifts of God, and solidarity with the poor and vulnerable form the foundation of the Church's health ministry—and these values should be known and understood by the people within the Catholic healthcare organization and its partners.

Strategy: *A purposeful process can begin to facilitate understanding of the mission, vision, and values of the new entity among the people in the collaborating organizations.*

To identify mission and values, organizations have employed focus groups involving physicians, community members, and employees representing all levels of management and staff. Involving the largest possible number of constituents in the process is the best way to achieve the broadest agreement or "buy-in." It is important to make clear to focus group participants, however, that although their participation is valued, all their perspectives and recommendations cannot be included in the final statements of mission, vision, and/or values.

In one newly merged organization, employees received a simple questionnaire with five questions:

- Listed below are the values that Hospital A and Hospital B held in the past. Indicate the values you think the merged organization should hold in the future. Circle three that are most important to you.
- Is there a value not listed above that you feel should be listed as a value of the merged organization?
- Is there a value (or values) that you feel is essential among coworkers to ensure a climate of good working relationships?
- Is there a value (or values) that you feel is essential for providing excellent care for patients, residents, clients, families?
- In one sentence, state what you think the merged organization's mission should be.

The results of this survey informed the new organization's mission and values statements.

Following the formation of the Western Maryland Health System, a merger of Sacred Heart and Memorial Hospitals in Cumberland, MD, the new system board appointed a task force of system board members, sponsoring board members, department heads, physicians, and employees to develop a mission statement for the new organization. The group took the mission statements of Sacred Heart and Memorial and examined them side by side. Initial discussion focused on similarities in the statements and in the organizations' heritages. Key words from the mission statements were listed alongside new words for the new organization. Task force members discussed what they would like the new organization to be. From these discussions, a new mission statement was developed and presented to the system and sponsoring boards. A similar process was used to identify a list of core values.

Once values have been identified, the next important step is to translate them into behaviors that can

be modeled, measured, and rewarded. Leaders should state clearly, "These are the behaviors we support, and these are the behaviors we don't support."

During the 18 to 24 months following the closing of a collaboration, the board of directors will need both frequent progress reports on the transition and an ongoing educational process that is systematic but flexible enough to deal with issues as they arise. In addition, the board members, new and existing, will need opportunities for relationship building. Board retreats, receptions following scheduled board meetings, and special social events can provide such opportunities.

Strategy: *Orientation for the board of directors serves to clarify new roles and relationships.*

Strategy: *Orientation for new board members integrates them into the existing group and emphasizes their effect on the board's continuity.*

Comparing the histories of the collaborating organizations (visual timelines can be used to highlight major milestones) can help prepare a new board to identify shared strengths and commitments and build on this common ground. Surveying the arrays of services offered by the collaborating organizations and the needs of the communities served can help prepare the board to identify areas of complementarity and new solutions made possible by combining resources.

Orientation programs for employees and other internal audiences provide opportunities for honest sharing of feelings and help build trust among these groups. Such programs should communicate the reasons for the collaboration and give reasonable, realistic assurances in response to concerns and fears. It is very important that the same orientation and/or education programs be offered to employees of the two or more formerly separate organizations. Programs designed for employees may deliver useful education for volunteers and auxiliary members also. These groups may, however, need different, more appropriate programs.

Strategy: *Plan and conduct orientation/education programs for all staff, management and nonmanagement, as well as auxiliary and volunteers.*

When the Bon Secours Health System of Marriottsville, MD, collaborates with another organization, orientation of staff begins with private interviews with a sampling of employees (15 to 20) at both the partner facility and the Bon Secours facility. These staff members are asked, "What do you like about working here? What concerns do you have about the change? What would you like to know about Bon Secours? What would you like to know about the partner organization?" The interview responses help leaders shape the orientation program. Senior staff from the system office then visit the two (or more) facilities and join leaders in conducting 90-minute employee orientation sessions. Someone from the partner organization tells the story of that organization, expressing pride in the past achievements and the values still evident. A representative of the Sisters of Bon Secours shares the story of the health system's foundresses in France and the United States. Then a speaker from the Bon Secours system explains the mission, vision, operating principles, and Catholic identity of the system. Participants are encouraged to ask questions during and after the sessions.

Medical staff members will have been involved in the process of collaboration since the beginning. In this phase, the task of communicating with the physicians is substantial and should be carefully planned. At the time of orientation programs for employees, similar sessions for members of the medical staff should be conducted. Also, physicians should be invited to attend the employee orientation programs.

Strategy: *Plan and conduct orientation and education programs for all medical staff.*

It is helpful to include physicians in the planning of the orientation program for medical staff. Also, because of constraints on physicians' time, it is a good idea to design the orientation as a series of short events, or perhaps one 50- to 60-minute session held early in the morning. Messages about the collaboration can be added to regularly scheduled programs (such as continuing medical education events) and regularly published communiqués such as medical staff newsletters.

The Bon Secours Health System recommends that sessions for physicians focus on "story"—both

those of the collaborating organizations and the individual physicians—and mission.

RESOURCES FOR DEALING WITH CHANGE ARE APPRECIATED.

The leaders of the collaborating organization(s) recognize that the transition has significant psychological impact on employees and others. They take steps to assess the current climate* of the organization, provide appropriate interventions, and track progress.

It is most important that leaders be committed to the vision of the new organization and champion the change effort. Leaders are the role models in the new culture; employees and others look to them for the appropriate behaviors for the new organization.

Leaders must recognize the needs of people who are coping with organizational change. Staff from pastoral/spiritual care, social service, human resources, mission, and employee assistance programs are trained to help people deal with the stress and practical concerns that may arise from such transitions. They can perform a critical function in contributing to successful culture integration. Also, professionals from outside the organization—psychologists, humor therapists, outplacement and career development specialists, or artists, for example—can be called on to help people deal with the effects of change.

Strategy: *Identify the supports necessary to address the psychological dynamics of significant organizational transition.*

Often, when collaboration has resulted in staff reductions, those still employed suffer from "survivor guilt," a condition that may be expressed as depression, fear, anger, a reduced desire to take risks, a reduced commitment to the job, or a lack of spontaneity.[8]

Critical to any collaboration is a well-designed, coordinated, and well-implemented communications plan. Staff experts from public relations, marketing, and business development should be included throughout the phases of the collaboration process to identify and clarify the messages needing communication, the audiences to be communicated with, and the strategies for communicating. In Phase Three, messages about the new organization and the benefits of the collaboration should be integrated into existing communications vehicles. Following are some tactics that have been used successfully by collaborating organizations:

Strategy: *Communicate systematically about leaders' vision for the new organization with internal and external audiences, including religious sponsors, employees, medical staff, volunteers, system staff, vendors, and the communities served.*

- A steady flow of information to department directors
- A hotline for employees to leave comments anonymously
- Focus groups with staff and managers
- Messages about the collaboration in every possible vehicle
- "Mission in Action" articles in employee newsletters
- Interviews with employees: "What makes you proud of this organization? What are your concerns about the collaboration?"

One organization set up a "listening post" within the facility, a place where employees could engage in dialogue with senior leaders to ask specific questions, raise individual concerns, make suggestions, and hear immediately from those most closely involved in the transition.

THE INTEGRATION PROCESS IS RECOGNIZED AS A POSITIVE EXPERIENCE BY THE NEWLY RELATED ORGANIZATIONS.

During Phase Three, leaders of the organization demonstrate support for and commitment to the work of the Transition Team. An important message to the internal and external audiences during this phase is the commitment of leaders to continuing the efforts for culture integration beyond the 18 to 24 months of this phase—over the long term.

Strategy: *Feedback from managers and physicians (and perhaps from community leaders) can provide input for planning discussions of the board.*

Also important during Phase Three is the

*Vendors such as Hay Group, Human Synergistics International, Atchison Consulting Group, Inc., and Aviat, Inc., offer survey tools that can be used to assess an organization's existing culture or "climate." Organizations have created custom surveys, as well. For an example, see Appendix C, "Self-Evaluation of the Workplace Culture," from Sisters of Charity Health Care System and Incarnate Word Health System (now combined as Christus Health).

reinforcement that comes from leaders and staff celebrating victories and success milestones together.

During this phase, evaluation questionnaires will be useful for gathering information from key audiences. These evaluations should include reflective questions such as "How do you see the advantages/benefits of collaboration being realized in your experience? How are they not being realized?"

Visits with various employee groups and informal interviews with staff can address the question, What do you (the employees) need to help you in this collaboration? In one new organization, a leader discovered that home healthcare nurses had not received nametags bearing the new organization's name. Small but symbolic, name tags for these nurses represented membership in the new culture. As a remedy, the leader made a commitment to deliver the new name tags within a brief time.

Strategy: *Celebrations of milestones (such as the first anniversary of the collaboration) and achievements (such as the completion of installation of new signage) solidify people's identification with the new organization.*

NOTES

1. *Mission-Driven Market Strategies: Lessons from the Field,* Catholic Health Association, St. Louis, 1998, p. 6.
2. *Mission-Driven Market Strategies: Lessons from the Field,* p. 11.
3. Daryl Conner, *Managing at the Speed of Change,* Villard Books, New York City, 1993, pp. 106-107.
4. *A Handbook for Planning and Developing Integrated Delivery,* Catholic Health Association, St. Louis, and Lewin-VHI, Inc., Fairfax, VA, 1993, p. 30.
5. *Mission-Driven Market Strategies: Best Practices Checklist for Organizational Linkages,* Catholic Health Association, St. Louis, 1998, p 17.
6. Rosabeth Moss Kanter, "Collaborative Advantage: The Art of Alliances," *Harvard Business Review,* July-August 1994.
7. Janet Schaffran and Pat Kozak, *More Than Words: Prayer and Ritual for Inclusive Communities,* Cleveland, 1986, pp. 106, 109, 149.
8. David M. Noer, *Healing the Wounds: Overcoming the Trauma of Layoffs and Revitalizing Downsized Organizations,* Jossey-Bass, San Francisco, 1993, pp. 13-14.

APPENDIXES

APPENDIX A

Due Diligence Checklist–Mission

Bon Secours Health System, Inc., Mariottsville, MD

Mission is one of 12 areas investigated in "due diligence." Human Resources, Risk Management, and other operational areas also cover "mission"-related issues.

1. Copy of Mission Statement of the organization.
2. Brief description of mission activities of the organization.
3. The two most recent JCAHO, CARF and all other accreditation letters for the organization or any related organization(s), including the underlying survey letter and follow-up progress reports as well as State or Health Department reports.
4. Description of the organization's social support.
5. Description of any guidelines for patient care and written statements of philosophy, operating principles, values and/or corporate ethics.
6. Does organization provide services such as abortion, assisted suicide, sterilization or contraception?
   - 6.1 List all procedures, if any, provided within the last three (3) years–e.g. elective abortions, elective sterilizations, in vitro fertilization, assisted suicide.
7. Description of charity care policy.
8. Description of policy(ies), procedure(s) with respect to the following:
   - 8.1 Informed Consent, do-not-resuscitate order, advance directives, right-to-die policies, and AMA discharges.
   - 8.2 Treatment of HIV Positive and AIDS patients.
   - 8.3 How investigations of charges of unprofessional, unethical and illegal activities are handled.
   - 8.4 Pastoral care (personnel, responsibilities, policies).
   - 8.5 Ethics committee, membership description, recent contributions.
   - 8.6 Patient's rights policies, consents, procedures and application.
   - 8.7 Patient Billing Rights.
9. Summary of recent patient questionnaire responses and methods of addressing complaints.
10. Summary of actions taken in response to any complaints of unethical and/or unprofessional behavior over the past two years.
11. For Nursing Care Center: provide a description of all patient rights, policies, consents, procedures, and applications.

APPENDIX B

Due Diligence Related to Mission

Catholic Healthcare Partners, Cincinnati

The following checklist is part of a larger due diligence document. The items listed are specifically related to exploring the mission, visions, and values of the prospective partner.

ITEM/DESCRIPTION	ADVANCE COPIES REQUESTED	TARGET DATE/ STATUS	LOCATION
Miscellaneous			
93. Mission, Values, Philosophy and Vision Statements			
94. Charity Care Policy			
94.1 Practices regarding Medicare and Medicaid 94.2 Collection Policy 94.3 Outreach projects in service to identify needs of the poor and underserved			
95. Political Advocacy Initiatives			
96. Practice regarding (for acute care only):			
96.1 Contraception (availability of natural family planning.) 96.2 Sterilization (therapeutic and electives, vasectomies, tubal ligations) 96.3 Abortion (therapeutic and elective)			
97. Pastoral Care/Chaplaincy Services			
97.1 Size and scope of services 97.2 Standards of the services; quality indicators and reports 97.3 Staffing—FTE's, qualifications, certifications, availability of staff, faith tradition, etc.			
98. Policies pertaining to consent to treatment and end of life			
98.1 Consent to Medical and Surgical Treatment 98.2 Advance Directives/Living Will 98.3 Nutrition and Hydration 98.4 Futile Intervention 98.5 DNR			
99. Ethics Committee			
99.1 Composition/scope/quality 99.2 Availability of case consultation			
100. Employee Practices			
100.1 EAP; Grievance Policy 100.2 Diversity in the workplace 100.3 Quality of work life (climate survey) 100.4 Leadership development; education and training. 100.5 Unionization 100.6 Health benefits related to abortion, contraception and sterilization 101. Customer satisfaction surveys			
102. Institutional Review Board policies and procedures; certification of compliance with applicable laws and regulations			

APPENDIX C

Self-Evaluation of the Workplace Culture

Sisters of Charity Health Care System/Incarnate Word Health System (now Christus Health)

The following is taken from a questionnaire given to staff members by Sisters of Charity Healthcare System and Incarnate Word Health System.

Staff members are asked to read the 30 statements and say whether they *strongly disagree*, *disagree*, *agree*, or *strongly agree* with them.

1. **Communication Climate**: Employees are kept well informed in this organization.
2. **Listening**: Management listens to employees.
3. **Collaboration**: People work well with each other.
4. **Ability to Change**: This organization is flexible and adapts to change.
5. **Decision-Making**: Employees are involved in decisions that affect their work.
6. **Taking Action**: Decisions are carried out promptly.
7. **Conflict Management**: This organization deals with conflict constructively.
8. **Community Focus**: This organization works to improve the health of the community.
9. **Creativity**: This organization encourages new ideas.
10. **Business Awareness**: This organization keeps up with trends that impact healthcare.
11. **Compassion**: In this organization there is a strong atmosphere of caring and concern.
12. **Learning Organization**: This organization encourages and supports personal and professional growth.
13. **Openness**: Employees in this organization are not afraid to openly express their opinions.
14. **Dignity**: Employees are treated with respect and consideration.
15. **Recognition**: People in this organization are recognized and rewarded for doing good work.
16. **Service**: Responding to the needs of the poor and the underserved is important to this organization.
17. **Trust**: Management and employees in this organization trust each other.
18. **Integrity**: In this organization management demonstrates high standards of honesty and integrity.
19. **Faith-based Foundation**: Being faith-based is important to people in the quality of the services they provide.
20. **Excellence**: People in this organization take pride in the quality of the services they provide.
21. **Quality of Life**: This organization is concerned with the quality of health and wellness of its employees.
22. **Employment Practices**: This organization hires and promotes people based on their ability to do the job.
23. **Diversity**: This organization values and promotes diversity at all levels.
24. **Expression of Spirituality**: This organization creates an environment that nurtures and affirms spiritual values.
25. **Accountability**: Employees in this organization are held accountable for their work.
26. **Organizational Focus**: Employees know the goals and direction of this organization.
27. **Reputation**: This organization has an excellent reputation in the community.
28. **Satisfaction**: This organization is a good place to work.
29. **Delegation of Authority**: Decision-making authority is delegated to the appropriate level in this organization.
30. **Performance Improvement**: This organization strives to continuously improve its performance.

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