Overcoming the Obstacles to Connected Health and Human Services

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A woman with a special needs child finally became so frustrated with multiple, conflicting “help” from all the social services agencies in her world, she took matters into her own hands. She held a party. She invited each of the seven caseworkers who were assigned to her son’s case to her house one evening. When they had all arrived and were seated comfortably in the living room, she announced, “I’m going out for an hour and a half. While I’m gone, I’d like you to introduce yourselves and discuss my son’s situation. By the time I return, I’d like you to have come to agreement on one comprehensive approach to help my son.”

Government leaders have been talking about human services that help the whole person for literally a hundred years. That’s the talk. The reality has been more like our special needs case above. But today, more and more health and human services organizations are actually getting traction. It seems that the art of the possible has changed.

We looked at the obstacles to integrated health and human services (HHS) and we reached three key conclusions (see the Sidebar: About the Study). First, the barriers are substantial. The obvious impediments are only the beginning. Second, government executives are making real progress by using some surprising approaches. Third, to break the logjam and integrate services effectively, executives are taking an entirely new look at IT.

Let’s define connected health and human services, well, comprehensively. It means providing just the right services at the right time in the right way to most effectively help an individual or family improve their well-being. It goes beyond prevention to proactivity—taking deliberate steps to ensure that families and
communities are strong. It includes mutual responsibility—with people in need sharing the commitment to build their own capabilities.

**Sidebar: About the Study**

NWN Corporation’s Smart Government Solutions group interviewed 31 health and human service executives in the US about their perspectives on the obstacles to integration. Of them, 56 percent were policy leaders, and the remainder were technology executives. Seventy-five percent represented state-level employees, and the remainder were local executives and officers in national associations.

**Leaders Are Making Headway**

Two cases follow that highlight the kinds of initiatives that change-oriented HHS executives find promising.

**Hampton, Virginia**

Virginia’s 1992 Comprehensive Services Act (CSA) set the context. It asked its communities to deliver child-specific, family-focused help for severely emotionally disturbed youth. Hampton took the new law seriously. The City Manager expected his department heads to cooperate, and he let them know their annual performance review would be based on how their colleagues rated them. Walt Credle, then Director of Human Services, recalls, “If the other department heads didn’t like the way I worked with them, it would affect my income.”

Hampton department heads had the opportunity simply to comply with the new law and the new expectations of cooperation, or to go further. Several decided, in the words of former APHSA Deputy Director Linda Wolf, to take themselves seriously. Credle emphasizes, “We made family-centered service more than just words on paper; we breathed life into it.”

Credle and his team looked around to see what they could use to improve the health and well-being of Hampton families. Eventually they launched three main initiatives, one of which was the Healthy Families Partnership program. Rather than starting from scratch, Credle and team merged the best features of three existing programs to target overburdened families beginning with prenatal care. In a partnership with local restaurants and banks, the city library, and others, Hampton launched a program of intensive home visits lasting until the children entered kindergarten. The services included parenting, problem-solving and medical guidance for the adults, immunizations and developmental assessments for the children and, frankly, personal attention. The focus? Improved family functioning. Ultimately Hampton put 10 teams in the field—50 home visitors, each one responsible for up to 25 families.
For the most part, these very successful workers were high school graduates, many of whom were pursuing their degrees.

Hampton is justifiably proud of its results. The community has reduced child abuse and neglect by almost 27 percent, reduced teen pregnancies and low birth-weight babies, and *reduced* the cost of service at the same time. In contrast, many of the communities surrounding Hampton experienced poorer outcomes and higher costs in the same period. Wanda Rogers, the current Director of Human Services, estimates it will take several generations of citizen-centered services to overcome the factors that are undermining Hampton’s families. She is confident, however, that her team is on the right track.

**Washington State Substance Abuse Program**

Washington State’s Health and Recovery Services Administration (HRSA) also improved outcomes and costs, but it used a very different process. According to Doug Porter, Deputy Secretary for HRSA, Washington’s Medicaid agency, the substance abuse program had been underfunded for many years. As a result, people who took the difficult step to sign up for treatment then had to stand in a queue that could take as long as six months before the client was served.

To get the financial support to expand the program, HRSA partnered with the substance abuse agency to analyze Medicaid claims data for two client groups with a substance abuse diagnosis—those who had participated in the program and those who had not. The analysis concluded that the substance abuse program reduced subsequent Medicaid expenditures for emergency room and hospitalization services.

The case was clear for expanding the program, but where would the money come from in difficult economic times? The Director of Substance Abuse and Porter convinced the Governor’s Office of Financial Management to transfer $45 million out of the Medicaid budget in order to fund 30,000 new slots in the chemical dependency program. How? They pledged to support a rigorous evaluation process that would test the original research conclusions. If the savings didn’t materialize, the expansion would be rolled back.

Porter explains, “In the event, we had difficulty ramping up the delivery system, so we didn’t reach as many people as we had intended. But we actually saved *more* money per person than we had projected. That convinced me it was a very good investment.”
These two examples tell us why the idea of integrated health and human services has persisted despite the risk and challenge it presents. Simply speaking, there’s value in it for everyone. The individual or family in need gets substantive, just-right help; the social service worker gets satisfaction from providing that help; the agency head gets accolades for improving outcomes; the community strengthens its fabric and improves its livability; and the finance director gets more bang for the buck. It’s a concept with legs.

The Barriers to Integration Are Substantial

With such a powerful value proposition motivating connected health and human services, one would think that only towering barriers could keep initiatives from popping up everywhere. When we asked HHS executives to describe those barriers, they highlighted several. We’ll use one real, but de-identified example to explain them.

Four years ago, one state’s Department of Health and Human Services (DHHS) (which included Medicaid, child welfare, substance abuse, mental health, elder care and public assistance) launched a pilot in integrated care. The leadership reasoned that its fragmented delivery structure interfered with care. Instead it would pull together mental health, substance abuse, long term care and Medicaid into a single, coordinated process. They planned to choose a pilot county, pool the funds from four separate divisions, and contract with a single managed care entity to provide the full range of services. This approach would give the contract vendor the latitude to, for example, spend more on substance abuse if that would pay off in reduced emergency room costs. In the words of the assistant secretary who architected the initiative, the process was like “crawling over 100 yards of broken glass.”

- **People in different agencies operate independently.** Integrating the four areas of human service involved getting the cooperation of four department directors. Even though they all reported to a single DHHS secretary, they were not accustomed to coordinating their services. Further, each department used its own separate, specialized providers. At the service delivery level, there was almost no cross-talk at all.

- **Narrow, earmarked funding streams interfere with coordination.** County governments were managing the substance abuse funds and taking 10 percent off the top for administration. Different county administrators were managing the flow of funds to community mental health centers. Long term care funds flowed primarily to individual care givers. Each administrative office and set of providers resisted losing control of its share of the money and enlisted the legislature in protecting its sinecure. Further, since the contracts had always been separate, no single provider had developed a comprehensive service capability. Any provider DHHS chose would have to bring in subject matter experts to fill the gaps.
Disconnected IT systems obscure common clients, defy simple processes and muddy decision criteria. With four separate departments and four separate payment systems, it was difficult for the initiative to identify which citizens were receiving multiple services. A person might be registered with her middle initial in one system and without it in another. The single contracted provider was required to master all four systems and submit claims for each type of service in the appropriate system. Pulling the data together about any client or family required a standing group of 15 data analysts. Of course the four departments remained obligated to report their independent service statistics to a variety of federal agencies.

Protecting client confidentiality prevents coordination. Each of the four service areas had a dedicated assistant attorney general to guide it in data sharing and application of HIPAA. Ultimately, with the support of the DHHS secretary, the four department directors demanded their squabbling attorneys to come to a consensus. They agreed that the initiative was a HIPAA-covered circumstance which allowed information to be shared with the contract vendor in order to manage the program. Extending the pilot to incorporate child care services or coordinate with the schools—both of which were outside the DHHS secretariat—would have been more problematic.

The slow process of demonstrating an effect on human outcomes undermines momentum. After four years, the pilot has demonstrated that the participants have better access to service, and care is certainly better coordinated. Both of these service outcomes are admirable. But not enough time has passed to show a measurable benefit in wellness for the 3,000 citizens who continue to participate in the pilot. In a difficult economic environment, expanding the pilot to other counties will wait until clear and compelling results emerge.

No one would say these barriers are easy to overcome. As the example above illustrates, it takes unrelenting leadership to address them. However, the executives we interviewed were able to describe initiatives which overcame all of the obstacles—if not in their own agency, at least in their experience.

What they learned in the process was that these “admissible” obstacles were only the beginning. As they and their teams cleared these barriers away, deeper and more systemic impediments bubbled up from under the surface. What makes this second set of obstacles even more daunting to attack? These are the “unmentionable” issues. Most organizations struggle even to acknowledge they face these particular challenges.
“Unmentionable” Barriers

Government workers may feel the same sense of despair that their clients do. One long-term social service executive lamented, “We all got into this business because we wanted to help people. But the structure we work in makes that uncommonly difficult to do. Many caseworkers feel the very same sense of hopelessness that their needy clients feel. Where does that lead? Good people just give up.”

Perversely, the “system’s” penchant for politicizing failure makes this problem worse. As committed HHS leaders can attest, having a highly public failure can actually reduce the organization’s ability to function—at least in the short term. For example, when a mentally ill HHS client killed her four children in the District of Columbia, the commissioner stepped down, caseworkers were fired or left voluntarily, child welfare case loads ballooned from an average of 350 per worker to over 2000 and case backlog grew by a multiple of 18. In this crazy environment, people were pressed to rush through “fixes” that would prevent such an event from ever occurring again. Although well-meaning, this frantic approach was not conducive to thoughtful, well-designed solutions.

People in need fall between the cracks because the cracks are gaping. “We all talk about trying to produce better ‘outcomes,’” says Janet Wiig, director of the Juvenile Justice Division and senior consultant at the Child Welfare League of America, “but you can’t do that unless you get your hands dirty with someone else’s work. And, usually, that is an effort for which there is little or no recognition.” And executives find themselves facing an audit in their own department if they allow their service metrics to slip. So instead of meeting with other agencies around a family of concern, some administrators bounce people from agency to agency to try to get someone else to spend their money on the problem. Says Jerry Friedman, president of the American Public Human Services Association, “Almost the entire reward system goes against an integrated system. Advocacy groups will be all over you if you appear to be pulling resources out of their particular area for the common good. But there’s no advocacy group for service integration.”

Again and again we heard that “the technology is not the problem.” But it surely is one of the problems. Many IT executives draw a clear boundary around the reach of their leadership, stating that the big ideas and the big changes have to come from the program side. For their part, agency executives take on substantial IT initiatives reluctantly, understanding that they are putting their jobs on the line. It is career limiting to admit that they find large IT projects unmanageable, and equally damaging, on average, to proceed. The leadership inertia this creates virtually guarantees that HHS information systems will lag the industry.
In spite of the barriers to integration—both admissible and unmentionable—leaders all over the country are getting traction. Oklahoma has connected child welfare and Medicaid systems. When a child comes into foster care, a medical history is developed from the history of claims paid. This record helps the child welfare professionals and medical professionals understand the child’s medical history and service needs more effectively. Maryland’s Department of Human Resources has a customer database that interfaces with child support, public assistance and child welfare. This allows agencies dealing with the same client to share eligibility information and to coordinate casework. The city and county of San Francisco is developing a “no wrong door” eligibility system for public assistance that it intends to share with other California counties at the completion of the project. Similarly, two neighboring county human services agencies in Colorado have linked their systems to better serve citizens across both geographies. Marc Cherna, the HHS director of Allegheny County, Pennsylvania manages revenue from 194 different funding sources to get the most reach out of his budget. In 2007, almost 97 percent of his $900 million budget came from non-county funds.¹

**Nine Surprising Lessons from the Leaders**

How are leaders making these advances? Our study found that they are using unconventional approaches to deliver extraordinary results. Here’s how:

1. **Advocates constantly trawl for a forcing function to start the ball rolling.** Every effective connected HHS initiative used a forcing function to overcome normal organizational inertia in cross-boundary initiatives. They chose from among three options: credible leaders, credible directions and credible deadlines.² First, credible leaders: A strong and attentive leader (or leadership team) that all the players respected could pull together concerted action. Second, credible directions: Lacking involved leadership, the players might recognize the overwhelming benefits of implementing a particular program or package of changes. Its obvious benefits would compel cooperation. And third, a credible deadline: No single leader pulled the players together, and they didn’t know exactly what to do, but the crisis they all faced demanded coordinated action of some kind. Paraphrasing Patrick Henry, they realized they would all hang separately if they did not hang together.

Every disconnected organization bubbled with a latent drive for improved effectiveness. Leaders at all levels were continuously testing for forcing functions to try to unleash that drive and get something started.

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¹Allegheny DHS Profile 2007  
²See also: Jane Linder, *Integrating Organizations Where Information Technology Matters*, 1989
2. **Committed executives thrash out the confidentiality issues.** States had decidedly different data-sharing environments. Some had established overarching, pre-approved data sharing templates and others couldn’t seem to find a way to share much of anything. In one disheartening example, the output of a computer match of children in two state health programs had been locked in a vault for months. The attorneys would not allow it to be used—even for the benefit of the children—until they settled their disputes over data sharing legalities. The executive who had produced the data said, “We all spend hours on developing technical solutions for data sharing. If we took one quarter of that time to work through the legal issues, we’d be much further ahead.”

It almost goes without saying that every effective initiative to integrate services found a way to share data among the participating organizations. The approaches varied (see the Figure below), but all organizations operated within existing law and maintained due care for citizens’ rights to confidentiality.

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**Agencies use a data sharing approach that is consistent with their legal environment and the way they want to use the data**

- Shared data is de-identified
- Pre-approved data sharing Memorandum of Understanding template
- Business partner agreement under normal HIPAA provisions
- Custom data sharing agreement approved by legal staff
- Personal releases signed by citizens giving informed consent

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**Increasing effort to share data**
The Secretary of Health and Human Services in one US state insisted that her direct reports share information with each other in order to serve citizens better. At her monthly progress meeting when there was precious little progress to report, her staff asserted that their respective assistant attorney generals advised them against any sharing. She called the state Attorney General and said, “Your infighting attorneys are driving me crazy. I need a meeting of the minds. Don’t tell me it can’t be done; find a way to get it done. Don’t blow me off. I’m the Secretary.”

Says Howard Hendrick, Secretary of Human Services in Oklahoma, “It’s probably a good thing that we don’t give broad access to child welfare and mental health records, even if someone may have good intentions. Statements in those records are often the impressions of professionals, not necessarily a fully vetted understanding of the context of those impressions and therefore, those statements may be taken out of context easily. We try to honor the reason information was collected and use it only for that purpose. But that doesn’t mean professionals can’t work together and still retain their professional confidences.”

3. High-touch trumps high-tech when it comes to people. Perhaps this shouldn’t come as an insight, but it does. If we want to change someone’s behavior, we have to reach them at an emotional level. That takes personal attention. The attention does not have to be delivered by people with masters degrees in social work. As the micro-lenders at Grameen Bank have ably demonstrated, it can come from friends and neighbors. But don’t expect anyone to change the way they act without it. The essence of effective service is the personal experience of the families receiving it.

For example, Maine spent the first three years of its Medicaid transformation grant building tools. If you’re thinking “information systems,” you’ve got it wrong. Cheryl Ring, Project Manager of Maine’s CMS Systems Transformation grant, explains that Maine has created a decision guide to help judges think through hard questions about when to grant guardianship that takes away people’s rights, and a template for getting clients’ informed consent for sharing information across agencies. It is also in the process of developing measurable standards for customer service that will allow the state to monitor and improve clients’ experience, as well as a “triage tool” for use by front-line staff to ensure that DHS clients reach the right person at the right time for the right reasons. Maine has also used a “visual mapping process” to literally make visible, and streamline, its long-term care eligibility determination system.

Make no mistake; this lesson does not imply that government agencies should shut down their technology operations. On the contrary, it actually raises the technology bar. Organizations must design systems that support high-touch experiences for people in need—which is far more difficult than simply putting up a self-serve portal.
4. **Leading from the middle is the only leadership that matters.** No leader we talked to felt that he or she was the “top.” Everyone, including legislators, very senior executives from CMS and state HHS commissioners, felt that they needed to hold hands with countless other decision-makers to move forward together. The implications are straightforward. Everyone has the opportunity to take the point; there is no “them” upstairs who own the problem.

Further, the heart of leadership in this environment is entrepreneurship—literally “taking the middle.” Rather than waiting for all the constituents to align, leaders incite a “little bit of civil disobedience.” They take action. For example, the architect of a comprehensive service pilot in Massachusetts said the following when asked how her team had dealt with the data-sharing issues: “No one asked the lawyers. Instead we focused on helping the families.” Pierre Imbert, director of performance management for the Department of Social Services in California, summarizes the approach, “I reject the notion that we can only operate in silos. Reach out and offer your own cooperation. Change the conversation from one that is confrontational to one that is open and free-flowing. Find the commonality.”

5. **Leaders use failure to advance their agenda.** What? We already said that failure was politicized, and therefore unmentionable. Executives intent on working across HHS boundaries used failure to build credibility and win over skeptics. Washington State’s Doug Porter describes how: “Like every other state, we run many pilots. People normally collude to say that everything succeeds. We didn’t do that. We were honest and pulled the plug on a failure—despite the howls, we cancelled the vendor contracts and disbanded the team. That gave us credibility to push even harder on a more promising pilot.”

Executives with an integration agenda also openly discuss systemic failures to put a human face on the initiative. Clarence H. Carter, director of the Department of Human Services in Washington, D.C., says: “When I am looking for cooperation, I begin the conversation with a story of failure. I talk about the mentally ill woman who had not filled her prescription recently, whose children were truant from school, and who had called the hot line several times. We—the collective ‘we’—had the information to know she needed help, but we did not act in time to save those four children from being murdered. That failure—in which every government silo was meeting its formal obligations—would convince anyone we need to do a better job on connected, person-centric service.”
6. **Successful initiatives often take seven or eight years to become unstoppable.** In an environment where people change jobs every two years on average, a commitment of this duration separates the “did do” from the “might have done.” It was necessary to sustain effort and energy through predictable ups and downs in funding until the initiative could demonstrate compelling results of the sort mentioned above. That just takes time. During that time, leaders spent a great deal of attention on managing momentum. They deliberately infused energy into the connected HHS agenda to maintain the focus and sense of urgency. They never gave up.

7. **Good programs show both better outcomes and better costs.** Leaders kept score. That’s not new. They used these results in a non-traditional way. Instead of hammering people who turned in poor results, they focused on positive outcomes and used these to attract outside investment, community resources and support to programs that were working. But it took do-more-with-less breakthroughs to convert resistant and fence-sitting associates into true colleagues. Oklahoma reduced its confirmation rate for abuse and neglect substantially over the past 10 years by improving early learning, food stamp penetration rates, and child support enforcement. These investments in families help children grow in healthier environments and ultimately save costs to the taxpayers. Similarly, Oklahoma is investing in universal pre-kindergarten with confidence that healthier environments for children will produce healthier families and ultimately cost taxpayers less. Florida invited community organizations all over the state to help needy citizens apply for support; as access to services improved dramatically, the state reported it saved $80 million in government handling costs.

8. **Executives manage the money with momentum in mind.** Creative financing notwithstanding, executives intending to integrate health and human services are challenged to sustain funding long enough to demonstrate results. That’s no problem when the paybacks from cross-agency collaboration are visible and immediate. It is much more daunting in the initiatives that take seven or eight years to show their merit.

Leaders used a variety of creative financing methods. Several concentrated on outside revenue sources such as federal subsidies and grants, foundation contributions, and public-private partnerships. Others developed vehicles to capture and redeploy the savings they were able to generate. One state partnered with a public university which enabled it to engage in efficient, government-to-government contracting for a series of projects. Taking the long view is essential, however. Savvy leaders allocate quick win savings to produce even bigger gains from longer-tailed investments in integration.
9. Chains of small, doable projects turn in far-reaching results more often than big transformations. It sounds backwards, but leaders made more substantial and sustainable progress in connected health and human services with a relentless series of bite-sized initiatives than with a big bang. The big bang project starts with a big, that is, expensive, planning effort. This is required to develop the business case to get the big funding. While executives seek and secure funding and go through the necessary RFP processes to hire a qualified vendor, years go by. Administrations change and executives move on. By the time it’s possible to take action, the leadership has drifted away, the momentum has dissipated, and the only viable next step is to start over again with another plan. One unfortunate HHS department spent $3 million for three separate comprehensive planning projects over five years, but never got to implementation on any of it.

Impatient leaders compact the “where are we” and “what should we do” processes, recognizing that the vision and the broad strokes of the solution to connected health and human service have been articulated again and again. Says Jone Bosworth, Director of Early Learning in Washington State, “I don’t have much tolerance for another visioning exercise. We know the answers already. Let’s get something done.”

Taking a New Look at IT
Obstacles to holistic, effective family-centered health and human services are legion. Despite the challenges, public sector leaders at all levels across the country are making progress. As they knock down silos and overcome hurdles with surprising approaches, they have learned they have to take a new look at the way they use technology.

Start Small and Expand
The health and human service agencies that have integrated effectively have started small and expanded, building on practices that work. They have leaned toward smallish projects that link existing systems and data rather than expensive, multi-year system replacement projects. They have favored flexible, expansible tools over almighty ones. As Herb Roe, the Director of the Information Systems Facility for Maryland’s Department of Human Resources, says, “The day will not come in the near future when we have the money to replace our mainframe public assistance system. We have budget limitations and have to be smart about how we allocate our money. No matter. We’ve already interfaced our public assistance and child welfare systems. We are considering new user-friendly front ends and business layers as viable alternatives to replacing these systems.”

John Wagner, Director of California’s Department of Social Services, continues, “Our solutions have to satisfy both the state and our administrative partners, the counties, so
one-size-fits-all won’t work. The good thing about today’s technology is that we’re no longer uniquely talking about building new, large systems. Instead we’re taking existing systems and facilitating communications across them. It’s less costly and more efficient. The long term IT architecture will take many years to develop. We can do a great deal in the meantime by starting small and moving quickly.”

**Diverse Delivery**

Leaders are embracing diverse delivery—creating a pieced-together quilt of effective programs, each one tailored to the community and the people who make it work on the ground. Some HHS executives have started off in this direction by simply developing an inventory of services. What programs and services are available to whom? Linda O’Grady, Senior Eligibility Manager in Wyoming’s Equality/Care/Medicaid Program, describes her simple step forward, “Our eligibility system has been hard for people to understand. So I looked at who we cover and why and broke it down into understandable categories: children, pregnant women, elderly people, and people with disabilities. Then I looked at how people qualify and access the services. Finally, I looked at who we don’t cover. It sounds obvious, but it wasn’t. Until I made it all understandable for people, they might not know if they would be eligible for services.”

**Shared Information Flows**

There is one fundamental requirement, however, to keep the fabric of the quilt whole: shared information flows. Let me emphasize—shared information flows, not common systems. Programs must be able to share meaningful information readily and automatically. IT architectures used to call for common identifiers to trace citizens from one database to another. Today’s can-do IT directors are taking a different tack. They are opting for middleware—data hubs that translate, cross-match and distribute the information to the systems that need it. In this way they line up one systems’ data definitions with another’s, ensure that each person has only one identity across all the systems, and readily connect people to their relationship networks such as families, support groups and case teams. Leon Saunders, Director of IT for Rhode Island’s child welfare, juvenile justice and mental health and rehabilitation agencies says, “We have a queue of agencies lined up to share information about children. First we’ll connect child welfare and juvenile justice so our caseworkers have more visibility into what’s happening with foster children. Then we’ll bring in corrections, the department of health, and so on. Once we put the data hub in place, each new linkage is a small project that expands our reach geometrically.”

Diverse delivery requires data cleanliness and careful attention to security. It requires ongoing attention to exceptions. It may require some organizations to upgrade their
information management capabilities. It does not require an investment in one, monolithic system that is shared by everyone.

The result is twofold. The people across the extended organization get visibility into results they can use to manage their work. At the same time, each local initiative can maintain the character and autonomy it needs to give its clients viable, appealing choices.

**New Organizational Structures for IT**

IT’s new art of the possible—start small and expand—is leading to structural changes in state IT organizations. Most state CIOs have been responsible for common infrastructure, including email, data centers, telecommunications and networks. But each agency IT director has traditionally reported to a separate commissioner and managed data and applications in his or her own silo. This structure has not prohibited sharing across agencies, but it certainly hasn’t helped.

On the heels of some IT hiccups, Maine’s governor stepped out. Brian Guerrette, Deputy Director of IT for Maine’s Department of Health and Human Services, explains, “Many departments had their own IT groups. The CIO, who reported to the Commissioner of Maine’s Department of Administrative and Financial Services, was involved mostly in IT policies and had no jurisdiction over the departmental IT groups. When some big IT projects ran into trouble, the governor turned to the CIO for help, but his hands were tied. Those projects did not report to him. So the governor signed an executive order, and now all IT people report to the CIO. There’s now one strategic direction for all of us.”

The District of Columbia has also decided to adjust its structure for technology management. As are many other states, it is adopting services-oriented architecture and middleware to join its disparate technological infrastructures to “find the consumer amongst the maze of agency programs,” in the words of District of Columbia’s Clarence H. Carter. He continues, “The District is attempting to weave together a common technological infrastructure for all of its health and human services agencies without having to rip out and replace its long-standing legacy systems. To help us do this, Mayor Fenty established a technology investment review board. In a very unusual move, he invited health and human services agency executives, not their IT managers, to participate. And he empowered me to lead the effort.”

In summary, the art of the possible in technology has changed—incremental is now beautiful. At the same time HHS leaders around the country have demonstrated that integrated service is eminently achievable. Not easy. But achievable.
Implications for Leaders

Leaders intent on making a difference for people should find the results of our study both heartening and somewhat daunting. The implications are clear; the responsibility for progress sits on our shoulders. On each one of us. As Linda Wolf, former Deputy Director of APHSA, counsels (and models by her own actions), “People have to take themselves seriously.” Leaders ready to make a move will want to:

- **Find the forcing function.** Identify (or be) the leader; lay out the compelling action plan; leverage a shared sense of urgency. Ultimately every initiative will need all three, but it just takes one of these to get the ball rolling.

- **Take one small bite of the elephant.** As any other large meal, elephants are eaten one bite at a time. Take on a small project that makes a difference. It doesn’t have to cure cancer or boil the ocean, as they say. Any positive difference will do. Then make another.

- **Take advantage of the data you have.** You already have some of the answers. Ask a hard question and put your data sets together to produce the answer. If you don’t have the resources or the expertise, find a partner.

- **Use IT middleware—connective tissue—to implement incremental, sustainable solutions.** There’s no need to wait for the $40 million dollar IT project to make headway. Use affordable IT middleware projects to make data flow across agencies without disrupting existing systems.

- **Make cooperation a condition of employment.** Just as the City Manager in Hampton, Virginia did, demand that your people cooperate with each other and with those in other agencies. As heretical as it seems, invite them to seek employment elsewhere if they are unable to embrace this premise of effective government.

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About the Author

Dr. Jane Linder is a principal at NWN Corporation. She co-leads the Smart Government Solutions practice which helps state and local governments improve their results by integrating their systems and processes. She has worked extensively with public and
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